Pain Incarnate: A narrative exploration of self-injury and embodiment.

Amy Chandler

PhD in Sociology

University of Edinburgh

2010

Declaration

In accordance with University regulations, I hereby declare that:

1. This thesis has been composed solely by myself;
2. This thesis is entirely my own work; and
3. This thesis has not been submitted in part or whole for any other degree or personal qualification

Amy Chandler

Abstract

This thesis comprises a narrative exploration of the lived experience of being someone who has self-injured. Self-injury, like pain, emotions, sensation and social life, is understood and examined as inherently embodied. The thesis is intended to contribute to sociological approaches to the study of embodiment and to sociological understandings of self-injury. Twelve participants were recruited in non-clinical sites. The sample was heterogeneous in terms of their experience of self-injury, contact with medical and psychiatric services, socio-economic background, household type, age and sexuality. Both men and women were interviewed in an attempt to counter the relative neglect of men in previous research. Two interviews were carried out with each participant: the first was a life-story interview, while the second explored self-injury more directly. The approach to data collection and analysis was intended to be collaborative, and comprised both narrative and thematic techniques.

The thesis demonstrates the importance of studying self-injury as an embodied, socially situated and socially mediated behaviour. An embodied approach underlines the importance of the visibility of self-injury. The existence of visible marks and scars created by self-injury were important aspects of the lived experience of participants. The ways in which these marks were negotiated in social life represented a key focus of analysis. My analysis reveals the importance and utility of attending to the practical and material aspects of self-injury in attempting to understand the behaviour. I highlight the diverse ways in which self-injury is practised, and the equally various meanings and understandings it holds for practitioners A variety of complex and contradictory justifications for self-injury are critically examined. These justifications share a concern with pain, incarnate, suggesting that self-injury is: a method of transforming emotional pain into physical pain; a way of relieving emotional pain; painful; painless; attention-seeking; private. A sociological, narrative analysis illuminates the ways in which these understandings and justifications can be located within biographical, interpersonal and socio-cultural contexts. By locating these justifications within socio-cultural contexts, the

complexities and contradictions of the accounts become understandable. My analysis confirms the importance of attending to socio-cultural understandings of bodies, emotions, authenticity and morality in exploring narratives about self-injury.

Acknowledgements

This thesis would not have been possible or even probable without the help and support of a number of people. Firstly, my thanks are due to Hugo Gorringe, Tom McGlew and Jan Webb for supporting my early forays into postgraduate study. Without their help and encouragement I would not have secured the funding which allowed this research to take place. Thank you to the ESRC for providing said funding. Above all, my thanks to my wonderful supervision team, Angus Bancroft and Steve Platt. By providing me with just the right amount of guidance, support and advice, they ensured that the research and writing represented in this thesis was academically (and grammatically) correct. Their input has been indispensable, though any mistakes are, of course, my own. Further thanks to my examiners, Adi Bharadwaj and Nick Crossley for being so supportive, engaged and interested, and making my viva such an unexpectedly enjoyable experience.

Thanks are also due to everyone in the department, but the following colleagues in particular have been subjected to and listened patiently to my ramblings about theory, structure, babies and sleep deprivation: Heather Blenkinsop, Jennifer Fleetwood, Kanykey Jailobaeva, Jennifer Peet, Gethin Rees, Miriam Snellgrove and Fraser Stewart. Ruth Lewis and Sarah Hill deserve special mention for being such amazing friends and providing vital emotional and intellectual support over the last 5 years.

Thank you above all to my research participants, who so generously gave me their time, insights and stories.

Finally, thanks to my family. Firstly, my sisters Polly, Emily and Chloe: thanks especially to Emily and Chloe for providing free child and cat care! Thanks to my parents, Jill and Mike, for listening, accepting, and quietly supporting. Thank you to Morpheus and Nightmare for distraction and stress relief. Thanks to Jonathan, for just about everything. Finally, to my son Zachary, who joined me half way through,

gave me a reason to have a break, and who all of this (and everything else) is dedicated to.

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Key to transcriptions

Guide to transcriptions

"*quotes from participants are italicised*"

*"**bold text** in quotes indicates my emphasis"*

"<u>underlined text</u> in quotes indicates the participant's emphasis"

"[…]" indicates text has been cut from the quote.

"……" indicates a pause in talk.

"-------" indicates unclear talk, obscured either by background noise or poor recording.

"*hehehe*" and "*hahaha*" indicates laughter

"*mmm*" and "*mhm*" and "*errm*" etc. indicate participants' verbal inflections.

Glossary of Scottish dialect

"aye" = yes

"didnae" = did not, didn't

"dinnae" = do not, don't

"cannae" = can not, can't

"couldnae" = could not, couldn't

"greetin'" = crying

“ken” = know

“kindae” – kind of

“mair” = more

“nae” = no

“shouldae” = should have

“wasnae” = was not, wasn’t

“werenae” = were not, weren’t

Chapter 1

Pain Incarnate: Introduction

1.1 Beginning

This thesis, and the research upon which it is based, concerns the narratives of people who self-injure. Self-injury here is defined as occurring where an individual cuts, burns, hits, or otherwise damages the outside of their body. Self-injury is known by many different names, however, and definitional confusion continues to plague research and writing on the matter. In particular, self-injury is often conflated with wider self-injurious behaviours such as self-poisoning, overdosing, eating disorders, and more 'decorative' practices like tattooing, piercing and scarification (body modification) (Hewitt, 1997). The term self-harm, or deliberate self-harm (DSH), is particularly problematic – sometimes referring to self-injury as defined in this thesis, while at other times used to refer to a much broader range of behaviours, especially self-poisoning.

Behaviours that are referred to collectively as self-harm and body modification are certainly related. All involve some attempt to change or alter one's body, and through this, perhaps, to modify one's self. However, it is my contention that, although related, in order to fully comprehend these behaviours they should also be examined separately. I suggest that self-injury holds qualitatively different meanings from self-poisoning, eating disorders, and body modification. Relatedly, this thesis will highlight the very different material consequences and practices that are specific to self-injury. I will demonstrate that these various practices and consequences can be related to diverse meanings and understandings particular to self-injury.

This thesis focuses upon the bodily and embodied aspects of the behaviour. Despite being a behaviour which irrevocably concerns and implicates bodies, the majority of

existing research has tended to overlook the corporeal aspects and practices associated with self-injury. In contrast, this thesis places the self-injured bodies of my participants, and their experiences and understandings of 'being' someone who has self-injured, at the centre of my analyses. This focus allows for a closer examination of self-injury within biographical, interpersonal and socio-cultural contexts.

As has been previously established, bodies should be central to sociological analysis, since it is within and through our bodies that we experience social life (Shilling, 2005; Williams & Bendelow, 1998). Our understandings of biography, life-stories and personal-narratives are shaped by changing bodies, aging, illness, birth and death (Frank, 1995; Gimlin, 2006; Smith & Sparkes, 2008; Sparkes & Smith, 2003). Further, in social interactions it is bodies that are at the forefront – the visible, sensory 'front' of social life (Crossley, 1995; Goffman, 1968; 1973). More than this, theorists have suggested that structural and cultural forces are 'played out' upon and through the body. This is understood to occur in concrete, institutional ways as in Foucauldian approaches, where bodies are managed and disciplined; and also in more implicit ways: from, Mauss' 'body techniques' (Crossley, 2007; Williams & Bendelow, 1998, 49-50), to Bourdieu's (1990) habitus and 'feel for the game', to Giddens'(1991) reflexive body projects.

This thesis is a narrative exploration of self-injury and embodiment. My approach is inspired by the classic illness narrative work of Kleinman (1988) and Frank (1995). Thus, I attend to the lived experience of people who self-injure, and this is accessed through an analysis of narratives elicited during my research interviews.

In this introduction I will provide background and context to the research. I will elaborate upon the definitional concerns raised above, providing further justification for my use of the term self-injury, whilst acknowledging the limitations and associated problems. I then introduce some contextual information regarding current understandings and concerns about self-injury. This establishes the importance of the research presented in this thesis. Leading from this, I present the aims of the research, indicating the research questions that informed the early stages of my

research practice. Finally, I provide an overview of the chapters that comprise the remainder of the thesis.

1.2 Definitions: from parasuicide to body marking: why self-injury?

Self-injury has also been called self-harm, self-mutilation, self-wounding, body marking, parasuicide, self-injurious behaviour (SIB), non-suicidal self-injurious behaviour (NSSI), to name just a few. These different terms are problematic for a variety of reasons. I begin this section by addressing those terms which attempt to ascribe or avoid ascription of suicidal motivations to self-injury. I then discuss in more detail the problems surrounding the differential application of self-harm and DSH. Finally I turn to debates regarding the allegedly proscriptive (Inckle, 2007) nature of terms such as self-mutilation and, arguably, self-injury.

1.2.1 Suicidal motivations: parasuicide, non-suicidal self-injury, self-harm

Debates continue to rage regarding the relationship between self-injury and suicide. Historically, self-injury and self-harm have been understood as suicidal behaviours (Adler & Adler, 2005). However, the exact relationship between self-injury, self-harm and suicide is difficult to ascertain. This leads primarily from the difficulty of retrospectively assigning motives to behaviours, an issue which has long been a problem in suicide research (Bancroft et al., 1976; Hawton & Van Heeringen, 2002). Although in some cases self-harm (broadly) might be understood as a 'failed' suicide attempt (Jeffery, 1979); self-injury has, even in historical psychiatric literature, been understood as a method of avoiding suicide (Shaw, 2002). This suggestion was first put forward by Menninger who, from a psychoanalytic perspective, argued that self-injury was "an attempt at self-healing, or at least self-preservation" (1935, in Shaw 2002: 195). This understanding is also found in more recent literature which reports the accounts of people who self-injure, who similarly argue that their behaviour is

categorically not suicidal: that it is life-affirming, rather than life-destroying (Cresswell, 2005a: 1673).

However, it is likely that important social factors will be implicated in the motives that are provided for self-injury or self-harm. Sociological studies have demonstrated that motivations and justifications are reliant upon and affected by existing socio-cultural understandings regarding appropriate and inappropriate behaviour (Mills, 1940; Scott & Lyman, 1968). Thus, Jeffery (1979) found that patients presenting with self-harm in an Accident and Emergency (A&E) department were treated more kindly if they were thought to have 'really' tried to kill themselves. Similarly, Bancroft and colleagues (1976) suggested that patients may have actually used more severe methods to harm themselves in order to ensure that their behaviour was viewed as suicidal, and thus taken more seriously.

In clinical literature there remains a split, however, between approaches to the study of self-injury and self-harm which view the behaviours as distinct from suicide, and those that examine them all as potential suicides, but seek to avoid ascribing motive. The terms self-harm and DSH are especially problematic in this sense. US studies use the terms to refer to self-injury (as defined in this thesis) 'without suicidal intent' (e.g. Gratz, 2003). However, in the UK, DSH and self-harm usually refer to any self-harming behaviour, regardless of intent. The International Classification of Diseases also makes no distinction between suicidal and non-suicidal self-harm (Nock, 2009b). There is disagreement, then, regarding: a) how far motivation can ever be accurately ascertained; b) whether self-harm refers to self-injury or more broadly to self-injury and self-poisoning; c) whether there are important differences between suicidal and non-suicidal self-injury. Indeed, Nock and colleagues have recently reignited this debate, arguing that there are important differences between suicidal and non-suicidal self-injury and that, regardless of the problems of ascertaining motivation, these should be studied as distinct behaviours (Nock, 2009b; Nock et al., 2006; Nock & Kessler, 2006).

Notwithstanding the (unresolved) problems associated with attempting to ascertain the extent of 'suicidal' motivation, the suggestion that suicidal and non-suicidal self-injury should be studied separately is also problematic because there is some evidence to suggest that, within individuals, the distinction is sometimes blurred. Solomon and Farand (1996), for instance, reported the narratives of young women who had self-injured. Most of the women were clear that their self-injury was not suicidal; however, one also noted that occasionally when she was 'out of control' her self-injury *was* suicidal. This example illustrates the complexity of the issue. I would suggest that any attempt to strictly separate off suicidal from non-suicidal self-injury might run the risk of silencing or overlooking the messy, multifaceted stories of individuals who may themselves not always be clear of their motivation, and whose motivation may change. These concerns are discussed further in Chapters 8 and 9, using Mills' (1940) vocabularies of motive and Scott and Lyman's (1968) work on accounts. My own analysis highlights the importance and necessity of sociological perspectives with regard to understanding motivations and constructions of suicide and self-injury.

The relationship between self-injury and suicide is further complicated because it is widely reported that there is a statistical relationship between self-injury and suicide (Jacobson & Gould, 2007). Indeed research often highlights the importance of self-*harm* as an important risk factor in completed suicide (O'Connor et al., 2009). However, it should be noted that a relationship between self-injury and suicide has only been identified in clinical samples (Nelson & Grunebaum, 1971 in Hawton et al., 2004, 200). As far as I know, no research has yet been carried out which attempts to ascertain how far untreated self-harm or self-injury might be associated with completed suicide.

1.2.2 Definitional confusion: deliberate self-harm, self-poisoning, self-injury

My decision to use the term self-injury rather than self-harm was influenced by my experience of doing research on self-harm as part of my undergraduate dissertation in

2003. Through doing this research I became aware of the inconsistent use of terminology around self-harm. In particular, I discovered that self-harm was sometimes used to refer to self-injury (as defined in this paper), but other times referred mainly to self-poisoning or overdoses. As indicated above, Jacobsen and Gould (2007) have since confirmed that part of this difference relates to geographical differences in the use of the terms self-harm and DSH. These differences persist, and much UK research continues to use the terms self-harm or DSH to refer to a range of behaviours including self-injury and self-poisoning, while US research uses the same terms to refer to self-injury alone.

There are, however, important differences between self-injury and self-poisoning. These differences, I contend, will have important effects regarding the lived experience of those practising the behaviours. Research has consistently found that cases of self-harm treated in A&E departments are more likely to be self-poisoning (Hawton et al., 2004; Horrocks et al., 2003; Taylor & Cameron, 1998). Studies have found around 90% of self-harm presentations at A&E are overdoses (Rasmussen et al., 2010). In contrast, community based studies of self-harm have indicated that the majority of those reporting self-harm have self-injured. These studies tend to use adolescent samples and find that of the approximately 13% indicating a life-time history of self-harm, around 30% had overdosed, while around 65% had self-injured (De Leo & Heller, 2004; Hawton et al., 2002). Studies that have examined self-harm and self-injury in community samples found correspondingly low rates of help-seeking. Hawton et al (2002) found that of those reporting self-harm, only 12.6% reported attending hospital as a result, with 23% of those who self-poisoned attending hospital, compared to 6% of those who reported cutting themselves. Thus, it is clear that although A&E statistics show self-poisoning to be the most prevalent form of self-harm, community samples demonstrate that self-injury is more common (at least in adolescent samples). Leading from the clinically conspicuous nature of self-poisoning, research into self-injury has been historically sidelined. Further, due to the definitional problems outlined above, research with samples who have self-poisoned has been used to explain self-injury (Chandler et al., 2010).

I chose to use the term self-injury because, especially in the UK context in which this research was conducted, this was a more precise description of the behaviours in which I was interested: self-cutting, burning and hitting. Following Crouch and Wright (2004) I was clear that these behaviours were qualitatively distinct from other self-harming behaviours, particularly overdoses. The embodied, sociological nature of my approach was especially important in indicating potentially significant differences in the lived experiences of self-injury versus self-poisoning. While self-poisoning and self-injury both involve damage to the body, in most cases, the damage caused by self-injury is far more visible and apparent. In some cases, the visible damage left when a person self-injures is permanent. It was my contention that the visibility of self-injury would lead to quite different social consequences. Further, the corporeal practices involved in self-injury can be seen as distinct from those involved in self-poisoning. When an individual self-poisons they ingest a substance (most often pills or tablets, though occasionally caustic poisons are swallowed[1]). The damage done is largely unseen (though there will of course be exceptions depending upon what is swallowed). When an individual injures the outside of their body, however, there are immediate effects, including blood, marks, redness, wounds and/or broken bones. Later there will be bruising, scabs, blisters and swelling. Later still there may be scars and even permanent disability. This thesis explores the embodied, lived experience of self-injury. It is my contention that this will differ markedly from the embodied, lived experience of self-poisoning.

1.2.3 Morally charged definitions: self-mutilation to body marking

The term self-mutilation is particularly common in literature from the late 20th century, and is still used in some literature (Farber et al., 2007; Hicks & Hinck, 2008). Most prominently, some psychiatric literature continues to use the term (Favazza, 1996; Favazza, 1998; Nock & Prinstein, 2005; Resch et al., 2008). This is no doubt related to the position and description of self-injury in the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) IV (1994). In the

[1] In different cultural contexts forms of self-harm vary. For instance, in South Asia, self-poisoning using pesticides is more common (Konradsen et al 2006). In the UK, self-poisoning primarily involves overdoses of analgesics or psychiatric medicine (Hawton et al 2004).

DSM IV self-injury is referred to as self-mutilation, where it appears as one of the criteria for a diagnosis of borderline personality disorder (BPD).

In a rather different vein, radical feminist writers have used the term self-mutilation more politically. Sheila Jeffreys (2000; 2006) has argued that self-injury should rightly be called self-mutilation, along with body modification, eating disorders, cosmetic surgery and the wearing of high-heels. Jeffreys contends that these behaviours are carried out disproportionately by women and gay men, and that they reflect the heterosexist and patriarchal nature of Western societies. Jeffreys' analysis is problematic on a number of levels. Most importantly, her research entirely negates individual agency. This leads from her research practice, which is based exclusively on secondary accounts and a limited reading of existing literature on self-injury. Jeffreys accepts, for instance, the understanding that it is almost solely a 'female' behaviour, a position I critique in section 1.3 and elsewhere (Chandler et al., 2010).

Self-mutilation is a morally and politically charged term, and one I preferred to avoid because it implies a specific understanding of self-injury as mutilative. This was not a perspective I myself shared, and others have noted that it is not necessarily the way in which other people who self-injure view their behaviour (Adler & Adler, 2005).

Inckle (2005; 2007) has argued that the term self-injury is equally proscriptive and limiting. She suggests that the term 'body marking' be used instead, as this avoids making assumptions about intention and distinguishing between, for instance, decoration or 'injury'. This approach reflects Inckle's concern with the similarities between behaviours categorised as body modification and those classed as self-injury. Inckle's project involved exposing normative assumptions regarding what is classed as 'decoration' and what is 'injury'. Although Inckle's work is instructive and important in challenging understandings about self-injury, my own research aims required a different approach. In contrast to Inckle, I was interested specifically in the experiences and understandings of people who had cut, burnt or hit themselves, and who defined this as self-injury. I would suggest that although it is important to highlight potential similarities between self-injury and body modification, there are

important differences – both in the way these are understood by those whose bodies are 'marked', but also in the way that these marks are interpreted and reacted to by others. These differences may not be experienced in the same way by all people; however, I was confident that my approach to the research would allow diverse understandings to be challenged and discussed.

Throughout the thesis I have purposefully avoided using the terms 'self-injurer' or 'self-harmer'. This reflects my concern that these labels are similarly morally and politically charged. Some authors have found evidence that for some people who self-injure, an important aspect of their identity is that of 'self-harmer/self-injurer' (Whitlock et al., 2006b). My research is primarily concerned with the perspectives of people who self-injure, and is premised on the idea that these perspectives will be diverse. The use of labels such as 'self-injurer' would be problematic for a number of reasons: the term implies a distinct category of person; the term may lead to lazy theorisation, suggesting that explanations and understandings will be shared by all 'self-injurers'; the label may be rejected by the person it is applied to; finally, for some people who have self-injured, the behaviour may have been transitory and incidental, thus, applying a label to such a person would be particularly inappropriate.

1.3 Self-injury: research context

This section introduces aspects of existing knowledge about self-injury. In particular, I discuss current understandings of the prevalence of self-injury and examine relevant debates around which categories of people are understood to self-injure. Finally, I briefly discuss my own position in relation to the research.

1.3.1 Prevalence of self-injury

Self-injury is characterised as a 'hidden' behaviour (National Inquiry into Self-Harm Among Young People, 2006). This leads from the finding described above (Section 1.2.2), which demonstrated that self-injury is under-represented in official hospital-

based statistics. Self-injury is also described as being 'secretive' by people who self-injure, and this aspect is readily noted in user-led support groups on the internet (www.firstsigns.org; www.nshn.co.uk) and in published research (Adler & Adler, 2007; Cresswell, 2005a; Hodgson, 2004; Solomon & Farand, 1996). However, this is contrasted with an equally prevalent view that self-injury is an 'attention seeking' act (Jacobson & Gould, 2007). This perspective is seen more often in psychiatric literature (Nock & Prinstein, 2005), and the contrast between these different understandings (self-injury as secretive versus self-injury as attention seeking) is discussed at length at several points in this thesis.

Despite the allegedly 'hidden' nature of self-injury, there are corresponding claims that the behaviour is increasing in prevalence, and has been since the mid 1990s (Adler & Adler, 2005; National Inquiry into Self-Harm Among Young People, 2006), giving rides to greater amounts of academic and media attention. However, related to its 'hidden' nature, there are no reliable statistics regarding rates of either self-injury or self-harm in the general population. There are statistics relating to hospital admissions, but as indicated above, these are likely to record only a small proportion of all people who have self-injured. There has been only one study which has measured self-injury in a randomly sampled, general population. Briere and Gil's (1998) research, carried out in the U.S., reported that 4% of their sample reported that they had self-injured in the previous six months. The short time-scale Briere and Gil attached to their question about self-injury probably resulted in a much lower rate than would otherwise have been found. Life-time prevalence of self-harm in school-based studies, for instance, has been recorded at between 12% and 14% (De Leo & Heller, 2004; Hawton et al., 2002; Ross & Heath, 2002). In addition to these school-based studies, others have examined the prevalence of self-injury in specific adult populations. Samples of college students have found rates of 17 to 20% (Croyle & Waltz, 2007; Whitlock et al., 2006a). Klonsky et al (2003) examined a group of military recruits, with 4% reporting a history of self-injury, though this study did not use very precise definitions.

Concerns regarding apparently increasing rates of self-injury are heightened due to the alleged relationship between self-injury and suicide. As noted above, self-harm is understood to be an important risk factor in predicting future suicide. This is formulated in the understanding that of those who have completed suicide, around 30%-40% will have a history of self-harm (O'Connor et al., 2006). However, with regard to self-injury specifically, the picture is less clear. For instance, the latter statistic relates to clinically treated self-harm in a UK context: therefore the majority of such cases are likely to be self-poisoning. In fact, very little is known about the future suicide risk of the majority of people who self-injure, and who do not appear to seek help, as they will not be represented in official (hostpital-based) statistics. Similarly, of the 40%-50% of completed suicides with a history of self-harm, it is unclear whether this refers to cases of self-injury, self-poisoning or both.

1.3.2 Who self-injures?

Due to the dearth of information about self-injury, especially in community samples, there are limited understandings regarding the types of people who self-injure. There is a popular, though increasingly challenged, belief that self-injury is practised mainly or solely by women (Chandler et al., 2010). This assumption appears to lead from a historical tendency in psychiatry to identify and associate self-injury with female patients (Brickman, 2004; Chandler et al., 2010). Brickman demonstrated how male self-injury was downplayed or dismissed by psychiatric discourse, suggesting that this led from psychiatrists' reluctance to interpret self-injury as a masculine, violent behaviour. Brickman showed that self-injury was instead reinterpreted as 'delicate self-cutting' and framed as a female, feminine behaviour. The understanding that self-injury is a largely female behaviour probably arose from the clinical nature of most existing studies. Clinical studies have historically been based upon in-patient samples, which are likely to contain more women anyway (Pilgrim & Rogers, 1999). Further, research has focused particularly on patients with BPD. As noted above, self-injury is one of the criteria for this diagnosis. However, BPD is also far more often identified in women (Bjorklund, 2006). Finally, the understanding that self-injury is a female behaviour has led to a slew of research

(Abrams & Gordon, 2003; Huband & Tantam, 2004; Machoian, 2001; Reece, 2005; Suyemoto & MacDonald, 1995) and theorisation (Kilby, 2001; Shaw, 2002) which focuses only on females. Thus, this understanding becomes self-perpetuating: as more research on self-injury is carried out with women, so it becomes a more entrenched understanding that the behaviour is only carried out by women. More recently, this view has been challenged (Gratz & Chapman, 2007; Klonsky & Muehlenkamp, 2007), however some recent work continues to maintain that self-injury is a female behaviour (Jeffreys, 2006; Shaw, 2002).

Community studies report different findings regarding the ratio of male to female self-injury. Briere and Gil (1998) found equal numbers of men and women reporting self-injury. Similarly, Klonsky et al (2003) found no gender difference in reporting of self-harm in their study of U.S. military recruits. Studies with adolescents have generally found more females than males reporting self-injury (Ross & Heath, 2002; Young et al., 2007). Information about rates in the UK tend to be problematic, since most record cases of self-harm (meaning self-injury and self-poisoning) and frequently do not include data on gender by method (e.g. Hawton et al., 2002; O'Connor et al., 2009). One exception to this is research carried out by Young and colleagues (2007) on adolescents in Scotland, which found that females were more likely to report both self-cutting and self-poisoning, while males were more likely to report self-burning and self-battery. This parallels Ross and Heath's (2002) contention that they were able to identify more males reporting self-injury because they included self-battery in their definition. To date, these potentially important gender differences in terms of methods of self-harm remain under-researched. Although it seems likely that more women do self-injure, most community studies indicate that anywhere from one third to one half of those reporting self-injury are male (Briere & Gil, 1998; Croyle & Waltz, 2007; Klonsky et al., 2003; Ross & Heath, 2002). Therefore, a continued focus on female only samples is unjustified.

Self-injury is also generally understood to be practised by 'young people' (Chandler et al., 2010). Research has, with one exception, found that (in clinical samples) self-injury begins in adolescence (Nock et al., 2006; Suyemoto & MacDonald, 1995).

Nijman et al (1999) found that the mean age at first self-injury in their clinical sample was 23. Certainly, community studies have found higher rates of self-injury among adolescent samples (12-14%) compared to adult samples (4%). However, as discussed above, studies on community samples of adults are limited, and the one general population sample asked about self-injury in the previous six months only (Briere & Gil, 1998). There are parallel concerns that self-harm is becoming *increasingly* prevalent among young people (National Inquiry into Self-Harm Among Young People, 2006), and some suggest that this is in part related to the increased awareness of the behaviour (Adler & Adler, 2007). It is difficult to ascertain whether this actually is the case, as there is no historical data regarding rates of self-injury in the community. The greater recognition of self-injury may well be in part related to greater awareness among lay and clinical groups or increased help-seeking.

Information regarding rates of self-injury according to other demographic criteria is also limited. There does appear to be some indication that people identifying as bi-sexual or homosexual may be more likely to self-injure (Skegg et al., 2003). Existing research has tended to find little difference in reporting of self-injury according to ethnic group (Ross & Heath, 2002). However, there have been some suggestions that in the UK, young women of south Asian origin may be more at risk of self-harm (Marshall & Yadzani, 1999). Conversely, other studies have indicated that Caucasian adolescents are statistically more likely to report self-injury (Hawton et al., 2002).

Results regarding socio-economic group are equally contradictory. The few community studies that have recorded relevant information report no differences according to markers of socio-economic position or background. However, other papers argue that self-injury is more common among middle class groups (Hodgson, 2004; Zila & Kiselica, 2001), or working class and unemployed groups (Favazza & Conterio, 1989). Suggestions that self-injury is practised more often by middle-class people tend to be made in psychoanalytic journals; while suggestions that it is practised more often by less affluent groups are found more often in psychiatric journals. It seems likely, therefore, that these different findings reflect the different

patient groups with which these disciplines engage (Chandler et al., 2010; Woldorf, 2005).

Self-injury, then, appears to be relatively common, with between 4% and 8% of people in community samples injuring themselves in the past 12 months (Briere & Gil, 1998; Klonsky et al., 2003). Up to 14% of adolescent samples report a lifetime prevalence of self-injury (Young et al., 2007). It is not clear whether rates are actually increasing or whether the behaviour is rather being more readily identified and reported. Although it has previously been understood that self-injury is carried out largely by women and young people, this is increasingly challenged. It is now generally accepted that both men and women self-injure, and that self-injury is not only carried out during adolescence. Nevertheless, research remains limited. Clinical perspectives continue to dominate, and little is known about self-injury in adult community samples.

1.3.3 Personal perspective

An important aspect of the context of this research is my own experience with self-injury. My interest in the topic is irrevocably tied up with my personal involvement with, and experience of, self-injury. I self-injured both regularly and intermittently between the ages of 12 and 26, primarily through self-cutting, but occasionally through self-battery. This close relationship with the subject matter has certainly informed my research practice. As a result of my self-injury I have many scars, which at present I choose to cover. Having such scars and living with them day to day informed my interest in how others negotiated having such marks. My personal experience of making wounds, marks and scars upon my body, made me aware of important narratives that appeared to be missing from existing literature. The embodied, messy, bloody and felt aspects of self-injury were rarely discussed. These concerns are not particular to me, or to self-injury. Others have noted the often disembodied nature of academic work ostensibly about bodies (Inckle, 2007; Sparkes, 1999; Williams & Bendelow, 1998). Indeed, most literature has tended to gloss over the details of what people who self-injured actually do. My research

practice was further led by my knowledge of others' self-injury. In particular, I knew many men who self-injured, and this made me especially critical of the absence of male perspectives in existing literature.

In some senses, this research can be seen as offering an 'insider' perspective into self-injury. However, I am cautious about making such claims. Others have noted the problems associated with claiming 'insider' status (Merton, 1972), and I wanted to avoid such pitfalls as far as possible. In particular, I sought to avoid assuming 'sameness' between my own and my participants' experiences and accounts (Cornwall & Jewkes, 1995). Nevertheless, my own experiences with self-injury are highly relevant to my research practice. I discuss this point further in Chapter 3, and elsewhere throughout the thesis.

1.4 Aims of the research

The research was designed to explore the lived experience of self-injury. This was in response to the dearth of information and research regarding the understandings and experiences of people who self-injure. In particular, I aimed to investigate the lived experience of self-injury in a diverse group of people. Thus, I hoped to include men and women, from a range of socio-economic backgrounds, who had different experiences with both self-injury and medical and psychiatric services. The approach was exploratory, reflecting the lack of existing sociological work on the matter. A narrative approach to the research was taken, which would allow for a critical 'reading' of the ways in which participants talked about their experiences with self-injury. In this way, I was able to locate and link participants' understandings of self-injury with the biographical, interpersonal and socio-cultural contexts they described.

Data collection focused on self-injury specifically, but was also oriented towards participants' broader life-stories. This wide focus was designed to explore the relationships between participants' understandings and meanings with regard to their self-injury, and the broader biographical, interpersonal and socio-cultural contexts in which their self-injury took place. The research was concerned with the practices and

practical aspects of self-injury, and of being someone who had self-injured. Analysis focused upon the ways in which each of these elements of the lived experience of self-injury were narrated.

1.5 Overview of thesis

This chapter has introduced some of the background context to this thesis. I have introduced my own definition of self-injury; briefly discussed the terminological problems associated with self-injury; and explained my reasons for using the term. I then provided an overview of current knowledge regarding the prevalence of self-injury, highlighting some of the difficulties associated with attempts to assess prevalence and incidence in different social groups. I noted my own position with regard to the research. Finally, I provided an overview of the aims of the research.

Chapter 2 expands upon and develops themes raised in this introduction, with a review of relevant literature on self-injury and self-harm. Moving on from issues relating to prevalence, this chapter will examine in detail some of the common understandings regarding self-injury and self-harm. I demonstrate that these existing understandings are limited, as they are based on studies which use restricted samples and methods. I critically discuss existing sociological work on self-injury. I then discuss the theoretical framework I will use for this thesis, introducing sociological theories relating to bodies, emotions and self.

Chapter 3 presents my methodology, detailing the ways that I planned to conduct the research, along with what I actually did. My methodological approach was broadly feminist, reflecting ethical and political concerns (Stanley & Wise, 1993). I present a critical and reflexive discussion of my research practice. Recruitment is discussed, and the final sample is briefly introduced. I then critically examine the research interviews, detailing my changing practices. In particular, I highlight my largely unsuccessful attempts to engage participants in collaborative analysis. I then discuss how the interview data were analysed. This provides an account of the ways that my practice altered, and my attempts to ‘do’ both narrative and thematic analysis.

Chapter 4 begins to introduce the data generated by the research. This chapter serves to ground the remaining chapters, focusing upon participants' narratives about the practical aspects of their self-injury. I examine the different stories participants told about the 'first time' they had self-injured, the ways that pain was implicated in participants' narratives, and the importance of making and caring for wounds. Important themes emerge here, including: authenticity; bodies; and sensations. I suggest that the way in which some participants' narrated their experiences with self-injury appeared to be oriented around claims of authenticity. Bodies are shown to be central to participants' experience with self-injury, and this chapter in particular highlights the diverse ways in which self-injury was practised. Through a focus on participants' talk about pain, this chapter introduces the importance of the sensations that self-injury is understood to elicit. This chapter also begins to develop the importance of social context in understandings of self-injury. My analysis here strives to be sensitive to temporal aspects – self-injury is located by participants in their wider biography. Practices and their consequences are shown to change over time and through participants' life-histories. Interpersonal considerations are also shown to be significant. Participants' understandings and interpretations of their behaviour are developed through interactions with others. Finally, wider socio-cultural contexts are implicated. The ways in which participants talked about their bodies, their self-injury and associated sensations drew on wider socio-cultural narratives. In particular, bio-medical models of pain were evident, and this discussion highlights the continued relevance of Cartesian dualism to lay understandings of bodies (Bendelow & Williams, 1998).

Chapter 5 extends and develops themes around sensation and embodiment, through a focus upon participants' talk about emotions. My analysis of participants' narratives regarding emotions and self-injury contributes to existing sociological work which has increasingly emphasised both the embodied, socially situated and mediated nature of emotions (Lupton, 1998b; Williams & Bendelow, 1998). Difficulties in communicating or expressing emotions are shown to be an important aspect of some participants' narratives. I demonstrate how participants drew upon existing socio-

cultural models of emotions, particularly characterising emotions in terms of control and release, and illustrating the ways in which these understandings were used in their explanations of their self-injury. This chapter also suggests that self-injury can be understood as an embodied method of doing emotion work (Hochschild, 1979; 1983, 2003). This concept is shown to be a useful way of exploring the ways that some participants described their self-injury as working practically.

Chapters 6 and 7 are closely related, each addressing different aspects of communication about self-injury. These chapters further extend themes raised in the preceding chapter, emphasising the importance of interpersonal relationships and exchanges in the lived experience of self-injury.

Chapter 6 examines participants' narratives about formal 'help-seeking' and the related theme of 'attention seeking'. I begin with a critical analysis of the problems entailed by these related terms. I highlight the difficulty of identifying 'help seeking', along with the morally charged way in which both 'help-seeking' and 'attention-seeking' appear to be understood. With these qualifications in mind, I go on to examine participants' narratives about formal 'help-seeking'. I discuss those who sought help for their 'self' as a person who had self-injured, before turning to narratives around help sought specifically for the wounds created by self-injury. A diverse and complex picture is presented. Some participants described little or no formal 'help-seeking'. Others had sought and received help from a wide and varied range of sources. Participants' experiences with formal services were equally varied. However, in accordance with previous work, many participants report that they had particularly negative, even damaging, interactions with these services. My analysis of these narratives suggests some possible reasons why negative stories tend to predominate. In particular, I suggest that the complexity of socio-cultural understandings regarding 'help' and 'attention' seeking play an important role. This analysis highlights the importance of morality in understanding socio-cultural beliefs around 'help-seeking' behaviour.

Chapter 7 turns to communication about self-injury in more informal contexts. Participants' narratives about their families were particularly significant here. Themes addressing emotional expression and repression, raised in Chapter 5, are further extended. Analysis of participants' narratives suggests that, for most, communication around self-injury in their households during adolescence was described as problematic. I demonstrate that, even where self-injury was 'known' it was not necessarily discussed. I suggest that in such cases the lack of verbal communication about self-injury, and negative emotions more generally, forms a non-verbal signal that such behaviours and feelings are taboo. This then problematises existing understandings of self-injury as a 'hidden' behaviour. I argue that this is not the case: in many instances participants indicated that families and friends were aware of their self-injury, but that it was not mentioned. Thus, rather than being 'hidden', self-injury was more often 'not spoken'. This issue highlights the importance of the visual nature of self-injury, returning focus to the self-injured body and the centrality of this to the lived experience of self-injury. The second half of Chapter 7 analyses participants' narratives regarding their management of these visual aspects of self-injury. These narratives centred upon their hiding and revealing practices. An examination of these narratives emphasises important differences in the ways that participants negotiated the marks created by their self-injury.

Chapter 8 draws together themes introduced in chapters 4 – 7. I provide further discussion and analysis of the suggestion that self-injury may be usefully understood as a form of emotion work. I suggest that examining self-injury as a form of embodied emotion work highlights two important issues. Firstly, this understanding of self-injury provides an example of embodied sociology at work – demonstrating that the behaviour can only be fully accounted for by locating it within interpersonal and socio-cultural contexts. Secondly, this understanding highlights the insufficiency of some sociological work on emotions which continues to overlook their embodied nature. I then turn to the related theme of authenticity, highlighting its importance in participants' narratives. I suggest that, in some cases, self-injury can be understood as a way of being 'in pain' authentically. I also suggest that authenticity is important to narratives of self-injury in other ways, as participants seek to injure themselves in

an ‘authentic’ manner, and to protect themselves against charges of inauthenticity or not ‘really’ self-injuring. Finally, I discuss the nature and contexts of the accounts that participants provided in the interviews. This draws together concerns raised throughout the thesis regarding the nature of accounts, and builds upon previous work which has highlighted the socially mediated nature of accounts of behaviour (Mills, 1940; Scott, 2004).

Chapter 9 provides a final discussion of the methodological and theoretical concerns raised and discussed in the thesis. I begin by critically reflecting upon the life-story, narrative approach taken by the research. I then discuss some of the limitations of the research. In particular, I focus upon my recruitment and sampling; ethical and safety issues; and my attempts at doing ‘embodied’ research. Following this, I draw together significant themes from my findings. I suggest that the study has successfully demonstrated the importance and utility of investigating the practical, corporeal, visible and sensate nature of self-injury. Further, I note that attending to these aspects of self-injury enables a socially situated perspective, where the behaviour is both better understood and more understandable when examined within the biographical, interpersonal and socio-cultural contexts in which it takes place. Finally, I conclude the thesis with a discussion of implications of the findings for those working with people who self-injure, and suggestions for further research.

Chapter 2

Literature Review

2.1 Introduction

The purpose of this review is two-fold. Firstly, I give an overview of current academic understandings of self-injury. I highlight important contributions, and discuss some of the limitations of existing knowledge of self-injury. Secondly, I introduce hitherto under-used sociological perspectives which I argue should be central to providing a more rigorous and comprehensive approach to the study of self-injury.

I demonstrate that current understandings of self-injury are overly dominated by clinical perspectives. This is problematic for a number of reasons. Clinical understandings are based on limited samples of medically treated patients, and therefore do not include the majority of people who self-injure, who are less likely to be in treatment. Clinical research tends to interpret self-injury individualistically and asocially. These interpretations obscure the impact of significant social and cultural influences.

My discussion of existing understandings of self-injury incorporates both clinical and social scientific perspectives. Where relevant, I refer to studies on both self-harm and self-injury. This is necessary due to the lack of research explicitly about self-injury, and the frequently imprecise use of terminology, as a result of which it is often unclear exactly which behaviours are being addressed. This chapter will demonstrate that, due to the imprecise use of the term self-harm, understandings of self-injury and self-poisoning often become conflated. This is not ideal, and I maintain there are important differences between the two. However, this conflation is found across academic, grey and user-authored literature. Thus, although inexact, it is important that such explanations are included in this review.

Section 2.3 summarises existing literature and approaches to self-injury. I begin with psychological factors and psychiatric diagnoses associated with self-injury. I then turn to findings that have indicated the importance of social and interpersonal factors. Following this, I introduce work which has examined the functions of self-injury. Finally, I highlight the limited ways that bodies have been implicated in existing understandings.

In section 2.4 I provide an overview of sociological theories which have informed my approach to the study of self-injury. This introduces my own perspective, as well as illustrating the theoretical framework that both informs and is extended by this thesis. In contrast to the majority of the work discussed in the first half of the chapter, this section highlights my concern with bodies, embodiment and identity, with emotions and emotionality, and with how these are located within and constitutive of social contexts. My approach to social context is three-fold and includes: the context of individuals' life-stories; the context of their interpersonal relationships; and, finally, the cultural context in which these life-stories and relationships are played out.

Before I begin the review, I will briefly detail the primary methods I used to locate the literature.

2.2 Methodology

Identifying relevant literature was an ongoing and iterative process. At the beginning of the project I was aided in two important ways. Firstly I had already collected a good deal of literature on self-harm published prior to 2003, for my undergraduate dissertation. Secondly, I was given a database of literature on self-cutting among young people, generated by my second supervisor as part of his work for the National Inquiry into Self-Harm Among Young People (2006). In the early stages of the research (2005-6) these were supplemented by additional searches of literature databases, including ASSIA, Sociological Absracts, and the Social Sciences Citation Index. I used a variety of terms, including: self-injury, self-mutilation, self-harm, and

self-cutting. These searches were limited to English language, though no restrictions were put on the dates of publication. These initial searches quickly demonstrated the scarcity of sociological and social scientific work on both self-injury and self-harm.

I widened the search to include clinical databases, using PsychInfo, PsychArticles and Medline. These searches generated far more results, a significant proportion of which concerned the self-injury of people with organic brain disorders. I omitted these papers, and restricted my attention to those papers that dealt with self-injury as defined in Chapter 1 (injuries to the outside of the body). As the research progressed, and I conducted more focused searches, I included papers that addressed either self-harm (e.g. including self-injury and self-poisoning) or which did not specifically discuss methods. These focused searches were necessary as the clinical literature on self-injury and self-harm is vast, and has continued to grow rapidly over the five years since I began the research. Thus, once I began my data collection and analysis, I conducted further literature searches in relation to themes emerging from the research process (e.g. pain, impulsivity, scarring). It should also be noted that there have been significant changes and developments in clinical understandings of self-injury and self-harm. I have attempted to indicate these changes where appropriate.

In addition to published literature, I also monitored grey literature on self-harm and self-injury. My approach was wide-ranging, including monitoring news and media sources for reporting relating to self-injury, and conducting web searches for information about self-injury and self-harm. Through these searches I was able to identify and examine a number of websites offering support and information for self-injury. Many of these were 'user-led', such as the prominent National Self-Harm Network (http://www.nshn.co.uk/), LifeSIGNS (http://www.firstsigns.org.uk/), and Recover Your Life (www.recoveryourlife.com). Many of these websites had open message boards where people who self-injured posted requests or offers of support, help and information about self-injury or associated problems. Further, some of the organisations involved in advocating for or raising awareness about self-injury also produced literature designed for a variety of audiences. These included reports, information leaflets and guidelines for parents, teachers, medical professionals and

friends and family of someone who had self-injured. Although this grey literature does not form a major part of the following review, where appropriate I draw on it to illustrate (admittedly particular and limited versions of) 'lay' or 'user' understandings.

Literature discussed in the second half of this chapter was also located through various channels and wide-ranging methods. In the first instance, social scientific literature databases were used to identify sociological material addressing bodies, embodiment, emotions, communication, pain and other themes that arose throughout the research. I also received support and suggestions for further reading from colleagues at the University of Edinburgh, and at a number of national conferences I attended during the research.

2.3 Existing research literature on self-injury

Existing research literature on self-injury is overwhelmingly clinical in nature. Social scientific research and commentary is particularly scarce. As this review will demonstrate, this scarcity does not reflect the potential that social scientific approaches generally, and sociology specifically, have to contribute to improving understandings of self-injury. The continued dominance of clinical understandings and interpretations of self-injury is problematic. The research tends to be based on limited clinical samples, generally female and psychiatrically diagnosed. Such samples are unlikely to reflect the majority of people who self-injure who do not receive formal treatment. Resulting explanations tend to obscure or minimise social, cultural or interpersonal factors, in favour of biological[2] or psychological factors. Clinical research frequently bypasses the opinions and perspectives of people who self-injure, relying upon doctors' interpretations of the behaviour, or quantitative, restrictive and problematic clinical questionnaires. Such approaches are liable to result in gendered, and even sexist, explanations (Busfield, 1996; Nuckolls, 1992). However, clinical work on self-injury has highlighted numerous important

[2] By biological, I refer here to a broad range of clinical explanations originating from biological psychiatry and relating to, for instance, hormonal factors or neurological systems

explanations for self-injury. Clinical explanations do not exist separately from lay understandings, and there is a growing consensus between clinical and grey literature regarding the functions and meanings of self-injury. Despite this consensus, the existing research literature on self-injury can be described as fractured. There are numerous discrete strands of theorisation, with correspondingly different terminological preferences, explanations, and understandings. This is epitomised in the differential use of the term self-harm. However, it can also be seen in the relative lack of cross-referencing between different disciplines: for instance, between psychiatric nursing and general psychiatry, or between clinical psychological approaches and biological psychiatry.

In this section I introduce important explanations for self-injury. Although many of these explanations are primarily clinical in nature, I discuss social scientific contributions where relevant. As indicated above, although the focus is on literature which describes self-injury, in many cases terminology is not consistent or precise. Throughout, I attend to the different terms used, highlighting these inconsistencies.

My treatment of the clinical literature is critical. I view the approaches taken in some clinical research as limiting, potentially inaccurate, and, in some cases, unethical. My perspective is influenced by social scientific work which has demonstrated the socially constructed nature of understandings and manifestations of illness (Busfield, 1996; Frank, 1995; Gaines, 1992; Martin, 1988; Martin, 2001; Scheper-Hughes, 1989) and challenged the authority and power of medical and psychiatric systems (Goffman, 1968; Lakoff, 2005; Scheff, 1966). Many of the general concerns raised in these various strands of work are reflected in clinical discourse regarding self-injury, as Cresswell (2005a) and Brickman (2004) have established. For instance, Brickman (2004) mirrored Busfield's (1996) arguments regarding the gendered nature of psychiatric work, demonstrating how self-injury was successfully framed as a female activity in psychiatric discourse, despite evidence to the contrary. Cresswell (2005b) has detailed the ways in which dominant psychiatric discourse on self-harm was challenged by user-groups such as the National Self-Harm Network (NSHN), in the 1980s and 1990s. These groups highlighted the disjuncture between what I would

call the lived experience of self-harm, and the psychiatric discourse which focused upon a detached concern with risk factors and, especially, future risk of suicide. This detachment remains a feature of much clinical research. However, the understandings popularised by groups such as NSHN are increasingly apparent in clinical and non-clinical literature alike. This may well reflect the changing nature of clinical psychiatric practices and discourses, and a move away from traditionally understood power structures.

2.3.1 Psychological factors, psychiatric diagnoses

Self-injury is generally understood to be indicative of mental ill health *or* mental distress. In formal psychiatric diagnoses it is only present as a symptom of BPD. Intermittent attempts have been made to classify self-injury as a psychiatric disorder in itself. Muehlenkamp (2005) and Favazzza (1998) argue that it should be classified under the section of the DSM IV (American Psychiatric Association, 1994) reserved for impulse control disorders not otherwise classified. Hawton and colleagues (Hawton & Van Heeringen, 2002), who have conducted much research in the UK on self-harm, refer to self-injury as 'deliberate self-harm syndrome', first described by Pattison and Kahan (1983). Although Pattison and Kahan argued that deliberate self-harm syndrome be included in a future version of the DSM, so far this has not occurred.

Self-injury is understood to co-occur with a wide range of other psychiatric diagnoses, including eating disorders, depressive disorders, anxiety disorders, substance abuse and post-traumatic stress disorder (PTSD) (Jacobson & Gould, 2007; Klonsky & Muehlenkamp, 2007). As self-injury is one of the defining features of BPD, it is unsurprising that clinically treated individuals who self-injure have been found to have high rates of BPD (Jacobson & Gould, 2007, 140). As Jacobson and Gould point out, information regarding the 'actual' relationships between self-injury and these various diagnoses is unclear. Many studies lack adequate control groups, or are based solely on clinical inpatients. Studies frequently use different terminology and definitions, further complicating the picture. While Jacobson and Gould imply

that the 'actual' relationships between self-injury and psychiatric diagnoses *can* be discovered, I would suggest that this is not necessarily possible or desirable. Rather, these debates can be seen to highlight the socially constructed nature of psychiatric diagnoses, as well as understandings of self-injury.

It is generally accepted, and has been found, that rates of self-injury are higher among psychiatric inpatients (Briere & Gil, 1998). It may be significant that self-injury is also found in higher levels among prison populations (Marzano, 2007; Morgan & Hawton, 2004; Morris, 2009). This could indicate that the nature of being incarcerated (whether in prison or in an inpatient unit) may increase the chances of self-injury. Similarly it may be suggestive of the different ways that men and women in mental distress are treated. Busfield (1996) notes that mental illness in men and women is both expressed and responded to differently.

It is increasingly accepted, however, that in non-clinical populations self-injury may occur in the absence of any definable psychiatric illness (Nock, 2009a). In one of the few papers to address self-injury from a sociological perspective, Adler and Adler (2007) make a similar claim, suggesting that self-injury is increasingly a lifestyle choice, rather than an indication of psychiatric illness. Their argument is slightly problematic. They maintain that self-injury is becoming more "popular" among non-clinical populations, when in fact there is no reliable information regarding historical rates of self-injury in non-clinical populations.

There is some disagreement then, in non-clinical and clinical literature alike, regarding the extent to which self-injury is indicative of mental illness. However, it seems to be widely accepted that self-injury does indicate mental *distress*. The ways in which self-injury's status as a symptom or sign of mental illness has been negotiated remains unresolved. Although a detailed engagement with this matter is out with the scope of this thesis, the relationships between self-injury, mental illness, and mental distress will be discussed at relevant points throughout.

Apart from formal psychiatric diagnoses, many studies have attempted to measure relationships between self-injury and a wide range of psychological factors (Dougherty et al., 2009; Gratz, 2006; Murray, 2005; Whitlock et al., 2006a). Two consistently highlighted correlates relate to impulsivity and emotional regulation, and I will discuss each of these in turn.

There is a widespread view that impulsivity and self-injury are related. Favazza's (1998) and Muhelenkamp's (2005) arguments for the reclassification of self-injury as a psychiatric disorder are based upon this understanding. However, the actual evidence to support this is problematic. A number of studies of non-clinical populations have found relationships between self-*harm* and measures of impulsivity (Croyle & Waltz, 2007; Klonsky et al., 2003; O'Connor et al., 2009). However, each of these studies used vague definitions of self-harm, making it unclear whether the relationship might actually be between self-poisoning and measures of impulsivity. Studies that have found a relationship between self-*injury* and measures of impulsivity are primarily clinical in nature, frequently focusing solely on people diagnosed with BPD (Brown et al., 2005; Dougherty et al., 2009).

Impulsivity itself is a problematic concept (Gerbing et al., 1987). Elsewhere, I have argued that the concept may be particularly open to gendered interpretations (Chandler et al., 2010). It is possible that the alleged relationship between self-injury and impulsivity owes more to broader socio-cultural understandings. Viewing self-injury as 'impulsive' might be more culturally understandable than accepting that some people might carefully plan to harm their body. Indeed, recent clinical research has found that although self-injuring patients described themselves as impulsive, this was not supported by laboratory tests (Janis & Nock, 2009). Further, qualitative research with people who self-injure, has indicated that in some cases self-injury may be habitual, or planned well in advance, rather than 'impulsive' (Adler & Adler, 2005; Adler & Adler, 2007).

As well as impulsivity, self-injury is also increasingly associated with emotional regulation and expression (see especially Gratz, 2007; Gratz & Chapman, 2007;

Gratz & Gunderson, 2006). Self-injury is viewed as related to difficulties regulating emotion. Thus far, this association has largely been investigated using psychological scales, developed to measure emotion regulation (Gratz, 2007; Gratz & Chapman, 2007). Gratz and colleagues have found that in non-clinical college samples, emotion dysregulation[3] is one of the strongest predictors of self-injury in both men and women (Gratz, 2006; Gratz & Chapman, 2007). They also found that in females, self-injury was further related to high scores on scales measuring emotional inexpressivity. Gratz and colleagues' work has been instructive in highlighting the important role that emotions appear to play in self-injuring behaviour, and particularly, in demonstrating that there appear to be important differences in how this is manifested in men and women. These findings have some support from qualitative studies, which frequently indicate that people who self-injure self-identify problems with emotional expression and emotional control (Abrams & Gordon, 2003; Adler & Adler, 2007; Alexander & Clare, 2004; Machoian, 2001). This area offers potentially rich material for sociological investigation, especially given recent developments in the sociology of emotions (Bendelow, 2009). In particular, sociological perspectives could critically engage with the ways in which 'appropriate' emotional regulation and expression are defined. These psychological factors are especially likely to be affected by different socio-cultural understandings, for instance, with regard to gender or socio-economic status.

Existing literature regarding the psychiatric and psychological factors involved in self-injury offers some useful starting points for future research. In particular, this work highlights important areas to which sociology can contribute to. The ongoing debates and negotiations regarding the status of self-injury - as a psychiatric illness, evidence of a psychiatric illness, or unrelated to psychiatric illness - emphasises both the constructed nature of clinical knowledge, and the need for sociological perspectives. Psychological correlates of impulsivity and emotional regulation are important in existing understandings of self-injury. I have suggested that these are problematic, and would benefit from sociological attention. A sociological approach to the study of emotion and self-injury is outlined further in section 2.4.2. In the next

[3] An inability to 'appropriately' regulate emotions.

section, I introduce social and interpersonal factors that have been identified as related to self-injury in existing research.

2.3.2 Social and interpersonal factors

Although clinical research tends to overlook social and cultural factors, a number of contributions have been made to understanding the social and interpersonal antecedents of self-injury. These can be identified in some of the 'risk factors' examined by some studies. For instance, it has been noted that both self-harm (De Leo & Heller, 2004; Hawton et al., 2002) and self-injury (Nock & Prinstein, 2005) are correlated with knowing someone else who has self-harmed or self-injured. In the clinical literature, this is examined as potential evidence for 'contagion' effects, and there have been some studies which have explored the extent to which this is a feature of self-injury in institutional settings (Crouch & Wright, 2004; Ross, 1979). Similar concerns are expressed regarding suicide, in particular the effects of media reporting on increases in suicide and self-harm in non-clinical populations (Coleman, 2004; Hawton & Williams, 2002; Stack, 2000a).

Adler and Adler (2005) and Hodgson (2004) explored these issues from a sociological perspective, examining how far self-injury might be a 'learned' behaviour. Each of these papers concluded that for some, self-injury was apparently 'self-learned', while, for others, it was learned from other people. Adler and Adler went the furthest, suggesting that from the late 1990s onwards, self-injury was more likely to be 'other learned' as knowledge regarding the behaviour was more widespread. This is a problematic claim, and my own research suggests that individual explanations for self-injury may well be mediated by moral concerns with being regarded as 'authentic' (See sections 4.2.1 and 8.3.1).

There is some evidence that – as with suicide – the likelihood of self-injury is increased if there are adverse life events, such as parental separation or death (Jacobson & Gould, 2007). Due to the lack of research on general populations, the picture is unclear. The most prominent adverse life event that has been associated

with self-injury is the experience of childhood abuse, particularly sexual abuse. Sexual abuse has been correlated with self-injury in numerous studies, both clinical and non-clinical (Briere & Gil, 1998; Gratz, 2006), and physical abuse has been particularly correlated with male self-injury (Gratz & Chapman, 2007). However, the extent to which this indicates a causal relationship is debateable. Though some authors have unproblematically accepted that self-injury in women is caused by sexual abuse (e.g. Kilby, 2001), more recently a meta-review concluded that there was no empirical evidence to support this (Klonsky & Moyer, 2008). However, qualitative studies have indicated that, for some people who self-injure and have been sexually abused, this experience is central to their understandings of their own self-injury (Alexander & Clare, 2004; Harris, 2000).

Some research has examined the family dynamics of young people who self-injure. Yip et al (2003) found that families who were experienced as supportive appeared to help reduce incidences of self-injury, whereas unsupportive or overly critical families led to increases in self-injury. Similarly, Wedig and Nock (2007) found that parental criticism was strongly associated with a range of self-injurious behaviours and thoughts (including self-injury). Although the findings are suggestive, the data collection techniques used were potentially limiting. For instance, Wedig and Nock examined parental 'expressed emotion' using a psychological scale to measure this. There was no corresponding qualitative aspect to the study; thus the young people (and indeed their parents) were effectively silenced, the complex and nuanced emotional life of a family was reduced to a quantitative indicator of 'expressed emotion'. However, although limited, these studies do highlight important areas that could more usefully be examined sociologically.

2.3.3 Functions

There is increasing consensus in the existing literature on the functions of self-injury. The most commonly identified functions are: affect/emotional regulation; a way of avoiding suicide; 'attention-seeking'; sensation-seeking and self-punishment. These

functions are repeated in various forms across a range of clinical, non-clinical and grey literature.

Self-injury is most often described as a form of emotional regulation. It is understood as being a method of releasing tension, frustration or other negative emotional states (Buckholdt, 2009; Klonsky, 2007a). Nock and Prinstein (2004) found that this type of explanation for self-injury was the most commonly endorsed in a sample of clinical adolescents. Support is also found in qualitative, non-clinical studies. For instance, in a qualitative study of self-injury among lesbian and bi-sexual women, Alexander and Clare (2004) found that self-injury was described as a method of 'releasing' painful emotions. Similarly, Adler and Adler (2007) reported that some participants referred to their self-injury as a being a way of 'expressing' emotions. The ways in which self-injury is understood to operate in regulating emotions appears to vary. In some understandings, self-injury serves to stop painful or negative emotions, perhaps by enabling these to be 'expressed' or 'released'. In others self-injury serves to control problematic or inappropriate emotions.

This understanding of the function of self-injury is clearly related to those explanations which focus on emotional dysregulation. These interpretations of self-injury suggest that certain individuals are unable to regulate their emotions, and thus 'resort' to self-injury. How and why this occurs is not well understood. Emotional dysregulation is an important feature of BPD, which may well be significant given that much research on self-injury has focused on groups diagnosed with this condition. However, it is likely that understandings regarding what constitutes 'appropriate' emotionality will be socially and culturally mediated. Some recent research has begun to investigate possible links between emotional dysregulation and different emotional styles in families (Buckholdt, 2009; Wedig & Nock, 2007). These have suggested that self-injury does appear to be associated with families which discourage the expression of emotion. However, the impact of broader socio-cultural understandings and practices regarding emotional expression and regulation is not discussed in this existing work.

'Attention-seeking' is a particularly controversial suggested function of self-injury. In particular, user groups such as NSHN and the Bristol Crisis Service for Women have been extremely vocal in their dismissal of this understanding:

"I'll tell you what self-injury isn't – and professionals take note. It's not masochistic. It's not attention-seeking. It's rarely a symptom of so-called psychiatric illness. It's not a suicide attempt… So what is it? It's a silent scream. It's about trying to make a sense of order out of chaos. It's a visual manifestation of extreme distress"
(Maggy Ross, of the Bristol Crisis Service for Women, in Cresswell, 2005b: 265)

However, Nock and Prinstein (2004) found that some of the adolescents in their study advocated a 'social positive' (or attention-seeking) function for their self-injury. Crouch and Wright (2004) explored this in a qualitative study of self-harm. They found that patients were unlikely to attribute an 'attention seeking' function to their own self-injury, but that they did identify it in others. Significantly, Crouch and Wright demonstrated self-injury, when seen as 'attention seeking', was viewed exceedingly negatively. This negative view of attention seeking and self-injury has also been noted in studies of the attitudes of clinical staff towards self-injury (McAllister et al., 2002a; McCann et al., 2006). These findings emphasise the significance of socio-cultural interpretations of the functions of self-injury, and again highlight the importance of sociological perspectives.

2.3.4 Bodies

Although bodies are often absent from existing work on self-injury, there are three significant exceptions. In clinical psychiatry there have been attempts to explain self-injury in terms of biological antecedents. In particular, these attempts have focused around the relationships between self-injury, pain and impulsivity. In a rather different manner, some papers have focused upon symbolic understandings of the corporeal practices involved in self-injury. Finally, Inckle (2005; 2007) has specifically examined self-injury and embodiment from a sociological perspective.

Social scientific accounts of psychiatry have highlighted the ways in which the discipline has claimed authority by searching for biological, measurable bases to

mental illness (Busfield, 1996; Lakoff, 2005; Pilgrim, 2002; Pilgrim & Bentall, 1999). Despite a great deal of effort, however, the links between biology and mental illnesses remain unclear. With regard to self-injury, biology is implicated in two key ways: defective serotonergic systems; and the endogenous opioid system.

It is suggested that people who self-injure have 'abnormal' serotonergic systems, and that this leads to their 'impulsive' self-injury (Favazza, 1998; Hicks & Hinck, 2008; New et al., 1997). The serotonergic system is increasingly implicated in a wide range of psychiatric disorders and symptoms, including depression, anxiety, eating disorders, impulsivity and suicide (Audenaert et al., 2006; Evans et al., 2000; Sher & Stanley, 2008; Yayura-Tobias et al., 1995). This interest has occurred alongside the development and popularisation of psychotropic medication such as Prozac and other selective serotonin reuptake inhibitors (SSRIs) designed to work upon the serotonergic system. With regard to self-injury, studies have mainly focused upon patients who have been diagnosed with BPD, and the results are relatively inconclusive (e.g. New et al., 1997; Simeon et al., 1992). Nevertheless, this understanding of self-injury is repeated across a range of clinical papers (Hicks & Hinck, 2008; Nock, 2009a). Further, this interpretation of self-injury is used to argue for the use of biological treatments, such as high doses of SSRIs. Favazza (1996; 1998) advocates this, despite acknowledging that there is little evidence to support such treatment.

The endogenous opioid system is implicated in self-injury via attempts to explain the sensations, or lack of sensations, reported by people who self-injure. In particular, it is widely reported that people who self-injure often feel no pain as a result of their injuries (Hicks & Hinck, 2008; Klonsky & Muehlenkamp, 2007). Some laboratory studies have found that clinical patients who report little or no pain during self-injury similarly report less pain in laboratory tests designed to measure pain 'objectively' (Claes et al., 2006; Russ et al., 1992). Leading from these findings, some have theorised that this lack of pain may be related to the endogenous opioid system and the 'release' of 'endorphins' (Winchel & Stanley, 1991). Again, rare efforts to measure a relationship between self-injury and changes in the endogenous opioid

system have been largely unsuccessful and based solely upon clinical samples (Coid et al., 1983; Winchel & Stanley, 1991).

Attempts to explain self-injury biologically have been generally inconclusive (Klonsky, 2007a). Nevertheless, biological understandings and interpretations of self-injury are present in some user and grey literature (Strong, 1998; Turner, 2002). In particular, the understanding that self-injury 'releases endorphins' and that these can contribute to a 'high' feeling (rather than simply a lack of pain) are particularly prominent, though this perspective is rarely found in clinical literature. These understandings were also present in the stories of my participants, and are discussed particularly in Chapter 4. To date, no existing work on self-injury has engaged with the ways in which psychiatric and clinical discourse is manifested in lay or user understandings. This thesis will attempt such an engagement, following similar social scientific work on the relationship between lay and biomedical understandings of depression (Stepnisky, 2007) and pain (Bendelow & Williams, 1995).

Bodies are also present in several papers which address symbolic aspects of self-injury. These include clinical work from the 1970s which presented condescending and sexist interpretations of self-injury as related to female sexuality, and in particular menstruation (Rosenthal et al., 1972; Simpson, 1980). This work has been unproblematically reproduced more recently (Froeschle & Moyer, 2004; Zila & Kiselica, 2001). Feminist theorists have produced similarly patronising, though certainly less sexist, interpretations (Crowe, 1996; Kilby, 2001). These papers suggest that the wounds created through self-injury are 'signifiers', attempts by women to communicate the "unspeakable" (Crowe, 1996) – frequently sexual abuse. These analyses highlight the importance of social reactions to self-injury, the potentially communicative nature of self-injury, and the importance of bodies and display. However, they are invariably limited by a focus on female self-injury and an assumption that self-injury is largely a response to sexual abuse. Further, these analyses are often based on secondary sources, with no attempt made to engage with the women they purport to 'speak for'.

I came across the work of Kay Inckle in 2008, when I was three years into my own research. Inckle had completed PhD research on gender, embodiment and (as she terms it) body marking. She conducted in-depth interviews with women who had self-injured (as I term it) most of whom had also engaged in wider practices of body modification. Inckle's work takes a radical and critical feminist perspective towards both body marking and sociological approaches to embodiment. In particular, she argues that gendered and marked (or otherwise 'non-normative', e.g. disabled) bodies have consequently different and differing experiences and understandings of self-hood. She contrasts her position with that of other sociologists 'of the body' who, she argues, tend to treat bodies as homogeneous - a position which generally implies that they are white, able-bodied and male (2007: 89-91).

Inckle (2007) addresses several issues which also became important in my own analyses. In particular, she explored the importance of social reactions to scars created through self-injury. She discussed the ways in which her participants talked about negotiating various social contexts with these scars. I discuss my own participants' experiences with this aspect of the lived experience of self-injury, in Chapter 7. Inckle also examined the significance of the corporeal materiality of practices of body marking; though her analysis focused on more 'decorative' forms, such as tattooing and piercing. Inckle challenges binary distinctions between injury and non-injury, and between mutilation and agency. She argues that:

"on close examination, from a position of embodiment, there are not quantitative factors that make up a bodily mutilation but, rather, a combination of factors, social and personal, that are embodied within the individual and read off in a social context" (2007: 150)

My own analysis, while less concerned with distinctions (however artificial) between decorative body modification and pathological self-injury, is nevertheless sensitive to the varying ways in which injuries can be interpreted. Indeed, the different ways in which participants talked about and understood their injuries and scars are central to this thesis.

2.4 Self-injury incarnate and in social contexts: What sociology could add.

2.4.1 Self-injury, bodies and embodiment.

Although self-injury, and self-harm more broadly, involve bodies in direct, intimate and sometimes extensive ways, academic work which engages with this aspect of the behaviours is rare. Sociology has arguably always engaged with the embodied nature of social life (Shilling, 2003), though this has certainly not always been explicit, and bodies have frequently 'disappeared' in much sociological work (Williams & Bendelow, 1998). As has been well documented, sociology has 'rediscovered' bodies over the last 30 or so years, though it is argued that there is still a long way to go before sociology can be said to have adequately incorporated bodies into its analyses (Shilling, 2007).

The theoretical stance that I take towards bodies in this thesis draws on the work of a wide range of theorists. My approach is broadly phenomenological, following Merleau-Ponty (2009 (1945)), and, later Leder (1990). This perspective takes as central the understanding that 'we' experience and live both through and in bodies. Our bodies generate experience; we both have and are bodies. However, the ways in which bodies are understood and experiences interpreted are, in my view, inherently social. Further, bodies are not only a focus of interpretation, or a source of experience – they are also meaning making. Bodies 'make up' society. As Inckle (2007) noted, bodies have concrete, observable effects upon society – most obviously according to gender, ethnicity and dis/ability. My perspective is primarily influenced by the approaches of Crossley (1995) and his work on agency and intercorporeality; and the call by Bendelow and Williams' (1998; Williams & Bendelow, 1998) for the practice of 'embodied sociology'. These authors have demonstrated the utility of accounts of embodiment which acknowledge and attend to the materiality of bodies, but which emphasise that this materiality is socially mediated and interpreted.

The question of how best to include bodies in social analysis is on-going and unresolved. Inckle and others (Crossley, 2001a; Howson & Inglis, 2001; Shilling, 2007; Williams & Bendelow, 1998) have highlighted the problems associated with attempting to theorise about or describe bodies – a project which of necessity involves attempting to put into words feelings and experiences which may resist verbalisation. Further, and as Inckle (2007: 140-2) comprehensively demonstrated, sociological theories which tackle bodies tend to be 'about' or 'of' bodies rather than 'from' them, 'reading' their signs, and speaking from a relatively 'disembodied' position. In contrast, Inckle (2007) and others (Davis, 1995; Williams & Bendelow, 1998) advocate an embodied sociology, which attempts to avoid dualism by acknowledging the embodied nature of selves and societies, and with the researcher him/herself speaking from an embodied, empathic position. Such discussions highlight the centrality of bodies to social life, biographies and lived experience and I engage with this throughout the thesis.

A theoretical position of embodiment (Inckle, 2007) is especially important for this study because of my own experiences with self-injury. Indeed, I would find it impossible to attempt to 'objectively read' my participants' self-injured bodies, since my own body is also self-injured. This position necessitates a particular form of empathy with the embodied experience of being someone who has self-injured. This close, embodied attachment to my research topic was instructive in guiding the focus of my research to areas that have traditionally been overlooked or minimised. These include: sensations experienced during and after self-injury; practical details regarding wound creation, care and maintenance; and the negotiation of social life with the marks (permanent or otherwise) left by self-injury. Each of these areas of concern can be rigorously examined using sociological approaches to the study of embodiment. Such approaches are increasingly varied and wide-ranging. In the remainder of this section, I introduce the perspectives that have been most important in guiding my research, and this thesis.

2.4.2 Corporeal materiality

One of my main research interests concerns how people who self-injure understand the practical aspects of their self-injury. That is: how do they say that they injure themselves; what do they describe doing with their wounds; how do they talk about their scars and scar management? With the exception of the work discussed above, these practical, material, corporeal aspects of self-injury are rarely addressed. Sociology has a range of useful theoretical approaches for studying and analysing such practices, and for engaging with the lived, corporeal and temporal nature of self-injury.

In particular, the concept of body techniques first formulated by Mauss and later developed by Crossley (1995; 2007), offer a useful way of considering self-injury. This approach to the study of embodiment engages with the social nature of bodies and the socially mediated nature of what bodies do. Crossley used Mauss' concept of body techniques alongside ideas Goffman introduced in his *Relations in Public*. In doing this, Crossley demonstrates the inherently social nature of action – it is always 'other oriented'. Examining self-injury in this way contrasts starkly with the individualistic manner in which it is more usually understood. However, understanding self-injury as 'other-oriented' should not be equivalent to viewing it as 'attention seeking'. Rather, explanations for and descriptions of self-injury should be understood and located within wider socio-cultural contexts and understandings. This is particularly relevant with regard to individuals' scar and wound management. It is also pertinent to the different ways that practices of self-injury are described. Further, understanding self-injury as a body technique allows a more diverse interpretation of the behaviour than previous deviance and social learning perspectives have allowed (Adler & Adler, 2005; Hodgson, 2004). Viewing self-injury as an embodied, socially mediated body technique allows self-injury to be viewed as a more dynamic practice, one that can be developed, experimented with, and tested out.

The corporeal materiality of self-injury can also be usefully investigated using narrative approaches, which highlight the temporal nature of both bodies and social life. Theorists working on illness narratives and time have been especially instructive here (Sparkes & Smith, 2003; Sparkes, 1999; Wainwright & Turner, 2006) and

Shilling's corporeal realism (2005, 14) similarly emphasises the importance of temporality. Bodies are not static; they change, age, develop and alter. This temporal perspective is especially important with regard to the corporeality of self-injury. Self-injury can effect permanent changes upon bodies, and the practice of self-injury can involve regular alterations to the surfaces of bodies. How these changes are understood, experienced and negotiated by those causing these changes remains under-explored.

2.4.3 Feeling bodies

Whilst rediscovering 'the body', sociology has also begun to address emotional and sensate aspects of social life. An examination of the lived experience of self-injury necessitates an approach which addresses both emotion and sensation. As discussed above, explanations for self-injury frequently centre upon its function as a form of emotional regulation (Buckholdt, 2009), its relationship to emotional problems (Klonsky, 2007b) and its painful or painless features .

Work which addresses the embodied nature of emotions has been central to my analysis of self-injury. Theorisation and research by Lupton (1998a), as well as Williams and Bendelow (1996a; 1996b; 1998; Williams, 2001), have demonstrated the inherently embodied and social nature of emotions. Emotions are felt and experienced in and through both bodies and minds. They challenge dualist attempts to split off mind from body. Emotions, like bodily practices, are understood as intersubjective and inter-relational, they happen between as well as within people (Burkitt, 1997).

My concern with emotions focuses on two particular issues. The first is the way in which emotions are talked about and understood. This leads from my narrative approach, which is concerned with the ways that talk is structured. Thus, in Chapter 5 I address the different ways that emotions are described as 'things' which can be 'released' or 'controlled'. In particular, this emphasises the embodied nature of emotions. I note that participants' narratives were frequently contradictory and

complex regarding 'feelings', viewing these as both sensate (bodily) and emotional (mental). Secondly, I focus upon the interactional and social aspects of understandings about emotions. Drawing on the work of Hochschild (1979; Hochschild, 2003 (1983)), I develop an understanding of self-injury as a method of emotion management. This extends and expands existing interpretations of self-injury as a 'coping mechanism', locating this more securely within socio-cultural contexts.

As I indicated above, distinctions between feelings, emotions and sensations were problematic in my participants' narratives. Although some advocate a theoretical distinction between these concepts my participants' found it difficult to separate descriptions of feelings, emotions and sensations. A study of participants' understandings of pain and self-injury is especially illuminating here. I draw upon previous work by Bendelow and Williams (1995; 1998), which similarly highlighted both the embodied nature of pain, and the ways in which pain challenges dualist understandings of mind and body. I emphasise the different ways in which pain is discussed, suggesting that wider understandings about pain are invoked and utilised in narratives about self-injury.

2.4.4 Signifying bodies, signifying selves

Previous work on self-injury has engaged with the allegedly symbolic nature of the blood and wounds self-injury creates. However, little has been written (with the exception of Inckle) regarding the social nature of the signification of self-injury. My concern with this leads from Goffman's work on performance and stigma (1968; 1973), and more recent work that has addressed the body as a site for the performance of the self, that may be specific to late modern societies (Giddens, 1991; Gimlin, 2007; Sweetman, 2000). This attention to the visible and performative nature of self-injury is an important aspect of an embodied sociology. Goffman demonstrated the effects of both visible and invisible stigma. This is especially important for a study of self-injury, as self-injury can be both visible and hidden. However, and as Goffman noted, even where a stigma is not visible to others, that it

could be leads to effects on social relations. I address this idea particularly in Chapter 7, where I examine the hiding and revealing practices of my participants. My analysis demonstrates the continued utility of Goffman's approaches.

Theorists have argued that in late-modern society, bodies have become ever more important sites for the performance of identity and self-hood: "there is a tendency for individuals to place ever more importance upon the appearance and presentation of the body as constitutive of self-identity" (Williams, 1998a: 753). Such an understanding emerges particularly in work which addresses bodily techniques similar to self-injury: cosmetic surgery (Gimlin, 2007), anorexia (Giddens, 1991) and body modification (Crossley, 2005; Sweetman, 2000). These analyses suggest that while bodies may have always been important sites for identity work, in late modern society the variety of techniques available for reworking bodies and identities is more diverse. While I do not engage overly with the historical specificity of self-injury[4], I do draw upon theories which emphasise the increasing preponderance of 'body-work' in late-modern, especially western, socio-cultural contexts.

The self-injured selves that I examine contrast starkly with those identified in the clinical literature. While the self-injured selves in clinical literature are composed of risk factors and individual proclivities towards depression, impulsivity, aggression or narcissism (as measured by clinical scales); the self-injured selves that I examine are socially situated, embodied individuals, whose life-stories reflect both socio-cultural contexts and inter-personal relationships. It is to these various contexts that I turn next.

2.4.5 Contextualising self-injury

Sociology as a discipline concerns itself with social relations and the social contexts in which these relations take place. Social contexts can take many forms, however, and this thesis focuses on three particular formulations of social context.

[4] Such a project is out-with the scope of the research I did, and as I discussed earlier in this chapter and Chapter 1, historical information about self-injury is scarce.

2.4.4.1: Narrating life-stories – interview and biography as context

Firstly, I am concerned with the social context of individual biographies, as articulated through life stories recounted during research interviews (Plummer, 2001). This is an area opened up by narrative research, which examines the ways that people construct and relate stories about themselves (Riessman, 1993). These stories are the focus of my research, and this concern is reflected in the methodology I use. Narrative researchers argue that examining the ways that stories about people's lives are narrated can tell us important things about social life – the interview is understood as a particular social context in which a story is told, and the stories told to the interviewer are understood to be particular to that context. However, it is suggested that the form that these stories take will reflect wider social trends and tendencies.

The work of Frank (1995) and Kleinmann (1988), in relation to illness narratives, is most instructive here and especially influenced my early decision to use a narrative methodology. These authors demonstrated the socially and culturally mediated ways in which people constructed narratives about their illnesses, arguing that these narrations both affect and reflect the ways in which illnesses were experienced. By similarly focusing upon the life stories and narratives of people who self-injure, I will highlight the ways that self-injury is understood and incorporated into the broader life-stories of the interviewees. My analysis indicates that these understandings may have concrete effects: both upon the ways that self-injury is practised, and the ways others responded to it.

2.4.4.2: Social Interaction – interpersonal contexts

My perspective is further influenced by sociological theories that focus upon interpersonal interaction (e.g. Gerth & Mills, 1965; Goffman, 1973), examining how this both reflects, reproduces and shapes social order and social norms. This is addressed in two ways. Firstly, the research interview itself is understood as a context in which social interaction about self-injury takes place. Reflecting my

narrative approach, the stories related in this context are not understood as any more or less 'authentic' simply because they are told in an 'extraordinary' context. Thus, throughout my analysis I reflect upon the ways in which stories about self-injury are told to me specifically. Secondly, I was interested in the different ways that participants talked about other social interactions in which their self-injury was a concern.

How self-injury is managed in interactions between people outside of clinical settings is largely overlooked in the existing literature. There is a substantial body of existing research which examines the reactions and understandings of clinical staff to people who self-injure and self-harm (e.g. McAllister et al., 2002a; McAllister et al., 2002b; McCann et al., 2006; Sanders, 2000), and there has been some relevant sociological research on this (Jeffery, 1979; May & Kelly, 1982). More recent research has examined the interactions between doctors and patients who self-harm, using interpretive phenomenological analysis (Hadfield et al., 2009). Hadfield et al's work is also relevant as some members of the team that carried out the research had personal experience of self-injury and, like myself, included this experience in their analysis. In taking cultural context, and including the body in their analysis, Hadfield et al's research represents a very hopeful position for future research into self-injury and self-harm.

Interactions in more informal settings are less well researched or documented, though Inckle did address this issue in her work, detailing conversations with her participants regarding the 'policing' of their bodies. Inckle's analysis of this focused specifically on the fact that these were *women's* bodies, suggesting that women's bodies were more stringently policed than men's. Her focus was on women who had, as she put it, 'non-normative' bodies (2007, 103):

"it is perhaps no surprise that women who have engaged with body-marking practices have experiences of their bodies being rigidly policed, and that this policing may be both prior to, as well as result from, their corporeal interventions and transformations."

Inckle's contention is certainly relevant to this research. However, as I discuss in Chapter 6, her distinction between normative and non-normative bodies can be challenged.

My analysis of the social interactions participants described happening around and about their self-injury is guided by Goffman's (1968) work on stigma. Self-injury is understood as a potentially stigmatising behaviour. In particular, Goffman's approach is useful as it highlights the different ways that stigma can be negotiated by individuals. Stigma can be hidden, or it might be revealed. My analysis focuses especially on this aspect of self-injury. Goffman's approach allows for an analysis of the visibility of self-injury. This further emphasises the importance of embodiment in analysing social life and social interaction.

2.4.4.3 Socio-cultural contexts

Both narrative and interactionist analyses highlight the ways in which forms of telling, behaving and communicating reflect wider social and cultural practices or beliefs. This represents the third and final level of my own analysis of the social contexts in which self-injury takes place. Although 'culture' has been found to be significant in sociological studies of suicide, there is less work on the way that this is reflected in individual understandings and practices (Stack, 2000a; Stack, 2000b). For instance, although levels of religious belief and divorce rates have been shown to be related to rates of suicide, how these broad cultural factors are actually implicated in behaviour is less well understood (Scourfield, 2005).

My analysis has led me to a concern with the cultural contexts of self-injury, in the form of common stories about self-injury, as well as shared understandings and meanings regarding the behaviour. When I talk about culture, I am referring to social practices and understandings that are transmitted or otherwise learned. This transmission occurs on many levels, including socialisation in families, media, schooling and so on. My interest is not so much in the methods of transmission, but in how social practices and understandings manifest themselves in the narratives and

behaviours of people who self-injure. In particular, this focus includes psychiatric and medical discourse as an aspect of socio-cultural context. This reflects my methodological approach, whereby participants' narratives and life-stories are seen as reflective of wider socio-cultural understandings (Plummer, 2001; Riessman, 1993). This is discussed further in the following chapter, where I describe and evaluate my methodology.

Chapter 3

Methodology

In this chapter I present a critical description of my research methods and practice. Section 3.1 will provide a discussion of the background to the research design. Section 3.2 describes my recruitment strategies and my final sample. Section 3.3 discusses the data collection process, addressing the strengths and weaknesses of my changing interview practices. Section 3.4 describes my approach to analysis. Finally, section 3.5 reflects upon the 'status' of the accounts that this research generated. The process of 'doing' this research was a long and steep learning curve for me. Therefore, throughout the chapter I attempt to reflect upon the changing nature of my research design and practice.

3.1 Research design

3.1.1 Aims and theoretical underpinnings

The research was designed to address several significant gaps in knowledge about self-injury. Most importantly, my review of the literature highlighted the dearth of sociologically informed research on self-harm and self-injury, as well as the limited nature of the few sociological studies that did exist. Therefore, my primary research aim was to develop a sociological understanding of self-injury, one that moved on from the deviance perspectives of Adler and Adler (2005) and Hodgson (2004). Alongside this, the research was designed to explore the understandings that people who self-injured had for their behaviour, and the social contexts that self-injury was described as occurring in. These aims reflected ethical and epistemological concerns I had with what was lacking or obscured in much existing work on self-injury: principally, the perspectives of people who self-injure. Informing my research aims was a strong belief in the socially situated, socially mediated nature of self-injury. I felt that self-injury could only be fully understood by engaging with the perspectives of those practising the behaviour, and attempting to examine how both the actor and

their self-injury are located within interpersonal, biographical and socio-cultural contexts. These aims can be summarised as a concern with the lived experience of people who self-injure.

My approach to addressing these aims was informed ethically and practically by feminist (Oakley, 1981; Stanley & Wise, 1993), and narrative or 'life-story' (Elliot, 2005; McCormack, 2004; Plummer, 2001; Riessman, 1993; Riessman, 2000) methodologies. Feminist methodological work has highlighted the sometimes exploitative manner in which social research has been carried out (Finch, 1984). Especially given the 'sensitive' (Lee, 1993) nature of my research topic, I was especially keen to address these concerns. Narrative methodological approaches can be seen to offer a solution to many of the problems highlighted by feminist theorists. Often, narrative or life-story methods encourage participatory or collaborative research (Plummer, 2001) and can be viewed as an attempt to tackle the often unequal, and potentially damaging, balances of power that occur in research relationships.

My theoretical concerns with bodies and embodiment especially force me to acknowledge the limits of strong constructionist approaches when it comes to studying corporeal bodies (Shilling, 2005). Self-injury has tangible, visible and sometimes fatal consequences. However, in both my research theory and practice I engage with and acknowledge the possibility of multiple and conflicting *interpretations* of reality. My epistemological and ontological approaches are similar to what Stanley and Wise (2006: 2.14) have termed Feminist Fractured Foundationalism:

> "Because different collectivities of people understand realities and facts from where […] they are situated, everyday fractures of understanding and meaning – reality disjunctures – frequently arise; however, these are negotiated […] around the shared premise that there is real meaning, facts and truth […] a social reality – to be arrived at"

Stanley and Wise argue that social research can 'have it all' – accepting the existence of a shared 'reality' whilst simultaneously acknowledging that this will be interpreted

differently by individuals. This perspective makes the social and biographical position of the researcher of paramount importance. Throughout my research I have attempted to engage in self-reflexivity (Plummer, 2001: 206). This approach involves acknowledging the ways in which my own social position and biography impact upon my research practice: from research design, to data collection and analysis. The practice of self-reflexivity offers an answer to the problem whereby multiple and conflicting interpretations of reality problematise the claims made by social scientific research. Such an understanding may lead to a situation whereby each individual can only ever present their own version of the world, potentially crippling researchers' attempts to understand and report upon the lives of 'others'. Stanley and Wise suggest, however, that "[t]he best alternative is that researchers should present analytic accounts of how and why we think we know what we do about research situations and the people in them" (Stanley & Wise, 1993: 166). The remainder of this chapter represents my most explicit attempt to do this.

3.1.2 Narrative and life-story

In this section I will elaborate upon what I mean by narrative and life-story. Narrative is understood as "the most basic way humans have of apprehending the world" (Plummer, 2001: 185). Despite this, there is no one definition of what a narrative actually is (ibid). Narratives are frequently conflated with the more mundane sounding 'stories'. Indeed, many writers (and I include myself in this) use the terms interchangeably. In practice it seems that stories and narratives are irrevocably linked. Stanley (2008: 437) defines a story as:

> "an account of things that have happened (usually, to some people), which has a beginning, middle and end, although not necessarily in this order; which involves some form of emplotment so that the story develops or at least has an end; it is produced for an audience, whether implicitly or explicitly; and it is a motivated or moral account because it represents a particular point of view or encourages a measure of understanding or empathy from the audience; and it works by being metaphorically and/or analogically connected (tacitly or explicitly) with the lives of its audience."

Narrative offers another layer to this mode of relating. Narrative represents the *way* that a story is told, and how this connects with wider socio-cultural practices and understandings (Stanley, 2008: 436). In this sense, narrative research addresses central sociological concerns regarding the interactions and relationships between individuals and broader socio-cultural structures and processes.

Narrative approaches serve to focus analytic attention on form as well as content. This reflects epistemological concerns regarding the nature of the 'data' elicited through interviewing. Rather than viewing participants as vessels of untapped 'knowledge', narrative approaches emphasise the mutual meaning-making that occurs in interviews (Elliot, 2005: 22). Recognition is given to the specific context of the interview itself as a site for this meaning-making, and the role of the interviewer in mediating, encouraging or limiting this process (Riessman, 1993).

Narrative methodology advocates a more interactive, if not egalitarian, approach to data collection. In narrative interviews, research participants are encouraged to engage in meaning-making. Life-story interviews in particular provide opportunities for participants to focus upon areas in which they are interested, rather than being guided by interviewer-led topic guides (Elliot, 2005, 22). These approaches are frequently accompanied by participatory, collaborative research practices, in particular 'checking back' with participants during analysis (e.g. McCormack, 2004). Given my ethical and epistemological concerns (detailed above), I felt that these techniques offered a way of doing research that was both ethical and valid. As I discuss later in this chapter, my attempts at collaboration were largely unsuccessful. Only later in the research did I fully engage with more cautionary perspectives regarding this type of collaboration (Barbour, 2001; McCormack, 2004; Stanley & Wise, 1993).

Life-stories, and the ways in which they are narrated, offer a way of linking individual stories with broader socio-cultural understandings (Elliot, 2005: 28; Plummer, 2001; Riessman, 1993: 3). Narrative and life-story approaches are closely related, and my early interest in narrative methodology led directly to my decision to

focus upon life-stories in my research. Life-story is distinguished here from life-history, following Angrosino (1989: 3). My focus on life-stories represented an orientation towards life 'in general', rather than a concern with recording a 'life-history'. I hoped that this approach would enable me to gain some sense of the social and biographical contexts in which participants' self-injury occurred.

3.1.3 Planning the interviews

I made the decision early on in the research that, ideally, I would conduct more than one interview with each participant. Methodological literature suggested that repeat interviewing was desirable, if not essential in narrative research (Elliot, 2005: 32; Plummer, 2001). This decision was also inspired by my wish to carry out collaborative research. Having at least two interviews with each participant would allow the time and space necessary for this endeavour. Following ethical review, it was decided that interviews would be limited to two, in order to avoid intruding into participant's lives more than necessary.

Having settled on conducting two interviews with each participant, I decided to use the first interview to focus upon the life-story of each participant (Plummer, 2001). This would serve several purposes: it would avoid over-privileging the position of self-injury in the participant's life; it would enable me to get some sense of the biographical, interpersonal and cultural context of each participant's life; it allowed the participant and myself to develop a research relationship prior to any requirement for them to discuss their self-injury. Finally, it would help the participant to understand my research aims and interests, by emphasising the importance I was placing on their life in general, rather than their self-injury specifically.

Conducting the data collection in two stages allowed me to attempt to engage participants in my analysis. Although my actual practice regarding this altered as the research progressed, I initially planned to provide each participant with a short, written summary of the first interview. They would then be encouraged to read the summary critically, and challenge it where necessary. This would be discussed in the

second interview, at which point we would also discuss self-injury more specifically, along with themes raised either in the first interview, or arising from the research more generally. In this way I hoped to involve participants in a mutual co-construction and analysis of our understandings of self-injury.

3.1.4 Ethics, health and safety

In part due to my close relationship to the topic of research, but also as part of more general 'best practice' in conducting social research, several ethical, health and safety concerns were monitored and addressed throughout the course of the project.

The safety of my participants was central to my research practice. Care was taken at all stages of the research to ensure that participants were informed about the nature of the study, and the potential for negative effects. I was highly sensitive to the fact that talking about past events and current behaviour, along with the focus on self-injury itself, could well cause participants upset and distress (Lee, 1993; McCormack, 2004; Plummer, 2001; Shaw, 2005). As far as possible I alerted participants to this, to ensure that their consent was as informed as possible (Crow et al., 2006). The two-stage nature of data collection helped in part to monitor participants' well-being, as I was able to check with them how the research process was affecting them. In most cases, participants reported that the experience was 'strange' but not negatively so, and in many instances participants assured me that the research had been a positive experience.

In order to address my personal health and safety, it was agreed that I would see a counsellor during the fieldwork. This would allow me a weekly outlet for any problems or challenges I faced in my personal life, which might be exacerbated by my researching self-injury. I felt that it was particularly important to do this during the fieldwork stage of the research, since I would be closely involved with the lives of people who had self-injured, and sharing stories with them which could potentially be upsetting and difficult for me to deal with. The support I received from the weekly counselling was supplemented by meetings and talks with my PhD supervisors. I was

lucky to have a supportive supervisory team, which enabled me to manage the research and my workload in a way which, together with the counselling, avoided any major upset during the course of the project.

Finally, my attempts to involve participants in data analysis were firmly rooted in ethical concerns. These ethical concerns were related in turn to concerns about the validity of any claims I would make on the basis of the research. At the beginning of the research, I was especially concerned that my analyses of the interview data would be invalid, that I might interpret the words of my participants in ways that they would not agree with, or in ways that they did not intend. Throughout the course of the research I reassessed these concerns, especially following a re-reading of Stanley and Wise's (1993: 168) arguments regarding the necessity (or not) of attempting to engage research participants in analysis. Nevertheless, my early anxieties concerning the impact of my research on my participants were central to my initial decision to use collaborative research techniques.

3.2 Sampling and recruiting

3.2.1 Recruitment

I was keen to avoid the sampling biases of most existing work on self-injury. As described in Chapter 1, previous work has focused overly on female, clinical samples, thus I hoped to recruit equal numbers of men and women. In addition, I hoped to recruit people from a range of socio-economic backgrounds. Much existing qualitative work on self-injury appears to privilege middle-class voices (e.g. Adler & Adler, 2007). In order to maximise my chances of recruiting a diverse sample, my recruitment strategies were varied, and my sampling both theoretical and purposive. I wanted to speak to a broad range of men and women who had self-injured, from a variety of socio-economic backgrounds, who had different levels of involvement in medical and psychiatric services. Such a sample would allow me to explore understandings of self-injury in diverse social contexts.

I planned to recruit primarily through community sites in order to attempt to involve at least some people who had not used services. In the first instance, I placed posters advertising the study (Appendix A) in four community centres located in less affluent areas of Edinburgh. I hoped that this would help me to reach participants from lower socio-economic backgrounds. Staff at the community centres put up the posters for me, and I also provided them with flyers that could be placed near the posters for people to take away. In addition, I began placing weekly adverts on an online community website. The research was also advertised to a voluntary service network I was involved in. In order to facilitate recruitment, I set up a website dedicated to the research. All of my advertisements included a link to the website, and the site provided details about the type of research I was planning, information about self-injury, contact details for me, as well as links to further information and support for self-injury (www.tardis.ed.ac.uk/~amy). The website also allowed me to set up an email account for the research (self-injury@tardis.ed.ac.uk).

In addition to advertisements, I also recruited informally through a variety of personal networks I had in the university; voluntary sector; and through non-academic employment I was involved in. In these cases, recruitment was not active, and I was approached by individuals who heard about my research and wanted to take part. Finally, part of my eventual sample was a result of snowballing from existing participants. Again, this aspect of recruitment was not solicited by me – rather, participants offered to pass on details of the study to other people they knew who had self-injured. I decided it was better to accept all offers of help, as informal concerns were frequently raised as to how successful I would be in recruiting anyone, especially men, who had self-injured. Although I was fairly confident about recruiting participants, I was aware that self-injury was viewed as a 'secretive' activity, and that people might be reluctant to come forward and talk about the behaviour.

Recruitment took place in two phases. During the first phase, between April and October 2007 I interviewed ten people, seven female and three male. I then stopped recruiting for six months, in order to conduct early analysis and complete

transcription. I recommenced recruitment in April 2008, and changed my advertisements so that they focused only on involving male participants. I was able to recruit a further two male participants during this time, so my final sample was made up of five men and seven women. Overall I was contacted by eleven males and nine females (including those who did eventually get involved) about involvement in the study. Five men who contacted me about involvement dropped out at various stages of the early recruitment process, either after receiving an information pack, or just prior to an arranged interview. One man who contacted me lived too far away from the research site to travel for an interview. Two women contacted me late on in the research about involvement, at a point where I had switched recruitment to men only in an attempt to achieve a gender balanced sample. My success with recruitment points to the importance and practical possibility of aiming for a gender balanced sample in research on self-injury.

In the early stages of the research planning, it was agreed that recruitment should be purposive and continue until 'saturation' occurred. Following work by Guest et al (2006), I provisionally suggested a sample size of 12 and this was agreed as a minimum. Although recruitment was largely successful, and could have continued, I decided to stop recruiting at 12. This was partly reflective of my belief that data saturation was indeed occurring, but was also related to my health and safety. At that point in the research I did not feel comfortable involving further people in the research, a situation which was exacerbated by my pregnancy and impending maternity leave. Further, by this stage, my weekly counselling had ceased. Despite receiving the counselling at a relatively low cost which was covered by my research funds, I had reached a point where I could no longer justify the expense.

3.2.2 The sample

The table below gives a very brief overview of the sample, roughly in the order in which I interviewed them. In the examined version of this thesis more biographical details were provided. It was agreed that to further protect confidentiality, these details would be removed in the final version. All of the names are pseudonyms.

Table 1: Overview of Sample

Name (age)	Occupation	Self-injury method[5]/time[6]	Household type/members
Anna (33)	Student (UG)	SBa; SC. (14-present)	Husband, three children.
Belinda (21)	Clerical	SC; SBa. (16-present)	Hostel.
Craig (29)	IT	SC; SBu (16-21)	Living with partner.
Dinah (32)	Charity	SC; SB; SBu (13-24)	Partner, one child under 3.
Emma (37)	Retired/incapacity	SC (15-35)	Alone.
Harriet (26)	Incapacity	SC (16-present)	Alone.
Milly (28)	Student (UG)	SC (16-20).	Shared flat.
Robert (33)	Student (UG)	SC (23-present).	Communal/hall
Rease (28)	Student (UG)	SC; SBu (15-early/mid 20s)	Partner
Mark (33)	Teacher	SC (17-20)	Shared flat
Francis (25)	Student (PG)	SBu; SC (19-22)	Partner
Justin (28)	Tradesperson	Self-cutting 8 years (16-23)	Alone

[5] SBa = self-battery; SC = self-cutting; SBu = self-burning.
[6] Ages from-to in brackets. Does not indicate periods of abstinence.

Although necessarily simplified, the table gives an overall picture of the sample. It demonstrates their differing involvement in self-injury; and their various household types. In addition, the sample was also diverse in terms of sexuality, with a significant proportion describing themselves as homosexual (Belinda, Emma, Robert, Milly) or bisexual, (Rease).

The sample was less diverse in terms of ethnicity and nationality. All but two of the participants were white and British (3 English and 7 Scottish).The exceptions were Belinda who was white and Australian, and Harriet who was Scottish and of East Asian ethnicity. A significant proportion of the sample were students. This feature of the sample is partly a result of the snowball section of the sample, most of whom were students (Robert, Milly and Rease). The section on occupation is designed to indicate socio-economic status; however, it largely obscures the particulars of the diverse socio-economic backgrounds of the participants. For instance, some of the students (Robert and Rease) were from lower socio-economic backgrounds; Harriet, although currently on incapacity benefits, had a relatively affluent background. Finally, although in Belinda and Emma I had a younger (21) and an older (37) participant, most were aged between 26 and 33. This no doubt led from my recruitment strategies, which were dependent upon my personal networks, those of existing participants, and upon the internet, a resource which might be more well-used by relatively younger people.

3.3 The interviews

3.3.1 Interview contexts

Most of the participants initially contacted me by email; therefore most of the negotiations regarding how the interviews would be conducted were carried out via this medium. I offered to meet all participants informally in the first instance, to give them a better insight into the research, who I was, and whether they really did want to get involved. Belinda, Dinah, and Justin took up this offer, and hopefully this helped them to make a more informed decision about involvement in the research.

This practice also helped to ease some of the tension of the first interview, as it would not also be a first meeting.

In all cases, participants were asked to indicate where they would like the interview carried out. I had expected most to prefer to be interviewed at home; however, the majority of the interviews were actually conducted in my office at the University. Perhaps because of the subject matter, participants seemed to prefer to talk somewhere away from where they lived. My office provided a more neutral space, not too private, or public. A minority of participants were interviewed in cafés (Rease) or bars (Mark and Francis). Harriet's first interview was conducted at the University, whereas for her second I went to her flat, this being the only instance where I interviewed a participant in their home.

Most of the interviews proceeded in a casual, relaxed and informal manner. At the start of each first interview I discussed the aims of the research with the participant, and we signed a consent form together (Appendix B). I felt that it was ethically important to make the consent as 'informed' as possible, having reflected upon the problems of incorrectly assuming tacit knowledge about research practices (Cordon & Sainsbury, 2006). Therefore the consent form covered both the participant's consent to be part of the study, the recording of the interview, and included a section on my future use of verbatim transcriptions and quotes. This gave participants the option not to be quoted verbatim. In practice all participants gave their consent for this. However, I maintain that highlighting this aspect of the research to participants will have improved their understanding of what happens to the data after the interview.

The interviews took between forty-five minutes and three hours, with most taking around two hours. Following one particularly long interview with Milly, I began negotiating the length of the interview at the beginning. I believe this was helpful for both myself and the participant in setting boundaries and expectations.

3.3.2 Who am I? Reflecting on the position of the interviewer and the effects of disclosure.

It is increasingly accepted that the 'position/s' of the interviewer should be acknowledged and engaged with throughout social research, as part of good research practice (Abell et al., 2006; Reinharz, 1997; Stanley & Wise, 1993). The ways in which the researcher may be perceived by those they are researching should be integral to both practice and analysis. This stance rejects attempts at 'researcher objectivity' and takes the subjective and changeable positions (or 'selves') of the researcher and the researched as essential analytical foci. The interview is viewed as a process of mutual meaning-making and co-production of knowledge (Bondi, 2005; Holstein & Gubrium, 1995). As one of the 'selves' I would present in the research was someone who had also self-injured, this orientation towards the possible effects and influences of the position of the researcher was of special importance to this study.

Although I was always quite clear that my own self-injury would have to be disclosed to participants, the issue was carefully discussed and debated throughout the early stages of the research. Ethically, I felt that it was important to be honest with participants about my own experiences. This followed from feminist methodological work which highlighted the unethical, and indeed impractical nature of attempts at interviewer objectivity and reticence (Oakley, 1981; Ryan, 2006). Early moves in academia towards more ethical research practices tended to focus around finding similarities and common ground between researcher and researched (Abell et al., 2006). This would be a problematic endeavour, and I maintained that my disclosure would be designed to explore *both* similarities *and* differences between myself and the interviewee, and that this approach would strengthen the quality of the research (Stanley & Wise, 1993: 59). I was also conscious that my disclosure might not always be welcomed by participants (Abell et al., 2006).

The decision to disclose my self-injury to participants was not easy, nor was it taken lightly. In general, my self-injury was and is kept hidden and I had concerns about the emotional effects and safety of my disclosure, as well as the extent to which this

might then lead to disclosure in more formal professional settings such as published work and conference papers. These concerns were tackled in two ways. Primarily, the matter was addressed through support and discussion with my supervisors. This led to the decision to keep disclosure minimal – that is, my self-injury would only be disclosed to people other than research participants if it was strictly necessary and not as a rule. Secondly, I was able to monitor, discuss and explore the issue in my weekly counselling sessions.

With participants, I disclosed my self-injury routinely in the early stages of the research relationship. My self-injury was mentioned in the research information leaflets and handouts that I provided, in most cases prior to meeting participants (Appendix C). I took an open approach to my self-injury during meetings and interviews with participants – making it clear that I was happy to answer any questions that they had for me, as well as offering information about myself and my self-injury if I felt this would be well received.

In general, this approach worked well on several levels. It helped me to clarify certain points and understandings during the interviews, tackling whether and how far meanings were shared or contrasting. It also helped to encourage and inform participants as to the level of disclosure and the type of talk I expected from them. Though I tried as far as possible to let the participant set these levels, it is quite likely that participants were led to an extent by the way that I talked about my own behaviour. Sharing my own experiences was also integral to fostering a research relationship and interview tone that was supportive and permissive. Some participants explicitly said that they enjoyed this feature of the interviews, contrasting it favourably with experiences they had had with clinicians or counsellors who remained silent and unresponsive.

Overall, the decision to disclose my self-injury had positive effects upon the research. However, there were some challenges and limitations. Firstly, at times the interview became unbalanced, and I disclosed ‘too much’ limiting the time available for my participants to share their own stories. This could be seen as a necessary downside to my approach, however in future research I would be more conscious of

this and therefore limit and monitor my input more closely. Secondly, and as I noted above, my disclosure no doubt guided and potentially limited what participants felt able to say. As far as possible I have engaged with these limitations in my analysis. Ultimately, such engagement is a strength of this approach rather than a weakness, as it allows such 'interviewer effects' to be acknowledged rather than ignored.

My status as 'someone who had self-injured' was only one 'self' that was implicated in my research practice. I tried as far as possible to be sensitive to the effects of my gender, age, social class and background, and my position as a 'researcher' or 'researcher in training' in my analysis. For my last two interviews (Francis and Justin) there was the further layer of my pregnancy, and therefore my position as a future mother (see Hallowell et al., 2005 for similar experiences). This became an important issue in my interviews with Justin especially, throwing into relief our different perspectives on families and intimacy. Justin described himself as commitment phobic, and particularly 'scared' of the idea of marriage and children. I chose to disclose my (at that point not overly noticeable) pregnancy. Although at the time I was conscious that my disclosure could have limited this conversation, in practice it allowed an honest and open conversation, with both parties being clearer about the position of the other.

Another important aspect of my self that had a significant impact on some interviews was my 'alternative' physical appearance[7]. As I discuss further in Chapters 4 and 7, several of my participants engaged in discussion around body modification and 'alternative' subcultures. It is highly likely that my own appearance had some influence here also, indeed, in some interviews participants referred directly to my own body modifications.

Finally, and as I discuss further in the following sections, my position as a 'researcher' appeared to have a significant impact on the interviews. Despite my attempts at encouraging participants to challenge my versions of their stories, few took up this challenge. Indeed, in most cases participants appeared to accept and

[7] I have several visible facial piercings and wear a lot of black.

affirm my interpretations of their lives. It is possible that their ready acceptance was related to a view of me as an 'expert' or 'professional', a situation which may well have been exacerbated by the University setting in which most interviews took place.

3.3.3 Constructing a history, telling a story.

The first interview was designed to focus around the participant's 'life-story'. By co-constructing a 'life-story' with participants I was able to locate self-injury temporally in the participants' life, as well as getting an impression of the contexts of the inter-personal relationships through which this life-story was played out.

In my pilot interview (Anna) the life-story was developed through the use of prompts taken from Plummer (2001: 125). In the actual interview, we only discussed three of these, as Anna talked quite freely and we did not have time to cover all of them:

1. Tell me about your life, in about twenty minutes or so if you can. Begin where you like and include whatever you wish.
2. What were the most important turning points in your life?
3. Tell me about the happiest moments in your life/

However, despite Anna's willingness to talk, I felt the interview lacked direction and that both Anna and myself were frequently unsure how much depth to go into, or what aspects of her life to focus on. Anna was of course aware of the focus of my research, and it was therefore her self-injury and mental health which were the dominant themes. This lack of structure and purpose led, at least indirectly, to the interview turning quickly to very sensitive areas (suicide) which I was not entirely ready to deal with. Anna was also aware that she was my pilot interviewee; therefore a lot of potentially awkward or tense moments were dissipated with self-deprecating humour on my part, Anna's patience, and mutual laughter.

In order to avoid this directionless quality, and also to refocus participants to their life 'in general' (rather than their mental health or self-injury specifically), I used a

life grid in the subsequent interviews (Appendix D). I developed this through attendance at a seminar on the use of the life-grid in sensitive research[8], and some published work on the matter (Bell, 2005). During those interviews where I used the life-grid, I carried out the writing, while the participant talked. I encouraged each participant to start wherever they wanted to on the grid; though in practice most followed the grid chronologically. It is possible that participants may have engaged with the grid differently had I suggested they fill it in themselves. However, practically, I felt that it was better that I filled in the grid. This meant that I would be able to read my own hand-writing and also emphasised the co-construction of the grid.

Participants used the grid to varying degrees. For instance Rease, said that she did not want to use it at all. Others used the grid initially, but as the interview progressed referred to it less frequently. Conversely, participants such as Milly and Justin engaged closely and rigorously with the grid, attempting to be precise regarding dates, times and situations. In these cases, I tried to reassure participants that the grid was there to prompt talk, rather than comprehensively record a life-history.

I found the life-grid to be a useful tool in most cases. The grid gave participants a better idea of the types of subjects I was interested in, as well as giving us a joint 'project' to work upon during the interview. This dissipated or avoided many potentially awkward silences by giving us something to focus upon. Finally, the way in which participants tended to use the grid (moving from top to bottom) meant that self-injury was usually addressed towards the end of the first interview, when the participant reached the final subject cell of 'health and ill health'.

As discussed above, I originally intended to offer participants the chance to become actively involved in the process of analysis and in the construction of their 'life-story'. I felt this would be a more ethical and valid way of generating data, avoiding as far as possible my 'imposing' potentially unwanted or unintended meanings or structures upon participant's words. However, subsequently, I have become aware of

[8] At the Centre for Research on Families and Relationships, Edinburgh University.

other perspectives, which criticise collaborative approaches, warning that they can potentially "exploitative or distressing" (Barbour, 2001: 1117). Indeed, in practice, this strategy proved hugely problematic. For instance, Anna, my pilot interviewee, was quite clear that she was not interested in doing this; she did not want to read either a transcript or a summary of the interview, telling me "*do what you want with it*" (Fieldnotes, April 2007). Belinda, my second interviewee, was living in a hostel when I spoke with her, with limited access to a computer, so it would have been difficult for me to send a summary, and I was concerned about how much privacy she would have had to read one had I sent it.

The next few respondents were interested in engaging with the research, and I was practically more able to provide them with summaries since they had access to email. For Dinah, Craig, Emma, and Milly I wrote up a short two or three page summary of what we discussed in the first interview, and sent it to them via email prior to the second interview so that they had time to read and reflect upon it. It was then my intention to begin the second interview with a discussion about the summary, and to encourage them to comment upon or challenge what I had written. At the end of the summary I also indicated four or five themes or issues that I had felt were significant, and encouraged the participants to add any further themes that they felt were important.

Dinah was the first person I did this with, and the process did not run entirely smoothly. I sent Dinah the summary a few days before the second interview. Although she had looked at it already, she brought her copy of the summary with her to the interview, while I had not printed a copy out for myself. The following is from the interview transcript:

[Notes on interview: I really should have printed out two versions of this (the summary) *so we both had a hard copy – I can feel the awkwardness of me sitting there and watching her]*

Dinah - you've not said anything that was inaccurate, or anything like that… …… . [massive pause]…… …… ……[cut] I didn't find it, it was a bit strange, but I didn't find it difficult to read what you'd written, I think its helpful, its helpful to have it like that

The interview proceeded in a rather stilted manner, although there were sections where talk was more relaxed. Markedly, Dinah did not engage with the summary a great deal, nor did she challenge anything that I had written. I had hoped that the summary would encourage further reflection and elaboration. In practice, the summary seemed to have served to fix the 'story'. Despite this problematic first experience I persisted and provided Craig, Emma and Milly with summaries as well. In each case, although the stilted nature of my second interview with Dinah was not repeated, participants similarly tended to accept my summary with almost no qualifications.

The process of writing the summaries was also difficult. I found it immensely stressful as, given the subject matter of the first interview, in most cases I was trying to summarise the participant's entire life. Others have noted the problems and stresses involved in presenting research findings to respondents (Hoskins & Stoltz, 2005). Further, in many ways the process was counter-intuitive. In my desire to encourage co-production of narrative it seemed I was simultaneously cementing the 'stories' of participants, and, worse, they were accepting this! Eventually, and following consultation with my supervisors, it was decided that the process of writing the summaries was not having the intended effects – and indeed appeared to be limiting rather than expanding discussion in some cases – was creating extra work and emotional strain for me, and should therefore stop.

There was one slight exception to this, however, in Rease who requested the entire transcripts of both of her interviews. Rease was particularly interested in my attempts at a more power-neutral methodology, and was keen to see what the transcripts looked like. However, despite her interest and willingness to engage, she too accepted what was written relatively unproblematically. She did make one request, that a negative phrase she had used to describe someone close to her be toned down, but that was all. This process of experimentation with attempting to engage research participants in the process of knowledge production was instructive. Following Cornwall and Jewkes (1995) and McCormack (2004), I discovered that participants

themselves are not always willing partners in this process. They do not necessarily share the same concerns as researchers regarding the perceived power disparities in research relationships, or the potentially different ways of telling and interpreting stories.

3.3.4 The second interviews.

For the first few interviews, while I was providing participants with a summary of the first interview, the second interview served two purposes. Firstly, it allowed myself and the participant to discuss both the first interview and my summary of it, checking that we had a similar understanding regarding what had been discussed, and what the key themes had been. As discussed above, in practice, my version of events was rarely challenged. Although this led to me deciding not to produce summaries for later participants, in the later interviews I still spent the first portion of the second interview going over the life grid verbally with participants. This served as an introduction into the second interview, and gave participants an opportunity to amend or add to what we had written in the life grid in the first interview. Occasionally, participants did take this opportunity to add to what had been said, though more frequently they agreed with everything. Again, this had the slightly uncomfortable outcome of seeming to fix the participant's initial narrative, rather than destabilising or questioning it. This raised questions about the utility of my own position as a reflexive, interpretive researcher, working as I was with people who did not necessarily share my concerns with the constructed and changeable nature of reality! Despite these challenges, I felt that it was ethically appropriate to at least give participants the chance to question or amend their earlier account, even if they rarely took up this opportunity.

The second interview was also designed to prompt further discussion around key themes that had been raised either in the first interview, or that had arisen from the research more generally. In the earlier interviews where I provided participants with summaries, I also indicated themes that I was interested in talking about further, as well as inviting participants to add their own themes. In the later interviews, I still

prepared a written list of themes, but this was produced at the beginning of the second interview rather than prior to it. Once we had discussed the first interview, we generally then moved on to discuss the themes, usually in the order that I had written them, although I tried to encourage the participants to address the themes in whichever order they preferred.

The themes that I identified for participants reflected areas of the participant's interview that I was particularly interested in. These themes lead inductively from a close reading of the interview transcript, as well as my wider reading around the topic. In some instances, the themes reflected what participants appeared to have highlighted as important factors in their self-injury. In the later interviews, I also raised broader themes that were emerging from the research more generally. Appendix E details the changing nature of the themes that I highlighted with each participant. This highlights my early and enduring interest in certain aspects of the lived experience of self-injury. In particular, pain, emotions, practical aspects of self-injury, and the influence of 'other people' on self-injury were raised with most participants. Some themes that arose with several participants are not addressed in this thesis. Guilt, responsibility and alcohol appeared to be important issues for several participants. Ultimately, this thesis can only address so many issues, and is not intended to be a comprehensive reflection of all of the concerns raised in the interviews. This identification of 'important' themes between the first and second interviews represented an early, yet instructive, level of my analysis. In hindsight, it is clear that even at this stage I was ordering the data according to wider research interests – developed from the process of doing the interviews, as well as my more general reading and thinking on the topic.

Like my other attempts to encourage greater participation in the construction of the interview data, my suggestion that participants come up with themes of their own was also rarely taken up. In fact, only Milly introduced her own additional theme. Participants did engage with the themes I had produced, however, discussing them in terms of relative importance – though never dismissing them entirely. Again, this raises questions regarding the impact and influence of the research process and my

research practice in fixing theories and explanations about self-injury rather than challenging them.

3.3.5 Reflecting on the interviews.

Although conducting two interviews may not have increased the validity of my research, the very fact of having more time with each participant increased the amount of data I was able to collect from each participant. Conducting the first interview around the life-story of participants was generally successful in allowing me to develop a sense of the contexts in which their self-injury occurred. The two-stage data collection also helped with the development of rapport between myself and the interviewee, with the second interview in most cases being a more relaxed, and in some cases more informative event.

My attempts at involving participants more fully in the co-production of research data were generally unsuccessful. It is possible that I could have done more to facilitate participants' engagement with this aspect of the research, perhaps by being more explicit about my own understandings about the flexible and changeable nature of interpretation and understanding. However, equally, it could be that my position as researcher prevented the level of engagement I sought. Participants could have felt unable to challenge my interpretations, either because I was viewed as an 'expert' or because I had also self-injured. If participants thought I had no experience with self-injury, they may have felt more able to challenge me. Finally, as I noted above, some participants were simply unwilling or unable to engage with the research out-with participating in the interview. In these instances, it would have been unethical to press for greater involvement. Indeed, as a final reflection, I am now unsure as to whether it is more ethical to offer this opportunity at all.

3.4 Analysing and writing

I was clear from the beginning of my research that analysis was not a bounded, limited part of research, but rather "a *pervasive* activity throughout the life of a research project" (Coffey and Atkinson, 1996: 10-11, in Silverman, 2005: 149). Although this section focuses explicitly on the more prominent aspects of analysis – my writing and formal analysis – I have tried to acknowledge throughout the links between my research practice, analysis and theory.

3.4.1 Field notes and 'the diaries'.

From the beginning of the research I kept regular 'field notes', mostly in the form of an electronic diary, but including hand written notebooks. These notes and diaries allowed me to think through (or write out) emerging and developing ideas and theories throughout the course of the research. They also served as a platform for my own reflexive practice with regard to the research. Due in part to my personal relationship with the research topic, but mainly as an aspect of good research practice, having space to work through and develop my position with regard to the research was essential. Regularly updating and reviewing these notes allowed me to track common ideas, developing theories, and to record and highlight my emergent analyses.

The diaries also served as a record of my relationships with participants outside of the formal, recorded interviews. I met with Belinda, Dinah, Emma and Rease on at least one, and sometimes several, occasions to chat informally about the research. Rease in particular was interested in my developing theories and read and commented upon versions of papers I presented at conferences. I also used the diaries to reflect on my research practice, taking care to write notes following each interview in order to record details about the contexts of the interviews.

In particular, the diaries were useful during formal analysis. Writing and recording my thought processes during this stage of the research served two primary purposes. Firstly, writing about analysis at the time enabled me to work through complex ideas, weighing up different ways of viewing the data and testing my understanding of the

codes that I developed. Secondly, this writing has been central to my ability to write this chapter, serving as a reminder of what I actually did. As I discuss further in the remainder of this section, my analytic practices altered, developed and (I hope) improved during the research.

3.4.2 Transcribing and making stories.

Transcription can be seen as an early stage in analysis, as choosing certain transcription practices is a first step in beginning to organise (analyse) data. In my early research practice, due to the time constraints of having to produce summaries for participants in relatively short periods of time, I initially transcribed interviews in summary form. This gave me an overview of *what* was said in the interview, but gave less indication as to *how* talk was structured. The summaries tended to obscure pauses, inflections, and often my own words. After the first four interviews, I began to space the interviews more favourably[9], which gave me more time to produce detailed transcriptions. I later went back and re-transcribed the earlier interviews I had initially summarised.

When it came to my later analysis the interviews had been transcribed verbatim. Although be no means as detailed or precise[10] as they could have been, the transcriptions indicated pauses, included inflections (such as um, err etc.), and importantly, included my own interjections and questions in full. As far as possible I attempted to reflect the feel of participant's speech by using any dialect or vernacular language that they used.

My practice of writing and providing summaries for participants in the early stages of the research was another stage of analysis. As I discuss above, this process was stressful. The summaries I was constructing were not just for my use analytically, but were written for participants. Thus, whilst writing, I was painfully aware of how I was constructing and summarising the 'life story' that had been developed in the

[9] I interviewed Belinda, Craig and Dinah concurrently, sometimes on consecutive days.
[10] By this I mean that I did not time pauses, or work to strict transcription rules such as those used in e.g. conversation analysis.

interview. I was very careful in how I wrote the summaries, as I was conscious that the reading of the summary for some could have been traumatic or painful. At the same time, I wanted to present as accurate a picture as I could of what had been discussed in the first interview. In some cases this left me in a difficult position, whereby I wanted to present a positive picture of the participant's life, but simultaneously had to report, of course, more negative aspects. The process of writing the summaries was a difficult balancing act between competing and conflicting aims, and, ultimately, the process was not helpful. However, the practice of writing out such summaries certainly highlighted the potentially diverse ways that the 'same' story could be written.

I also wrote summaries of interviews that were explicitly constructed for the purposes of analysis. As these would not be read by participants, they were less problematic to write. The practice of writing summaries, both of individual interviews and later of individual 'cases' (consisting of both interviews from one participant) helped me to develop my understanding and interpretations of participants' stories. I used techniques developed from narrative analysis in this process, a paper by McCormack (2004) being particularly helpful in directing my writing. At this stage I also began to compare cases, examining similarities and differences in both the form and content of the interviews and cases.

As comparison progressed and I accumulated more and more summaries, the data began to feel more and more overwhelming. At this stage, the decision was taken to attempt more structured comparisons by beginning to code the data using computer aided qualitative data analysis software (CAQDAS). I was initially wary of using coding or computer programmes to aid analysis. I was highly conscious of the potential that coding had to 'fracture' participants' responses, and for splinters of data to be taken out of context resulting in potentially problematic and invalid analyses (Riessman, 1993; Ritchie et al., 2003, 229). CAQDAS specifically had been similarly critiqued, with some raising concerns that the use of such forms of data management could lead to formulaic and restricted analysis (Coffey et al., 1996).

These concerns were important, as they suggested features which ran counter to my exploratory, theory-building aims.

I decided, however, to take a pragmatic approach to the use of coding and CAQDAS. With twenty-four lengthy interviews, I needed some method of managing the data, and coding and CAQDAS offered this. I felt that so long as I remained sensitive to their potentially restrictive aspects, these methods could be beneficial.

3.4.3 Looking at the bigger picture: coding and CAQDAS

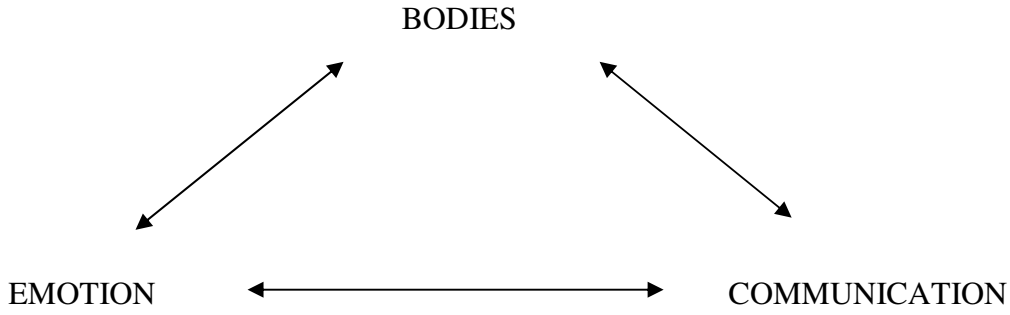
My use of coding and CAQDAS altered as analysis progressed. Initially I set about coding using an approach influenced by grounded theory (Strauss & Corbin, 1998). I commenced detailed reading of the transcripts, coding all aspects of the interview, developing new codes constantly. This resulted in huge lists of codes for each of the interviews I treated in this manner. However, I felt uncomfortable with this method of coding. It was designed to allow me to highlight 'important' themes from the interviews, and these themes would apparently 'emerge' through the process of coding. I felt that this approach was disingenuous. Firstly, it tended to privilege a quantitative approach to the themes – importance being related to the number of times a theme came up, rather than its qualitative importance – either to me or the participant. Secondly, I was highly conscious that the themes were not 'emerging' out of the data. I was privileging subjects and themes that I was already interested in: I was not an 'objective' research instrument.

These concerns were amplified because in the early stages of the research I had already identified three broad themes that I was interested in pursuing. These themes had developed during the course of the interviews, my reading around the topic of self-injury, and my theoretical interests. I began to reflect upon the necessity of coding in this 'bottom up' manner, when I already had 'top level' themes that I was interested in exploring. My research aims were exploratory in nature, and the 'bottom up' approach to coding was not the only way for me to address these aims. It became evident that it might be more fruitful to code in a 'top down' manner –

searching for and allocating pre-set themes in the interview data, rather than pretending that I was identifying them 'objectively', only to discard those I was less interested in anyway.

I began, then, to recode all of the transcripts using just three broad codes, reflecting my theoretical concerns: bodies; emotions; and communication (Figure 1). This process was helpful in forcing me to interrogate and assess what I meant by each of these themes. There were numerous and multiple overlaps, and this served to confirm and develop my theoretical perspectives. Throughout most of the coding process I viewed the three themes as triangular, each influencing, and being influenced by the other two, and each aspect being equally 'important'.

Figure 1



As my writing and analysis progressed, however, I began to assign greater importance to the theme of bodies. This decision was partly pragmatic, allowing me to focus my analysis (and the thesis!) more clearly. However it also reflected my increasing theoretical concerns with the importance of material, corporeal bodies in understandings of self-injury.

Whilst coding the interview transcripts using these broad themes I reflected carefully upon how I was assigning different types of talk to the codes. Frequently, sections were coded with all three themes, and this reflected their inter-related nature.

Nonetheless, I found it useful to code the data in this manner, giving me a way of organising my analytical work as well as challenging my assumptions and understandings about each of the themes. My research diary was especially important at this stage, recording and giving space for a reflexive attitude towards my research practice. This entailed asking questions of myself, and interrogating the coding decisions I was making.

Once most of the interviews had been coded with the three themes I began to develop sub-codes. I went about doing this in two distinct ways. In the first instance, I developed theoretically driven sub-codes. These were developed for pragmatic reasons, for papers I needed to write for conferences. Thus, I was interested in developing a sub-code on *emotion work* because I had already written a paper on this, and the process of doing so convinced me that this was a matter I wanted to investigate further. This code was located within the broad code of *emotions*. I had also produced a paper on self-injury and attention seeking, which had entailed me developing a sub-code of *attention-seeking* which I located within the broader code of *communication*. Finally, I presented a paper on self-injury and pain, for which I developed a sub-code of *pain*, within the broader code of *bodies*. The practice of reading through the transcripts, conducting key word searches, and developing and refining these sub-codes helped to improve my familiarity with the data set. These sub-codes represented important theoretical interests that I held.

Alongside this, I was concerned that, thus far, my analysis had been guided mainly by my theoretical and intellectual interests. I decided that at least some of the analytical work should try to identify codes in a less directive manner. In doing so, I remained sceptical about how far this process would be objective. I would still be identifying themes I was more interested in (for theoretical, intellectual and even biographical reasons). However, by coding in this more open manner, I was able to systematically organise the data into manageable themes. This process also forced me to look at the data closely, to see what was ‘there’.

Therefore, I recommenced sub-coding the broad codes, but with a more open attitude. To do this, I carried out detailed readings of each code. Whilst doing this I highlighted sections of text, and made brief notes in the margins. This generated a series of initial themes. Themes were created by identifying subjects that arose frequently, or which I subjectively felt were important (either to me or to the participants). I then began to sub-code using the initial themes. During this process, the themes were streamlined, altered and adapted. The final sub-codes that I generated through analysis can be found in Appendix F.

3.5 The status of the accounts

I want to conclude this chapter with some reflections on the 'status' of the accounts. This issue first arose in the early stages of the research design process, when I was deciding how many interviews to do with each participant. I initially felt that I would get more 'depth' and perhaps more 'truth' if I conducted multiple interviews with each participant. My review of the literature along with my monitoring of online resources about self-injury suggested that certain explanations were relatively common. I was interested in exploring how far these explanations were 'true' and I felt that repeat interviewing would be more likely to elicit different explanations. However, as previously discussed, ethically this approach was more difficult to justify. Further, throughout the course of the research, I began to question how I could make assessments as to the 'truthfulness' of different types of accounts.

The participants in my study provided very different types and forms of account, as I discuss in detail in Chapter 8. For some participants, such as Anna, Harriet, Emma and Milly, telling their 'life-story' was not unusual; they had been involved in counselling, psychology, psychiatry, or writing an auto-biography in Emma's case: activities which had required such self-reflection time and again. For other participants, Justin in particular, the process of talking about their life in an interview was entirely uncharted territory. The interview required them to engage in a type of talk that was relatively unfamiliar. With regard to self-injury itself, participants again had different levels of experience with talking about the issue. Justin maintained that

he had never spoken to anyone apart from me about his self-injury, Anna was clear that her self-injury was discussed with very few other people. In contrast, other participants, such as Milly, Harriet and Rease, were far more open about their behaviour, and as such described talking with others about their self-injury far more often. The types of accounts that the research produced then were various. In particular, some were more practiced than others, and I felt that it was important to address these differences.

Scott and Lyman (1968) and Mills (1940) highlight the problems of studying motivation, and the unhelpful assumptions that can lead from such studies. Following Mead, Mills maintains that a sociological study of motives should treat them as originating from situations rather than from 'within' individuals (1940: 906). This perspective offers the possibility of answers, whereas attempting to discover what a person 'really' means is, as Mills points out, impossible (p. 909). These debates resonate with late-modern concerns with authenticity (Giddens, 1991), an issue which I returned to throughout my analysis.

I addressed the problem of the 'status' of the accounts by focusing on what Mills termed 'vocabularies of motive' and what Scott and Lyman called 'accounts'. This approach was ethically more justifiable as it avoided having to make (impossible) claims regarding the 'truth' of participant's explanations. Instead, my analysis considered the forms of participant's explanations, and attempted to relate these explanations to the social and cultural contexts in which they were manifested. These contexts included, of course, the context in which they were put to me – the interview itself.

Chapter 4

Practising self-injury

4.1 Introduction

4.1.1 Synopsis

This chapter will focus on the physical, bodily aspects of self-injury through a focus on the corporeal practices involved in self-injury. I will begin by briefly discussing what I mean by 'bodies', expanding upon theoretical issues raised in Chapter 2 and addressed throughout the thesis. I then move on to discussing the ways that participants implicated (their) bodies when talking about their self-injury. First, I examine the ways that participants talked about the methods they used to self-injure, focusing particularly on participants' descriptions of their early self-injury through an examination of stories about the 'first time' that they self-injured. I then move on to the ways that participants talked about the physical sensations that their self-injury elicited, both pleasurable and painful. Finally I turn to participants' talk about tending to their injuries and scars. I examine their discussions about healing, before discussing participants' orientation towards their scars.

4.1.2 Bodies and self-injury: theoretical concerns

Although this chapter focuses on 'bodies' I am clear that 'bodies' are theoretically and conceptually problematic. They cannot be easily separated from emotions or minds, as represented in problematic dualist understandings (Crossley, 2001b; Williams & Bendelow, 1998). The ways that 'bodies' are understood and experienced by people are intimately related to the social contexts they inhabit: these understandings are linked to wider socio-cultural discourse regarding what bodies are, what they should do, and how they should feel. This understanding of the close

inter-relationships between bodies and emotions, and how these are expressed in socio-cultural beliefs and discourse informs the structure and central arguments of the thesis. This chapter focuses on bodies, through an examination of those aspects of self-injury which are most evidently *material* and, to a lesser extent, *visible*. This distinction is not easy or straight-forward – there are aspects of both emotions and communication which can also be understood as material and visible. Certainly, emotions are (as I will discuss in Chapter 5) inherently embodied (Williams & Bendelow, 1996a). Similarly, communication happens through and between bodies (Burkitt, 1997). Finally, as I argue in Chapters 6 and 7, an examination of the inter-relationships between bodies, emotions and communication is especially useful in examining self-injury.

As well as being an attempt to separate out the corporeal, carnal aspects of an embodied behaviour, this chapter necessarily addresses the attempts my participants and I made to put into words ideas and experiences which often resist verbal expression: the consistently unresolved question of how to 'talk about bodies'. I am conscious that by attempting to talk about 'bodies' in this manner I may well be propagating a Cartesian vision of a disconnected body and mind which has been criticised by some (Crossley, 2001b; Williams & Bendelow, 1998). I maintain, however, that focusing on bodies, emotions and communication in turn will highlight rather than minimise the close inter-relationships between these analytic themes.

As discussed in Chapter 2, my approach to bodies acknowledges their material, corporeal nature. This view emphasises the need for a "temporal element to social analysis" (Shilling, 2005: 12), which reflects my concern with the changes in the self-injured/self-injuring body over time. This concern with the temporality of bodies and embodiment is central to some of the ideas I present in this chapter. Self-injury in some cases (where visible, permanent marks are left on the body) represents a rather particular behaviour whereby memory of a 'bodily event' is likely influenced by the permanent marks themselves (Burnett & Holmes, 2001). While other behaviours which are less visibly permanent might more readily recede into the past,

for the self-injured body, the memory may be kept 'fresh' as it were by the continued existence of scarring.

Finally, my perspective follows phenomenological theorists in locating the body as a key site for 'lived experience' (Crossley, 1995; Leder, 1990; Merleau-Ponty, 2009 (1945)). We experience and perceive *through* the body: we are in the body and we are bodies. Self-injury is a behaviour which especially highlights this, as it involves acting upon bodies, and through bodies: the body of the person self-injuring is both actor and acted upon. Thus, I argue that any attempt to understand self-injury *must* attend to the bodily aspects of the behaviour, as it is a behaviour which inherently involves, implicates and affects the body. To date, the bodily nature of self-injury has been almost completely overlooked[11]. This chapter will demonstrate the importance of attending to the corporeal practices involved in self-injury, enacted upon and by the bodies of those who self-injure.

4.2 Making the wound

In this section I will introduce the ways that participants described injuring themselves, the tools and methods that they used. I then move on to descriptions of the immediate 'aftermath' of self-injury – the blood; the injury/wound; the participants' reaction to these. Participants described a range of self-injurious behaviours. They had cut, burnt, scratched, picked at and hit their bodies, using a variety of tools, and *"concentrating*" on almost all areas of the body that were accessible. They related these activities to me in different ways: matter-of-factly; as part of their 'life-story'; or sometimes as a separate and well defined narrative regarding a particular act. In particular, the 'first time' that participants had self-injured was a key narrative for some.

4.2.1 Early self-injury and the 'first time'

[11] A key exception to this, as previously noted, is Kay Inckle's (2005, 2007) work.

For some participants, the 'first time' that they had injured themselves was a well-remembered, perhaps well rehearsed, story. Those who could remember their 'first time' frequently related this to me in some detail. For Anna the first time that she self-injured was *"way, way back"* when she was aged 14. Like several other participants, she located the beginning of her self-injury in a quite distant past:

"and….. I spose as far as the self-harm went like….. that ..that started when I was 14 ***so this goes back like way, way back*** *em and I star… I broke my wrist. First time, I did anything I broke my wrist.* ***Got a hammer, and I just smashed it till it literally till it smashed I broke both bones in my wrist……. and I did that again and I did it again, I did it three times****. Em…… and then….like* ***it kindae progressed from there and I just started hitting myself with things so I would just have bruises*** *and ….. and it wisnae….. … ah…it probably wasnae till I had Brandon that I started actually cutting myself…"*

Anna is rather matter-of fact here she "*just*" smashed her wrist, with a hammer, until the bones broke. This method of self-injury – self-battery – is discussed less often than self-cutting in existing literature. For Anna, it was the main way she injured herself from the age of 14 to her early 20s. She described how, after initially breaking her wrist, she went on to bruise herself regularly (using a rolling pin), sometimes breaking more bones: *"I'd broken my wrists […] I'd broke toes, fingers, ribs everythin…*.". Belinda and Dinah also described hitting themselves. Belinda described doing this just once, as a way to avoid cutting herself. While Dinah described self-battery (and burning) similarly – as being ways of avoiding self-cutting – though she said that she had done this often whilst she was self-injuring: "*I was still cutting, […] well I was still, like doing stuff, like trying to avoid it, just like burning myself, like doing, like hitting my head and stuff*". So while Belinda, and especially Dinah, described using self-battery and self-burning in order to *avoid* self-cutting, this differed from Anna, who had initially used self-battery as her primary form of self-injury. For Anna, self-cutting only started after the birth of her first son when she was 28, following a break of several years where she did not injure herself at all.

Anna's location of her 'first time' in her (distant) past was similar to the stories told by Milly, Francis, Dinah and Mark, who all indicated that their self-injury could be

traced back to much earlier childhood behaviour which, although they did not name this as 'self-injury' they clearly described as 'self-injurious'. These participants therefore had several stories of their 'first time' – the early self-injurious behaviour, and then the *"actual self-harm"* (Milly). These narratives indicate that for these participants, their later self-injury may have led them to engage in post-hoc rationalisations of earlier behaviour, re-categorising it as 'pathological'. In doing this, they claimed continuity between different self-injuring behaviours carried out at different points in their life-story.

Mark talked about his childhood eczema and explicitly linked the sensations and bodily aspects that he associated with his eczema to his later self-injury:

"I guess it's linked to eczema, I've always had eczema as a kid, really bad eczema. My sister has it worse, mine's pretty much cleared up, but certainly as a kid – scratching, incredibly satisfying, you know that feeling…. Em… which mum, did everything to stop us, and she's right, cos ***we would scratch until we bled. Em… and that would always have that positive association with bleeding, cos it went with, release of pain, you know pain relief. So if you're, you'd scratch and scratch and scratch and scratch, and eventually you'd break the skin****, and, and, it would stop, it would heal over and it would be worse that ever, you know – ahhh! Em…* ***probably the scratching, and the cutting always felt just like that, em, … only, … more acute… em…. Yeah ----- effective?*** *--- in terms of you'd feel the skin ……"*

This passage highlights the intensely corporeal/bodily aspects of both Mark's memories of eczema, and his association of this with his later self-injury. A feature which Mark highlighted as important in his practice of self-injury was that it was a practical method of 'doing something' when he was faced with situations where he felt powerless. The material, embodied body is central to this – it is both an 'object' to be acted towards, but more than this, when the body is acted towards the effects (with self-injury) are instant, dramatic and immediately *felt*.

Milly similarly described early childhood skin complaints, though in her case, she emphasised that these were not a 'condition' of any kind, but related directly to her own practice of "*picking*" at her skin. This was only one of a range of early self-injurious behaviours that Milly described:

*"Em… .. self-harm**. I used to bang my head off the wall, when I was younger**. I don't know why, I don't know why at all. And **I always, had an immense problem with picking spots, any cuts, or grazes, I would pick at, and I would pick at till they got infected**. And when I was little my mum used to put mitts on me, in bed, big massive gauze things, and micro pore. I don't know how my mum and dad coped with the frustration of me doing this. So much so, and I don't know if this was when I was about 10 or 11, because my body was trying to fight the infection, I used to get these little nodules on my head, almost like glandular, cos they're obviously trying to combat all this stuff. So I've got a lot of scars, of just me being stupid when I was little, and picking at my spots….. em… and yeah I used to bang my head on the wall. **I don't know when, the… actual self-harm started**…."*

These early skin-picking and head-banging behaviours were just the beginning; Milly went on to describe further self-injurious behaviour at the age of 13. The following excerpt demonstrates how Milly traces this behaviour through to when the "*actual"* self-harm started, before further detailing how this led on to "*the proper stuff*" when she was 17:

*"But, .. my first distinct memory, of knowing, and this is only looking back, and giving it a label, was when I used to do my paper round, **when I was 13, and I used to walk home, and I used to scrape my arm along the wall, until it was grazed, completely grazed, and I would tell people I had fallen over**. And I'd do the same thing with nail files, usually on my arms… and yeah, it was odd. And just give myself these grazes, and burns, and that kind of thing. And it wasn't until, I was about 16 or 17, that there was a girl at school, who was very open about her self-harm, and she used to do it with razor blades. And it wasn't that I thought it was cool, or maybe I did, with mindset….. em, … she was making a statement, and I was just like wow, that's a fucking amazing statement to make. And, **… I can't even remember the first time I did it, in fact yes I do. I did it on my knee, I picked a razor blade out of a Bic razor**, and Jesus Christ they're fucking difficult to get out hehehe … em, and, … yeah, I did it on my knee, and then I did it on my leg.. and… didn't think anything of it, at all. I think I possibly told a couple of my mates, and they were just like, oh you're just being daft. **And the proper stuff, like the really deep stuff, probably kicked off when I was 17**"*

Milly describes her self-injury as progressing in stages which can be traced back to her very early childhood. This seems to be an attempt to 'naturalise' her self-injury, that is, she is suggesting that the desire/motivation to injure herself had existed from a very young age. Dinah similarly described herself as always being covered in scabs and cuts as a child and also talked about having an "*obsession*" with blood and bleeding from a young age.

Locating self-injury in early childhood might serve a number of purposes. In Mark's case, his proposed link between his early eczema and his later self-cutting, seemed to focus on providing an explanation. This explanation focused on the similarity of the physical sensations and corporeal materiality of both his eczema and self-cutting: this emphasised the importance of the 'release' felt when scratching and cutting skin, as well as the 'release' of blood witnessed and experienced when scratching or cutting the skin. In contrast, Milly and Dinah's description of their early self-injurious behaviour seemed to have been employed to testify to the *authenticity* of their later self-injury. This was particularly the case with Milly, as she was clear that she had not begun to cut herself until after she saw a girl at school doing this. Milly emphasised that she had "*certainly claimed it as my own*" though she had evidently struggled with the issue of whether and how far she had been "*copying*" the girl at school through whom she found out about self-cutting:

"the girl, that I was friends with, at school, turned round and told me that I was being an idiot because I was copying her. And at the time, I was like – shit… ***this kind of……scraping the arm up the wall thing, it had been there for a long time,*** *and I'd not been able to manifest it in this cutting way before, and yes –* ***if I hadn't met her or hadn't seen what she'd done, then I might not have gone along that route at all****…."*

For Milly, then, and perhaps for Dinah and Mark also, the location of self-injury in early self-injurious behaviours remembered from childhood, was an important part of both explaining and justifying their later "*actual*" self-injury. These bodily practices were important aspects of these participants' understandings and explanations for their later self-injury.

4.2.2 Exploring the body and the 'first time'

Francis also remembered early self-injurious behaviour from primary school, though he largely dismissed this as not relevant. Francis did, however, have a careful and well defined story about the 'first time' that he had self-injured:

"That's right, first time I did it I think I was ironing a shirt, (A – ok) and ***I, I sort of burnt myself with the iron on purpose, it was sort of, em, just put the iron against my skin****, I, and it was just sort of like, it wasn't particularly****, I wasn't feeling distraught*** *or, or I didn't think I was, you know, and on the surface I wasn't feeling, particularly distraught or, or any- you know, hysterical or anything, it was just, I was wondering what it would do****, I was wondering what it would do to my skin, how much would hurt****, and em, … so I, sort of had this burn mark on my skin for a little while, and yeah it was easy to just, if pe-someone noticed it, it was easy to say, oh yeah I accidentally burnt myself with the iron."*

Francis suggests here that (at least on the "*surface*") he was not feeling any particularly negative feelings, his self-injury was more oriented towards a curiosity regarding what putting the iron on his skin might do – how it might feel and the effects it might have. The idea that self-injury might incorporate curiosity, experimentation and even playfulness regarding the body was something that Francis suggested was a key aspect of his own self-injury: "*I think part of it is just investigating your own body, like investigating your own senses*". This sentiment was also reflected in some of the other participants' stories, particularly Mark, Dinah and Rease who described self-injury in more positive terms.

For instance, Rease, like Robert, described self-injury as being something that she "*discovered*" by 'accident.' Following this discovery, Rease said that she went on to try out (or experiment with) different methods of cutting herself:

*"Yeah but the first time I did it, I didn't actually know self-harm existed. Which sounds really odd. But em****, I'd sort of accidentally cut my finger with, eh, a pair of scissors? And, kinda went, hey that felt good****. You know.---- bemused by that so kinda,* ***mental thought to self- do that again later and see how it feels y'know****! Heh. So later on I kinda went and did it on purpose. Just on my finger a little. Then, again later on. I was downstairs in ------[…]------* ***it was all very ,very, controlled, I'd got all the kitchen knives out, in a row, and sort of, cut my wrists****. And it sounds like a total fucked up thing to do, but it, kinda, was a really positive thing, it really made me feel better. …."*

This excerpt in particular contrasts starkly with the out-of-control, 'impulsive' self-injury described in much of the clinical literature, as discussed in Chapter 2. After accidentally injuring herself and realising that it "*felt good*," Rease went on to experiment with self-injury in a similar manner to Francis. After initially trying

various kitchen knives, Rease described 'moving on' to razor blades, this stage also involved some experimentation, which again Rease framed in very positive terms:

"so, em, … it was even, .. I cut my leg and, I was just sort of pressed onto the leg, and was about to pull it across, but, ***it was so sharp because it was new, that the skin just burst, and, was really deep, so I went into shock, which is a really odd feeling, but, again this is fucked up again, it was one of the best feelings I've ever experienced****. So, em… but* ***I also realised at the time though, that I needed to be more careful****, cos I realised how dangerous it could be, that I had to be a bit more, controlled about it, and know what I was doing."*

Despite injuring herself quite severely, and going into "*shock*", Rease still maintains that this was a positive experience, a positive feeling. Further, she frames the episode as a lesson, where she realised that she needed to "*be more careful*". This theme of experimentation, play, and lessons learnt demonstrates that the way that self-injury is practised relates closely to the individual's interactions with their bodies.

Robert's story of his 'first time' also resonated with the theme of exploration and experimentation on and with 'the body':

*"(A - So do you remember the first time?) I do actually, aye, em. It was with, em, one of they wee, em, plastic fan things …. Eh, its like ken (A - the little? Oh ok, ok) the face ones, well my mum and dad used to have, em, like ones with the hard blades, you know how they've got the soft blades now (A - oh right yeah) well years ago they had the hard, the right hard plastic blades, and, I took it, em, and it was, I was just actually I, it was quite, it was actually quite a warm day, (A – mhm) and I thought ken I need something to cool myself down, eh, and it was like right, and I had actually like****, it was near my face, and I thought, I wonder what that would feel like ken, like for me actually, just to cut my skin with it*** *(A – mm) em, and that was it (A – mhm) ken what I mean and I just sorta like cut it, and it was like, it was that one there, fact actually no it was that one (A – mhm) cos I done about, three or four of them, (A – yeah) at the same time, em, and I just, ken, done that . ……. So that was pretty much, that was the first one."*

As with Francis and Rease's narratives, Robert describes his self-injury as leading from a curiosity regarding how a cut might feel. Robert's narrative is similar to Francis' in that neither refers directly to any 'emotional' feelings, but rather to a concern with 'physical' feelings and the effects of an injurious interaction with an inanimate object (plastic fan; iron).

These excerpts emphasise the centrality of participants' bodies to their practice of self-injury. The *feelings* that self-injury is understood to elicit as well as the material/corporeal effects of using various tools (hot irons, hammers, knives, scissors, razors) on the surface of the body. These narratives also suggest that the ways that people who self-injure talk about/remember how their self-injury started hints at broader issues regarding the ways that people experience and relate 'living in their bodies'. Francis highlights the importance of experimentation and learning about/discovering the body, seeing his self-injury, at least in part, as being an aspect of this – a 'normal' part of growing up. Similarly, Rease described her self-injury as a positive act, which enabled her to become both familiar, comfortable and in control of her body during a difficult adolescence. These optimistic accounts contrast with previous literature that frames self-injury as a negative, damaging response to equally 'pathological' (albeit ultimately 'normal') happenings such as menstruation and puberty (e.g. Froeschle & Moyer, 2004; Zila & Kiselica, 2001).

The matter of having known already about self-injury before starting is important to note here. Some participants, especially Rease, but also Robert and Justin, emphasised that self-injury was something they 'discovered'. In contrast, others were clear they had 'learnt' it from someone else, Milly in particular. Still others, such as Mark and Francis, initially described discovering it themselves, but later retracted this. For instance when I initially asked Mark if he had come across self-injury prior to starting he replied "*absolutely not*". However, both Mark and Francis decided during their interviews that they had been aware of self-injury before they began self-injuring, and that this may well have informed their own behaviour. This followed initial claims by both that they had never come across self-injury prior to starting. Authenticity is important then in the stories and claims that Francis and Mark made. In Mark's case this was ironically highlighted by the case of Richey Edwards[12], who was himself struggling with accusations of inauthenticity. I explore this further in Chapter 8.

[12] Erstwhile member of the band the Manic Street Preachers who famously carved "4 Real" into his arm, following accusations of fakery from a music journalist.

4.2.3 The injury

Some participants provided quite graphic descriptions of certain wounds or injuries they had created through self-injury. These descriptions oriented around the terms deep and bad. The concern in most of these narratives appeared to be to suggest that the wound had been bad (deep) or not that bad ('just' scratches). These stories about wounds also served the purpose of demonstrating how their self-injury had "*progressed*" over time, invariably getting more and more "*severe*" (Anna).

Both Craig and Harriet, for instance, described their self-injury as developing out of 'scratches' inflicted when they were teenagers. Craig said that he thought his self-injury began by "*just scratching yourself with a compass at school or something, but I can't remember the first time, there was anything serious."* Harriet told a similar story about how her self-injury "*just like started off like using like scissors and stuff like, to scratch my arms and thing and then, kinda like progressed to using blades.*" Like Craig, Harriet said that she could not remember a specific 'first time'. Although Anna's self-cutting did not begin until she was much older, she too described this as developing from "*like scratches, ken just superficial cuts with things, then deeper cuts."*

Craig and Anna each emphasised the severity of their later wounds thorough relating specific instances of self-injury. Craig related an episode where he had been out drinking and woken up at a friend's house:

"…woke up and was basically stuck to the mattress, with blood hehehe cos what I figured out, was I just sort of serrated bread knife and I just slashed my leg, I've got three scars, and erm, you can see, I'm not anatomist so I'm not quite sure but… tubes and stuff like that inside and erm, I actually ended up sewing it up, myself"

Craig showed me the scar that this incident had left on his leg describing the incident as "*the pinnacle of it, that was the worst thing*". Although he did emphasise the 'stupidity' of not seeking medical help, and noted that the scar continued to cause him physical discomfort, he evidently had some degree of pride regarding the

incident, joking that "*sewing your own leg up's pretty hardcore*!" Craig is also perhaps making a claim here regarding his control and mastery over his body.

In contrast, Anna's descriptions of the severity of her wounds were told in a more serious tone. Anna was still injuring herself when I spoke to her, and though Craig's 'worst' example had been one of his last acts of self-injury, for Anna, her self-injury was an on-going behaviour, and one which she was evidently concerned about. In describing the later progression of her injuries, she said: "*Then it [the self-injury] was doon here [lower arm] and then it got closer to the wrist and then it got like deeper, and its just getting mair and mair dangerous."*

In contrast, Milly and Mark, like Craig, described some of their final acts of self-injury as being particularly deep or severe. In each of these cases, the production of a particularly "*bad*" wound was understood to have contributed to the participant ceasing self-injury. Mark was especially clear about this, suggesting that had he not cut himself badly on that occasion, he would likely have ended up cutting himself much more often, but less severely.

While Milly, Mark and Craig suggested that producing a deep cut had contributed to them stopping self-injury, a contrasting theme in other participant's descriptions of their wounds was the continued need to make 'deep enough' wounds. Anna in particular illustrated this issue graphically:

*"Em, and last week, the week before, whenever it was when I cut myself last. It was pretty scary I have to say. Because I cut myself, there was like half a dozen or so on this arm, and I was like ohhh… noo**, its no worked** its nooo… and I went back and I did one, and then I did another one and it just went – whoohhhe. It opened up and it was deep, ken it was like right in deep."*

This issue was also raised by Rease, who talked about her self-injury increasingly "*not working*" which had led, she felt, to an overdose, and fantasies about cutting off some of her limbs. The idea that self-injury might sometimes 'not work' also came up in a discussion I had with Harriet:

*"I found**, it's a lot easier, to cut my leg, than it is to cut my arms, I can go deeper on my legs,** for some reason, […] yeah, you can like totally like, ----- go into it. Its like, **trying to cut my wrists is like a nightmare its like – it doesn't work**!! (A – heheh) hehe, you're like 'grrrr why won't it work?' and I found that you're wrist, it, closes up straight away (A - yeah ok) you cut and, within like, half an hour its closed itself up […] (A - so is it sometimes, kind of, do you feel sometimes that you need to go to a certain deepness, do you know what I mean?) yeah (A - like, ok…) sometimes, you just get your blade and go like that and that's it (A – mm) and sometimes I would just go like tiny little scratches all on my arm its just like, it just act, like, drawing that blade across your arm its like, it feels good, but they're like, they fade away really so its like, when you've done it its like you'll feel these little lines, but then it just disappears"*

This passage highlights the different ways that self-injury can be experienced and practiced. It demonstrates that, for Harriet, an aim of self-injury is sometimes to produce 'deep' cuts, and that she is sometimes unable to do this. Harriet suggests that this is a combination of different tools used (she described finding razor blades the 'best' tool to use, whereas knives did not "*work*"), and cutting different areas of the body – unlike Anna, she described having difficulty making 'deep' cuts on her wrists.

The ways in which participants described their wounds varied in important ways. Depth and badness were important concepts, though in different ways. For some participants a deep or bad wound was described as a signal to stop; for other participants the aim of self-injury was to create a deep or bad wound. These different orientations towards the depth or badness of wounds are significant and imply quite different methods and understandings of self-injury. Importantly, the different ways in which participants described their wounds resists simple or straightforward explanation.

4.3 'Physical' sensations

The feelings associated with self-injury were of central importance to some participant's explanations. Feelings are perhaps the most obvious point at which any perceived boundaries between 'bodies' and 'minds' must dissolve. The word 'feeling' itself is used to refer both to 'physical' sensation and 'emotions' and

emotionality (Lupton, 1998a: 41). Participants talked about the 'physical feelings' associated with the act of self-injury in two main ways. Several participants emphasised the positive feelings and sensations that self-injury elicited. Most participants also referred to pain and self-injury. Understandings regarding the relationship between pain and self-injury are addressed in detail as there are contradictory discourses around this in existing literature, and these are reflected in the narratives of the participants. In particular, this discussion focuses around the question of whether or not self-injury hurts.

4.3.1 A "pleasurable sensation"

Mark, Rease, Francis and Justin all emphasised the positive feelings and sensations that they associated with self-injury. Mark, Rease and Justin all implied that these positive or 'pleasurable' sensations were the result of bio-chemical changes in their bodies, brought about by their self-injury. Mark suggested that "*whatever, … neuro-receptors are open, it, fills them, satisfies them*". Later in the same interview, Mark considered whether similar injuries, occurring in different contexts, might 'feel' the same. He compared his own self-injury with the experience of a friend whose arm had been cut in quite different circumstances:

"but I was just wondering if the physical sensation is probably the same (A - yeah, I guess…) em,…… I ***mean both of them you've got endorphins flowing if you've, if you've got up the nerve to pick up a knife and cut yourself or you're being thrown out of a club by a bouncer you're, the adrenaline is flowing and all the rest of*** *it (A – yeah) so the physical sensation I think is probably pretty much the same – I don't think Edward even noticed"*

Mark suggests then that although the contexts are different, both self-injury and other-injury have the same chemical or physical effects, the "*adrenaline is flowing*". This leads to what Mark categorises as similar sensations: these are experienced as satisfying in the case of self-injury, and yet led his friend Edward to perhaps not even notice he had been injured. The adrenaline, in Mark's understanding, is the important factor, though the context apparently mediates how this is experienced: satisfying or anaesthetising.

Participants' definitions of the 'pleasurable' aspects of self-injury were often related to their understandings of pain. Here Mark's conclusion that the physical sensation must be the same was related to his understandings of bio-chemistry. The physical sensation to which Mark refers is one that is pleasant, but still painful. Mark struggled with definitions of pain and pleasure, especially concerned with distancing his behaviour and feelings from what he termed "*masochism*."

"you know, you take an area, rub it with a ----- em, …. You do that with a r---- with a sharpened or, or –[pointed?]-- implement, yeah, I mean that's not painful. …… and I don't think, ….. Its not masochist, … or my understanding of masochism, is that it is the pain, and its not, but its not there, cos its, it is a pleasurable sensation, cos its so its, yeah, sorry! Heh. It does hurt the next day though."

The issue of masochism was also raised by Craig ("*I'm not really masochistic in any, kind of way*") and Rease, who suggested that self-injury was seen by others as masochistic for women and but not for men. She argued that this could not be the case, as self-injury for her was not painful and in fact that it actually felt "*good*". Both Rease and Mark's discussions highlight the complex and contradictory nature of wider understandings regarding the pain/pleasure dichotomy.

Like Mark, Rease also suggested that 'endorphins' might play a part in explaining why self-injury felt so "*good*". She was particularly emphatic about the pleasurable aspects of self-injury, for instance describing cigarette burns as feeling "*wonderful, like bubbles*". Similarly, Justin described his earlier episodes of self-injury as being mainly carried out in order to feel a "*rush*", a "*buzz*" or "*good*". Justin associated these feelings with "*seeing the blood*" and returned to this idea several times in the interview:

"I definitely remember kind of, you know, getting sort of a rush, from it, you know if you were feeling a bit down and you kind of just, you know, saw the blood and then you'd be like, […] give you a kind of rush […] I guess like, just sort of seeing the blood kind of always made me feel a bit kind of, like, …. good"

Justin also associated these feelings, in part, with bio-chemical understandings of the body, implicating "*adrenaline*." However, he particularly associated these feelings

with the material, visible blood that was revealed or released when he cut himself. Mark and Rease also talked positively about the more visible bodily aspects of their behaviour. Indeed, Rease suggested that one of the reasons that self-injury was so difficult to stop, was because she could think of nothing that was really comparable in terms of bodily sensations and effects:

"I think its, its really difficult to get somebody to, sort of, use alternatives, because ***its such a powerful, em, thing*** *and because it involves the body so strongly and, … but its, you know like the, … the actual cutting and the, the blood thing and, there's not much else that can kind of, stand in for that really"*

The idea that self-injury can be pleasurable, it can feel good, was an important feature of Rease, Mark and Justin's explanations for their self-injury, and was also mentioned by Harriet. It is perhaps significant that although the other participants did not talk in such positive terms about the feelings associated with self-injury, none mentioned any particularly negative feelings or sensations. Even those who said that they did feel some pain during their self-injury did not describe this as a negative experience. This was put most clearly by Francis, who said that self-injury caused him pain, but that this was "*a good pain, not a bad pain*." I will discuss the issue of pain further in the next section, however I want to emphasise here that attending to the pleasurable and positive aspects of the practice of self-injury – an issue which is only really accessed by attending to the embodied nature of self-injury – could help to explain why, once started, people continue to self-injure, and why they might find it difficult to stop.

4.3.2 'Physical pain' as an aim and outcome of self-injury

For some participants, the experience of 'physical' pain was central to their practice of self-injury. Francis, Milly, Craig, Harriet and Belinda all talked about self-injury being a way of masking or changing 'emotional pain' with or into 'physical pain'. The idea that self-injury is a functional method of coping with 'emotional pain' by either converting or transforming it into 'physical pain' is common, and can be seen

in existing clinical and academic literature (Jacobson & Gould, 2007; Solomon & Farand, 1996) as well as in lay discourse on the internet (LifeSIGNS, 2005).

Participants used this explanation in subtly different ways. Harriet, for instance described self-injury as "*masking*" the "*other pain*" saying "*you'd forget about the other pain you were in cos you're like – oh, my arm hurts or whatever.*" Craig made a similar suggestion, though he also invoked the idea of control: "*if your arm's hurting for whatever reason, then that gives you something more to con- to worry about, and something that you can probably control*." For both Craig and Harriet, the physical pain of self-injury acted as a distraction from 'other' pain, or worry. In contrast, Milly suggested that physical pain was *easier* to deal with:

"but, again what I was saying about the …. …. … … em, … … the having something physical, to, .. deal with (A – mhm) … .. rather than dealing with, the kinda metaphorical stuff (A - yeah) but having something physical, and having .. having a physical pain, to deal with, was easier than dealing with, the, the pain that you couldn't put your finger on (A - mm, yeah, yeah) so --- not that it took it away, but, it was still really helpful"

As I discuss further in Chapter 5, participants frequently appeared to have difficulty naming the problematic emotional or mental states that their self-injury was apparently addressing. In the excerpt above, Milly explicitly suggests that the physical aspects of self-injury, and the physical pain of self-injury, were easier to deal with and that this was helpful. This could be seen as similar to the distraction idea suggested by Craig and Harriet, but it draws out more clearly that orienting towards physical wounds, and physical pain, was experienced by Milly as being easier than dealing with the "*pain that you couldn't put a finger on*". It may be significant that Milly is able to name this feeling as 'pain' or 'painful' – despite also describing it as metaphorical. This may suggest that feelings that are experienced as metaphorical (Milly), confusing (Belinda), or otherwise difficult to categorise, are viewed as painful. Further, this indicates the dual-purpose nature of pain as a concept in these narratives, referring to both physical and emotional sensations. In many ways, this duality can be seen as appropriate, given the inextricability of bodies and minds/emotions.

Francis and Belinda each talked about the physical pain of self-injury being a way of feeling *something* rather than 'numb' (Francis) or 'confused' (Belinda). When Francis was self-injuring, he told me that he felt as though he "*should*" be feeling "*things*" but that he felt "*incapable*" of doing so:

"that got to me, after a while, ***that I felt I was incapable of feeling anything****, you know incapable of emotion and…. Em…. I didn't like that, I wanted to be able to feel I wanted to, you know, live or experience stuff or. …….. and so,* ***self-harming was, you know a way of, feeling, pain, you know feeling pain cos it was something*** *(A - yeah, yeah) it was like, a strong feeling, em, whereas you know, up to that, around that time I felt like I was in, cotton wool or something you know, just all like muffled, and em, nothing was getting to me, nothing was affecting me"*

In contrast to Milly, Harriet and Craig, who described physical pain as being a distraction from negative or amorphous feelings; for Francis, the physical pain of self-injury was a way of feeling "*something*" rather than "*nothing*." Again this points to the impossibility of separating out body, mind, emotion and feeling from one another. Francis describes 'feeling incapable of feeling', referring particularly to an inability to experience emotions; this lack of emotional feeling is replaced, through self-injury, by a physical feeling of pain. This explanation shares with the others the orientation that this is *preferable*: the pain experienced through self-injury is *preferable* to (or 'better than') both un-nameable 'feelings' and an absence of 'feeling'.

Belinda similarly emphasised that self-injury, both the pain and the physical materiality of the wound, was preferable to her mental state, or "*whatever's in my head*":

"I, need to feel something, just for a little bit, not always, just for a little bit, something that I know is real and its there and its concrete and its, this is, this, and that's that, and its real and its just, sort of more black and white (A – yeah) ***my arm hurts its bleeding, it's a feeling, instead of just confusion*** *and… not understanding things and, … … and just, yeah not understanding……mm… it's a big thing for me ----[very quiet, unclear] ---- and trying to make something of, whatever's in my head, to make it into something understandable and manageable – manageable"*

In the above excerpt Belinda combines several themes raised in this section. She emphasises that the physical pain, and the corporeal materiality of self-injury can act as a way of managing otherwise confusing 'feelings'. This further emphasises the interrelated nature of bodies and emotions, as well as the importance of 'the body' as a site for 'reality'. Certainly for Belinda, bodily injuries are experienced as more tangible and therefore 'better' than 'confusing' emotional feelings.

4.3.3 'It doesn't hurt': feeling nothing at all.

In contrast to those accounts where physical pain played an important part in participant's descriptions of their practice of self-injury, some participants claimed that they did not feel pain during self-injury. This reflected another dominant theme in existing understandings of self-injury, also present in both academic and clinical literature as well as user/lay discourse (Jacobson & Gould, 2007; Murray, 2005; Solomon & Farand, 1996). Some of the participants described their self-injury as *both* a way of experiencing physical pain *and* as something which caused them little or no pain. Further, even for those participants who did say that they felt pain during self-injury, several were clear that this was not 'bad pain' – it was manageable, or even 'good'. These contradictory understandings are seen in the literature as well and point to the intensely subjective nature of pain. This highlights the situated nature of narratives. Participants' memories of pain are mediated by the purpose and context in which they are relating the memory: in this case an interview about their self-injury. What is important is what participants say about the relationship between pain and self-injury, rather than the inaccessible matter of what self-injury 'actually' felt like.

Anna was the most clear that she felt no pain at all during her self-injury – and this applied both to her cutting and her earlier self-battery. In clinical literature, experiencing no pain during self-injury is generally attributed to dissociation or depersonalisation, which Anna said was a term she had only recently heard when I asked her about it. Dissociation is particularly raised in the clinical literature as being associated with self-injury and sexual abuse (Brodsky et al., 1995). Broadly, it refers to an individual feeling disconnected from their body or self, in extreme cases this is

likened to an out of body experience. Anna herself talked about being in a different "*mental state*" when she cut herself, suggesting that this affected how much it hurt:

"So, there is definitely a difference between… I dunno whether it is as I say if it's a situation or… mental state, or whatever, but there is definitely a difference, between…. like being cut or being hurt or whatever…and and, cutting yourself, definitely… I mean ***and there's some difference in the pain threshold****"*

Anna and I discussed this further, contrasting self-injury with other accidental injuries. I suggested that self-injury might hurt less because it was an expected injury, but this idea was rejected by Anna:

"…because if you were sitting like now, calm and kinda fine, to take, a razor blade to your arm… or or wherever, I bet you wouldnae be able to do it… whereas… I dunno… like, ***it's like you go into this zone or something*** *I just… I always say that, like when I cut myself there's something inside me and it has to I have to get it out… and that's the only way I ken of to get it out, it's like there's evil, in me. That sounds so bizarre, but…….. heh and its like a battle for control between me and th th this whatever's in me and that's the only way I can get it out and so its definitely …….. I dunno….. ----[unclear]----* ***I'd say yer in a different – state, different place, whatever mentally****……."*

Anna emphasised again the 'different state' – suggesting that self-injury would be impossible for someone who was calm. Anna goes on to invoke the idea that something 'inside' needs to be 'got out', although she uses terminology (evil; battle) which is particularly dramatic (and would no doubt be labelled quite differently from a psychiatric perspective), the same sentiment is reflected in less dramatic terms by other participants when talking about 'release'. This is discussed in more detail in Chapter 5.

Harriet used the term dissociation without prompting from me, saying that she felt no pain at all when she self-injured whilst dissociating, but that she felt some pain if she self-injured when she was not dissociating. Harriet also implicated biochemical explanations in order to account for her lack of pain:

"I think its different at different times, cos sometimes, … I've just, totally out of it, and ***I'm dissociating a lot, I don't feel it****. But other times, I do (A – ok) so it just*

*varies but, I think like, sometimes you don't**, you don't feel as much pain as you'd think you do** (A – yeah) its like, cos like when I was trying to explain it to a group of, of like school kids*[13] *I was like, explaining about how like there was like, like all these **chemicals in your brain that get released (A – mm) so that it acts as like as a pain killer** (A – mhm) when you're, when you're doing it so you don't, you don't actually feel the pain that you think you would*

So even where Harriet was not dissociating, she said that the pain was not as much as you would expect, and she attributed this to "*chemicals*" in her brain. This is similar to the suggestions put forward by Mark and Rease in order to explain why self-injury felt good. The 'release' metaphor is again employed here, in this case to describe the 'release' of chemicals from the brain. Mark, Francis and Rease all echoed Harriet's claim that the pain felt during self-injury was not as expected. Francis saying it was "*manageable*" and a "*good pain*" whilst Rease said that she "*didn't feel pain, as, other people would feel the pain.*" Mark said that it "*certainly wasn't painful, not in the sense that you think of pain as being something that you want to avoid"*. These discussions highlight the difficulty faced when attempting to account for and describe pain. As others have demonstrated, lay understandings of pain are related to dominant cultural discourses which reflect bio-medical interpretations of the body, but also hint at moral messages regarding appropriate and inappropriate feelings and responses (Bendelow & Williams, 1998). With regard to self-injury, individuals must account for their engagement in a behaviour which is objectively 'painful'. In most cases, my participants justified this (Scott & Lyman, 1968), claiming that the pain was different for them, or that it simply did not exist.

Robert also said that he did not feel pain when he self-injured, and his description and explanation of this could also be interpreted as dissociation, although he did not use the term himself:

*"it was like there was just **no pain whatsoever** but its like, I mean, like I say I mean I have low pain threshold, but, like, sec- I stuck the Stanley knife and stuff into my arm it was like, there was just nothing – there was no pain (A – mhm) it was like, **it was like as if I had kinda removed myself from my body,** em, and it was just like, it was like as if I was sorta standing behind myself watching myself, actually doing it, but I*

[13] Harriet had been involved in awareness raising about self-harm in high schools, this included giving presentations to high school students.

*didnae actually feel any pain (A – mhm) and it was like**, I could see the blood and stuff eh, but it was just like there was no pain whatsoever**, em, because I kinda done all sorta five of them at the one time eh? (A – yeah) em, so it was kinda like, it was just kinda weird. So there was just nae pain eh, or at least, there just seemed like there was **nae pain, at all**"*

Like Harriet, Robert described his self-injury as causing no pain at all, but elsewhere in his interviews he suggested that it did cause pain. For instance, when describing how he began to self-injure he said:

*"I kinda thought well if I keep doing this, then, every time I'm emotional, or, emotional pain, then, **I'll give myself a wee bit a pain for a couple of minutes** and then it'll just be that'll be it it'll be gone"*

The inconsistencies around the issue of pain in Harriet and Robert's narratives could be interpreted in a number of ways. It may indicate that self-injury is experienced and practised differently by individuals at different times: as Harriet suggested, when she dissociated she did not feel pain, whereas when she was not dissociating she did feel pain. It is also possible that in these narratives, contradictory existing discourses around self-injury (that it does not hurt; that it transforms mental/emotional pain into physical pain) are being employed relatively unreflexively by participants. It could be that 'pain' is sometimes used to describe an injury, rather than the actual sensation or feeling caused by the injury (for instance when Robert talked about 'giving himself a bit of pain' or when participants talked about 'hurting' themselves). Finally, it is more than possible that these inconsistencies reflect the constructed and evolving nature of understandings about self-injury. Participants did seem to use the interview in some cases as a way of exploring possible explanations and possible understandings regarding their behaviour, and I certainly tried to encourage this exploration.

4.4 Tending the self-injured body: Healing and Scars

In the minutes, hours, days, weeks, months and years following an act of self-injury, the self-injured body generally carries some form of mark or scar, as the skin heals.

Examining this aspect of self-injury was particularly important to some of my participants' descriptions of their practice of self-injury, and to their understandings regarding what self-injury meant to them. The marks and scars created by self-injury must be addressed on a daily basis, particularly in the immediate aftermath of the injury, especially if it is severe. I deal more closely with issues of hiding or revealing these marks and scars in Chapter 7. In this section I will detail the ways that participants talked about caring for their healing wounds, moving on to the ways they discussed their scars and marks.

4.4.1 Healing as distraction or self-care

Several participants emphasised the importance of caring for the wounds they created on their bodies through self-injury. For some, the acts of caring and tending for wounds appeared to be related to the more general aim of distraction from negative mood states. Milly, for example, said:

"I had this coping mechanism that I could use to stop, everything, because then ***I could concentrate on, you know cleaning up wounds,*** *and you know feeling that throbbing pain in your arm, your like, I'm alright, I'm still alive kind of thing"*

She also later emphasised the importance of the "*physicality of having something, to tend to and, and watching something physically heal*" which was "*a comfort, because then the mood was forgotten about*." This related to Milly's contention that dealing with self-inflicted physical injuries was easier than dealing with her emotions, but also, as she added here, self-injury wounds were easier to deal with than the *"incidental stuff that's happening around you*." This relates more generally to issues of control which were brought up frequently by participants. For Milly, and for other participants, self-injury was something which was more easily controlled than either emotions or other people, and therefore when either emotions or other people were getting 'out of control' self-injury offered a way of feeling 'in control' as well as distracting and comforting the self. That self-injury left wounds which healed was an important aspect of this for some.

Rease also talked about the importance of healing, and tending to self-injury wounds and scars as being a way of looking after the 'self':

"the healing, the sort of self-healing, and I think a lot of people have said about that, that em, about the emotions that you, can't sort of see them, or, or feel them, and, deal with the pain of them, but, ***when you have like, scars and they're healing's like, you're looking after yourself, you're looking after the sort of mental stress that you're going through but in a, very, em, physical and ---- symbolic way that's a bit more, real****, I suppose"*

Rease emphasises the importance of the physicality of the healing – suggesting that this was more 'real'. As Rease herself suggests, this indicates a particularly symbolic understanding of the body. This could also relate to broader theoretical ideas which suggest that the body is increasingly seen as the only 'real' site for the expression of an authentic self (Riley & Cahill, 2005; Sweetman, 2000).

In contrast, Francis and Dinah both talked about interfering with the healing of the wounds left by their self-injury, indicating that this was an important aspect of how they practised self-injury. Dinah related this explicitly to control:

"and there's also I suppose I made it harder when I was self- when I was cutting myself as well cos I was like, oh, like this might have healed much much quicker if I'd, you know, left it alone, know what I mean? [----unclear, very quiet----] trying to exercise self-control over things"

Similarly, Francis said that he had tended to scratch off scabs formed following his self-burning, as soon as they began to heal. So for some participants, the healing of the wounds left by self-injury offered a way of 'symbolically' healing themselves, or caring for themselves. For others, interfering with this healing process (by picking scabs off) was a part of their practice of self-injury.

Participants' talk about the healing of wounds, and tending their own wounds was quite different from that of other participants who described the care that other people gave their wounds. Anna and Emma each related harrowing experiences in A&E departments, where their wounds were treated in a much more negative manner. These narratives are discussed in more detail in Chapter 6, but I introduce

them briefly here. In Anna's case, a doctor attempted to apply steri-strips to a wound which had "*severed an artery*". Following this experience (Anna was sent home with the wound still bleeding, it became infected and she got septicaemia), Anna maintained that she would no longer go to A&E to get her wounds treated. Instead, she had a stockpile of dressings and bandages at home. She said that she would *"rather die, seriously would rather just die, I wouldnae go through that again for anybody. It was, horrendous."* Similarly, Emma described having staples applied to a wound on her stomach, with no local anaesthetic. The treatment Emma and Anna described receiving in A&E contrasts starkly with the care that other participants described giving their own wounds. This comparison demonstrates that the tending to and treating of the wounds left by self-injury has the potential to be experienced as a positive and nurturing, as well as negative and damaging.

4.4.2 Feelings about scars

Participants expressed a range of opinions regarding their scars. For some, they were experienced as positive 'marks' upon the body; whereas other participants were much more ambivalent about their scars, going to some lengths to conceal or remove them. With the notable exceptions of Rease and Mark, most other participants referred to their scars using the oppositional terms big/little and good/bad.

Rease was particularly positive about her scars, reflecting her generally positive attitude towards self-injury. She described her scars as "*beautiful*" and felt that they were a part of her "*story*":

"it is about adornment and celebration, so, yeah. And in a way my scars are as well actually, cos ***I do think they're really beautiful,*** *and, they're like a part of my, my experience, my history. And I very much believe about, em, your experience – written on the body, and the body telling a story. So. It pisses me off that, in this society its all about keeping the body clean"*

Rease contrasted her own, relatively upbeat understanding of her scars with that of "*other people*" who she knew "*hated*" their scars. As I discuss below, only a couple of participants in this research might be described as hating their scars, with most

appearing to have more neutral opinions. Mark however, expressed a similarly affirmative understanding of his scars. He described one scar in particular as acting like a "*badge*". This scar had been created during a significant event, and Mark felt that if this had not happened, his self-injury may have taken a different course:

"But, because that one was so bad, em, … it almost serves as, as a -----unclear--- I don't need to cut, I've got that […] Its like er, its like a badge. […] I think if I hadn't done that, my arm would have been a lot more – covered in small cuts"

Mark felt that the existence of one scar in particular, acted as a permanent reminder that he did not "*need to cut*". That scars could act as a reminder of past experiences, good or bad, was indicated by a number of participants. Anna and Robert expressed much less positive opinions regarding this. Anna, for instance, felt that the existence of her scars represented a reason *not to stop* cutting:

"the scars are there for, forever now, so……. I ***think that's kinda a bad thing though, because it, … see if its something that faded over time, you might sorta go, oh well, it all faded so, that's it I'll no bother****. But I've got these scars now, they're there now, the damage is done, I just cut on top eh scars now, just, covered… totally utterly covered…….. so its like, phew……..****what's the point, of stopping****"*

Anna's orientation towards her body was markedly negative, and this extended to her descriptions of some of her scars, which she said were "*horrible*". Robert's view of his scars was also rather negative, although for different reasons, relating more to memories evoked by the scars.

" I do know, em, that, that some people, are actually, do have like, more scars on their arms than what I do […] ken what I mean so its like, but I mean obviously they're there, em, and they're kinda remind me (A – mm) yeah, sorta like a place that I was, which wasnae very nice but"

Like Mark, Robert's scars acted as a reminder, however Robert interpreted this more negatively, suggesting they reminded him of time and place that had not been pleasant. The different orientations of these participants towards their scars indicates the importance of attending to individual understandings regarding the scarring that self-injury can leave. The highly different ways in which scars were interpreted can

also be seen to relate to widely diverse understandings about future actions. While Mark and Rease had both stopped injuring themselves, Anna and Robert both continued to do so. Most significantly, while Mark used his understanding of his scars to justify his avoidance of self-injury, Anna saw her scars as a reason to continue.

Other participants talked about their scars more neutrally, even when they used prescriptive descriptions such as good/bad. In most cases, I would suggest that a scar is given these labels according to how obvious or noticeable it would be to other people. For most participants, bad and big referred to scars that could be easily identified by others as self-inflicted, or which drew attention and comments if they were seen. In contrast, scars that were "*little*" were not easily identified and/or were easier to cover. Although Mark, Rease and Francis all talked about scars as being positive in some ways, only Belinda described a scar as 'good' saying that her "*wrist didn't scar very good*". Belinda seemed to use the word scar differently from other participants, however, with scar seeming to mean the initial wound rather than the mark left once the wound had healed. Belinda's description does imply that a "*little*" scar is not necessarily also a "*good*" scar however. This may relate to the finding discussed in section 4.2.3 where some participants suggested that for self-injury to be successful a certain amount of damage had to be inflicted – the wound had to be "*deep*" enough.

It is possible that there is a gendered dimension to participants' understandings of their scars. Rease was particularly explicit about her own struggles with normative understandings of gender and bodies, and she suggested that in some ways her self-injury had been an overt challenge to dominant discourse regarding 'clean' or 'perfect' (female) bodies. Further, both Mark and Francis talked more generally about men "*liking*" scars (whatever their origin), and viewing them as "*cool*". However, with regards to participants' understandings of their scars from self-injury, there was no clear difference in the ways that the men and women appeared to understand them. As discussed further in the next section and extended in Chapter 7, most participants described some form of scar minimisation or concealment,

suggesting that even for the men I spoke to, the scars left by self-injury were not unproblematic. This points to the problem of conducting analysis along the lines of gender alone, issues relating to class, ethnicity, age, sexuality and one's status as a current or past 'self-injurer' are all just as likely to play a part in understandings regarding scars.

4.4.3 Scar removal and reasons

Several participants had made some attempts to minimise, conceal or otherwise remove their scars permanently. In Chapter 7 I discuss the ways in which participants described hiding and revealing scars temporarily. Anna described trying to minimise some of her scars using 'bio-oil' a product marketed for reducing scars and stretch marks. However, she said that it had not worked well "*it kinda does fade them, but, 'fraid I think I've got too many big, deep, …. kinda big scars now that it just, it wouldnae work*". Anna suggested then, that her scars were too severe to be removed. This attitude reflected her generally pessimistic orientation towards her body and her future, reflected further in her interpretation of her scars as being a reason to carry on self-injuring, rather than (as with other participants) a reason to stop.

Harriet also referred to some of her scars as "*really bad*". Harriet had gone to perhaps the most extreme lengths of all of the participants to remove her scars, getting plastic surgery to minimise and reduce the scarring on her arms:

"Eventually I managed to get like, like, went to the plastic surgeon got the injections, and, a lot of people were quite angry, that I was able to get that help, because their scars are untreatable (A – oh) H - and also, because I was still self-harming, and, .. they're like, but I got told, we have to, you have to wait 2 years before you'll get treatment, but the thing is, all the scars on my arm are so old, they're like, years and years old, that they, that, the doctors, didnae have a – [clue]"

Harriet describes getting the plastic surgery on the understanding that she had stopped self-injuring. In fact, this was not the case, and Harriet was still injuring herself, though largely elsewhere on her body. Harriet said that some people, others she knew who self-injured, had been angry about her getting treatment when she was

still injuring herself. She justified what had happened by emphasising that the scars on her arms were "*old*". Although Harriet did describe her scars as "*really bad*" however, she did not describe them in as negative a manner as either Anna or Robert. Indeed, she also went on to tell me that she did continue to cut her wrists, but restricted this to areas she could cover up with a watch. It is possible, then, that Harriet's feelings about her scars were not necessarily that negative, and that her reasons for getting them removed by plastic surgery lay more in her concern with the feelings of others about her scars.

Justin described having had some success in minimising and concealing his scars. He had tried a gel pad treatment designed to minimise 'bumpy' scars:

"I also looked into like you know, trying to see, er, ways of kind of you know, making scar, tissue look less, obvious and stuff erm, … I got this quite interesting stuff that was like em, … ***kind of like em, a gel pad, a silicone gel pad (A – right) that kind of, comp- and actually, made hu- you know you had to wear it, like every night*** *(A – right) and then, like it consistently kind of pushed it down (A – ok) but then if you don't keep using it you know it sort of, they sort of show more (A – right) and you end up kinda going back to the, state (A - ok, ok) but, em,* ***that flattened it off****, (A - so were they quite raised before that?) yeah, yeah …erm… so, em, …. … so that, you know that was again, kind of, you know trying to kind of, get to the point where you don't feel kind of worried about kind of…"*

He followed this treatment by getting a tattoo over the worst of his scarring, in an explicit attempt to cover up the scars so that he would feel more 'comfortable' wearing short sleeves. These practices, then, were again oriented particularly towards minimising scars for the benefit of other people. Justin had undertaken these scar minimisation techniques (the gel pad and tattoo) in preparation for a holiday where he felt he would have to wear clothes that would reveal his scars.

Emma and Dinah also described getting tattoos in order to cover up some of their 'worst' scars. Dinah especially said that she felt getting tattoos had helped her to become more comfortable about her scars, particularly about other people seeing them. She had got one particularly "*bad*" scar covered up by a tattoo because she was "*fed up of people asking about it*". Although Emma said that she was not embarrassed about scars, she did express some ambivalence about how many she had

and her continued inability to 'show them' to her parents. These concerns are discussed and expanded upon in Chapter 7, where I more explicitly address the different ways in which participants negotiated social life with their scars.

With the notable exceptions of Anna and Robert, who appeared to view the scars themselves negatively, and Mark and Rease, who seemed to view their scars particularly positively, most other participants were more ambivalent. In most cases, scars were only problematic when they could be noticed by other people.

4.5 Bodies, feelings and self-injury

This chapter has introduced some of the material, corporeal aspects of self-injury by examining the narratives participants had around 'what they did' when they self-injured. Section 4.2 examined participants' narratives around the 'first time' that they self-injured. This analysis suggests that for some participants, self-injury was understood as something deeply rooted in their past, early in their biography. I have suggested that by locating their self-injury in their early history, participants may be claiming that the behaviour is authentic, comprising a part of their essential self. Even where participants did describe learning the behaviour from others, they were often reluctant to admit this, and provided justifications to explain this learning. These explanations were similarly oriented towards claiming that their practice of self-injury was authentic. Other participants describe self-injury as an almost 'normal' aspect of growing up and exploring their body's limits. These narratives tended to suggest that self-injury had been largely self-learned. Concerns with authenticity were also relevant here, with some participants being initially reluctant to identify their prior knowledge of self-injury. Despite this, two participants did re-categorise their self-injury from self-learned to other-learned during the course of the research.

Section 4.2.3 discussed participants' descriptions of their actual practice of self-injury. This analysis suggested that for some participants, self-injury was oriented

towards creating "*deep*" enough wounds; that injuries had to be a certain severity for the self-injury to have "*worked*". Several participants suggested that their self-injury had progressed over time, from superficial cuts to deeper cuts. For some participants, this increasing severity was on-going. For others, self-injury reached a "*pinnacle*", whereupon a particularly "*severe*" injury was a catalyst in their ceasing the behaviour entirely.

Section 4.3 began to introduce the feelings that participants described associating with self-injury. I demonstrated that for some participants self-injury was explicitly associated with pleasurable feelings. Further, participants' narratives around pain and self-injury suggest that for most participants, self-injury elicited physical sensations that were not negative. Even where they were labelled as 'painful' this was manageable or good pain, not "*bad*" pain. I noted that narratives around pain did seem to mirror lay and clinical understandings of self-injury as a behaviour which transformed physical pain into mental pain; yet simultaneously did not hurt. My analysis of this issue suggests that this complex and contradictory matter reflects dominant dualist models and understandings of body/mind and pleasure/pain. Participants' discussions around the (physical) sensations elicited by self-injury demonstrate that these matters are not either/or.

Finally, section 4.4 turned to the material consequences of self-injury: wounds, scars, and participants' orientations towards them. I showed that for some participants, the care of their wounds was an integral aspect of their self-injuring behaviour. Physical healing acted as a metaphor or symbol for mental/emotional healing, or more mundanely, the care of wounds offered a distraction from other concerns. This contrasted starkly with the punitive and damaging 'care' participants described receiving in medical settings, an issue I take up further in Chapter 6.

Participants' feelings about their scars were then addressed. I demonstrated that opinions about scars varied widely. However, I suggested that for most participants, scars were viewed relatively neutrally, and that they only became 'good' or 'bad' when visible to others. Indeed, as section 4.4.3 showed, most participants who had

attempted or succeeded in permanently removing scars (through plastic surgery, tattoos, or other means) did so in order to avoid the comments of others, rather than any intrinsic dislike of their scars.

This chapter has illustrated a number of ways in which the bodily, visible, material aspects of self-injury can be usefully analysed. The embodied nature of self-injury will remain central to the following chapters and I will continue to demonstrate that this is essential to a full understanding of self-injury. This chapter has also begun to show the importance of biographical, interpersonal and cultural contexts in participants' understandings of self-injury. The location of self-injury within individual biographies is important in understanding how self-injury is understood and the meanings it has. The way in which the self-injured person negotiates social life and the opinions or comments of others about their body has similarly been shown to be important, mediating participants' practice of self-injury as well as their understandings. Finally, this chapter has shown that participants draw on wider understandings about self-injury in order to structure their narratives about their own behaviour. Clinical and lay interpretations of what self-injury is thought to 'do' are important, as are wider understandings about bodies and what it means to be authentic. In the next chapter, I turn to the more emotional aspects of self-injury discussed by participants. Although the focus is upon emotions, however, the discussion remains firmly embodied.

Chapter 5

Emotion Incarnate

5.1 Introduction

In this chapter, I will focus on the more explicitly 'emotional' themes and issues raised in the interviews. Several existing explanations for self-injury centre on such emotional aspects – suggesting that self-injury serves to 'release' tension; to 'relieve' negative mental states; to express feelings. However, existing understandings tend to view emotions as disembodied, purely mental states with the feeling individual frequently divorced from socio-cultural contexts. As noted earlier, my own analysis of emotions is both embodied and interactionist. Thus, this chapter will engage with the emotional explanations that participants had for their self-injury and attempt to relocate these explanations within socio-cultural contexts and understandings. I critically assess the ways in which participants used concepts of (emotional) control, expression and invalidation. Throughout these discussions, I suggest that accounting for the embodied nature of emotions makes these explanations more meaningful and understandable. Further, this chapter suggests that participants' narratives around emotional control, expression and invalidation reflect broader concerns with both power and authenticity.

5.2 Control

One of the ways that self-injury is currently understood in a variety of existing literature is that it is a form of 'tension release'. A number of my participants also drew upon this idea when explaining their self-injury to me. Closely related to the concept of release is that of control. These concepts have been shown to be important in theorising emotion, particularly in studies which examine lay understandings (Lupton, 1998a).

It is important to bear in mind here that in some of the interviews, these issues were not linked explicitly to emotion. In fact, what exactly is being controlled or released through the act of self-injury was not often named. Anna, for instance, talked about her self-injury as something she did when "*things*" or "*it*" got out of control. However, with regard to the theoretical literature, these concepts are apparently regarded as emotional, and certainly for some of my participants this appeared to be the case. I want to be clear before I present this data, then, that my labelling of these issues as 'emotional' is not always entirely satisfactory. It is possible that this relates to the more generalised problems some participants seemed to have with naming and talking about emotions. These problems further relate to the inter-connected nature of bodies and emotions. The metaphor of control and release in particular lends itself well to an embodied (rather than purely emotional/purely bodily) understanding.

Participants used the concept of control in a number of different ways. I have tried to separate these into themes. Firstly, I will introduce the ways that participants described self-injury as being a way of controlling feelings. I then move on to the specific metaphor of control and release which was used by some participants. Finally I problematise the use of the term control by contrasting this with the few instances where participants used the word power instead.

5.2.1 Control over 'feelings'

Several participants described self-injury as being a method of controlling, or feeling as though they had control, over their 'feelings'. The term 'feeling' is often used in contradictory ways – to refer to either opinion and/or a physical sensation; Lupton, for instance, found that 'emotions' were frequently defined as 'feelings' (1998, 41). To some extent this can be seen in the narratives of my participants. However, I would argue that this is not necessarily contradictory, but rather reflects the complex and embodied nature of experience and being: opinions, emotions, bodily sensations are all 'felt', and it may be difficult – or even impossible - to identify or separate these concepts.

Belinda said that her self-injury was "*something that I sort of have control over feeling"*. She contrasted the "*concrete"* feelings she felt through self-injury with the confusion of what she described as her "*inside"*. Belinda seemed to suggest that she had little or no control over the "*inside"* of her self – she described this 'inner' state vividly, using the metaphor of a busy, traffic-logged city on two separate occasions:

*"… in my head and in my body its like a huge, like, em, London traffic where like, just, its so busy and there's cars and there's people and its so busy and so noisy sometimes**, its just so confusing**, and you can't hear yourself think, or get anything straight or just make everything stop and slow […] its all over the place*"

Self-injury, Belinda maintained, felt more concrete, and this was a preferable feeling. Craig echoed this idea when he suggested that the feelings (embodied, emotional) from self-injury might be experienced as more easily controlled than other emotional states. For both Craig and Belinda then, there appears to be some element of distraction – self-injury serves to distract from undesirable emotional or mental states – from worries or 'internal busyness'. In part this is related to the 'feeling' of pain, as discussed in Chapter 4. However, the issue of control was also important – self-injury felt more 'solid' but it was also experienced as something which was more readily controlled than these 'inner' feelings. This clearly relates to the embodied nature of self-injury – this solidity appears to be associated with material corporeality.

Rease stated that she preferred "*outside things"*, and that "*inside things… freaked [her] out"*. She related this through two stories about overdoses she had taken. In each case, she was clear that this was a distinct experience from self-injury, and that if she had not been so 'desperate' self-injury would have remained her preferred activity:

"*there was one night that I couldn't sleep, and I was feeling really panicked, an**d I self-harmed and I didn't feel better**, and I just kinda lost it so I started rummaging about and found all the pills that I keep in the house, and just downed them all. And then I got a bit hysterical and kinda lost it a bit, cos- I freaked out at what I had done. Em. And also I don't really like, inside things? It sounds a bit nutty but**, like,*

the self-harm is on the outside, and it's controllable, *but obviously I didn't know what these pills were doing to me, so, I was really freaked out about that*"

Rease was "*freaked out*" by her overdose particularly because she did not know what the effects would be – they were unknown. In contrast, self-injury, being on the outside, is more controllable. I would suggest that this difference is largely due to the relative visibility of the two behaviours – self-injury can be controlled more easily because it can be seen. This suggests a potentially important difference between self-injury and overdoses in terms of motivation and actual effects. Indeed, Rease implies that the overdose itself was more an 'out of control' act: she "*lost it a bit*". This contrasts with her descriptions of her self-cutting and burning which she suggested were more measured and planned.

It is possible that the concept of control may offer a partial explanation as to why some people self-injure: that is, the experience of self-injury is understood as something more 'concrete' over which they feel they have more control – this is contrasted with seemingly uncontrollable 'internal' emotional/mental states. Of course, this is partial and will not apply to all people. For Belinda, Craig and Rease, however, 'control over feelings' does seem to have been understood as playing an important role in their self-injuring behaviour. Importantly, this control is enacted through and upon the body – again indicating the inter-relatedness of bodies and emotions.

5.2.2 Control and release

Related to the idea of 'control over feelings' is that of 'control and release'. These concepts were used by some participants to describe how self-injury 'worked' or functioned. Robert, Milly, Craig and Rease all referred to the concept of 'release' while Anna and Harriet both referred explicitly to 'release' as a form of control – though in slightly different ways.

In her second interview, Milly said she now saw crying as a "*release…in the same way I used to see self-harm as a release*". Similarly, Craig talked about various

activities enabling 'release', particularly drinking, but also exercise. Craig described his self-injury as "*trying to get some kind of overload of emotion out*". He felt that drinking also helped with this, and suggested that if he had not also drunk alcohol then his self-injury might have been "*less, frequent […] and it may have been more, violent, …. Because I think it would've tended to build up […] until it got completely, impossible to deal with*". These conceptualisations of emotions in terms of 'build up' and 'release' are consistent with themes identified in sociological literature on emotions (Lupton 1998), along with the idea that emotional 'release' is healthy. For Craig, managing this 'release' was important, and he stated that his concern when he had self-injured was that if he did not hurt himself he might hurt other people: "*… I don't have anything […] still only have a few outlets for it […] it has to come out somewhere […] and I'd rather injure meself than other people*".

The concept of release is closely related to that of expression, which I discuss in more detail below. For instance, in explaining why she had at one point planned to cut off her own hand, Rease said: "*I felt like I need that – catharsis – you know I felt really coiled up inside, and this massive rage, and didn't know how to deal with it, and I wasn't allowed to express it*". Although Rease differs slightly in that she names the emotion (rage) that was inside and needed to be expressed (let out), this sentiment appears to be similar to other participants in that something 'inside' is experienced as overwhelming and as 'needing' to come out. In particular, this description could be seen as similar to Anna's talk of "*evil*" which needed to come out, discussed previously in Chapter 4. Rease and Craig's narratives both hint at the potential danger of this internal state being ignored. Craig was concerned that he might hurt someone else, while Rease felt that things had got so bad that she was contemplating cutting off a limb. At that time, she felt that her self-cutting was no longer "*working*". That this need for 'release' might lead to more severe self-injury is also reflected in Anna's narrative, and evident in the extract reproduced below (p. 121) – whereby the 'release' does not come from the "*crappy cuts*" but the later, more severe cut: "*that's the one*".

Robert also used the concept of release when describing his self-injury. He said that he had first experienced this when he cut himself by accident. Robert described this release as being something that removed emotional pain. He also described this as a 'cleansing' – "*it was just sorta like releasing it, clean myself out […..] I thought well if I do that then that kinda is a release, … em, it like kinda took away all the sorta emotional pain*". Robert also suggested that without self-injury he might have killed himself: the belief that self-injury might keep a person alive, by providing a 'lesser' release, compared to the more final release of suicide, was also expressed by Rease, and similar findings have been reported elsewhere (Solomon & Farand, 1996).

Anna and Harriet both used the concept of release alongside that of control. Anna's narrative was significant in that she did not relate these concepts explicitly to emotion at any point during the two interviews. Further, Anna's use of 'control' was generally very positive. She described herself as a "*control freak*", but she seemed to take some pride in this – control appeared to be a positive state, something to aspire towards:

"*Em and* ***it was like right, regain control, this is what I'm gonna do, I'm gonna cut myself,*** *well it wasnae as calculated as that.. but cut myself… and I cut myself, my right arm I cut myself and it just wasnae,…. it wasnae deep it was just ken what I mean it was just, crappy cuts.. this is gonna sound so bad em, … and so I covered it up…and I was like ah, no…. ken, its not happening, so I got my blade and I cut my other arm and .. it…. Was, literally like I could feel it and hear it sortae like tearing open, but it was like it was happening to somebody else but,* ***that was it that was the one, it was like , its worked this time*** *that fine, d'you know what I mean? But its… its like, its like being there but not being there… … its like, its like being there but not being there…* ***and its, like, releasing something… and then when that whatever it is is released then your sortae regaining control****…… s'what its all about, its all about, control*"

For Anna, control was something to be strived for, and self-injury, by 'releasing' something, was a tool which enabled her to 'regain' control when she felt she was "*losing it"*. This use of the concept of control contradicts Simon Williams' more negative interpretation, where control is framed as 'not pleasure' (1998b, 442). Further, Lupton's work suggests that there is a widespread belief that too much emotional control is "potentially damaging" (1998, 70). Lupton demonstrated that this understanding existed alongside the contradictory view that control over one's

emotions was desirable. Indeed, for Anna, it appeared that a loss of control was dangerous and potentially damaging. Similarly, for Rease, in her description of her overdose compared to her self-injury, a loss of control was similarly viewed as more hazardous. These complex understandings of release and control, the simultaneous 'need' for control over and release of emotions, reflect more widespread contradictory views regarding appropriate or healthy emotions. These ideas are closely related to issues of emotional expression, discussed in section 5.3.

Like Anna, Dinah and Francis also described themselves as desiring control, liking control, or preferring to be in control. This applied with regard to situations generally, but more pointedly, to control over their own lives and selves. Francis described feeling especially unsettled by his drinking when he felt "*out of control"* and Dinah noted that control was "*definitely a big, big factor […] when you cut yourself, you control that and you control how much it bleeds*". For Dinah, then, self-injury enabled her to do something that she was in control of. However, Dinah also described injuring herself in a more 'out of control' manner, relating how she was taken to A&E by friends on a number of occasions when she had not been "*careful*" and had been discovered. This suggests that within individuals, reasons and motivations for self-injury will vary according to time and context.

In Dinah's case, for instance, her 'out of control' injury occurred when she had been drinking. This parallels Craig's narrative about his 'worst' injury, also carried out when he had been drinking heavily. Alcohol was significant in several participants' narratives. However, equally, alcohol was expressly not a part of other participants' stories. Anna, for instance, claimed to hardly drink at all as she hated being out of control, and alcohol was not mentioned at all by either Belinda or Harriet. This diverse picture reflects existing literature and discourse, whereby in some cases self-injury has been found to be correlated with alcohol and drug abuse (Hasking et al., 2008); whereas other research has indicated that levels of alcohol consumption do not vary between those who self-injure and those who do not (Ogle & Clements, 2008).

Harriet did also discuss 'release' alongside 'control'. She described her self-injury as being a way of "*releasing tension*". In particular, she emphasised that this meant relieving the "*physical feelings of anxiety and stress*" such as "*tension headaches*". It is possible that Harriet's emphasis on the physical symptoms of her distress is related to the problems she described regarding having her inner feelings recognised or validated, discussed in Chapters 6 and 7. Like Belinda and Rease, this appears to reflect a preference for 'outer' as opposed to 'inner'. I would argue that Harriet's emphasis on her physical symptoms could be related to her desire to affirm the authenticity of her feelings, relating to wider socio-cultural tendencies that privilege physical health over mental health (Bendelow, 2009). I extend this discussion further in Chapter 8. As regards control, in her second interview, Harriet described how she cut herself "*earlier"* as a way of gaining control:

"I need to do it, just to, kind of relieve that tension inside and I'm like, and the longer I kind of put it off, like, I know its gonna be worse, whereas if I kind of like do it, earlier, then its like, … its, ***I can take control. [….]Whereas if I kinda leave it, it gets like, out of control more****"*

There are similarities here with the undercurrent of danger that featured in other participants' narratives – the concern about what might happen if the tension is not relieved, or 'let out'. Further, this is similar to Craig's suggestion that he might have self-injured more severely but less regularly had he not also had the 'release' of drinking, accompanied by more frequent acts of minor self-injury.

There are subtle differences between Harriet and Anna in their use of the concepts of release and control. For Anna, self-injury causes a release which enables her to take control, whereas Harriet 'takes control' by choosing to injure herself, and therefore relieve tension earlier, than she otherwise might. What is similar in all of the narratives that used the concept of release, however, is a concern with what might happen if whatever is experienced as 'inside' is not 'let out'. These accounts can be interpreted, following Scott and Lyman (1968), as justifications for self-injury. Tacitly, they accept that self-injury is not ideal, but by invoking the potential danger of not 'releasing' they attempt to affirm self-injury as an acceptable, even responsible, course of action. Self-injury is further justified by drawing on more

widely held socio-cultural beliefs about the need for both emotional control and release (Lupton, 1998a). In this way, self-injury is framed as being understandable and logical.

5.2.3 Power and control

Control and power are closely related concepts and theoretically they are important to studies of bodies and embodiment. Foucault used the concept of power to suggest ways in which bodies are disciplined and controlled by institutional and ideological means (Williams & Bendelow, 1998). While Giddens has suggested that individual control and power over the body is an integral part of the 'reflexive project' (Williams & Bendelow, 1998, 34). My use of power and control here is more mundane, however, and I focus on the ways that these terms were employed in the narratives of my participants. I suggest that in different contexts and for different people, the terms power and control are used in different ways. In this section I will provide some evidence regarding the ways that the concepts were used in relation to self-injury. I will also discuss the concept of impulsivity, which I will argue can be understood as signifying a 'lack of power'.

A key feature of the use of the terms in my research is that the term control was used far more often than power. Indeed, only two participants used the term power when talking about their self-injury (Francis and Rease), while the term "*powerless*" was used by Mark when he was considering why self-injury was so effective:

"*… so, yeah I guess, pain and body, pain isn't what its about blood isn't what its about […] its,* ***it's the controlling aspect*** *[…] its about, actually, doing something which you actually, can feel the results of straight away […] which* ***I guess if you're feeling quite helpless and powerless*** *and, …"*

This resonates with the other narratives which refer only to control – the notion that self-injury can be a way of feeling control or power for people who are otherwise powerless or lacking in control. Milly for instance said that "*if you can't control something, you'll give yourself something that you can*" and Harriet expressed a

similar sentiment. Francis referred more directly to the idea of self-injury being evidence of *power* or mastery over the body:

"*…maybe its just sort of, part of.. you know reali-* ***realising your own powers, or, realising your own control over your body*** *or control over, you know sort of, you know if you wanted to you can…. […] … you can, affect yourself, you can sort of affect change you can, do things to yourself,* ***you have power, this is yours, this is my body, I'm, I own it, I'm in control of it****, and, … I can, do what I like with it …"*

Finally, Rease said that self-injury actually made her feel 'powerful' and she explicitly put this in the context of feeling like a 'victim' and otherwise powerless. The idea that self-injury might relate to power is highlighted by Plante, who suggested, rather dramatically, that "[t]here is a terrible power wielded by an adolescent who self-injures" (2007, 55). However, this acknowledgement that self-injury can be powerful is rare, and perhaps more markedly, it may not be readily identified by those who are actually self-injuring.

Some of the people I spoke to were clear that at times their self-injury was 'impulsive' – something they felt they had little control or power over. This was particularly the case with Belinda and Harriet. Belinda described her earlier self-injury as being "*impulsive*". She contrasted this with her more recent self-injury which she felt was more controlled, and more 'rational': *"… it's changed over time […] from, ….* ***An intense impulsive need****, to something that I want to do, but I think about it more carefully and, think, I don't know I feel more in control of it*". Harriet described her self-injury as being something that she continued to experience as an 'urge' or an 'impulse'. She talked about this particularly in relation to some of the psychotropic medication that she took which, she told me, was supposed to help to 'control the urges':

"… cos like the medication that I'm on before like, controls the urges to self-harm […] and I - coming off it I was like, I was like wanting to hurt myself because I wasn't – didn't have that, kind of, con – like help with these urges"

Both Harriet and Belinda associated impulsivity with a lack of control. This reflects clinical understandings of what impulsivity is (Favazza, 1998; Herpertz et al., 1997; Muehlenkamp, 2005). As I noted in Chapter 2, viewing self-injury as 'impulsive' is problematic and not well supported by existing literature. Clinical understandings of impulsivity tend to interpret it as an individual (often internal, biological) factor. This view obscures a variety of social reasons why a lack of control may be experienced, such as issues relating to gender, age, socio-economic status or sexuality. The narratives of my participants provide further evidence that this is a complex issue. As well as suggesting that the behaviour can alter over time within individuals, the emphasis on control in many of my participant's interviews suggests that the label of 'impulsivity' may be particularly inappropriate in many cases. Nevertheless, for some, Harriet in particular, this description of their behaviour is important, and may well be an appropriate reflection of how 'urges' to self-injure are experienced.

These issues in turn raise epistemological concerns regarding the status of participants' accounts. Harriet's description of her self-injury as 'impulsive' may well reflect how she experiences the behaviour. However it is unclear how far she is drawing on psychiatric discourse and clinical understandings of what impulsivity means. It is also possible that she might be deploying the term in order to abdicate herself of responsibility for her behaviour, or because, in the context of the interview, she felt I would be more receptive to 'technical' terms. I address these concerns further in Chapter 8.

The concepts of control, power, and impulsivity all relate to emotional issues, and in particular, to feelings. As I noted above, I do not accept that a discussion of 'feelings' is contradictory simply because it refers to a range of opinions, emotions or sensations – rather, I would argue this merely reflects the complexity of lived experience. When my participants talked about power, control and impulsivity, they were talking about *feelings* of power, *feelings* of release, *feelings* of control (as well as control over feelings). Talk about impulsivity refers to a lack of control over 'internal' potentially 'emotional' *feelings*. What these concepts all touch upon, and which I now go on to discuss in more detail, is the issue of emotional expression.

5.3 Expression and invalidation

In this section I will expand upon the issue of emotional expression and self-injury. This is closely related to the metaphor of 'release' which was used by a number of participants when describing their self-injury. In particular, emotional expression can be seen to relate closely to communication. While 'release' seems to refer to a personal, individual mechanism; expression seems more likely to implicate communication to others. Distinguishing between release and expression is not easy. However, I would suggest that there are some indications of difference, and this can be linked to the concept of invalidation. Emotional expressions are perhaps more open to invalidation than are emotional releases. An expression may invite a response more so than a release, though this is not to say that an emotional release does not do this.

Emotional expression was raised by a number of participants as being an element of their motivations for self-injuring – and this appeared to be slightly different to the concept of release. Harriet, Anna, Rease and Francis each suggested that self-injury could be a form of emotional expression. However, the issue of not being allowed or able to express emotions was raised far more often. Finally, many participants also talked about having their feelings or emotions invalidated – denied, overlooked or minimised. These issues relate closely to arguments I will raise in Chapter 7 regarding the problematic nature of communication about self-injury and negative moods, particularly within households.

5.3.1 Self-injury as emotional expression.

The idea that self-injury might itself be a form of emotional expression is raised in existing literature (e.g. Alexander & Clare, 2004), and some of my participants made this suggestion. Anna described her self-injury in this manner when she was talking about her fears around inadvertently killing herself by cutting too deeply:

"… it gets scary … because …. Like there's always the … the …… there's always the sortae, …. D'you know like if you're upset or …. Angry or whatever it's a …….. …… d'you know ….. …. Ah …. ***What am I tryin tae say, d'you know if you go "arrgghh" an jus … swipe an go deep*** *[…] an god knows what could happen*"

Anna appears to be saying here that the self-injury can take on the form of expression: what she describes seems to be an act which to an extent expresses the anger or upset that she is feeling. As discussed above, Anna also used the concept of release to describe her self-injury, which does raise a further question as to how far expression and release are different at all.

Emma suggested that her self-injury had been to "*express, how desperate things are inside*". She linked the idea of expression with communication, as she noted that there was some contradiction between her desire to 'express' these feelings through self-injury and her subsequent hiding of the wounds and scars that resulted. Harriet made a similar link between her self-injury as expression, highlighting the importance of the visual and visible nature of self-injury: "*I was like hurting so much, but I couldn't express that pain […] and I couldn't understand it, but by causing it physical pain, I could see the scars on my arm*". Like Francis (see below), this actually seems to be more about creating a visual marker for 'internal pain' rather than *expressing* the emotion/pain per se. However, Harriet went on to say that with anger in particular "*… it's just easier just like, if I just go and cut myself […] that's the way to, no other way of expressing it*". Rease also briefly noted that expression was "*a big part of what self-harm is about […] not feeling able to express, what I felt*".

Francis suggested that his self-injury might have been "*sort of trying to, create, … sort of a, a wound for pain that you're, sort of feeling internally, that you can't express, that you can't sort of visualise*". Francis was clear that he was exploring these issues in the interview, and therefore he offered several different, and tentative, suggestions about his motivations for self-injury. This excerpt alludes to both the idea that self-injury might express some sort of 'internal pain' but also notes that this is pain that cannot otherwise be expressed.

The idea that self-injury might itself be a form of expression is complicated, as the idea of expression can be so closely tied to communication. Further, in some cases, what initially seemed to be a description of self-injury as expression, on closer examination might be more reflective of a need to create something visual to signify internal pain. It is likely that these issues represent multiple layers of meaning and motivation for people who self-injure, and that these meanings and understandings will change and shift over time, or be employed differentially according to context.

In relation to the idea of self-injury as expression, several participants described having problems expressing, or feeling able or allowed, to express emotions – the suggestion being that self-injury then became the 'only' way of expressing certain feelings. I discuss this in Chapter 7 in relation to communication and the hiding and revealing (of scars and wounds) practices of participants, however in the next section I will provide further examples of the problems participants described having with emotional expression.

5.3.2 Emotional repression and self-injury

Harriet, Francis, Rease, Emma and Craig each talked about feeling unable to express certain emotions, or feeling that they were not allowed to express certain emotions. In particular, anger seemed to be a problematic emotion. That this was named more often may, however, be a reflection of my own interests, as this was an issue raised by the psychotherapy I received during the fieldwork. Thus, I did directly prompt participants about anger, whereas I did not tend to name other emotions very often.

Francis talked about feeling "*incapable of, feeling emotion, just completely numbed*". He explored this idea in some detail, and his narrative raises several issues that are addressed in this chapter – the problems of defining emotion, and separating expression and display from feeling:

"*the times when I have self-harmed I think it is that it's, that I have felt, yeah numb and, …like I know all these things are happening but and I, …. I wasn't, em, …you*

know I wasn't, getting upset and crying about it, I wasn't, em, you know, …. … I was sort of self-containing it, ***I was containing it really and sort of, you know, … yeah em, …. …. not expressing it I suppose****, and….. I think I've been, … and so I was sort of, …. .I felt it wasn't right, or, it felt wrong, to be, to have, to know, that I should – that I'm upset, to know that these things have upset me, but not, but the, you know I'd learnt, or I'd got into the habit of really, … not displaying that"*

Francis' discussion raises issues of morality as well – he feels that it was 'wrong' of him not to be more emotionally expressive, or more generally emotional. There also seemed to be some confusion as to whether the emotions were 'there' or not; whether they existed at all if they were not being expressed or displayed. Francis' narrative here also invokes the embodied nature of emotion, both in his reference to "*containing*" emotion, and his habit of not "*displaying*" his emotions.

Harriet talked a lot about not being able to "*express*" herself, and she was clear that she felt this was an important reason why she self-injured. She described how, as a teenager, she had been unable to express herself verbally, and the main focus of much of the counselling and therapy she had undergone had been on teaching her how to "*express*" herself. However, she said that she still found it difficult, and continued to find writing things down far easier than saying them. Harriet also described the problems she had trying to communicate her distress to others: "*sometimes you don't know … how to like express what you're …. What you're going through without it like being … sounding as if you're threatening them* [with self-injury]". Harriet felt that she had severe problems expressing 'herself' and she linked this to her need for self-injury. As discussed above, she suggested that with anger in particular she had "*no other way of expressing it*".

Emma also described "*not talking*" when she was a teenager, saying that she "*stopped talking"* for 2 years when she was 15. She suggested that this was her way of "*dealing with*" depression. Emma related this to her family, who, she said "*didn't let things out*". She related a series of different stories which expanded upon this issue. For instance, she told me how her mother never expressed emotion, and had not even cried at her own mother's funeral – which Emma described as "*weird*". She

also recounted various occasions where her mental health had been particularly poor, indicating that this was never talked about explicitly by her parents:

*"I used to play scrabble with my mum in the evenings. Cos I was, quite upset about the break up, just everything happening at once, I was a bit of a mess. And I used to play scrabble with my mum in the evenings cos I never went out for about a year, cos I didn't know anyone in Edinburgh anyway…. **You know, my hands would be shaking so bad, with the anti-depressants that I could hardly put the tiles down… That's kind of the way in my family, nothing is talked about**, so…. Em… she was just quite happy to erm….. hehe… she was just quite happy to, sit and play scrabble with me…"*

Emma said that an important part of the gradual (and continuing) improvement in her mental health was related to her "*learning to cope with emotional stuff a bit better, […] by expressing it, which em, is totally alien to them* [her parents]". Emma suggested then, that the atmosphere in the family household she grew up in discouraged emotional expression and that this was a major contributing factor to her mental health problems. She also noted that her sister had also suffered from mental health problems but that she had otherwise "*managed to escape it*". Emma recounted a conversation that she had with her sister about this, who maintained that she was better able to express herself because of her relationship with her husband who helped her to learn how to express herself rather than "*clamming up*". Unlike Harriet, then, Emma explicitly related her problems with communication to her family's tendency towards emotional repression. In contrast, Harriet offered no explanation for her problems, though it may be significant that she talked about her family very little.

Rease also described not feeling "*allowed*" by her family to express herself. She related this in part to her father's religious beliefs, which she felt meant that she was unable to express elements of her own less traditional spirituality. At the time Rease was self-injuring she described how her relationship with her father was particularly strained because although he was unhappy with Rease's ideas about religion and spirituality, he was also conducting an extra-marital affair:

"I was sitting there, you know, why are you telling me this? Like I'm your, friend, or something, and obviously, thinking, you know, your this religious person, you know, this Christian, whose so --- into you, you know, because over the years, I'd sometimes made an attempt to tell him, how I felt about stuff. And he'd always turn round and say, Rease I can't believe you're thinking that, how can you think such a twisted thing, or, you know. Kinda, ***not allowing me to express myself****. And here he was telling me about an affair!"*

Like Harriet, Rease also named anger and rage as emotions that were particularly problematic, and which she "*didn't know how to deal with*" and "*wasn't allowed to express*". Rease further suggested that part of the reason she felt unable to express emotions – especially negative ones – was a concern with 'burdening' other people. Craig also raised this issue, explaining that one of the reasons he did not tell people when he was self-injuring was because he did not want to 'burden' them. Belinda also said that she did not express anger 'outwardly', though she suggested that this was because her father had quite violently expressed his anger when she was growing up, and she was concerned to not "*ever be that way*".

5.3.3 Invalidation

An even more prevalent theme was that of emotional invalidation. More than half of the participants referred to some type of emotional invalidation. I have used the phrase emotional invalidation to describe a variety of situations described by participants. These include circumstances where feelings and emotions were experienced as being overlooked, minimised or downplayed by other people.

Emma, Anna and Rease all described very similar situations whereby they had been admitted to hospital following an act of self-harm (either cutting or, in Rease's case an overdose, and in Emma's cutting and an overdose). For all three women, a key feature of the narrative was that following, and during, the hospital stay, the feelings that they had which had led to the act of self-harm were ignored, minimised or I would suggest – invalidated – by their families.

Anna highlighted her mother as being particularly dismissive of her feelings and behaviour. In the following excerpt Anna talks generally about her mother's

awareness of her problems, referring explicitly to the period of time when Anna was 27 and had recently been diagnosed with post-natal depression:

"its just no mentioned, its never spoken about she's not got a clue what I've been through, not a clue, when I was in hospital I finally told her that I self-harmed …and she went "well, we'll be stopping that then won't we""

Anna was clear that this dismissive attitude was not recent, or focussed solely on her self-injury, but that her mother had always been like this. For instance she recounted how she had told her mother about starting her menstrual periods, to which her mother had responded: "*'oh, I thought that might happen' and that was it! That was the whole conversation!*" Anna found this situation especially intolerable because her mother apparently believed that they were "*best friends"*.

Emma, as discussed above, described her family as incredibly uncommunicative, however she also talked about trying to "*protect"* her parents, by not telling them about the worse aspects of her mental health. In the following excerpt Emma recounts trying to prevent her parents from finding out about an incident of self-injury:

"I tried to keep that from them, the biggest….em… but my mum went up to visit me in, … cos I did that when I was in the [psychiatric hospital], and my mum came up to visit me, when I was, I'd been taken to the [general hospital], em,… and she appeared in the [general hospital], while I was trying to phone my dad, cos he was supposed to come and visit me that day. I was trying to phone him to say not to come. Hehe. And er, … my mum walked in and just went 'what in God's name have you done to yourself' heheh. And I'm like….. that's a strange reaction, you know, I've just seven stitches in my arm, and em, my stomach pumped, and em, you know, … ***you're, almost blaming me****"*

Emma herself pointed out the contradiction between her desire for better communication with her parents, and her attempts to hide her self-harm from them. This was paralleled in her self-injurious behaviour, whereby on one hand she described this as an expressive act, but on the other she was careful to keep the scars and wounds hidden. Despite being clear that she herself struggled to communicate

about these issues, Emma talked about becoming increasingly exasperated by her family's inability to do so either:

"As long as I can remember, em, ***we've never had a discussion about, ….. anything, er, of great import****. You know, we'll talk about the weather, we'll talk about em, … my cats, we'll talk about, how lovely my niece is, but eh, even, you know after, 10 visits to the, the [psychiatric hospital] […]you know my parents, I would go walking with my mum, and she would, she would sort of, very very awkwardly sort of, … just kind of stammer out 'so how you doing' hehehe, and that would be it […] you know, 'are you, still on the medication?'….. no I, jees* ***is that all you can, ask me about? […] you know, after all I've been through*** *hehehe - all you're worried about is whether I'm still on the medication or not*"

Rease also described her family as responding in what she saw as a woefully inadequate manner following her overdose:

" *… I woke my dad up and I'm like, you know, dad I've done this really stupid thing. And it wasn't a suicide attempt. At – sort of extension of the self-harm, or, panic, or, the self-harm not working, and thought mebbe, something might. So I woke him up, and jus like, em.* ***So I got an ambulance, and, got my stomach pumped and stuff, and but, again, em, nothing came of it. Can you believe how much my family doesn't talk****! Heheh, it was ridiculous!"*

Rease went on to describe her second overdose, and in this instance it was the hospital staff who she felt did not acknowledge her distress:

*" And, finally because I was so sick of where I'd got to, you know****, couldn't believe I was doing this to myself, couldn't, you know, just, -- wanting to tell someone*** *so I was like, em, I [told] her, my mum's an alcoholic and I wasn't coping, and* ***she just went, 'Oh right, ok'. And, and then buggered off****. And I was like, no hang on a minute, I just dropped this massive bomb, that I've not told anyone, and not been able to talk about and, your, your just walking off! So again, I shut down. You know.* ***Nobody wanted to talk about anything****! It's just nuts!"*

What I want to draw out here is that Rease, Anna and Emma all felt that their distress, their feelings, were not validated. All described responses (or lack of responses) which they frame as being inadequate. So, there is a situation whereby individuals who have described having 'problems' expressing themselves, and especially expressing negative emotions, have their attempts at expression (self-injury, self-harm) invalidated, overlooked or ignored.

Other participants discussed a variety of other ways in which they felt that their feelings or emotions were invalidated. Craig, for instance, suggested that part of his reasons for self-injuring might have been that he was a "*fairly melancholy person […] you know, that would be my default state – and being told not to be like that*". Similarly, Anna said that there was "*nothing worse than somebody saying, 'don't feel bad' or, 'how do you think it'd make me feel*?'".

As I note above, Harriet talked a lot about the problems she faced when trying to get her distress recognised. She told me that she was often told by others, including her CPN (community psychiatric nurse), that she "*looked fine*" when she felt far from fine. This was a dominant theme in Harriet's interviews more generally – the apparent lack of fit between her external appearance ("*fine*") and her internal feelings ("*really anxious*"). This could be related to the function of self-injury for Harriet, which she suggested enabled her to 'see' the pain she felt inside, emphasising the importance of the visual over less easily identified 'inner feelings'. This idea was also raised by Belinda and Francis, who both talked about self-injury being something more 'concrete' than their inner state of confusion or numbness.

Dinah and Robert each described rather different situations, where their emotions/emotionality was not recognised at all. Dinah told me that she was described as "*cold and unemotional*" by her family, and that although she had felt this was not true, she nevertheless assumed that other people thought this about her for a long time. This is similar to the other stories of invalidation in that it refers to an inconsistency between the way that Dinah felt, and the way that she was described by other people, and by her family in particular. Similarly, when I asked him whether his parents had been aware of his eating disorders and self-injury, Robert recounted the following:

"…it's quite funny actually because like em, …. I have actually, like sat, since that point eh, ken sorta maybe a couple of years later, em, I did actually turn round and ask my mum, I was like 'ken did you not actually realise that there was something wrong?' […] and she was like, she says 'well we did' she says 'but we ken, ***we just thought ken, that as long as you were happy, ken as long as you were fine eh' and***

it was like 'but I wasnae fine' *…. It was like ken, that was why, it was like ken I was going through like a really difficult time and all that eh,… em, and it was like ken well, …. I dinnae ken, parents just seem to say the wrong things at the wrong time, its like 'oh well you came through the, you came through the other end'"*

Robert's family apparently did not openly discuss his distress, despite him being anorexic and bulimic over several years: *"I mean they could see that I was losing the weight and they could see that I was like, deathly pale and all that, but it was never actually mentioned"*. This is paralleled in Dinah's narrative, when she told me that her father and step-mother had been apparently "*oblivious*" to her self-injury, not finding out about her behaviour until she told them several years later.

This issue of emotional invalidation is raised by Freund (1990) in his work on the 'expressive body', and these ideas seem particularly relevant here. Freund develops Hochschild's concept of 'status shields' in an attempt to develop a theoretical position which incorporates emotions, bodies and social structure. People of lower statuses, Freund argues, lack 'status shields' and thus lack any significant defence against the aggression of others (1990, 466). This aggression includes having one's feelings or perceptions ignored, invalidated, or termed irrational, but further to this:

"The invalidation of one's feelings, however, may be more threatening than the invalidation of perceptions, since feelings as a form of information are experienced as the deeply authentic, existential ground of who we are" (*ibid*)

I will extend this discussion in the final section of this chapter, where I discuss self-injury as a form of emotion work, and further address the issue of emotional authenticity with regard to self-injury.

5.4 Emotions and social life

Thus far, this chapter has demonstrated how self-injury was variously conceptualised as being a 'release' of emotion; an expression of emotion; and a form of emotional control. These are similar to many of the activities that Hochschild (1979; 2003 (1983)) labelled 'emotion management' and in this section I will further expand on

this idea. Hochschild's work has been critiqued on a number of points however, perhaps most significantly for implying that emotions that are not 'managed' are somehow more 'authentic' (Wouters, 1989). This thesis suggests that the concept of authenticity is particularly relevant with regard to self-injury, and I conclude this section with a discussion of this.

5.4.1 Being emotional 'appropriately'

Emotion management is a concept developed by Hochschild to describe the 'work' that is done to emotions in order to make them appropriate to the 'feeling rules' of a given social context. She distinguished this from instances where individuals 'act' out emotions in order to attempt to 'fit' a situation, emphasising that "… the emotion management perspective fosters attention to how people try to feel, not, as for Goffman, how people try to appear to feel" (Hochschild, 1979: 560). An example that Hochschild gave was of a bride actively trying to make herself 'feel happy' on her wedding day, however she developed the concept over several years and through different publications, the most significant being her work on air hostesses and commercial 'emotion management' (Hochschild, 2003 (1983)), and her later work on the 'second shift' and the 'emotion work' carried out in families (Hochschild, 2003). In *The Managed Heart*, Hochschild described how air hostesses controlled their feelings of rage and animosity in order to present a pleasant and personable face to the customers who in many cases induced these feelings (2003 (1983): 25). The methods that the air hostesses used included a wide range of cognitive and bodily techniques; the important factor in all of these was that the 'emotion management' must go undetected in order to be successful.

There are three significant similarities between self-injury and the forms of emotion management Hochschild discusses: firstly, that self-injury, like emotional management, is used by some people to 'work on' and alter emotional states; secondly, that many people who self-injure hide their self-injury, just as those practicing emotional management also seek to do so without being noticed; finally, Hochschild's participants described a range of embodied methods of doing emotion

work, which could be compared to self-injury. Evidently, this mode of self-injury is not universal. As I discuss in Chapters 6 and 7, for many people who self-injure it is equally important that people *do* see the self-injury, or are aware it has occurred. Nevertheless, I would argue that in some cases at least, self-injury can be understood as a form of emotion management.

Rease, Mark, Justin and Francis all described self-injury as something that made them feel 'good' (Rease, Mark). It acted as a 'jump start' (Francis, Justin). Anna said that the 'release' provided by self-injury enabled her to carry on with daily life, to think rationally. Similarly, Belinda said that self-injury stopped the confusion in her head, again, allowing her to continue with her life.

Another way that Hochschild's theory can be seen to apply to some of the narratives is in her emphasis on the contextual nature of 'feeling rules'. I would suggest that in the cases of some participants – particularly Emma, but also Craig, Dinah and Francis – the 'feeling rules' in the contexts of the participants' families discouraged emotional expression to such an extent that this contributed to individuals being left with no way of knowing 'what to do' with strong, negative emotions. The influence of the social, emotional and interpersonal dynamics of families on the development of self-injury is controversial, and is an issue that is rarely raised in the literature (perhaps because these ideas are so similar to those of Laing (1960) whose work seems to be generally unfashionable nowadays).

However, several of my participants were very clear that they felt their family was in no way 'to blame' for their behaviour (the issue of blame, and the problem of 'blaming the parents' reflecting a critique of Laing's work). Mark and Milly in particular stressed this point, but it may also be significant that both Harriet and Robert seemed reluctant to talk about their families. Conversely, some participants clearly felt that their upbringing *had* contributed to the feelings that led to their self-injury. Anna, Emma, Rease and Justin all stated this strongly, while Belinda, Dinah and Francis each explored the issue with me.

Applying a broader lens to this issue, Milly, Rease and Dinah all suggested that wider societal and cultural mores discouraged emotional expression. Milly talked about the problems she felt she had regarding 'appropriate' emotional expression. She said that in the past she felt she had 'inappropriately' expressed her emotions, and discussed the challenges of expressing emotions enough, but not doing so 'inappropriately':

"I'm lucky that I can, em, …. I can go through those emotions without feeling too, … em, … detrimental towards myself […] cos I know, ***society these days is just so, …. …. 'one must not show one's emotions'*** *[…] to the world kinda thing. And I'm not really showing them to the world but, I'm just, …. Making sure that I'm still allowing myself to be human*"

Milly's discussion certainly relates to theoretical debates around understandings of (emotional) control and release and the importance of broader socio-cultural beliefs about this (Lupton, 1998a; Williams, 1998a). Similarly, Dinah talked about "*the total Scottish culture, British culture, but you're keeping things to yourself, not wanting to worry other people*". Part of the reason Dinah felt people had thought that she was "*cold and unemotional*" was because she tended to 'express' emotions privately rather than in front of others. Rease and Craig conveyed similar stories about not wanting to 'burden' other people with their problems or emotions. There appears to be some suggestion then that the lack of emotional expression described in some families could relate to wider social and cultural attitudes towards emotional expression.

These ideas are discussed by Wouters (1989) in his critique of Hochschild. He argues that although Hochschild's work suggests that emotional expression is often limited or constrained by late modern commercial activity, it can equally be argued that emotional expressivity is actually more possible now, in late modern, Western society, than it ever has been. Williams (1998a) extends these debates, suggesting that late modern society is actually characterised by a contradictory tension between expression and control over emotions, a theme also identified by Lupton (1998) in her empirical research. My participants' narratives reflect these concerns, however there was less conflict between concepts of control versus expression than implied in

some of the theoretical work. Rather, participants' tended to use both control and expression in positive ways, with some participants suggesting that control could be achieved through expression or release.

These tensions can be related to debates around the construction of mental illnesses. Most mental illnesses are characterised by some kind of emotional 'problem' – whether it is inappropriate emotional 'displays' or inconvenient and apparently unexplained emotions more generally (Bendelow, 2009; Busfield, 1996). Some types of depression could be characterised as 'unexplained sadness'. BPD is characterised by an inability to regulate emotional expression and particularly "inappropriate and intense anger" (Bjorklund, 2006, 5). Further, these could be related back to the concept of emotion management, by arguing that people may be more liable to be 'labelled' – or to 'self-label' (Thoits, 1985) – as having a mental illness if their attempts at emotional management fail somehow.

5.4.2 Emotional authenticity and visible pain

Hochschild's theory of emotion management has been criticised for implying the existence of 'authentic' emotions, as well as a 'true' or 'real' self (Wouters, 1989, 97). Wouters provides a rigorous critique of Hochschild's work, demonstrating how much of her theory relies upon a problematic distinction between public and private, and between the 'managed' self and the allegedly more authentic, 'real' self. I take into account such criticisms in my own use of the concept of emotional management. Following Wouter's critique, I do not suggest that emotion management detracts from an 'authentic self' or that it therefore results in inauthentic emotions – rather, I would suggest that emotional management is intrinsic to social life, and to individual selves and identities. Practices of emotional management are a part of that self, and indeed are so intrinsic that they cannot be satisfactorily split off from 'unmanaged' emotion. This leads from my conceptualisation of emotions as essentially social 'complexes' rather than private or individual (Williams, 1998a; Wouters, 1989).

However, the concept of authenticity can be seen to be important to self-injury in other ways. An issue which arose in some of the interviews was the concept of 'real self-harmers'. This was initially raised by Anna, who talked about people 'copying' self-injurious behaviour in psychiatric hospitals. She said that she could not understand how such people were able to self-injure, since it must hurt them, because they were not 'really' 'self-harmers'. Belinda too talked about people 'inauthentically' self-injuring, for her this was related to the issue of 'attention seeking' – Belinda suggested that her own reasons for self-injury were more acceptable than those of other people who were injuring just to be "*cool*". Milly picked up on this issue when she discussed how her self-injury had started – that she had 'copied' it from a girl at school - however, Milly was clear that she '*claimed it as my own'* – which seemed to be claiming some level of 'authenticity' to the behaviour.

This issue of 'real self-harm' and 'authentic' self-injury can be tied to the authenticity of emotions. This issue could relate to the problems many of the participants described having more generally with getting their emotions 'validated' – and the frequent occurrences whereby emotions and feelings were invalidated. This might lead to a greater concern with self-injuring behaviour being seen by others as 'authentic'. Self-injury could also be seen as more authentic by being more concrete, relating directly to the corporeal physicality of self-injury. I refer here to Belinda, Harriet and Francis, who all described confusing, troubling, but more importantly 'intangible' feelings, and who each described self-injury as providing something 'more real' than these amorphous 'feelings'. In each of these cases the common feature is a lack of confidence, or an uncertainty, regarding emotion – either on the part of the individual who self-injures, or on the part of others who 'invalidate' or otherwise dismiss the individuals' attempts at emotional expression. Indeed, Simon Williams (1998a: 748) suggests that there is a wider 'search' for "more 'authentic', ways of being and knowing" in late modern society – and it could be argued that self-injury might be understood as being a part of such a search.

5.5 Emotions and self-injury

I have raised a range of 'emotional' issues in this chapter. Viewing emotions as communicative, inter-subjective complexes, I have demonstrated that emotional control and emotional expression are important, both in understanding self-injury, but also in understanding the ways that emotions are conceptualised by people. In particular, this chapter has provided support to existing theoretical debates which have emphasised the centrality of bodies and embodiment to understandings and experiences categorised as 'emotional' (Lupton, 1998a; Williams & Bendelow, 1998).

I discussed the concepts of emotional expression and release. My analysis of participants' use of these terms in their explanations of their self-injury affirms that although there are important differences in the way these are understood, they are certainly related. I suggested however that the 'release' of emotions might be less open to invalidation than the 'expression' of emotions. Several participants related their self-injury to their up-bringing, and to family 'modes' of emotional expression and repression. Others related this to broader socio-cultural understandings regarding the appropriate management and expression of emotions. Nevertheless, release, expression, control and invalidation can all be related to broader socio-cultural understandings regarding the appropriate place of emotions in social life. I have shown that participants drew upon established understandings of emotion in order to justify their self-injury. Framing self-injury in terms of control and release makes the behaviour understandable, if not entirely acceptable.

Using Hochschild's concept of emotion work, I have suggested that self-injury can be made more understandable by viewing it as an embodied method of doing emotion work. This perspective further affirms the embodied nature of both emotions and in turn self-injury. Through self-injury, emotions are acted upon via the body, eliciting both a physical and emotional 'release' whilst simultaneously providing a visible marker.

Finally, this chapter has also introduced another element to the broader theme of authenticity. I have suggested that self-injury might be understood as an attempt to demonstrate 'authentic emotion'. In its visible and visual nature, self-injury concretely 'shows' distress and upset – both to the self who is injured, and to the people around them.

The visible nature of self-injury is discussed further in the following chapters. In these, the power that self-injury can have to communicate to others (whether intentionally or unintentionally) is discussed. This communication is particular to self-injury (as opposed to e.g. overdoses) because it is immediately and dramatically apparent. Further, self-injury continues to 'communicate' in the days, months and sometimes years after the initial injury. Scars and marks continue to affect social life, as participants negotiate life with them.

Chapter 6

Self-injury, help-seeking and attention seeking

6.1 Introduction

6.1.1 Synopsis

This chapter is the first of two that broadly address the ways in which communication about self-injury was described by participants. Here, I examine the inter-related and problematic concepts of help-seeking and 'attention-seeking'. Help-seeking in this chapter is limited mainly to formal help, from doctors, psychiatrists, counsellors and therapists, while Chapter 7 will examine what might be called informal help-seeking, where self-injury is communicated to friends or family. Attention-seeking is introduced in depth in the final section of this chapter, but remains a concern throughout chapters 7 and 8.

I begin with a brief discussion of help-seeking and attention-seeking, highlighting their problematic nature and explaining my own use of them. I then turn to participants' narratives about help-seeking. First, I detail participants' stories about support that was oriented towards the participant's (self-injured) self, or towards disorders or conditions understood to underlie their self-injury. Secondly, I examine the narratives of participants who had sought or received help for the wounds or injuries created by their self-injury.

The second section of the chapter critically examines the concept of 'attention-seeking'. I demonstrate how participants struggled with the negative connotations of the term. Some endorsed this negative understanding, whilst others challenged accepted and potentially damaging interpretations of 'attention-seeking'. This discussion is closely related to the preceding discussion of help-seeking, and in the last section I extend these themes, further emphasising the double-bind that people

who self-injure are in: namely, that if they seek help for their behaviour they run the high risk of being labelled 'attention-seeking' and yet 'attention' is frequently exactly what they need (Crouch & Wright, 2004). This raises important questions regarding wider social and cultural attitudes towards help-seeking in general, but in particular relating to emotional and mental distress. This leads in to Chapter 7, where I discuss the issue of display and visibility of both self-injury and emotional distress in more detail.

6.1.2 Help-seeking and attention-seeking: problems and contradictions

Both help-seeking and attention-seeking are problematic terms, though for different reasons. Help-seeking is widely used in medical and sociological literature to discuss patient behaviour in relation to illness. It is generally understood to be a 'good thing', and much research focuses on exploring why people do not seek help for certain illnesses, and how far this relates to the type of illness or the type of person (e.g. O'Brien et al., 2005 examines gender and help-seeking). With regard to mental illnesses, help-seeking is seen as particularly important, since it is understood that people frequently do not seek help for mental distress (Biddle et al., 2007). Further, gender, age, social-class and ethnicity are all thought to have important effects upon help-seeking behaviour and are likely to lead to biases in existing understandings about rates of mental illnesses in the general population (Biddle et al., 2007; Busfield, 1996; Pilgrim & Rogers, 1999).

Self-injury is understood as a 'hidden' and 'secret' behaviour, with very low rates of help-seeking (National Inquiry into Self-Harm Among Young People, 2006). Despite this, and as discussed in Chapter 1 and 2, most research has focused on clinical populations, comprising people who are obviously already receiving 'help'. Research that explores the help-seeking behaviours and experiences of people who self-injure is scarce, and this chapter will at least begin to address this deficit.

However, help-seeking is a problematic concept, and the narratives of my participants certainly demonstrate this. What is defined as help-seeking, for instance, may not always involve the active involvement of the individual concerned. Help may be imposed, individuals may be coerced into accepting it, or they may be taken to different help providers by someone else. Similarly, 'help' might not be perceived as such by the individual, it could equally be viewed as interference, or even, in extreme cases, as violence. Further, the help-seeking individual may not have their behaviour interpreted in this way by those they are seeking help from. Attention-seeking is one way in which help-seeking behaviour can be re- or mis-interpreted by others.

Attention-seeking too is problematic. It is highly morally charged: if help-seeking is morally virtuous (a 'good thing') attention-seeking is certainly a vice (a 'bad thing'). Despite this, attention-seeking and help-seeking are in some cases ostensibly the same behaviour. The difference lies primarily in how the behaviour is interpreted by others. Attention seeking is particularly important with regard to self-injury, since, as noted above, it is a charge frequently levelled at people who self-injure. Further, the literature regarding this is contradictory. Some commentators are clear that self-injury is sometimes an 'attention-seeking' behaviour (Jacobson & Gould, 2007; Nock & Prinstein, 2004), while others claim that this idea is a 'myth' and that in fact self-injury is *never* about attention-seeking (McAllister et al., 2002a). This latter position tends to argue that it is a hidden and secretive behaviour. As I will demonstrate in this chapter and Chapter 7, the stories of my participants suggest a far more complex picture.

6.2 Routes to and forms of formal help-seeking

With the exception of Justin and Craig, all participants described seeking or receiving support of some kind from formal services, either for their self-injury or an apparently related illness or condition. I will begin by discussing the narratives of those participants who described receiving general support for themselves as someone who self-injures, or for ostensibly related problems. I will then turn to

narratives which addressed support received specifically for the wounds that their self-injury created.

6.2.1 The whole person: support for 'the self-injurer'

Most participants talked about having sought or received care in general for their self-injury, using counsellors, therapists, psychologists, psychiatrists, GPs and charities or help lines. The methods and motivations regarding how these services were accessed varied however, as did the ways in which participants talked about these issues.

Milly, Robert, Mark and Francis had all sought out counselling themselves in response to mental distress. Milly and Robert had each seen three different counsellors. They both appeared to view receiving counselling as relatively unproblematic, and took a pragmatic approach. Robert, for instance, talked about seeking out counselling when he was struggling at college.

"I actually, spoke to the counsellor during my period at [residential college] as well (A – mhm) had a, an appointment with her because I was getting really depressed, and, couldnae handle the workload and things eh, so I spoke, I had a chat with her."

More recently he described visiting a counsellor to cope with a recent medical diagnosis and changing his college course. Milly and Robert both described counselling as a relatively unproblematic resource which they drew upon when in emotional distress.

Mark had seen a counsellor briefly when he was suffering from depression, and was also currently seeing a counsellor for something that he said was unrelated but did not disclose. Therefore his counselling was apparently largely unrelated to his self-injury. Mark was relatively positive about his self-injury in general however, and therefore it makes sense that he would not have felt the need to seek 'help' for his self-injury in particular. Francis had also seen a counsellor around the time that I

interviewed him. Whilst this was also not explicitly about his self-injury, Francis said that he had discussed his self-injury with the counsellor, and found this useful:

"I've had sort of 5 or 6 sessions with them, and, em, … … you know sort of, ah, it wasn't immediately obvious, the, the benefit it was having on me but, afterwards, I sort of feel like ***its probably, been quite a positive thing to have*** *done. em, yeah, I mean, yeah my concern, one of my concerns about, having done it, I think, I think its quite a shocking thing, to, .. to just see that you've permanently changed your body, you know that alone, regardless of, I imagine its sort of similar to getting a tattoo or something, you know that its actually,* ***you've permanently changed, an aspect of your body, you can't take that back now****, and em, …"*

The embodied nature of self-injury is highlighted here, as Francis particularly notes that counselling helped him to come to terms with the fact that his self-injury had "*permanently changed*" his body. Although he had found counselling beneficial in beginning to come to terms with his self-injury and family problems, Francis was much more ambivalent about receiving counselling however, and this seemed to relate to his family's more general dismissal of his negative and 'self-pitying' feelings.

Francis, along with Anna, Emma, Harriet and Milly, had also received support from his GP about his self-injury. Milly visited her GP and was prescribed anti-depressants. Francis sought help from his GP soon after his first act of self-injury, and we discussed this at length in his interview, as I was surprised at his decisive attitude towards this.

"F - I was concerned and that's when I went to the GP and -
A- (interrupting) yeah, I guess I was quite struck by the fact that you went to your GP, [---], an interpretation of it could've been that it was quite decisive action like, well there's something wrong here, lets get to the GP and get it sorted, I sort of, and especially when they offered you counselling and you didn't take it, I guess I was wondering what, you were kind of expecting them to say
F – yeah
A - and do about it
F – I think it was par-, I think it was really more that, at that stage I hadn't told anyone, and it was really just going to someone, to tell someone, like. And even just that act of getting it off my chest
A - yeah

F - I had, I mean that made me explain why I, I mean I can't actually remember what I was thinking at the time but"

Francis' views on this are slightly conflicting: he felt that he needed to 'tell someone' and therefore visited the GP, but he appeared to feel that this was enough and that a counsellor as well would be somehow self-indulgent. Francis' decision not to seek further help at that point may well have led from his family's reaction to his behaviour. As I discuss further below (Section 6.4), Francis' sister in particular accused him of 'attention-seeking' and it is possible that such reactions led to him deciding not to seek further support.

Anna, Emma and Harriet had each had extensive contact with psychiatric services, and some of this was accessed through their GP. Emma's psychiatric care had recently been given over to her GP following the retirement of her long-term psychiatrist. Harriet was initially treated by her GP when she first "*took ill*" at the age of 16. This situation was complicated, however, as her GP at this point was apparently her father, so she had to be transferred to another surgery. Despite this, she remained concerned about how confidential her treatment would remain, and she worried that when she used out of hours services that this would get back to her father:

*"… its like, its hard like, having, … a dad as a doctor, because everyone knows him, and you're like, like – 'oh, your dad's a GP isn't he' its like – yeah (A – mm) and they find that ------- how can you be unwell when your dad's a GP (A – mm) its like you go to the like out of hours, and they like, look at you and their like, hehe, yeah…. Kinda like, its strange, them like knowing, knowing I'm ill. Like**, hope they don't say anything** – I know they can't say anything bad but sometimes you worry like, they might say 'oh I saw your daughter and… in like out of hours sort of thing"*

Psychiatric services were used extensively by Anna, Emma and Harriet, and Dinah had also had some involvement with psychiatry. With the exception of Dinah, these were generally presented as services which participants had *had* to access – that is, they did not necessarily choose to go, but rather their attendance was part and parcel of their being diagnosed with a mental illness. Accessing these services went with the territory of being diagnosed with post-natal depression/manic depression (Anna);

bi-polar disorder (Emma) and borderline personality disorder (Harriet). Anna was referred to psychiatry after her post-natal depression was identified at a routine check, and had remained involved with services ever since. Emma had different episodes of involvement with psychiatry, neither of which she directly accessed herself. In the first instance, she was taken to the doctor by a friend at university who was worried about her, and subsequently referred to a psychiatrist and therapist. In the second instance, which occurred when Emma was 27, she visited her GP with what she thought was an ear infection, was diagnosed instead with depression and referred to psychiatry again.

Harriet did not discuss explicitly how she came to be involved with psychiatric services, though we did briefly discuss how her case was escalated to an 'emergency' status:

"H - I think I was lucky when I was like in adolescent services cos they got me seen, really quick, it was like, got an emergency appointment,
A – yeah
H - cos like, 'no we need to get her seen', and I'm like – ooo.
A – yeah, no that's what happened to me when I was, it was when I was 16, was that I was on a waiting list, like for a psychologist, and like crises were happening, and I got put on an emergency thing, got seen,
H – oh, ***mine was straight away an emergency***
A – yeah
H - I think the school was persua- said they had to get her, in, as an emergency because, they couldn't , have me in school in the state I was"

Through this discussion, then, Harriet implies that her 'state' was so severe that her school instigated her involvement with psychiatry. This excerpt also demonstrates one of my attempts to involve my own story in the data collection, though not terribly successfully here. I was attempting to create common ground between my experiences and Harriet's. However, Harriet appeared to interpret this as a challenge, following which she sought to affirm that *she* was the one in the 'worse' state. This represented an incident where there was a clear conflict between: my position as a researcher; Harriet potentially positioning me as 'therapist'; and my status as someone who had similar experiences to those I was researching.

Dinah's interaction with psychiatry was quite different. Like Emma, she accessed psychiatric services on two separate occasions. The first was when she was 19 and was instigated by her then partner, Gianni, who was controlling and abusive. She was clear that, partly for these reasons, this did not go well:

"Oh I told you aye, when I mind ***Gianni made me go and see a psychiatrist*** *when I was 19 I think I told you that, I've just remembered heh. Ehm…. Ironically enough, he added to everything, you know, he didn't help, but he wanted me to go and do something about it! Very strange, weird thing going on there. Ehm, but I went to see some, I went to see my GP who referred me to the young people's unit when I was 19.. .and, they were the ones that said, you can, you can go to a group therapy thing if you want… (A – right) and I was like, no thanks, I don't want, cos I was really really shy, I d don't really want to talk about this in front of oth-, I'll talk to my friends, and I might talk to an individual but I really really didnae want to speak to.. […] Because I know, and I know what triggers it, and I know why I do it and w-what's the point of going to see a professional who might, … just I dunno, just seemed a bit silly. Especially that, cos I was like****, I'd been forced to go as well which didn't help****"*

Dinah notes that she felt she was clear enough about her reasons for self-injury, and therefore felt further intervention or 'support' was entirely unnecessary. This also perhaps highlights the inadequacy of some of the services recommended to people who self-injure. Emma also indicated that she had been offered group therapy, but had declined for similar reasons to those expressed by Dinah – a disinclination to discuss problems with groups of 'other people'. The second instance was prompted by Dinah herself when she was in her late 20s. She described becoming increasingly concerned about her own moods, and requested a referral herself. This referral came through shortly after the death of her first daughter, and therefore the support she was offered was oriented towards this. Again, Dinah experienced this as inappropriate. She felt she was coping perfectly well with her grief, and she noted that her self-injury preceded her loss by many years. She therefore felt that the support she was offered was again misplaced, and ceased her involvement with services.

Dinah's case contrasts with those of Emma, Anna and Harriet. Dinah appears to have had much more choice and control about her involvement with psychiatric services. While Dinah successfully terminated her involvement with services, Emma, Anna and Harriet were each admitted to psychiatric hospitals on numerous occasions.

Conversely, this could indicate that despite their relatively passive engagement with services (in that they received the help rather than sought it) the services that Emma, Anna and Harriet were involved in were experienced as necessary, if not entirely beneficial.

Participants' narratives about their experiences with psychiatric hospitals were also varied. Harriet described being initially very wary and scared about being admitted to a psychiatric hospital, and successfully resisted admission, despite apparent pressure from both her school and her psychiatrists. More recently, Harriet claimed that she had begun to view admission to psychiatric hospitals as a helpful part of her overall care plan and was far more pragmatic about her admissions. These admissions now were instigated by Harriet herself, and she had to ask to be admitted.

"it's always like, planned admissions (A – ok) like, we plan it an everything and, ok, we're gonna fit you in. But now it's up to me to say when I need to go in (A – mhm) I mean I've been in twice this year, was in in April, and then I went back in in June"

In contrast, Emma and Anna implied much less control over their admissions to psychiatric hospitals. For instance, Emma referred to being 'taken back' to a psychiatric hospital. Anna discussed this in detail, demonstrating clearly that although on paper she admitted herself to the hospital, this was not how she experienced it. In this excerpt, from Anna's first interview, she is clear that she was not 'sectioned'[14]: "*It … was a case ae, well, there was nae choice am.. I I wisnae sectioned, ehm…… but …. It was just a case eh well it's for your safety so … go…*" Referring to the same incident in her second interview however, Anna reveals that she had been told that "… *if I didnae go in I was gonna get sectioned*". As Anna makes clear, although she was not officially sectioned, she nevertheless felt that she had no choice but to admit herself to the hospital.

6.2.2 The wound: treating the injuries

[14] The term 'sectioned' refers to an individual being admitted to a psychiatric hospital for treatment or monitoring, without their consent, under the terms of the Mental Health Act 1983.

Several participants described receiving help specifically for the injuries they inflicted upon themselves. In most cases, this involved visiting A&E departments, though participants' routes to and experiences of A&E differed.

Anna described visiting A&E when she injured herself severely, for instance when she was unable to stop the bleeding herself. She described this explicitly in terms of wound severity: "*Last year I had to go into A&E cos I'd severed the artery in my arm, and the blood was just going wheeew, spurting out em…"*. Emma also talked about visiting A&E only when the wounds were too severe for her to treat herself: "*I didn't really tell people, em, … … . unless it was, it needed medical attention, in which case I took myself to (A - yeah, ok) […] to, hospital and stuff*". Emma frames this in terms of her general tendency not to tell anyone about her self-injury, implying that a hospital visit was a last resort. Emma did not discuss in detail (and I did not ask) how she determined whether a wound needed medical attention or not. She did, however, describe wounds that were stitched and stapled up without anaesthetic. I discuss this instance further below (section 6.3.2).

Harriet also described taking herself to A&E, and she too suggested this was a decision she took on the basis of the type of wound that had been inflicted, and whether or not it was likely to require stitches: "*sometimes I'll take myself in the car, because, sometimes, … I really need to get it seen to because its like, it needs like, sutures on it and everything.*" Harriet's narrative around this issue was complex however as she mentioned that on some occasions she took herself to A&E, only for the wounds to have already "*closed-up.*" Harriet related this story whilst explaining how hard she found it to cut her wrists, which was *"a nightmare its like – it doesn't work*!!":

"hehe, you're like 'grrrr why won't it work?' and I found that your wrist, it, closes up straight away (yeah ok) you cut and, within like, half an hour its closed itself up (A – mm) and you go to hospital and they're like, 'but its closed up' (A – mm) --- you dinnae cut that deep it just, it somehow it closes (A – mm) … like, oh, it doesn't actually look like I've done anything"

This could indicate that although Harriet's stated intention for visiting A&E was related to the severity of the wound, this was perhaps not always entirely the case. Alternatively, it may suggest that Harriet was sometimes so distressed she was unable to accurately gauge how much damage she had inflicted.

Harriet also told me that in many (if not most) cases, she did not take herself to A&E, but rather an ambulance was called by friends. This aspect of Harriet's narrative was especially illuminating, and again points to the importance of social aspects of her self-injury. In this case, Harriet describes how an ambulance would be called because of her friends' fears about her intentions, rather than her actual self-injury:

"A - like how, it might be a really stupid question right, but, em how do you, how do you decide, like, that, ok right I need to go to A&E, like, is it cos its, so bad, or, do you know what I mean?
H – yeah….em……. normally when like an ambulance has come out, and the police, its been my friends that's called them because I've been in touch with them, and, I'm not really with it, and they're like getting really worried about me that I'm gonna, do something serious."

As Harriet indicates here, in most cases when an ambulance was called (either by Harriet or her friends), the police were also in attendance. Harriet was rather ambivalent about these situations, partly expressing embarrassment at the fuss being made over her, but the excited manner in which she related these stories to me indicated some level of enjoyment also:

"I was like in A&E for self-harm, like, every week, from like April to the June, and A&E are absolutely fed up with me, and they're like going – 'you're self-harming, just so you can come here aren't you?' and I'm like 'no' and their like 'you're just attention seeking' and I'm like 'no, I'm not' like ooh. It's scary, cos, ***every time you self-harm, and, you, like, you call for an ambulance*** *a lot of the time the police come out! And I'm like, ok! I'm like, what do my neighbours think, with the police coming out, and the ambulances coming out? And I'm like, oh, my god. Heh. Like, just not making a good name for myself round here! Hehe. Heh. Police, stuff, out, like 2 police cars ----- outside my door!"*

The section I have highlighted in the above passage may also be significant, implying perhaps Harriet's readiness to involve formal services when she self-injured. This apparent readiness to seek formal support was further reflected in her

use of a wide range of different support services – far more than any other participant reported.

Harriet's use of A&E can be contrasted with Dinah, who said that her visits to A&E had been entirely down to the intervention of friends. Dinah's narrative was quite different from Harriet's however. While Harriet implied that she communicated her intentions or actions to her friends[15], Dinah was clear that the only reason her friends ever found out about her self-injury, and subsequently took her to hospital, was on occasions where Dinah had drunk so much alcohol that she was not "*careful*".

" I mean I've probably been to the hospital about 5 or 6 times, there's probably times I can't actually remember to be quite honest, the only times, times where I ever got in a state, in a situation where people found me, was when I'd been drinking, so, you know, most of the time wasn't, ***I was never, I was[n't] doing it in front of other people and many people didn't know about it, and when they did find me, it was really bad*** *and it was probably cos I was drunk I wasn't being care-, you know* ***I wasn't being careful****…. Ehm….hehe. yeah, aye that's definitely what was going on…oooh. Don't care what I do, you know what I mean?"*

It is unclear from the transcript and tape whether Dinah meant that the amount she had drunk made her less careful about <u>hiding</u> her self-injury, or less careful about <u>making</u> or <u>caring</u> for the wounds.

None of the other participants described visiting A&E as a result of their self-injury. Rease said that she had gone to A&E on two occasions, because of overdoses she had taken. Milly related an incident where she did seek help for a wound she had inflicted, and like the stories of Anna and Emma, she related this to the severity of the injury:

"… because I'd never cut with a knife before, I didn't know…. About the pressure, or, how deep it was gonna go and bla bla bala, and I gave myself that one that night [scar on forearm], and it was so deep, so deep, I absolutely, shat myself, and ended up having to go and speak to somebody, and .. Colin's reaction was… bang on"

[15] Harriet lived alone and as far as I could ascertain, most of her social interactions took place via the internet and phone and were therefore 'active' – requiring her to instigate communication.

Like Dinah, Milly had been drinking prior to this injury. However, she associates the severity of the wound not with her lack of care necessarily, but her lack of expertise – she was not used to using a knife. The depth of the wound on this occasion scared her so much that she 'had' to go and speak to somebody. This case can be further contrasted with Craig's comparable narrative about his 'worst' injury. While Milly felt that she 'had' to speak to somebody about her injury, Craig indicated that he had stayed in his room for a week and stitched the wound himself.

With most participants it appeared that they had not attended any formal support services for the care of wounds mainly because they were able to manage the care themselves, and largely because the injuries they had inflicted were not of a severity which warranted a visit to A&E. Harriet's stories complicate this, as she appears to have visited A&E with non-severe wounds (i.e. wounds that did not require specialist treatment). This is further problematised by both Craig and Anna, both of whom described caring for relatively severe wounds themselves. In Anna's case this was in response to poor care she received from A&E, which led to her trying as far as possible to bandage and steri-strip her wounds herself. As noted above, Craig described actually sewing up his wound himself in order to avoid visiting a hospital:

"… woke up and was basically stuck to the mattress, with blood hehehe cos what I figured out, was I just sort of serrated bread knife and I just slashed my leg, I've got three scars, and erm, you can see, I'm not anatomist so I'm not quite sure but.. tubes and stuff like that inside and erm, I actually ended up sewing it up, myself. ***Cos I didn't want to go to hospital – I can't go to hospital, they'll lock me away, for being a mental!*** *So erm.. that kinda, yeah, I think I probably stayed in my room for like a week or something, and didn't really do anything. Was horrified that I'd get gangrene, hehehe, or bleed to death or something like that… it seems nonsensical now"*

Craig expressed extreme concern and embarrassment about his behaviour. Craig's narrative here is particularly distinct from Harriet's discussions around seeking help for her wounds, and highlights the diverse ways in which participants approached and understood their behaviour. This contrast also emphasises the importance of the material injuries that self-injury involves in experiences and understandings.

However, it also stresses that the injuries themselves (even when similar) can be experienced and understood very differently in different contexts.

6.3 Experiences of help-seeking

6.3.1 Negotiating self-injury

Harriet and Anna each had stories regarding the policies and attitudes of staff in psychiatric hospitals towards their self-injury. This has been an important matter for groups such as the National Self-Harm Network (Cresswell, 2005a), who have campaigned for in-patient wards to allow self-injury. These groups argue that if self-injury is prevented, with no other appropriate coping mechanisms in place, the individual concerned may suffer even greater distress and injury than if they were allowed to injure themselves 'safely'. Such a 'harm reduction model' is controversial, with some advocating the approach as best practice (Harrison, 1998), whilst a well known treatment programme in the US valorises the use of 'no-harm' contracts (SAFE Alternatives, 2007). Anna's experiences over the years reflect these conflicting perspectives:

"Right, cos even in [psychiatric hospital], like, the three times I've been in, its changed each time, em,,.. to start of it was like (in stern, military-esqe voice)'you will not self-harm, you will not cut yourself, we will search you' […] but then by the next time it was , kay, we know you do it, be safe, fine, ok. And ***then by the third time, it was,… I dunnno, how I think it <u>should</u> be… it was like, d'you know, that's fine, we know you cut, be safe, if you need dressings, get them****, if you want to talk you talk, if you dinnae, well leave it, and we can talk later or, or whatever…em, and its like there's nae questions asked. Okay, excellent."*

Anna clearly preferred the 'harm reduction model'. However, she went on to relate how, in a more recent hospital stay, not all of the staff were following this model, which caused her some distress:

"Until this, one woman, who I suppose is this old school frog marched me along, 'show me what you used, give me it'. And I gave her this piece of glass, cos we'd been glass paintin, and I'd took it and smashed it. Em. 'is there any more, or do I have to strip your bed?!' I was like, strip my bed and I'll deck you.. and it wasn't

until I came out and I said to my CPN and she was like 'oh, no, no, no, that's not supposed to happen' and I's like, no, I know that."

This quote emphasises the lack of power that Anna experienced in hospital, though also hints at her resistance *("strip my bed and I'll deck you*"). This parallels the experience Anna described having in A&E, which is described below. In both cases, Anna frames herself as perfectly aware of 'best practice' but in each instance experiences herself as unable to challenge the 'poor practice' of the medical staff involved.

Anna's experiences and descriptions of her stays in in-patient psychiatric wards were quite different from Harriet's. Anna was particularly negative about the psychiatric hospital, describing it as "*scary*" and emphasising the difficulty she had coping with the lack of power she experienced when an in-patient. In contrast, Harriet described her stays in hospital in a much more positive tone. Although she said that her very first experiences with hospitals had been, like Anna's, "*scary*", she described how she now "*used*" her stays more effectively. Harriet related a story about her interactions with hospital nurses which highlights the different ways that the two women appear to have experienced psychiatric hospitals:

"… once I started using the hospital stays constructively …. It, … really helps me. But to start with, and, like, they put in a rule like, if you self-harm in any form, you will get discharged. They didn't have it to start with, like sorta saying, no, it's a rule, if you do anything, you'll get discharged. And it made me take responsibility. ***Everyone thinks, oh, when you go to hospital, all the responsibility gets taken off you, but, you, I had the responsibility to make sure I didn't hurt myself in any way cos I would get chucked out****, and also that, if I was to go back, I would go and talk to somebody […]last time* ***I picked the same nurse*** *every time, because she would understand me. And she, she had the time to sit and listen to me."*

Harriet described experiencing the 'no harm contract' in a very different way from Anna. Where Anna experienced this as disempowering, Harriet describes having such a contract as being helpful, in forcing her to take responsibility for herself so that she did not get "*chucked out*". Harriet also implies a greater level of control and power in her stays in the psychiatric hospital: she "*picked the same nurse*" to speak to. Later, Harriet discussed her hospital stays further, in a narrative which further

emphasised the lengths she had to go to in order to get the support she felt she needed in these contexts:

"when I'm in hospital, like, I got told – right, when you're not ok, go straight up the top to a nurse (A – mhm) but like, some of them are just like – 'oh we don't have time' and the last day I was in there I was getting really anxious about leaving (A – mhm) and not, I tried 3 nurses, and none of them had time to talk to me (A – mhm) they kept going – 'I'm busy, I'm busy' and I was like – ok. …. Its like, I need to talk to you and you're like going 'I'm busy' you know like, getting really, really stressed out, and I was like ooohhh. Get told to talk to people and instead getting like more, anxious and worked up, you don't have time…… you kinda like build up the courage to go and find somebody and go – and you worked out what you wanted to say to them and like"

While this excerpt suggests that Harriet was far from successful in getting the support she wanted, it also implies that she was relatively determined in seeking the support, trying three different nurses. Research has frequently demonstrated the negative ways that patients who self-injure are viewed by medical staff (McAllister et al., 2002a; McCann et al., 2006). Sociological work on staff attitudes has suggested that these negative attitudes may be related to moral judgements regarding different behaviours. For instance, Jeffery (1979) found that staff were more sympathetic towards patients whom they thought had 'really' tried to kill themselves. In contrast, those who were deemed to have been 'attention seeking', by presenting at A&E with non-serious overdoses, were viewed as 'rubbish'. Similarly, May and Kelly (1982) demonstrated the different ways that patients in inpatient psychiatric wards were viewed by staff. In both papers, staff judgements of patients' moral worth centred around understandings of responsibility. Patients who were viewed as 'responsible' for their actions were treated more punitively than those who were not. This may at least partly explain why patients who have self-injured might be viewed particularly negatively: they are seen as wholly responsible for their situation. They are consciously and therefore culpably 'deviant'. In Harriet's situation her, in many ways, responsible attitude toward seeking out help may have been reinterpreted by nursing staff as evidence that she was not 'really' in need of any help.

6.3.2 Horror stories

Those participants who had attended A&E as a result of their self-injury invariably had horror stories about the treatment they had received there. These horror stories are reminiscent of and parallel literature from user-led groups such as NSHN and LifeSIGNS who campaign for better treatment for patients who have self-injured, as well as similar narratives reported in academic literature (Harris, 2000).

Anna related in detail her last visit to A&E, an experience which left her adamant that she would not return: *"I'd rather die, seriously would rather just die, I wouldnae go through that again for anybody. It was, horrendous*." Anna led into the story from a discussion where she likened her self-injury to being similar to a "*druggie*" or an "*alcoholic*" needing their "*fix*", which led to her contrasting the types of treatment she saw these groups of people receiving, compared to the treatment she had received. I have reproduced the excerpt in full to convey some of the complexity of Anna's narrative:

"I always say, if an alcoholic gets or or any drinker gets so drunk that that they drink till they pass out and the cut their head and and need it stitched or whatever, they get treated, and if a drug addict takes a an overdose, they get treated. And yet, … on, many occasions, I've needed either, antibiotics for an infected cut, or stitches or whatever, and ***you get treated like the lowest form eh life****. It's just so bad. Last year I had to go into A&E cos I'd severed the artery in my arm, and the blood was just going wheeew, spurting out em… and we went in, and it was like wrapped in this totally blood soaked tea towel, went in and the, the triage nurse, sortae put steristrips on it, she says that'll hold it, I'll bandage it, 'til you get it seen. And I seen this doctor, and he put me in a cubicle****, he looked it and he went 'oh, you did it' - 'aye' and so then he moved me into this dirty cubicle, em, he'd left the screen open****… while he was like looking at it and treating it and everything, left the curtain thing open… em, he refused to stitch it… and , the, the blood was just like, everywhere, it wouldnae stop bleeding, you shouldae seen it, he refused to stitch it, and he fought, and I mean literally fought, and fought and fought, he went through hundreds of steristrips, because, they were just falling off… and I was like… **You're just no in a place to argue are you, like mentally, physically, emotionally your no in a place to argue, well I wisnae****. And, I was, I was j.. and they wouldnae let Mike come through he had to sit in the waiting room[…] So anyway, it ended up that… he steristripped it, and put a .. one of these… sterile pad things over it, right, by the time I had got home that had burst off and it was bleeding again, so I just wrapped it up and left it,*

em… and, ***within like sorta 24 hours of that it was infected, […] I was so ill, ended up wi septicaemia"***

There are several important aspects to Anna's story. She describes herself as feeling powerless; she was in "*no place to argue*". Her husband was prevented from staying with her, removing a potential advocate and source of support. Anna relates this directly to her having done the injury herself, suggesting that the doctor provided the type of treatment he did explicitly because she had injured herself. She points out how counter-productive this approach ended up being, as due to the poor treatment the wound was infected, and she required further treatment for septicaemia. Anna's body is central to this narrative. She had to visit A&E in the first place because she was unable to control the bleeding of a severed artery on her own. The doctor's disapproval of Anna's behaviour is played out on Anna's body, as he "*fought"* with the wound, attempting to close the laceration with steri-strips rather than sutures. Whatever the doctor's reasons for taking this approach, from Anna's perspective this was experienced as a further attack on her body, one that led directly to her developing an infection.

The doctor in Anna's case is framed as having a problem morally with the fact that Anna had created the wound herself. This was echoed in Emma's 'horror story' about a visit to A&E.

*"**I have been discriminated against**, cos I, I turned up, I'd cut my arm, and my stomach, … and em, …. … taken myself up to A&E and, er, … … … they, … I had to get 11 staples, em, to, to sort of patch it up, and em**, they didn't bother giving me anaesthetic or anything they just went, well, you're a self- harmer, click click click.** You know, it was, … I was just lying there going, 'your not gonna give me anaesthetic' they went **'nah, you're a self-harmer – you did this to yourself so, … don't really care' and I'm like, but – but you're just stapling me up with nothing!** […] em, …. … and I spent, you know I stayed over night in the, the psych ward in the, [hospital] (A – mhm) and em, … I thought they were gonna, take me back into the [psychiatric hospital] again but they didn't**, they just let me go**. And eh, I went straight to college heh!"*

Like Anna, Emma is clear that the damaging and violent treatment she received from the medical staff was understood as directly related to their negative moral interpretation of her self-injury. In each case, Anna and Emma interpret the actions

of staff as suggesting that they 'deserve' such treatment, as they inflicted the wounds themselves. Anna suggests that the treatment meted out to her is worse than that given to other patients, such as alcoholics or drug addicts, who have also 'done this to themselves'. This is a significant parallel, as some other research has also associated the treatment of self-harm patients with other similarly 'self-inflicted' categories of patients (Jeffery, 1979). Jeffery, like Anna and Emma, argued that the treatment of such patients was based on the moral judgements of staff.

Harriet also mentioned that she had heard about people who had been stitched up without anaesthetic, though she did not say she had had this happen to her. However, she did imply that sometimes her visits to A&E were not supportive. She was accused of 'attention-seeking' by staff on at least one occasion, and she said that doctors in particular were sometimes "*really horrible*".

Rease and Dinah had also had negative experiences at A&E. Rease attended due to an overdose, where she experienced the response of the staff to her attempts to open up about her reasons for her behaviour as entirely inadequate. Dinah, as previously discussed, only attended A&E for her self-injury when she had been drinking and other people took her. She noted that this appeared to impact negatively on the care given to her at A&E:

"I ended up wi my… flatmate, ehm, took Lexy and her pal took me to hospital, and I was completely away with it… I mean, like, and I wasn't even that dr-… that's the thing I suppose when I was really hyper I didn't really need that much to drink anyway.. and I was completely away with the fairies, like talking to myself and like nn.. and, like just left, no no interest whatsoever, and just, ***you know what they were interested in was if I'd been drinking and then…. put the stitches on and then away****, you know what I mean and huuuh, its like…* ***Which suited me, to be quite honest****… it did suit me, cos I didn't really want, particularly want anything to do with the services, but… ehm… its just… bizarre, just totally .. and* ***utterly dismissive about the whole*** *- "*

Dinah suggests that staff were mainly concerned with how much alcohol she had consumed, and were generally "*dismissive*" about the self-injury itself. However, although looking back Dinah labels this as negative care, she is also clear that at the time she certainly preferred this lack of interference. The attitude of staff is similar to

Emma, Rease and Anna's experiences, in that staff appeared uninterested in treating any of the women outside of the injuries they presented with. Rease, Emma and Anna appear to have interpreted this dismissive attitude far more negatively than Dinah, who admitted that at the time she had been quite pleased about the lack of interventions offered.

6.3.3 More hopeful indications

Many of the participants described some of their experiences with services more positively. These more positive narratives tended to be about counselling oriented support services, though Harriet did note that the treatment she got from nurses at A&E was often good:

" Like, some of them are, like, not too, are kinda nice with you, and others are like really horrible (A – mhm) H - just depends on who you see, but I think, ***the nurses usually are quite nice****, but the doctors are like, 'we don't have time for people like you' (A – mm) H - … its like, mmm, I don't know, its like,* ***there's a load of nice nurses in there*** *(A – mhm) like, their like 'ohh, what did you, what happened', and 'what made you do this?' and, (A – mhm)* ***… kinda really gentle with you*** *(A – yeah) and, like, which kinda helps*

Harriet describes this care as being positive both in terms of how she was treated as a person, in that she was asked about her intentions and allowed to talk, but also in the way that her injuries and body were treated: 'gently'. This experience is of course far more positive than the violent and upsetting treatments described by Anna and Emma in the previous section.

Several participants, who had received counselling, appeared to regard this relatively positively. Anna and Emma each said that they had received very helpful counselling from a psychologist. Both seemed to label this treatment as 'good' in part because they were able to develop a positive relationship with the professional involved. Significantly, both also emphasised that these particular psychologists had helped them to understand their self-injury. For instance, Emma said that the "*biggest*

difference" had come from a psychologist she saw in relation to her fibromyalgia, a condition she developed several years after her self-injury had stopped:

"… the, the guy sort of wheedled out of me, he was very clever, cos he could, he could make me come up with things, and I'd think I'd done it myself, when he'd sort of steered me in the right direction to, to, … em, you know, he sort of steered me towards that conclusion, but he did it very skilfully so…. ***I knew I was being manipulated hehehe, but I really enjoyed it****!"*

Similarly, Anna told me that only following a year of counselling from a psychologist had she started to understand the possible links between her relationships with her parents and her self-injury. As discussed above, both Robert and Milly described using the services of counsellors, and their willingness to engage with counselling on different occasions indicates that they found the process useful.

6.4 Attention seeking

'Attention seeking' is related to help-seeking in a number of ways. Firstly, 'attention seeking' was used as a negative label for some participants when they sought help for their immediate self-injury at A&E. Secondly, help-seeking and 'attention-seeking' could be viewed as involving the same or similar behaviours – the main distinction being that the use of 'attention' rather than 'help' implies that the 'attention' is not needed. For instance, people receive 'medical help' or 'medical attention'. However, when the word attention is removed from a 'medical' context, it implies that the attention may not be needed or deserved. In contrast, help-seeking even out with a medical setting still implies that the help is both necessary and needed. Importantly, and as I will demonstrate in the following two sections, the term 'attention seeking' has more negative moral connotations than help seeking.

6.4.1 Negative accounts of – that is 'not me'

Both Harriet and Craig explicitly said that their self-injury was not about attention seeking, though they did so in markedly different ways. Craig discussed this in the

context of explaining his 'worst' incident of self-injury, where he had cut his leg with a bread-knife, and subsequently sewed it up himself, rather than seeking medical treatment:

"you don't want to go to the hospital, and [say] 'I did this to myself!' and I was probably embarrassed as well… cos ***I know a lot people say if they've not done it themselves, or for attention seeking or anything like that, but em, it was kind of the opposite, certainly in my case,*** *and I think a lot of other people's cases I didn't want people to be talking about it and stuff"*

He was also clear that he kept his injuries hidden from other people, and avoided talking about his self-injury entirely. He did note, however, that his friends at university (when the majority of his self-injury occurred) *had* in fact been aware of his behaviour, and *had* attempted to talk to him about it. Craig related this to me in a way which suggested he was unsure about this – and it did directly contradict some of his other statements regarding how far he had been able to keep his self-injury "*to himself*":

"(A - did any of your friends at uni know?) ***I didn't think so, but I found out later on that they did.*** *Erm… there was a few of them, kind of confronting me about it.* ***Apparently*** *they were saying that they thought I'd really deny it, or get defensive about it, but* ***apparently I just kinda went yeah****, and just didn't want to talk about really. So they didn't particularly know what to do about it. […]****But yes they did… they did know****….."*

Craig's use of "*apparently*" and his initial claim that he had not thought that his friends knew, complicates the reading of this excerpt. It seems to suggest that Craig did not remember this happening – and this does unsettle the more general message from Craig's narrative, which was that nobody knew. I am not suggesting here that Craig *had* self-injured 'for attention' – but I am suggesting that because of the negativity around understandings of self-injury as attention seeking, people who self-injure may well try very hard to portray their self-injury as 'private' or 'secret' – both to themselves as well as to other people.

Harriet's narrative was very different from Craig's in that, as discussed above, she described numerous and varied attempts to 'seek help': she regularly attended A&E;

she used telephone help-lines; she visited online support groups and message boards; she texted and phoned friends; and she got telephone support from her CPN. Despite the differences in their help-seeking behaviour, Harriet was equally adamant that was not 'attention-seeking'. She related this to me whilst discussing the reactions of staff-members at A&E during a period of time where she had attended weekly:

"I was like in A&E for self-harm, like, every week, from like April to the June, and ***A&E are absolutely fed up with me****, and they're like going – 'you're self-harming, just so you can come here aren't you?' and I'm like 'no'* ***and they're like 'you're just attention seeking' and I'm like 'no, I'm not'*** *like ooh. It's scary, cos, every time you self-harm, and, you, like, you call for an ambulance a lot of the time the police come out! And I'm like, ok! I'm like, what do my neighbours think, with the police coming out, and the ambulances coming out? And I'm like, oh, my god. Heh. Like, just not making a good name for myself round here! Hehe. Heh. Police, stuff, out, like 2 police cars ----- outside my door! (A[sarcastically]-wow)"*

Harriet is clear then, that her behaviour does not constitute 'attention-seeking'. My response betrays my own feelings on this matter – as Harriet related this story to me (in an excited and enthusiastic fashion) I did feel that what she was describing to me *was* 'attention-seeking'. At the beginning of the research, my views on self-injury 'for attention' were rather derisive – I felt sure that my own self-injury was 'private' and hidden, and I found people who 'showed off' their scars and wounds embarrassing. I had also been fairly convinced by much of the literature (often user-written) that claimed that no-one really self-injured 'for attention' anyway. Over the course of the research these views have softened considerably. However, at the time that I spoke to Harriet, there is some evidence that my opinions regarding what she told me were not neutral. My own changing opinions have certainly informed my analysis, and my decision to focus on this aspect of self-injuring behaviour. I am sensitised to the negative moral connotations of 'attention-seeking' precisely because I used to feel so negatively about the matter. Harriet did not appear to be aware of my attitude – or perhaps did not care – for she related numerous further stories which involved similar behaviour.

Harriet's narrative on this issue highlights the close relationship between 'attention-seeking' and 'help-seeking' – what Harriet clearly saw as perfectly acceptable

attempts to seek help for her self-injury, was interpreted by the staff at A&E (and to a certain extent, by me) as being 'attention-seeking'. This issue is also evident in Francis' narrative, whereby he described seeking help very soon after he first injured himself – telling his mother and seeing his GP – but this was interpreted by his sister as 'attention-seeking'. Francis did not explicitly defend himself against this claim in our interviews. However, Francis did talk about a school-friend who he felt may have self-injured for attention. This was part of a long narrative where Francis discussed a girl he had known when he was 15, who had scar tissue on both arms from *"wrist to elbow*":

"(A – did she wear like short sleeves and stuff, like?) I think she, she usually wore long sleeves, I, I mean she mustn't have done all the time cos I saw them, […]I think, I mean, knowing, the person that she, was, presumably still is, she, she is, em, …. She was always, … …. Sort of quite, em, ***she liked being the centre of attention sort of thing*** *and she did, she would, she was quite, she sort of, yeah had histrionics, and sort of, you know would ….* ***Would em, … would do things just to get people's attention, so, … I don't know whether that might have affected where she, wanted the scars or****, (A – yeah)* ***how she displayed*** *them, I don't know whether it was something that she wanted people to talk about (A – interesting they still didn't though, well, if they didn't)"*

Francis suggests that the placement of his friend's scars, and her at least occasional revealing of them by wearing short-sleeves, coupled with her personality, contributed to his understanding that her self-injury may have been *"for attention*". As I note at the end of this excerpt, whether this was the case or not, her self-injury was not apparently discussed openly anyway, which Francis attributed to their age (15) at the time.

6.4.2 Accepting the charge

Belinda, Robert, Anna and Milly each said that they had, at least on occasion, self-injured 'for attention'. For Anna, she was clear that this only described her very first act of self-injury, where she broke her wrist with a hammer, an act that was designed, she said, to:

"*get a bit of attention, and* ***that sounds bad*** *and it …. like…. that's no what the self-harm's about* <u>*at all*</u>***, its not about getting attention because nobody knows about it****, em…. But I think that that was."*

So although Anna felt that this first incidence of self-injury had been about seeking attention, she was adamant that this did not accurately describe her self-injury more generally. Anna also indicates the negative moral implications of this issue with the phrase "*that sounds bad*."

Anna's claim that nobody knew about her self-injury raises an important point regarding how 'private' self-injury is. Anna certainly framed her self-injury as a 'private' act, and something she did not tell anybody, unless she "*really, really trusted them, which is never*". However, in the intimate context of her family home, with her husband and sons, her self-injury *was* known about, and she described how she would tell her husband if she injured herself, since he would find out anyway, and that her sons did ask about her scars and wounds. The negotiation of self-injuring behaviour in the context of such close familial relationships problematises discourse on self-injury which emphasises how 'private' it is. This was discussed, albeit briefly, by other participants. Emma felt that her self-injury had driven away potential romantic partners, who had been "*scared off*" by her scars. Dinah described self-injuring throughout two of her past relationships, and at the start of her current relationship. Although Robert did not live with his partner, he did describe him as a 'support' – noting that he had said that Robert should phone him if he ever felt like hurting himself, which Robert did occasionally do.

Like Anna, Robert described his <u>early</u> self-injury as being 'attention-seeking', and contrasted this with his more recent self-injury, which was not. He too indicated an awareness of the negative manner in which 'attention-seeking' can be framed, saying "*I think at that point* [his early self-injury]*, it was more eh a cry for attention, more than anything,* ***which sounds really pathetic now.***" As I discuss above, Robert's discussions around how far his self-injury was hidden or not were confused, and part of this may have been because his practices around hiding or revealing his self-injury may well have changed.

Belinda's narrative on this issue also highlighted the negative connotations of 'attention-seeking' and she also applied this description to her early self-injury only. Belinda presented a number of justifications for her 'attention-seeking' behaviour, and she clearly struggled with the issue as she discussed it in our interviews, saying for instance: "*I hated to think that I was doing it for attention, even though I was doing it for attention. But I wasn't doing it for attention to be cool*". Belinda contrasted her behaviour with that of others, implying that her reasons for needing attention were more valid – it wasn't "*to be cool*". Belinda suggested that her self-injury had been a necessary step, after years of being ignored when she attempted to communicate or seek help for the physical abuse that was occurring at home, or the bullying she experienced at school:

"I mean I, hehe, if you try so many ways of getting people's attention, like, you tell people at school and then, they call the meeting with the principal […] and ***you tell them everything and then they just disregard you. How are you supposed to get people's attention?!*** *How are you supposed to tell them?"*

Belinda framed this early self-injury as an explicit attempt to initiate communication with others:

"And that's why originally I started, cutting. Because ***I, wanted people to know*** *(A – mhm) em, that, you know, come on, listen to me and, and, in their eyes it seems a bit drastic, but if that's what I had to do! Hehe. You know, I just, I didn't know what to do with myself and I didn't know, what to think and what to feel, and, and* ***I wanted people to believe me*** *(A – mhm)* ***wanted people to listen*** *(A – mhm)* ***or to notice or just to do acknowledge, or something!*** *(A-mm) em, and that's originally, why I started"*

Belinda's other attempts to communicate or ask for help, were, she said, disregarded: as her parents had warned her, she was not believed. Self-injury, apparently, would be more believable than Belinda's own words. As discussed in Chapter 7 (p. 193), Belinda's mothers' reaction to her self-injury did not offer the care or acknowledgement she had wanted, though Belinda did describe having a supportive dance teacher, who spent a lot of time talking with her. This appears to have been the extent of the 'attention' Belinda received, and she was clear that her self-injury since

that point had been "*a me thing*, *not a them thing*" – not for others. Despite this, and as I discuss elsewhere (Chapter 7), Belinda did not really hide her self-injury, and indeed appeared to feel unable to.

6.4.3 Resisting negative moral interpretations

Milly's discussion of her 'attention-seeking' self-injury largely resisted the negative features of the other participants' accounts. Milly's narrative described a degree of openness regarding her behaviour, for instance talking about how "*obviously*" people saw marks on her arms and "*of course*" she told others following an act of self-injury. She described some of her self-injury as being "*conscious, very conscious in retrospect, attention-seeking*". However, she also said that:

"*a lot of the conscious effort is not to do with attention-seeking, this is how I see it anyway, em, but subconsciously, there is something that is, crying out for help, and I didn't know how else to cry out for help that night*"

There is some confusion in Milly's account then, around whether the 'attention-seeking' had been conscious or subconscious. This issue also sits uncomfortably alongside Milly's discussion of her attitude towards being "*appropriately emotional*" – which apparently involved being emotional *away from other people*. This then is a slightly odd feature of Milly's narrative: self-injury is oriented (relatively unproblematically) towards other people, whereas emotions and emotionality should be performed or expressed away from other people. It could be that this reflects Milly's different and changing attitude towards these issues between her first and second interview. Milly talked about 'attention seeking' frequently in the first interview, while her discussion of being emotional 'appropriately' occurred in the second interview, during which she only mentioned 'attention seeking' on one occasion:

"Although, yeah, there, there were times where I was doing it that, that, em, … I would, I would kind of hint, to people that I was doing it, and ***yeah that was an attention seeking thing but I only did that with a couple of people****"*

Milly's attitude towards this issue was different in her two interviews, which illuminates the negotiated, partial and flexible nature of these understandings and interpretations.

I have demonstrated in the above discussion that the issue of 'attention-seeking' is both morally charged and complex. Rease's account of her self-injury adds a further layer. Here she discusses 'revealing' her self-injury, and how this was not 'attention-seeking':

"also I think I did wear a short sleeved t-shirt to school once, and I had, … actually written something on my arm, em, with a razor blade, em, but ***it wasn't, like, sort of attention seeking*** *it was just, I dunno, it was just em, ……. I think it was partly em, I don't know if anybody else is like this with self-harm, …. Maybe its just me, em my tomboyishness, but, I've always kinda felt like a really weak person, em, and I always felt like em, … self harm was, it sound weird but its like, something I've achieved, like it was an achievement, and, …. You know like the macho thing with like guys showing off their ----- and sort of going though, em, sort of eh, sort of trials or something or em, burn themselves or cut themselves to show that their tough. There's a little bit of that, ..."*

Rather than 'attention-seeking' Rease describes this act of revealing her self-injury as being something quite different – she interprets it rather as a display of strength, or machismo. This challenges what some of the other participants implied regarding the difficulties of 'revealing' self-injury, or seeking help for self-injury whilst also avoiding being charged with 'attention-seeking'. Rease's emphasis, however, is on *her own* understandings and interpretations of her behaviour. In contrast, many of the other participants' discussions of this issue focused on the *interpretations of others*. What Rease describes is (non-verbal) communication however – and it is communication oriented towards others, as well as to the 'self'.

6.5 Contradictory narratives

This chapter has shown that most participants engaged in at least some forms of formal help-seeking for their self-injury. Significant exceptions to this were Craig, Justin and Mark. It may be important that these exceptions were all male, certainly

this finding lends a small amount of support to the suggestion that men may be less likely than women to disclose or seek help for their self-injury. It is likely that the people who volunteered for this research may have been more likely to have sought help for their self-injury, or rather, that people who had not sought help for their self-injury may have been more reluctant to speak to me. In Craig and Justin especially, however, I was able to speak with two people whose experience with self-injury had expressly not involved any contact with formal services. Belinda also reported minimal contact with services – certainly, since she had left home at 17 she did not report any contact with medical services about her self-injury. All three of these participants indicated that they were concerned about being labelled 'mad' or 'dangerous' by others should their self-injury have been found out. Previous work by Biddle and colleagues (2007) has suggested that fear of negative labelling may be particularly important in discouraging help-seeking for mental ill-health among young people.

This chapter has demonstrated that in several cases, where participants did 'seek help' they did not necessarily describe themselves as being particularly active or powerful in this. Those participants who described the greatest involvement with psychiatric hospitalisation each framed their contact with services relatively passively: hospital stays and medication were prescribed and taken, though not always without protest. Both Anna and Emma indicated that they had not 'sought help' for mental illness, but been diagnosed and identified as such when attending medical services for other (non psychiatric) issues (post-natal care and an ear infection, respectively). Dinah's first contact with psychiatry had been instigated by an abusive and controlling partner.

In contrast, other participants did describe a more active role in help-seeking. Dinah sought and ceased involvement with psychiatry herself later on in her life. Francis took himself to the doctors after his very first self-injury. Milly and Robert each sought help from counsellors at various points in their lives when they felt they were not coping well. However, in both of these cases, they suggested that this help was sought after a period where they had attempted to "*cope"* alone, again paralleling similar findings by Biddle et al (2007).

Harriet's narratives about her help-seeking were particularly rich and varied. She described early contact with psychiatry where she was referred by others, identified as 'at risk' by her school. Her more recent attitude seemed to be far more active, with Harriet describing seeking help (on the instruction of her psychiatrists and CPN) regularly and from various sources. However, Harriet also described the problems she had with this – she struggled to have her distress taken seriously unless she had "*done something*". A similar double-bind was identified in research carried out by Crouch and Wright (2004) in an in-patient adolescent psychiatric ward. In Crouch and Wright's research, however, the patients were concerned at being labelled an 'inauthentic self-injurer' by other patients. Harriet's experiences seem to indicate that her distress was labelled as 'inauthentic' or at least 'not serious' by medical staff themselves, unless she had injured herself, following which she received care and treatment.

This chapter has also demonstrated that the concept of 'attention seeking' is both closely related to that of help seeking, as well as being morally problematic. Several participants expressed negative opinions about their own or other people's 'attention seeking' behaviour. These negative attitudes have also been found among medical staff, both with regard to patients presenting with self-harm (McAllister et al., 2002a; McCann et al., 2006), and more generally towards 'deviant' patient groups (Jeffery, 1979; May & Kelly, 1982). Research regarding staff attitudes towards self-injury tends to conclude that viewing such patients as 'attention-seeking' is unhelpful, if not false. My research (along with Crouch and Wright) indicates that these negative attitudes are also found among lay people, including those who self-injure. In particular, research carried out with people who self-injure (this study included) suggests that if self-injury is labelled 'attention seeking', it is viewed at best as inferior to more 'secret' self-injury, and at worst, as an 'inauthentic' behaviour. As Harriet's narrative indicates, this can result in contradictory and complicated situations where a participant injures themselves in order to demonstrate authentic pain (whether to themselves or to others), but the very visible nature, and the act of

revealing the injury is equally likely to lead to a charge of 'attention seeking' and inauthenticity.

Rease and Milly's narratives offer a different and perhaps more positive perspective. Both women seemed able to resist, challenge and in some ways transgress normative and negative interpretations of 'attention seeking'. These issues are taken up further in the following chapter, where concerns with authenticity, morality, display and revelation are further explored. Chapter 7 focuses on the ways in which participants negotiated or avoided communications about their self-injury in informal interpersonal contexts.

Chapter 7

Display and Revelation: self-injury in informal interpersonal contexts

7.1 Introduction

This chapter expands upon and develops themes around communication, emotions and the materiality of self-injury. In particular, the focus here is upon communication about self-injury in informal interpersonal contexts. Display is developed as a central theme here, incorporating the display of emotion, and the display of self-injury. In the first half of the chapter I explore participants' narratives about the ways in which self-injury was communicated in the context of their households. As most participants began self-injuring as adolescents, much of this talk is centred on the role of parents. This section highlights that self-injury was more commonly *not* talked about. Communication instead was described as occurring non-verbally, through the display (both inadvertent and purposeful) of the wounds and marks created during self-injury.

Section 7.3 addresses the ways in which participants dealt with communications around their self-injury in other informal contexts. This introduces the theme of hiding and revealing, introducing the different ways that participants described negotiating comments (expected or actual) about visible aspects of their self-injury.

Section 7.4 expands upon the theme of display and visibility. This develops discussion initiated in Chapter 6 in the section on attention seeking. Specifically, this section addresses a conundrum: although self-injury was described as being 'not talked about' – some participants said that they did not hide their self-injury. This section then deals with participants' hiding and revealing practices. Some participants were clear that they very carefully hid their self-injury from certain people; whereas other participants said that they did not.

I suggest that these hiding and revealing practices are important in illustrating participants' experiences of self-injury, and their understandings about its meaning. Further, participants' narratives about their hiding and revealing practices highlight the importance of the corporeality of self-injury in terms of the lived experience of participants. In particular, this relates to the marks that self-injury leaves, and how participants described negotiating social life with these marks.

7.2 Communication about self-injury in the family

Communication about self-injury within the family was an issue I asked most participants about. I was interested to know whether parents were aware of participants' self-injury, and if so, how they had become aware. Self-injury is often described as being a 'secretive' act, and I wanted to know what this meant in practice. Did it mean that self-injury was kept from everyone, or just some people? Participants' stories about this illustrated that the matter of self-injury being 'private' was certainly far from straight-forward, and often either reflected or was complicated by participants' broader talk about communication in the family more generally. I begin this section by introducing those participants who talked about their families in relatively unproblematic, positive terms. This positive attitude jars with other comments they made which suggested potentially problematic modes and methods of communication. I then move on to those participants who described family communication about self-injury as non-existent – sometimes despite attempts by the participant to challenge this. Finally, I discuss the stories of three participants who described explicitly negative reactions to their self-injury from family members. What all of the narratives in this section share is a distinct difficulty regarding communication about self-injury specifically, but which also hint at more general problems faced with communication about 'difficult' emotions or issues.

7.2.1 Supportive families, silencing atmospheres

Milly, Dinah, Mark and Francis all stressed that their early family life had been, on the whole, a very positive experience. Mark and Milly especially expressed a concern that some perspectives on mental illness were too quick to 'blame' parents. Similarly, Dinah related how some of the counselling she had received had immediately addressed the issue of her parents, saying that, with some pride, she had informed them that her family life was fine: supportive, loving and warm. These positive experiences and associations are important, and were evidently very significant to the participants. However, I would suggest it is equally important to attend to the nuances of family life, and the ways that it can and does have both positive and negative effects. With regard to communication within the family, each of these participants also talked about less positive aspects of family life, which I argue reflect a more widely held socio-cultural attitudes towards the appropriate communication of negative emotions.

Dinah addressed this issue most directly, saying that although her family, and especially herself and her mother, were very close, warm, and loving, there had been problems growing up with communication about emotions:

"…aye, I do find it strange when I think, talking about my family cos I think I told you when I to, when I spoke to the two psychiatrists over the time, they asked me about my family and I said, well, I got on really well (A - yeah, yeah) really really well hehehe, you know, there's ***, there's just communication when it comes to emotions that****, (A – yeah)* ***is obviously, a problem***"

Dinah directly identified communication as a problem. This issue is further clarified with regard to her self-injury, as Dinah told me that although her mother had 'always known' about her self-injury, her father and sister did not find out until she was in her mid-twenties.

A dominant theme in both of Dinah's interviews was the importance she placed on communicating about emotions. She told me that she felt that her mood and behaviour were now much improved, in large part because of her improved ability to communicate about her emotions. This emphasis was similar to points raised by Emma and Rease. Emma also directly stated that she felt her mental health was

improved because she was better able to 'express emotion'. Rease, like Dinah, said that her current relationship with her partner had helped her mental health. Both also talked about doing a lot of 'work' with partners to improve the level of communication in the relationship.

Francis also described a close and supportive family. Francis' case was unusual in that he told his family about his self-injury very soon after it started. In fact, his mother was the first person he told, before going to see his GP. This was in stark contrast to most of the other participants who indicated that they had not talked about their self-injury for some time after they first started, and certainly none described seeking help so quickly. However, in his second interview, Francis talked more about his mothers' attitude towards what he described as 'self-pity':

*"I mean **self-pity is definitely em, …. Something I was, I grew up to really, not like**, (A – mm) em, … I don't know if it was an explicit thing, or if it was just the environment I grew up in (A –mm) …. That **it was, …. frowned upon**, I mean I think its just that, I mean my mum is one of 9 kids, […] and I think, in their household when she was growing up there wasn't, any room for self-pity, you know no-one was, you just got on with things and, you know I think she probably grew up quite quickly having to look after her younger brothers and sisters […] so it was sort of left to the two eldest, girls, Ann and then my mum (A – mhm) I think they probably did a lot of the, work around the house sort of thing, em, they're both doctors now, (A – mm) so, don't know if that says anything, em, …… so I think yeah, and, and having the cleft lip, as a kid you know, she probably … I don't know, she was just, definitely someone who….. hates self-pity (A – right) you know, think, thinks it's a very unattractive, quality (A – mm) **more than that, I think, probably actually not that its unattractive, its just, its wrong, to be self-pitying***"

Francis ascribed his mothers' attitude towards self-pity to her upbringing, and suggested that this had been passed on to him. Francis went on to suggest that this attitude explained his approach to counselling (initially suspicious), as well as his tendency to "*not display*" emotions. Like Dinah, Francis emphasised the potential importance of communicating about emotions in explaining his self-injury. Moral understandings of emotions are illuminated in Francis' suggestion that it is "*wrong*" to be self-pitying. This negative attitude was further reflected in Francis' recollection of his sisters' response to learning about his self-injury:

"I found [her response] quite, well at the time quite hurtful but, em, .. well, you know, now its quite sort of funny in a way cos she was just like oh you know, so you do it- ***stop attention-seeking*** *sort of thing*"

Francis defended his sisters' response by emphasising her own physical illness (she had been diagnosed with a severe debilitating condition at 17), as a way of explaining why she had little time for people who "*make their own problems […] in terms of, physical, injury and stuff*." Francis described a family that did communicate, and did discuss his self-injury. However, beneath this support and care were underlying negative attitudes towards both Francis' self-injury and 'self-pity' in general. Potentially, this could leave little space for problematic emotions or emotional states to be communicated.

Milly's narrative alluded to the moral aspects of communicating about emotional states. She talked in detail about the problems she had with expressing her emotions "*appropriately*" and this focused especially around her family. I asked Milly how emotions could be expressed 'appropriately' and she discussed this in relation to her sisters' pregnancy, and the big changes this entailed for the whole family:

"*I, I don't quite know what that role's gonna be like, but, em, .. and, I don't know why, but the other day when I was round at my folks, it was a big kinda family meal and I think it'll probably be the last one before, the sprog is born, em, … my mum had knitted all the, these little, woollen stuff, and Jenny and Micky are standing there going 'aww they're so cute ahhh' and, they went out, the three of them went out to get something from the car and I just welled up (A – mm) and I don't know what it was, because, there's so many times that I get emotional and I don't know where it comes from. […]****, I get this kind of well of emotion, and I don't know where its come from, so I'll kinda, I took myself away from that situation****, my dad and my brother were sitting watching the rugby,* ***and I took myself away from that situation, because I just, I wanted to get this, this kinda tears out. Went out the back, had a cigarette, let the tears flow, kind of, .. that was that, nobody knew****, came back in, plonked myself down, and, you know I was thinking about it rationally (A – mm) em, as to, where these feelings were coming from, and I think, I kind of, its, it's the change thing, its, you know its ok that I'm feeling (A - ---- make me cry! Hehe) I know! It,* ***but its ok, its accepting, for myself, that its ok to feel, that way, and not necessarily go 'look everybody I'm upset' because it's not the right place to do it,*** *(A – aha)"*

Milly described feeling emotional about the changes occurring in the family, but she felt it was inappropriate to express this to her family, so she removed herself from the situation, and 'released' the emotion without anyone knowing. Embodiment is central here, Milly describes 'releasing' her emotions by crying. This relates closely to what was discussed in chapter 5 about emotions, rationality and release. I want to demonstrate here that communication is also intimately linked to these concerns. Milly is clear that her upset should not be communicated to her family – "*it's not the right place to do it*". This sentiment is further reflected by Milly when she relates her fathers' response to her admission, at 18, that she was feeling depressed again – he told her not to tell her mother, as it would upset her. Like Dinah, Milly characterised this attitude towards the communication of emotions as being part of a wider cultural understanding:

"so, em, … yeah and I'm just, I'm lucky that I can, em, … that I can go through those emotions without feeling too, … em, … detrimental towards myself. (A – mm) ***cos I know, society these days its just so, … …. One must not show ones emotion****s (A – yeah) to the world kinda thing. And I'm not really showing them to the world but, I'm just, … making sure that I'm still allowing myself to be human (A - yeah, yeah, absolutely) yeah… ….. …. **…. I think it's appropriate to do whatever you want, when you're by yourself** hehehe*"

Although Milly had not injured herself for several years, her attitude towards the management of emotions was nevertheless suggestive of what are often seen as key features of self-injury – that it is a way of 'releasing' emotions, and that it is best done alone. However, Milly was also one of the participants who described her self-injury as, occasionally, 'attention-seeking' whereby the injury was not hidden, but actively 'displayed'.

Mark, like Milly, emphasised the positive nature of his family and upbringing, and wanted to avoid any suggestion that they might be 'blamed' for his self-injury or depression. When talking about some counselling he was receiving he said:

*"the classic one was, last week when she's 'you know, we haven't really talked about your mother yet' was like oh, here we go! […] my poor mum, you know, there's a reason for that, cos she's lovely****, I don't wanna drag her into this*** *hehe you know"*

Despite this attitude, when I asked him about it, Mark was unsure whether his parents knew about his self-injury, but was clear that it had certainly never been discussed. He noted that, when he had been a teenager, his father had been "*quite dismissive*" about "*things like depression and all the rest of it, [but that] these days he's much more understanding*". This dismissive attitude, similar perhaps to Francis' mother's, might at least partly explain why Mark had never discussed his self-injury with his parents. Both Mark and Francis' descriptions of the ways that their families communicated about self-injury, or not as the case may be, suggest that communication could be implicitly discouraged by parental attitudes towards states like 'depression' or 'self-pity'. In the next section, I discuss those participants who were more direct about the extent to which their families did not directly address their self-injury.

7.2.2 Silent families

Robert, Craig, Justin, and Rease each described varying degrees of silence regarding their self-injury in family contexts. Like those participants in the previous section, Robert and Craig discussed this in the context of their families being 'fine', whereas Justin and Rease were more critical. Justin's was perhaps the most extreme case; he presented a picture of a family where communication was *"non-existent*" especially regarding his self-injury or any other "*emotional*" issue. This situation seems particularly incongruous given that Justin was one of four siblings, and was home-schooled by "*hippy*" parents until he was 14. Justin was extremely disparaging of both his parents and his upbringing, and suggested that both he and his older sister struggled in their emotional and social development precisely because they were home-schooled for such a large portion of their childhood and adolescence:

"*I know it's a bit crap to kind of you know blame your childhood on everything that happens (A – hehe) your parents and stuff but, you know I do wonder how, the fact that, you know* ***I had extremely limited … sort of social and emotional experiences, as a child*** *(A – mhm) and you were in a sort of an environment that was very .. <u>similar</u> and, you know with your parents, in your house, you didn't have to constantly go out to different, you know a different school and meet different teachers, meet different pupils and stuff, and that sort of, flexibility wasn't built in from the start*"

Although Justin started cutting himself while he was still living at home, his parents were apparently unaware of this – certainly, it was never discussed. Justin was the only participant who said that he had never talked about his self-injury with anyone apart from me.

Craig said that he thought his mother had been aware of his self-injury, but he was also clear that it had never been mentioned. Craig told me that he did not know why his parents had split up when he was 13, and this seemed to indicate a general lack of communication in the family, at least about 'difficult' issues. Robert too felt that his parents must know about his self-injury, since he did not hide it from them, but again, it was not something that was ever mentioned:

" em, so, so I mean its not, ***its not really mentioned by my family*** *(A – yeah) ken and* ***obviously everybody's seen it and I dinnae try to hide it anymore*** *(A – mm) ken its like well, what's the point trying to hide it now, its like they're there [his scars] and that's it, nothing I can do about it. (A – mm) so I mean it's not really sorta mentioned…. I, at least I'm never asked about it anyway (A - yeah, yeah) its maybe sorta look ken, and they say ken, look at his arms and stuff eh, (cough) but I do know, em, that, that some people, are actually, do have like, more scars on their arms than what I do (A – mm) ken what I mean so its like, but* ***I mean obviously they're there [his scars],*** *em, and they're kinda remind me (A – mm) yeah, sorta like a place that I was, which wasnae very nice but (A – mhm)* ***but em, its never, its never ever mentioned****"*

As discussed in chapter 5 (section 5.3.3) Robert's family apparently did not discuss his eating disorders either, despite his visible weight-loss. That his self-injury is also never mentioned appears to fit with a general atmosphere of non-communication in the family. Like Craig, Francis and Mark, this seems to be particularly around what might be seen as 'difficult' or 'emotional' issues.

Finally, Rease's narrative also suggested that her parents did not discuss her self-injury. She noted that following her first overdose, at 17, her self-harm was not discussed by her family: "*So I got an ambulance, and, got my stomach pumped and stuff, and but, again, em, nothing came of it. Can you believe how much my family doesn't talk! Heheh, it was ridiculous*!" Rease overdosed again when she was 22, an

event which she described as partly related to "*the build up of 5 years and still no talking about anything"* - in this instance, her father responded in the following manner:

"I spoke to him on the phone and he was like, 'Rease, you can't keep doing this'. That's all he had to say. And I'm like, well, I wonder why I'm doing this, you know, its just, ***not even asking that question****. […] And that was it."*

Rease expressed exasperation about this response: this highlights the importance of the *type* of response or acknowledgement. As I discuss further in the next section, if self-injury is acknowledged at all, the *ways* that family members respond to self-injury were intensely important to participants.

7.2.3 Extreme negative reactions

Belinda, Anna and Emma all described responses to their self-injury from their mothers, in each case these were framed as negative experiences. Belinda's mother "*totally freaked out*" when she noticed marks on her arm:

When I was……..tttt… 17, (A - mhm) err, three days before Christmas, ran away from home. (A - ok) Reason being, that mum found out I was cutting (A - right) and went ape, like completely, just flew off the handle.(how long before Christmas?) 3 days…. (A - ok, yeah, ok, how did she find out?) […] em, … I was mashing hehe, mashing potato in my kitchen, and I had scars on my wri-, or, marks on my wrist, and she questioned me about it, and I …. You know, couldn't see the point in lying (mm), and so I just told her straight, you know she I was thinking in my head that ***she's always wanted me to be honest, so I did, and she completely lost it****. Erm, and then I got really scared, cos she lost it so much, and I got pissed off, because I was thinking why are you being angry at me, (mm)… shouldn't you be trying to help me? Instead of just like, shouting at me about how much of a disappointment I am to you and, and all that, shouldn't it, you just be saying 'are you ok'? Instead of shouting at how bad I am. Em, so, I ran away"*

Belinda describes being so hurt, upset and scared by her mothers' response that she ran away from home. In her discussion of this she expresses anger about her mothers' reaction, suggesting that it was not sufficient – "*shouldn't you be trying to help me*?" This sense that the response to self-injury is insufficient or wrong in some

way can also be seen in Emma's case, as discussed in section 5.3. Emma described trying very hard to keep most aspects of her self-injury and self-harm from her parents, however on one occasion she did not manage to prevent her mother from visiting her in hospital following an overdose and severe cut to her arm. Like Belinda, Emma experienced her mother's reaction as negative and hurtful – to the extent that she felt that her mother was *"almost blaming*" her. This reaction may seem odd, given that Emma had indeed harmed herself – indeed, this may indicate that for some people, self-injury and self-harm are indeed understood (or perhaps excused) as something that is *not* their fault.

Finally, Anna described her mother's response to finding out about her self-injury in similar terms – her mother dismissed her behaviour, saying "*well we'll be stopping that then, won't we*" and the matter was never discussed again.

What all of these accounts share, is an impression that self-injury is 'not to be talked about'. Even for those participants who described warm, loving families, verbal communication about self-injury specifically, but 'emotional' issues more generally, was portrayed as problematic, or more commonly, non-existent. For the majority of the other participants, who described less positive family backgrounds, self-injury was equally 'not mentioned'. Where self-injury was not mentioned, despite being visible, this silence can be understood as a powerful communication: indicating that the subject of self-injury is taboo. The cases of Emma, Anna, Rease and Belinda demonstrate that even where self-injury is at least mentioned or acknowledged, the manner in which this is done can be highly problematic, and indeed can be experienced as damaging and hurtful.

7.3 Communicating about self-injury out-with the family in informal situations

In this section, I examine participants' narratives regarding how they addressed communications about their self-injury in informal situations outside of their immediate households.

7.3.1 Responding to questions about scars, marks and wounds

Milly, Emma, Robert, Rease, and Dinah all talked about giving 'honest' responses to questions about their visible scars. Both Dinah and Robert also discussed lying about them sometimes, and Emma still covered up her scars in certain contexts, in order to avoid questions or comments. Milly, Rease and Mark gave the impression of being much bolder about this – each claiming that they *almost never* purposefully covered their scars up. These approaches to scar management meant that Milly and Rease in particular had several stories about people commenting upon or asking about their scars, though they told me about quite different experiences.

Milly's stories concerning conversations about her self-injury scars were generally very positive, and she described responding to even potentially negative comments in a positive manner:

"there will be people that say, you know 'what's that' (A – mhm) em, and I'll go, 'its just something stupid that I did when I was younger'. And ***some people give me respect for it****, em, not in a 'oh good on you' kinda way but, eh, a, a em, 'oh right, well that's interesting' in a way, and* ***other people have gone, em, 'well that was a bit stupid wasn't it' … and I'll be like 'well yeah it was, hehehe, but, I'm over it'*** *hehehehe. So, just having that confidence to be able to show it"*

Milly went on to describe further incidents where her scars had been noticed and commented upon, but this time by other people who had self-injured. In these instances, Milly suggested that her practice of revealing her scars, and therefore inviting commentary, was a positive one precisely because it enabled and inspired other people who self-injured. In framing her openness in this manner, Milly challenged other possible interpretations – such as the concept of 'attention seeking':

"she pulled me aside and said, em, 'see those marks on your arm, is it self- harm?' I said 'yeah' …. She said, 'cos, I've been doing it too' and at, at that moment, cos I'd had a couple of people say that to me and I'd been like 'aahoo, ok, what d'you want me to do?!' heheheh (A – heeheheh) ***and just but, being there, and saying, here's my story, em, not necessarily going into complete in depth****, em, reasons why (A – mhm) cos quite often they're not, in depth, but, being able to say 'yes I've been*

through this and this is how, this is the process of how, I got myself out of the, the cycle (A – mhm) ***is, really nice, for, for people to hear, just a comfort****"*

Milly emphasised the positive effect that she felt this interaction had on the girl who asked her about her scars. She also suggested that over time she herself had become more confident in dealing with such questions.

Rease told me two contrasting stories about people commenting upon her scars. The first concerned a woman "*staring at my scars, I suppose in sort of horror*," Rease was still self-injuring at the time this occurred and the woman in question went on to comment:

*" '****what if you want to get married, what will your future husband say'?*** *(A – yeah) and I just sort of looked at her and* ***I'm like 'what do you mean?' hehee. Like for a start you're assuming I want to get married, which I don't, and secondly, … if my future husband, you know, had a problem with that, then he wouldn't be my future husband!*** *Heheh (A - hehehehe yeah, yeah) you know, it was just the most ridiculous, its kind of like, you know, … Again about your body not belonging to you,* ***I'm just like, that's ridiculous, like for a start how dare you say that to me, cos again its her, … em, sort of, taking my experience and my body and twisting it, into something, you know for her, and what it means to her, and not looking at what it means to me.*** *And then again like, also like selling my body like its em, it matters to somebody else, like, judgement"*

Rease describes being affronted by the woman's misinterpretation of her scars, and her "*ridiculous*" assumptions about Rease's lifestyle and beliefs. This scenario could be seen to represent the danger inherent in other people's assumptions about self-injury. Skeggs (2001) and Freund (1990) have each made similar arguments regarding the potentially damaging effects that such invalidation (Freund) or misrecognition (Skeggs) might entail. Perhaps what is most striking in the case of Rease is that such situations did not cause her to stop 'revealing' her self-injury to others, though she did describe a great deal of ambivalence and concern with other people's continued 'misinterpretation' of her scars.

Rease presented the following story to me, which highlighted a more positive and affirming, way in which 'others' had responded to her scars:

*"the woman I was working with just sort of said to me one day, em, 'you're**, those scars are really beautiful, I like the way they catch the light**, and I was just wondering if' em, cos she thought they were- actually a fantastic thing to say! She said 'I was wondering if, they were a part of your tattoos, em, like, you did them as a sort of, em, (A – yeah) do you know what I mean like some people do scarification (A – scarification) yeah, or, if it was, self-harm'. Em, and I was just**, I was dumbstruck for a while cos I was like, that's, the best approach anyone has ever said**, you know, its such a lovely sort of…"*

Although each of the examples Rease gave me involved people making 'assumptions' about her scars, she was clear that the manner in which this was done in the second example was far more acceptable. As I discuss below, other participants were far more ambivalent about the 'assumptions' of others.

Belinda, Robert, and Dinah all told me that they occasionally lied about the origin of their scars, while Mark and Francis both talked about employing diversionary tactics in order to avoid further questions. Indeed, it is important to note that even Rease and Milly said that they occasionally deliberately wore clothing to cover up their scars if they 'couldn't be arsed' explaining them that day. Mark described himself as being relatively open about his scars, especially with his friends. However, he related a situation whilst teaching where he had avoided explaining his scars by telling a student it was "*none of your business*". Similarly, Francis described how he usually dealt with questions about his scars:

*"I guess I don't feel 100% comfortable …….. you know explaining it, or trying, cos I feel like I have to justify myself (A – mm) when people notice it, and as I say it doesn't happen very often, but, people do say 'oh what's that on your arm?' (A – mm) and **I don't really want to go into it at the time (A – yeah) so I tend to say something like 'oh you know …. You know, buy me a few beers and I'll tell you about it'**"*

Belinda described having a similar aversion to having to "*explain things"*. Belinda's concern with having to "*explain*" particularly about her recent split with her girlfriend had, she said, led to her not self-injuring, even though she had wanted to. As discussed further below (Section 7.4.3), Belinda shared with Harriet an understanding that self-injury could not be successfully hidden. Belinda talked a lot about her worries regarding the "*assumptions*" others might have about her scars or

injuries, and what these might imply about her. This concern led her, in some situations, to lie about the cause of her injury:

"I have my plan in my head – I burnt myself on the oven hehe. Em, but yeah, I mean, if someone's going to ask me, ***I'd prefer that they just ask****, you know, 'oh, where'd you get your scar from' or something like that than, to say, 'oh, you must be really sad'! (A - yeah, yeah) cos yeah, I can, deal with that, cos then* ***I can say, a lie, or I can tell them the truth, depending on, if I trust them, or I like them, or, can be arsed, explaining or just don't want anyone to know!*** *Em, so then, you know, if I don't want them to know then I can just make up an excuse"*

Belinda was clear that she would prefer a direct question than an "*assumption*" about her intent, or the origin of an injury.

Robert also described having excuses ready when he injured himself. On two occasions, Robert had cut his face, an especially difficult location to cover up. Robert's narrative around this issue was slightly confused in that he described having these excuses ready, and he talked about largely hiding his self-injury; however he also talked about numerous instances where his self-injury was noticed. This may reflect the changing nature of Robert's self-injury – as I discussed in Chapter 6, Robert felt that his early self-injury had been a "*scream for attention*" implying that his more recent self-injury was not. The following excerpt demonstrates some of these complexities:

"…the ones on my face were quite difficult actually (A - yeah!) em, … it was like sorta emm, …. ***Because obviously all the rest of them I could sorta cover up wi, like, jumpers and stuff eh, it was the ones on my face when I did it, I dinae ken why I did it to my face*** *(cough) em, I'd kinda, and people were sorta like saying 'oh what have you done' its like****, 'oh I cut myself with a razor'*** *that was, the first one, that was there, […] I used another one, when I done, the one, sorta like, somewhere else, I cannae remember exactly where it is, em, … and I had said, I'd, like, stood up and, I, caught it off the corner of a door, like one of the cabinets in the kitchen or something eh, and it was like the other one, eh, ken it was, again I think that was like ken, … think that was the razor (– mhm)* ***so every single time I was asked I had an excuse****, em, and still to this day actually like ken my nieces and that'll say to me 'ken you've got a scar on your arm and all that eh' (A – mm) and its like* ***ken I've never hid it from them****, ken its like ken, 'how did you do that' and its like ken, and just turn round and say 'ken I've cut myself' and its like, ken, and its like 'you've cut yourself?' 'aye' and its like ken, 'I wasnae in a very good place at that time when I did it'* ***so its not something I've ever hid from them****"*

Robert's narrative could be seen to reflect the tension between wanting to be seen to be 'honest' and the equally (morally) virtuous position of either not being someone who self-injures, or not 'burdening' others with problems.

7.3.2 Negotiating the (unspoken) 'assumptions' of others

Much of the participants' discussions about interactions with other people regarding their self-injury focused upon what were sometimes termed 'assumptions'. Participants often expressed concern about the ways that other people might interpret their self-injury. In many cases, these concerns did not appear to be related to participants' experiences of having their self-injury explicitly misinterpreted, as with Rease's narrative above. Rather, participants' concerns centred upon the often unspoken assumptions of others.

I explored this issue with Belinda particularly, as she expressed anxiety about having her self-injury discussed by others on a number of occasions in the interviews:

"So in a way it's easier to be open, ish. But at the same time, people who don't ask me about it and just think in their heads, and make up their own conclusions – I'd prefer that they did ask me about it, actually, but if, if they make up their own conclusions they'd be like oh, you know, then it will go round camp you know – 'have you seen Belinda's arm?' hehehe that sort of thing."

In particular, Belinda was concerned that the 'assumptions' of others would then be passed on to others, without enabling Belinda to mediate and offer her own interpretation. Leading from this, Belinda suggested that she would rather people asked her about marks on her arm, and her narrative suggests that this could be because this would allow her more control than unspoken 'assumptions':

"I can, deal with that, cos then I can say, a lie, or I can tell them the truth, depending on, if I trust them, or I like them, or, can be arsed, explaining or just don't want anyone to know! Em, so then, you know, if I don't want them to know then I can just make up an excuse, and if I do, then yeah, it's a good starting point I guess."

Belinda's narratives regarding these unspoken assumptions challenges Kay Inckle's (2007) analysis which seems to imply that it is improper for 'normatively embodied' people to ask questions of those who are 'non-normatively embodied' (2007, 120-2). Inckle raises this issues within a broader discussion about attempts to 'pass' as normatively bodied, and how comments from 'ignorant' normatively bodied people can be discriminatory and "shame-inducing" (2007, 121):

"It's still amazing though, like you said, the way that people think they have a right to know, and it constantly pisses me off and blows me away at the same time the way that people really do think they have the right to know" (Inckle 2007, 119)[16]

While Inckle's analysis certainly taps into the emotional experiences of negotiating social life with a 'non-normative' or self-injured body, it is limited by her focus on the negative consequences of communications about the bodies of those 'non-normatively embodied'. In contrast, Belinda's narrative highlights the negative consequences of *avoiding* communication, particularly for the person who *is* the non-normative body.

Indeed, Inckle's analysis also seems to overlook the moral framing of communications, in particular, the idea that it is seen as 'good' to be 'open and honest'. Belinda also addressed this, and again, her narrative helps to unsettle this idea and demonstrate how complex these moral and ethical arguments can be:

*" - oh, you **know we should be really open about it**, but, however much people say that you know, you can't – I don't think you can really, cos you know you've got this fear that you're gonna scare them, you know, or em, yeah…."*

So Belinda acknowledges the moral imperative towards openness, but highlights that in practice, this is difficult to enact. Other participants also expressed similar "*fear*" around how their scars might impact on other people, and in particular on how other people might view them. For instance Belinda shared with Justin, Craig and Robert a concern that others would think they were "*crazy*" if their self-injury was discovered.

[16] Inckle's presentation of her analysis was not standard. This quote is from a section where Inckle had presented a fictionalised account of a conversation between herself and her respondents.

While Belinda worried people might think she was suicidal, Craig, Robert and Justin said that they were worried that they might be 'locked up' if people became aware of their self-injury.

Significantly, in most cases, participants had not been expressly told by someone else that they thought they were crazy, and none of these participants had actually been threatened with incarceration for their self-injury. Rather, participants may have been projecting their understandings about what other people might assume that their self-injury indicated: mental illness or suicidality. I discussed this with Emma:

A – yeah, … and do you, can I just ask a question about that? right, tell me if I'm being out of order but do you, ***do you know that's what they think*** *or do you*
E ***– no, that's***
A - kind of you,
E - ***projecting*** *onto, yeah, em, … … … …. … .. a couple of people have, just thought it was too scary, and, … sort of backed off, sort of potential partners and things, just sort of backed off*
A – yeah
E - not getting involved with that… em, … … … which is a bit unfair, cos, especially since I don't do it anymore

Emma accepts here that she may have been 'projecting' a negative understanding of her self-injury onto others. However, she goes on to suggest that she has identified concrete effects, arguing that potential partners have been scared off by her self-injury scars. It was not clear whether in these instances Emma had been told this was the case, or whether in these cases Emma again 'projected' her own understanding of why they backed off. Whatever the case, Emma herself felt that her scars scared people off, and she experienced this as unjustified.

These examples all demonstrate that participants' understandings of what other people thought were important to and perhaps indicative of their own feelings about their self-injury. In the next section, I explore this issue further, in an examination of the ways in which participants reacted to such understandings in their practices of hiding and/or revealing their self-injury to others.

7.4 Hiding, revealing and display

In this section I discuss participants' narratives regarding their display of the marks and wounds created by their self-injury. For some, the decision to reveal their self-injury at least to some others, or more pointedly, to stop hiding it, was framed as a decision that was taken at a certain point in their life-story. For others, self-injury was still something they preferred to hide from others. Participants had various reasons, and had employed different strategies to achieve this. Throughout this section I want to make clear that these actions (oriented towards either hiding or revealing) are integral to the lived experience of self-injury. As evidenced by the stories of some participants, these decisions had to be continually refreshed, even years after self-injury has stopped.

The role of bodies is fundamental here, emphasising the centrality of bodies to the lived experience of self-injury. This highlights the importance of the self-injured body, and how it can continue to influence and mediate social interaction long after self-injury has stopped. This section also addresses moral aspects to discussions around the appropriateness of displaying both emotions and self-injury.

In the process of tackling the above concerns, this chapter will also challenge the prevailing belief that self-injury is a 'hidden' behaviour:

"In the vast majority of cases self-harm remains a hidden and secretive behaviour that can go on for a long time without being discovered. Personal testimony submitted to the Inquiry shows that most young people make great efforts to hide their scars, bruises or other signs of self-harm and are extremely reluctant to talk about their self-harm or what may be troubling them. Most family and friends are likely to be unaware that someone close to them has self-harmed. This may help explain why research – for example that by Meltzer et al (2001)7 and Green et al (2005)8 - found that parents were often completely unaware of incidents of self harm which their children reported to the same study."(National Inquiry into Self-Harm Among Young People, 2006: 19)

In contrast to the above quote, the narratives of my participants suggest that self-injury is frequently *not* hidden or kept secret, although it is rarely openly discussed.

Further, I suggest that the emphasis on secrecy and privacy regarding self-injury is reflective of wider socio-cultural and moral attitudes regarding the appropriate expression of emotion. In particular, this relates to understandings that negative emotion *should* be hidden, and that self-injury – as representative of negative emotion, and therefore failing social bonds – should also be kept hidden. Due to these morally charged narratives around appropriate expression, people who self-injure may be more likely to present their behaviour as 'hidden' even when this is not entirely the case. Further, these moral understandings may lead to 'others' observing evidence of self-injury being less inclined to mention it.

7.4.1 Deciding to reveal

When I spoke with them, several participants did not hide the marks that their self-injury had left. In all cases where participants 'revealed' their self-injury, the marks were several years old, with scarring mostly white[17].

Dinah, for instance, wore short-sleeved t-shirts when I spoke with her, and this revealed several visible scars, and some tattoos. Dinah told me that when she was younger she had hidden her self-injury carefully:

"oh aye, always, I mean I always wore, like, long sleeved, long sleeved tops, and, or things round my wrists or, you know, obviously bits here that weren't on my legs, cos I've got a lot of scars on my legs as well"

Dinah also described focusing her self-injury on areas that could be more easily covered, such as the tops of her thighs. However, over time, Dinah's practice regarding this changed. In her mid-twenties, she began to worry less and less about covering her scars up.

"Also around then when I met Adam, I started wearing short sleeved things, before then I'd always been very careful, even when I was training to cover them up. But after that, my wardrobe changed a lot and I didn't care as much if people saw my scars."

[17] Although the way that scars form can differ widely, on Caucasian skin, recent scarring tends to be a red or purple colour. Over the course of several months and years, the scars eventually go white.

Dinah associated this changing practice partly with meeting Adam, her current partner, as well as getting some of her tattoos. These tattoos served both to cover up some of her scars (one in particular which she disliked), as well as distracting from her scars and decorating her arm. The gradual 'revealing' of self-injury, once the participant was no longer 'actively' self-injuring, was also indicated in the narratives of Milly, Craig and Justin.

Tattoos were also implicated in Craig, Justin, Emma and Milly's narratives about their changing practices regarding scar covering. Justin and Emma described getting tattoos for the explicit function of covering up scars. Justin in particular told me that he got his tattoos, and used a scar minimisation treatment, in order to be able to wear short-sleeves on an upcoming holiday.

In contrast, Craig and Milly implied that their tattoos had accompanied a greater confidence in and with their bodies, as well as giving them greater reason to wear more revealing clothing. Rease similarly associated her self-injury scars with her tattoos and piercings. Though she was clear that at the time the self-injury was not decorative, she now saw her scars as "*beautiful*" and was clear that she felt it was proper and right that they should be displayed. Rease's orientation towards her scars was particularly positive, and reflected her more generally positive attitude towards self-injury. Indeed, she implied that she had a positive attitude towards her wounds when she was actively self-injuring and had in fact chosen to 'reveal' them when they were still fresh. This was in contrast to the stories of most of the other participants, who generally suggested that they had hidden their self-injury whilst they were still injuring, and only began to reveal the parts of their bodies that bore scars once the scars were less recent.

I discussed this issue with Belinda, who suggested that revealing older scars was "*easier*" because they were "*easier*" to explain to people. This related particularly to Belinda's belief that people might think she was suicidal if they knew she self-

injured. Therefore, Belinda suggested that if people saw older scars it would be obvious that any suicide attempt had been unsuccessful:

*"I think as well if you say – that it, it was , **if you say ages ago**, if you talk about it in a past tense, **people don't worry about you so much**, because like you know, oh your ok, because your obviously still alive and you're here, but if you say oh it was last week, then people think 'oh my god their gonna kill themselves' and that's like the whole, hype around it that people think, and I hate that, that that's what you want to do when its, definitely not what I want to do"*

This excerpt also relates to the narratives of other participants who talked about wanting to avoid 'burdening' others with their problems. Participants who had chosen not to hide the scars left by their self-injury tended to make this decision several years after they had last injured themselves. However, as discussed in the previous section, participants were not always able to reveal their scars without consequence. Questions were invariably asked, and these intrusions were not always welcomed. Indeed, fear of such questions and intrusions led several participants to tend towards hiding their scars.

7.4.2 Hiding: reasons and justifications

Although Anna was the only participant who said that she currently kept her self-injury entirely hidden, most participants described keeping their self-injury hidden some of the time, or had done in the past. However, although Anna described keeping her self-injury hidden from "*everyone*" this was not the case in her home and with close family – her husband and sons saw her scars, as had a niece, whom she said was one of the few people outside of her immediate family who knew about her self-injury. Therefore, even for Anna, the extent to which her scars were kept hidden was dependent upon context. The way in which Anna talked about her hiding practices could also indicate something more generally about the way that 'privacy' is understood in different ways. For instance, someone describing their self-injury as 'private' may mean that it is kept hidden from absolutely everyone, or from everyone outside of the immediate household, or from everyone apart from a sexual partner.

Emma also described keeping her scars hidden in certain contexts. In contrast to Anna, however, Emma was relatively open about her scars in most public settings. However, Emma shared with Anna a problematic relationship with her parents. Both women specifically kept their scars hidden from their parents, though for different reasons. Anna's hiding of her scars from her mother in particular, seemed to be oriented towards self-protection. When her mother had seen her scars she had been dismissive, which had hurt Anna, who subsequently preferred to avoid the issue entirely by keeping her body covered. Emma, on the other hand, kept her scars hidden from her parents in order to "*protect*" them. This concern with protecting her parents even led Emma to avoid visiting them in hot weather:

"… they know, that there's scars, but they've never seen them (A – no) E - I always keep them hidden, I try and avoid going up to visit them in the summer, when it's hot […] because we don't talk about stuff. ….. …..it, it makes it very difficult to, … to openly show, you know, em, … … scars and things that eh, …. They'd probably rather not know about [it]"

Further, Emma suggested that if her parents found out about the extent of her self-injury and the resulting scars they would "*be really upset and really horrified*." Emma also suggested that her scars had "*scared off*" people she had wanted to get close to, and this could have further contributed to her tendency to hide her scars in some situations. Francis expressed a similar ambivalence about his scars, and particularly his concern about other people's opinions of his scars: "*because I think, you know people have preconceptions about it and stuff like that*". Both Emma and Francis were adamant that they were not ashamed of their self-injury, or of their scars, however, each suggested that at the same time they were concerned about the ways that their scars might be interpreted, and that this sometimes led to them preferring to hide them:

"Yeah, I don't know I kind of, I suppose there's a bit of disparity cos, in my mind I sort of feel like I'm ok with it, like, I'm perfectly, happy with, you know, …. ….. what I've, you know I don't have, any reg ***- I don't really regret doing it*** *or I'm, really ashamed of it or, you know anything like that, but at the same time I'm not….* ***I don't, wouldn't want to just openly talk about it at work****, or, … you know in a sort of, if I don't know people very well, em, cos they just think, I think and I think that's basically cos of,* ***I think they might have preconceptions*** *and sort of they might have,*

you know or maybe its something that I don't really wanna focus on, or, I don't know, …" (Francis)

Here Francis expresses similar concerns to Belinda's regarding the assumptions or preconceptions of others. However, while Belinda said that she would rather people did ask her about her scars, Francis preferred to keep his covered and avoid both questions and assumptions.

Mark described generally not hiding his scars, saying that he simply preferred to wear short sleeves, and noting that in most cases people did not mention his scars anyway. Nevertheless, Mark said that he had purposefully covered his arms when working in a particular school, with affluent students. He indicated that in this context, his scars were likely to have been taken as a form of weakness, saying that these students would "*take anything, anything, you know anything that's kind of ----- no wonder the teachers felt stressed*".

7.4.3 'Just' revealing/displaying

Although most participants who described revealing their self-injury implied that they did so through choice, some participants indicated that they had no choice regarding how visible their scarring was.

In Robert's case, the reason he was unable to hide some of his self-injury was because it was on his face, which he jokingly noted made it hard to cover up. Belinda, however, suggested that she could not cover up the injuries on her arms, specifically in the summer: "*I can't really hide it, because it's hot, its summer hehe, I'm not, I don't want to hide it, I wish it wasn't so visible sometimes*." This contrasts with Anna's narrative, where she described particularly disliking summer time because she was invariably too hot as she "*had to*" wear long sleeved clothing to cover up her scars. What is significant here is that both women suggested that they would rather their scars were not seen by others, but that Belinda, unlike Anna, felt unable to cover her scars up. I found this perplexing, especially since I have generally always covered up my scars, even in hot weather. What this may point to

are different thresholds regarding embarrassment, and different priorities. For instance, Anna and I discussed the problems we faced when wearing long sleeved clothes in hot weather:

Anna - I dinnae get any mair undressed than this, cos its just… pretty messy [bit unclear, quiet?] Summers… I hate summers…
Amy – mm
Anna - people are stripping off, and they're going, are you not too warm? No, fine, great, nice today! Heheh
Amy - I spent the whole summer once working in a warehouse, where the uniform was either a t-shirt or a sweatshirt, and they're all like, are you not hot, and I'm like no, no, I get really cold!
Anna - I know! Hehe I'm always cold! Hehe

In contrast, Belinda seems to have felt it to be more desirable to deal with comments about her self-injury than questions about her choice of clothing. Similarly, Belinda suggested that when she returned home to Australia, she would be unable to hide her self-injury from her mother:

"… when I go home to see my mum, obviously my mum's going to see cos, you know, heh, some places on your body scar more than others I've found. So yeah I've got a couple of scars that aren't gonna go away, erm, very visible. Em, but yeah she's gonna see so, I don't want lots. … yeah, I just don't want people to see, I just, it's a me thing."

Again, Belinda suggests here that she would rather her mother did not see her self-injury, but at the same time, she feels unable to hide her scars. This contrasts with the stories of other participants who appeared to feel more able to wear clothing which covered up their scars.

Harriet implied a similar orientation towards the hiding of scars in summer time. In the following extract, she suggests that her concern about people seeing her recent self-injury sometimes led her to self-injure different, more easily hidden, parts of her body:

"[I] used to be mostly like cutting my arm and everything, and I think, the urges are like, really strong to like, totally slash your arms up (A – yeah) and then like, but, if I do that, everyone's gonna know, and, so you can only use that in winter when you can hide it. So if I think I just like, phew stop doing it where people can see!"

Belinda and Harriet appear to share an understanding that in summer time short sleeves must be worn, and that therefore self-injury on the arms at this time of year cannot be hidden. This is in contrast to the understandings that Emma and Anna (and I) have in that wearing concealing clothing in summer is far preferable to either revealing self-injury, or injuring other parts of their (our) bodies. What could be an important distinguishing feature that separates the embodied and lived experience of self-injury for Emma and Anna from that of Belinda and Harriet is the amount of scarring that the women had on their arms. Emma and Anna each had extensive scarring on their forearms, while Belinda and Harriet both had very little. Equally, of course, the different orientations of the women towards covering up their scars could have led to the different levels of scarring.

7.5 Power, bodies and inter-personal contexts

This chapter has explored participants' narratives regarding the ways in which their self-injury was addressed in informal interpersonal contexts. In particular, I have demonstrated the importance of the visible aspects of self-injury. Immediately after self-injury, and in some cases, forever after, participants described making decisions about what to do with their scars or marks: to hide, or reveal. I have suggested that the decisions that participants made regarding the hiding or revealing of these marks were varied but tended to be closely related to their understandings of what 'others' might think.

In the first part of the chapter I suggested that in most cases, participants' families indicated that self-injury was not something to be spoken about. This message was conveyed both explicitly through negative and damaging responses, and implicitly, by self-injury being ignored. The stories participants told about the reactions of people out-with the family indicated that these silent or negative responses were wide-spread. Participants experienced this in different ways. Some regarded this as unproblematic, and were glad when they could undertake daily life without undue comments. Others indicated that they found it difficult when people did not say

anything, and preferred it when people did ask about marks and scars, as this would enable a response to be given. This finding contradicts Inckle's (2007) suggestion that people with non-normative bodies might prefer not to be asked. Rease and Milly both had positive narratives, which suggested that self-injury could be acknowledged in an affirmative manner that was neither negative nor silencing.

Power and control appear to be relevant in these narratives. Some participants implied they had more control than others over whether their scars were revealed, and how they were then interpreted. Rease and Milly for instance suggested that they almost defiantly *never* covered up their scars. In situations where they explicitly chose to reveal the scars on their arms, Rease, Milly and to a lesser extent Dinah and Robert, were perhaps taking command. In contrast, Belinda and Harriet suggested that they felt unable to cover their scars. Their exposure of their scars was framed as a less powerful act than that of those participants who described themselves as choosing when and where to reveal. This was further highlighted by Rease and Mark's narratives about choosing to hide in certain contexts, where they either could not be bothered with comments, or recognised that to do so may have been especially dangerous.

The narratives of Harriet and Belinda contrasted especially with those of Anna, Emma and Francis. All of these participants expressed concern about the negative assumptions or opinions others might hold regarding their scars. However, Anna, Emma and Francis' narratives implied that they were far more successful in hiding their self-injury from others. In particular, Anna and Emma viewed the hiding of their scars with potentially inappropriate clothing (long sleeves in summer) as unproblematic, and certainly preferable to revealing their scars. Harriet and Belinda on the other hand implied that the comments attracted by dressing inappropriately were reason enough to avoid injuries in obvious places during the summer (Harriet) or were more resigned to having to deal with negative reactions and comments (Belinda). I want to emphasise here that although most participants wore short sleeves when I interviewed them – and many had visible scars – their understandings regarding the exposure of these scars differed widely.

This chapter has also demonstrated that the hiding and revealing of self-injury appears to be affected in some cases by moral discourse around emotions and emotional expression. I suggested in section 7.2 that participants' problems with communicating about self-injury to their families reflected both their family's understandings regarding appropriate emotionality, but also wider socio-cultural discourses. In these cases, the label of 'attention-seeking' is employed to invalidate and discourage displays of negative emotion, and self-injury can be seen as a display of negative emotion *par excellence*. While some theorists have suggested that the wounds created by self-injury 'cry out for response' (Crowe, 1996), my research has shown that whether this is the case or not, they are very often not responded to. Scarred, scabbed or bleeding arms may well conjure up dramatic imagery, but in mundane and 'every day' life, they are nevertheless frequently ignored.

In the final substantive chapter of this thesis, I extend previous discussions around morality, authenticity and self-injury, further demonstrating the importance of the material, visible, corporeal aspects of self-injury.

Chapter 8

Accounts and Authentic Pain: Body, society and self-injury

8.1 Introduction.

This chapter extends and develops theoretical themes introduced in chapters 4-7. I examine three related concepts: emotion work, authenticity, and motivation. Underpinning each of these is a concern with the body, and with morality. Thus, I will further demonstrate the centrality of the body to understandings of self-injury. A focus on morality will illuminate the relationships between understandings of self-injury and wider socio-cultural beliefs around bodies and emotions. Demonstrating the existence of these relationships serves to emphasise the importance of locating understandings, explanations and accounts of self-injury within social and cultural contexts.

The first section will extend the discussion of emotion work begun in Chapter 5. I have suggested that self-injury might be understood as a method of emotion work, and here I critically interrogate this idea. I demonstrate that although self-injury can be viewed in this manner, to do so, understandings of what emotion work actually entails must be questioned. I suggest that some sociological studies continue to sideline or downplay the role of bodies in both emotions and emotion work. I propose that this may reflect wider socio-cultural biases towards cognition and 'the unconscious' in understandings of emotions. Through this analysis of self-injury and emotion work, I conclude that sociology must redouble its efforts to demonstrate and emphasise the importance of bodies in understanding the significance of emotions in social life.

I then turn to the concept of authenticity, a focus of important criticism of emotion work, especially as conceptualised by Hochschild (1979; Wouters, 1989). Here, I

turn this argument on its head, suggesting that self-injury can be seen to represent an attempt to 'be authentic' rather than looking at it as a representation of either 'false' or 'authentic' feelings. I demonstrate that for people who self-injure, the need to be seen (or to see themselves) as authentically 'in pain' is a key aspect of the way that they narrate their experiences with self-injury. I argue that this interpretation may explain how the body comes to be seen as an understandable and acceptable site for the 'authentic' expression of pain.

Finally, I examine more explicitly the explanatory claims made by my participants, using Mills' (1940) vocabularies of motive, and Scott and Lyman's (1968) accounts. I suggest that the accounts given by my participants were more often in the form of justifications. That is, responsibility for the behaviour was accepted, but the reasons given for the behaviour drew on commonly held views of emotions and health in order to give them legitimacy. I note that participants also gave excuses (where responsibility was denied) but that these were generally linked to accounts given to 'other people'. I suggest that my status as someone who had self-injured may have encouraged such accounting. Further, I note that justifications were necessary for most participants, since even if they no longer self-injured, most carried with them permanent marks and scars which had to be continually explained – both to themselves and to others. In conclusion, I suggest that the existence of marks and scars make justificatory accounts more likely, as individuals claim responsibility for their behaviour (and therefore a label of sanity), thus maintaining a coherent sense of self.

In a final discussion, I draw together these themes, demonstrating that each contributes to a more complete, and importantly, more sociologically informed understanding of self-injury. This understanding puts self-injured bodies at the centre of the analysis. Doing so demonstrates the embodied nature of experience and of emotions. This focus also enables a better understanding of why certain types of accounts may be employed by people who self-injure – the materiality of the permanently scarred, self-injured body necessitates a self-narrative which adequately incorporates self-injury into a coherent and morally acceptable self.

8.2.1 Emotion Work

As I have already suggested, self-injury can be seen as a form of emotion work. For some of my participants, self-injury was understood as a method of controlling or coping with strong emotions or feelings – doing so either by *changing* feeling, *eliciting* feeling, or simply causing the participant to "*feel better*". Although Hochschild's (1979; 2003 (1983)) formulations of emotion work have addressed the practical methods through which people did emotion work, subsequent sociological treatment of the matter has tended to overlook this, focusing instead on feeling rules. Where emotion work itself is examined, the focus tends to be on mental, cognitive or even 'unconscious' aspects, with the bodily and embodied nature of emotions and thus emotion work being generally overlooked (see e.g. Bolton & Boyd, 2003; Theodosius, 2006). I argue that the drift away from the embodied nature of emotions in research on emotion work is problematic. Downplaying the role of bodies in emotion results in incomplete and partial understandings. In contrast, a more explicit engagement with the role of bodies in emotions and emotion work provides a more comprehensive impression of the socially situated self. Addressing the bodies as well as the minds of social actors will itself force analysis into a more explicit engagement with the material nature of social life. In particular, this entails attention being paid to the visible and invisible nature of different forms of emotion work, which in turn requires an examination of Goffmanian hiding and revealing practices. Ultimately, this will lead to a more grounded understanding of social life as it is experienced by social actors, actors who *are* both bodies and minds.

My analysis explicitly orients itself towards bodies. This approach establishes the necessity of an embodied approach to emotion work. As self-injury so overtly involves bodies in the managing of emotions, it is an ideal focus for an elaboration of embodied emotion work. In particular, this demonstrates the importance of attending to the practical methods that people use to do this work.

I illustrate this point in the first instance by providing examples from the research which focused upon the way in which self-injury was understood to operate as a method of working upon or with emotions. Following this, I discuss the relevance of bodies in both self-injury and emotion work. I suggest that self-injury might be viewed as a challenge to attempts to manage emotions using the mind or cognition alone, and that this should certainly be seen as a warning to those theorists of emotion who have latterly drifted towards a disembodied analysis of emotions.

8.2.2 Examples of self-injury as (embodied) emotion work.

This section is split in two, though both sections will illustrate the ways that participants understood their self-injury to have acted upon their emotions. Firstly, I present data from participants who described their self-injury as being a method of eliciting or creating feelings. I briefly contrast this with Robert's narrative which used the opposite formulation, where self-injury was described as acting to remove emotion. Secondly, I discuss the stories of participants which concentrated upon the managing of emotions.

8.2.1.1 Eliciting emotion, creating feeling

Both Belinda and Francis talked about self-injuring in order to feel "*something*". For Belinda this "*something*" was required to replace feelings of confusion, whereas for Francis the "*something*" replaced feelings of numbness, or an absence of feeling. For Francis, his practice of self-injury was strongly related to his belief that he should have been feeling something – a belief which suggests the existence of feeling rules. In this case, the feeling rule was that if one's parents have split up, and one's father has been diagnosed with a mental illness, one should be feeling something more than "*numb*."

*"**I felt it wasn't right, or, it felt wrong, to be, to have, to know, that I should – that I'm upset, to know that these things have upset me, but not, but the, you know I'd learnt, or I'd got into the habit of really, … not displaying that** […] I felt I was incapable of feeling anything, you know incapable of emotion and…. Em…. I didn't*

like that, I wanted to be able to feel I wanted to, you know, live or experience stuff or. …….. and so, ***self-harming was, you know a way of, feeling, pain, you know feeling pain cos it was something****"*

For both Francis and Belinda, the feeling that self-injury elicited was "*pain*." In Francis' case this could be viewed as appropriate – the situation with his family is one that could be understood to cause painful feelings. Francis felt "*incapable*" of experiencing these feelings and interpreted his self-injury as being a way of feeling "*pain*" rather than nothing at all. This reflects the common narrative of self-injury being a way of 'doing' physical pain in place of emotional pain and further highlights the interconnected nature of physical and emotional pain. Indeed, in the passage above Francis does not indicate whether he is talking about emotional or physical pain. This could reflect the impossibility of attempting to separate out these concepts.

For Belinda the feeling rule is less clear, though it can certainly be suggested that feelings of confusion are rarely viewed as positive. Belinda herself apparently views these feelings of confusion as so unacceptable that something must be done to remedy the situation. Key to this is the level of control Belinda is able to enact over these feelings, through her self-injury:

"I just, it sort of, I think now, it's just to feel something else, to replace the feeling, like with something……that I know, and something that I sort of have control over feeling, and it's to replace a different feeling, to think about something else for a while, that's what I think it is now."

Here Belinda provides more detail about how self-injury works for her. Self-injury replaces her feelings of confusion with something that is different but, importantly, this different feeling is also something that Belinda feels she has more control over. The need for control over feelings could be said to be a very general feeling rule, there are few, if any, social situations where a lack of control over feelings is required or encouraged. Self-injury, in this sense, might be likened to other more socially acceptable methods of doing emotion work in the face of 'uncontrollable' feelings, such as smoking cigarettes or taking deep breaths.

The feelings which self-injury was said to elicit were sometimes described in positive terms. Indeed, although Francis described his self-injury as causing pain, he noted that this was "*a good pain, not a bad pain*." Some participants took this further, suggesting that self-injury actually operated to make them "*feel good*". This was the case for Rease, Mark and Justin. Justin's narrative in particular fits closely with traditional conceptualisations of emotion work. He said that his early self-injury, between the ages of 16 and 18, had primarily been carried out in order to give himself a "*buzz*" which he likened to a 'pick me up' of whisky.

"*I guess like if it was in sort of social situations where there was a whole bunch of people downstairs, you could, you know,* ***cut yourself, get a rush****, and then, you could kind of, you know it was like sort of, you know almost like a sort of, almost like drinking (A – mm) basically, like* ***it would give you a kind of you know, Dutch courage or something*** *(A – mhm) errr, and so, ... and then plus once you sort of start something like that, I think you know you sort of, it sort of becomes habit, or, or whatever"*

Justin's earlier self-injury was described as being a method he used to enable him to socialise more successfully. He noted that in later life, he used alcohol in much the same way.

Mark and Rease described their self-injury as making them "*feel good*" in the face of depression, and both intimated that self-injury had played a part in their eventual 'recovery' from depression. For instance, Mark suggested that in some cases his self-injury was related to feelings of depression or "*brittleness*" and that the act of cutting ended cycles of such feelings. His description is further suggestive of the embodied nature of these feelings, and the impossibility of separating the physical from the emotional:

"everything's really brittle (A – mm)……. … … you know, it can all go wrong any time , em,…… ……it doesn't matter what you do, cos tomorrow's gonna be the same, then the next week's gonna be the same, there's no end to this in sight …. …… … the cutting definitely breaks the cycle (A – mm) ***you wake up the next morning, and it's a new day, (A – yeah) and it does feel different*** *and it is different… …. … em, …. I'm not saying it's a sensible move, (A – yeah) I can't quite, ---- the feeling you get the night before after the cutting, …. …. … I think* ***it's like a weight off your chest (A – mm) you can sleep -----, you can actually go to sleep****"*

This passage suggests that, for Mark, self-injury leads to these more positive feelings through three routes. Firstly, self-injury has allowed him to feel in control of something, and that in itself is positive. Secondly, it relieves some tension *"a weight off your chest*". Finally, these factors contributed to allowing him to sleep. Belinda, Dinah, Anna and Harriet all also talked about problematic emotional states (primarily anxiety) leading to difficulty sleeping. Belinda and Dinah both indicated that they had used self-injury in order to "*exhaust*" themselves so that they were able to sleep. In these cases, self-injury can again be seen to act as a method of doing embodied emotion work – by 'exhausting' the participant, or by 'relieving' problematic emotional states enough for sleep to occur. The sociological importance of sleep has recently begun to be explored (Williams, 2002). Certainly, it is clear that good quality sleep is generally understood to be related to positive mental health. In the cases where self-injury is used to facilitate or induce (through exhaustion) sleep, it can therefore be understood as a practical and logical method of working on emotions in order to better participate in 'normal' life. Further, the role of sleep or sleep disturbance in some participants' stories emphasises the importance of bodies in experiences of mental distress.

In contrast to these participants, Robert suggested that for him, rather than creating feelings, self-injury *removed* unwanted emotion:

"once I did it was like it was gone, it was like, there was just nae emotion whatsoever, it was just, em, …. I suppose ***like everything had been lifted****[…] I mean once it was, once it was done, … it was like ken, everything, like I say* ***the emotions and that, they were gone, they were away****,* ***it was like as if I'd been cleansed****, it was like as if, the, em, I suppose, like ken, people call blood letting and stuff eh"*

The way that Robert describes this process is suggestive of the release metaphor discussed in Chapter 5 (Emotions and Self-Injury). Release could be likened to the removal of emotion – in fact as I noted earlier, participants who invoked the concept of release were often unclear about what was being released. Robert's narrative suggests that for him what was being released was emotion, and that it was released almost materially, through the "*letting*" of blood.

8.2.1.2 Managing emotion, dealing with feelings

Other participants described self-injury as operating slightly differently in the management of their emotions. Rather than creating, eliciting or removing emotions, these participants talked about self-injury in terms of its ability to release or relieve emotions or feelings, or to serve as a distraction from feelings.

Harriet, for instance, described self-injuring in order to relieve tension and anxiety, and in a slightly different formulation of the release/relief metaphor, Dinah suggested that self-injury helped to relieve feelings of guilt. Dinah's discussion of this issue highlights a possible explanation as to why other participants described their self-injury in terms of self-punishment. Dinah talked in detail about how responsible she felt for other people's feelings, and as a child and teenager, how these feelings of responsibility had at times become over-generalised, so that she felt what might be popularly termed 'the weight of the world on her shoulders':

"I think it was more me being really really daft and thinking oh my god I've really embarrassed myself, well, you know, ***I'll have to punish myself for doing something really awful****, and that's the thing I kinda always felt that I was……hurt… not hurting other people, but it was usually because I thought that I had done something to other people, you know I felt responsible for stuff that I done to other people, you know ----unclear---- when I was younger and I was really sensitive, it was just kinda like oh no, I've done this, and that's hurt that person, that's hurt,* ***I would have these big lists, of all these people that, you know I could've possibly have damaged*** *and you know what I mean, it was just kind-of a big sorta spiral of blaming myself for hurting other people"*

In Dinah's case, self-injury made her feel "*better.*" What I am suggesting here is that self-punishment (in the form of self-injury) could be understood as a type of emotion work. If emotion work includes ways of 'working upon' feelings – and self-injury is being used to work upon or relieve feelings of guilt, then it can be understood as a method of emotion work.

In contrast to narratives which suggested that self-injury acted to release or relieve the participant from problematic emotional states, other participants described self-

injury as providing a distraction from feelings. Milly for instance, was clear that self-injury did not alter the "*underlying feelings*":

"*it was almost a distraction, from the mood rather than a, a kind of changing of the mood which is why it was so continuous […] the mood kinda dissipated, and went back up again, and nothing was really solved.*"

Milly's narrative suggests yet another way in which self-injury can be seen to operate as a method of emotion work. In her case, self-injury serves to distract from the problematic emotion – not, as with some of the other formulations, to remove the problematic emotion. Indeed, Milly is clear that the mood returned, as self-injury for her did not "*really*" solve the problem. This contrasts with the narratives of Rease and Mark, where self-injury itself was framed as effective, serving to successfully solve problems: with body image and feelings of self-hatred (Rease); and with a difficult relationship and problematic emotional states (Mark).

The idea that self-injury works because it distracts was also invoked by Craig and Harriet. Both suggested that the physical pain of the wound/s caused by self-injury gave them "*something else*" to think about, to orient towards. Craig specifically suggested that the level of control people who self-injure have over their injuries, in contrast to other less controllable aspects of their life, might be significant. Belinda also used the notion of control when discussing this – she said that she felt she had control over her injuries, which she contrasted with her uncontrollable emotions. I am not clear whether Craig was referring to uncontrollable emotions or situations, or possibly both. As with Anna's narrative, Craig's use of control was rather generalised, perhaps pointing to a broader understanding of control as a positive state or feeling.

These narratives, where self-injury can be framed as being a method of doing emotion work call into question some of the existing literature on emotion management. As I argue above, some of this literature overlooks the embodied nature of emotions, but further, it tends to overlook the way that different methods of managing emotions actually work. However, in Hochschild's (1983) study of air-

hostesses, she describes a number of ways in which they physically managed their emotions (p. 25). The air hostesses' training was designed to encourage them to use more cognitive methods. These cognitive methods were unseen (not displayed) and therefore were more socially acceptable. Similarities can be seen with self-injury. As I have argued, 'hidden' self-injury is viewed as 'better' (more acceptable) than displayed self-injury; perhaps because it is hidden, but also perhaps as a function of it being more successful as emotion work. Self-injury *is* often 'private' or carried out alone. However, that certainly does not fit for all cases. In some instances there is clearly an element where it is essential that the self-injury be witnessed, or at least that it *might* be witnessed – this is discussed further in section 8.3 on authenticity.

8.2.3 Emotion work and the body

Each of the examples above demonstrates the centrality of bodies in participants' attempts to both explain their emotions and manage them. Participants drew upon bio-chemical models to explain why their attempts to manage their emotions through their bodies were successful. For instance, Justin attributed his 'buzz' to adrenaline; while Rease and Mark suggested endorphins and chemicals were responsible for the efficacy of their self-injury in improving their moods. These narratives lend support to arguments made by Rose (2003) regarding the importance of bio-chemical expert narratives in understandings of the body. Further, the idea that self-injury relieves or releases an emotion or feeling (tension, guilt) is again suggestive of the combined and inextricable body/mind. Doing something to the body is understood to release something which is more usually understood as mental or cognitive. However, this release is experienced as embodied, just as emotions are experienced, or felt, simultaneously through the 'body' and the 'mind.'

8.3.1 Authentic pain: the body as an 'authentic site' for the expression of emotional pain.

One of the key criticisms regarding the concept of emotion work/management is that is assumes that there are emotions which are not worked upon, and that these

'spontaneous' emotions are more authentic. This is most applicable to work which examines commercial emotion labour, and it is in her work on this area that Hochschild argued this most strongly (Hochschild, 2003 (1983)). However, the problem of authenticity applies equally for emotion work that is done outside of the workplace. Indeed, Duncombe and Marsden (1998) grapple with this issue in relation to their research on the emotion work done by heterosexual couples in order to maintain their relationships. Rather than attempt to add my own answer to this question, in this section I will look at the concept of authenticity in a rather different manner. My reasons for doing this are two-fold. Firstly, I would argue (following Duncombe and Marsden, 1998) that it is virtually impossible for us to know the 'authenticity' of the emotions of other people – or even of ourselves – since it is impossible for us to be examined or to examine ourselves outside of any socio-cultural context. Our emotions may always be being 'worked upon' in some manner, by our 'selves' or by 'others', in response to socio-cultural contexts. Secondly, the concept of authenticity itself is an important one with regard to late-modern social life. Others have commented upon the late-modern concern with 'truth', 'reality' and 'authenticity' (Giddens, 1991; O'Connor, 2006). It is also argued that in these 'uncertain' times, the body has increasingly become the only site where individuals are able to 'be authentic' (Benson, 2000; Sweetman, 2000).

Authenticity here is taken to relate to 'real-ness' or 'truth-ness'. In contrast to some existing work (e.g. Gubrium & Holstein, 2001), I do not want to suggest that an 'authentic', 'real' or 'true self' actually exists. Rather, I wish to acknowledge that the existence of an 'authentic self' is generally held to be important by people in 'late modern' Britain (Giddens, 1991). This further affirms my aim in this section, which is to illustrate and demonstrate the way that participants can be seen to have used the concept of authenticity in their narratives, rather than making any claims as to the existence of any 'authentic thing' (whether self-injury, or 'self').

I examine self-injury and authenticity in two, related ways. Firstly, self-injury can itself be understood as a way of doing 'being in pain' authentically. This is reflected in the narratives of those participants who stated that their self-injury was one of the

only methods they felt they had of being taken seriously. This was especially evident in Harriet's narrative, but is also implied in the stories told by Belinda and Milly. I suggest that these arguments are related to a cultural tendency to devalue and dismiss 'emotional' pain (Bendelow, 2009).

Another perspective was raised in the narrative of Anna, who suggested that some people who self-injured were not being authentic. They were not 'really' self-injuring. This was also raised by Belinda, who suggested that people with different motives might not 'really' be self-injuring. Further, the concern with practising a behaviour 'authentically' reflects similar concerns raised by theorists of youth subcultures (Riley & Cahill, 2005; Williams, 2006).

Each of these issues raises the importance of the body and of morality. I suggest that bodies are central in participants' attempts to create or present an 'authentic' self. Morality is significant since it is morally virtuous to be, and be seen as, authentic (Ashforth & Tomiuk, 2000). In this way, individual, embodied practices can be made culturally and socially understandable. An analysis of the moral nature of narratives about self-injury and authenticity serves to locate the participants securely within existing socio-cultural narratives and concerns.

8.3.2 Self-injury and authentic pain

As discussed in section 6.4.2, Harriet and Belinda were both quite clear that their practice of self-injury had sometimes been oriented toward other people. I would argue that part of the reason they felt that they needed to self-injure in order to get attention can be related to several inter-linking ideas around the issue of authenticity. For Harriet and Belinda, getting attention without self-injury was experienced as problematic. Belinda felt that she was not listened to, Harriet felt unable to speak. Importantly, both Belinda and Harriet suggested that their problems were not recognised or understood. Belinda described trying to talk about and communicate her problems, but being disregarded. She suggested that following this, she tried self-injury as a way of signalling her distress in a way which could be 'believed':

"I wanted people to believe me […] wanted people to listen (A – mhm) or to notice or just to do acknowledge, or something! (A – mm) em, and that's originally, why I started. […]I mean I, hehe if you try so many ways of getting people's attention, like, you tell people at school and then, they call the meeting with the principle, […] and you tell them everything, and then they just disregard you. (A – mhm) How are you supposed to get people's attention?! How are you supposed to tell them? Hehe. And, I guess, em, … I guess that's what, you know, I saw, that Seb – everyone was like, worried about Seb"

On seeing the attention that her friend Seb appeared to receive following his self-injury, Belinda describes how she decided to try this method herself. The problems which Belinda was having at this time included her recovery from physical abuse at the hands of her father, and disturbing memories associated with this. A key question here is why Belinda, and Seb, had to 'resort' to inflicting physical injuries upon their bodies in order that their less visible distress be acknowledged. I would suggest that this might be related to the relative cultural importance accorded to physical versus emotional pain.

Harriet talked about this in a slightly different, but related manner. She spoke about her experience of being someone who self-injures and the difficulty she then had of getting her distress recognised without resorting again to self-injury:

"…its like sometimes it feels like, … you want, you go down and try and speak to somebody but its like – but ***you've not done anything so, they think, 'oh you're fine'*** *like, its like sometimes like, well, if I do something then maybe people'll realise then that I'm hurting, inside (A – yeah) and then they're like – but why didn't you come to us before you did it? Its like, well I tried to! But you wouldn't help me! (A – mm) so its like, quite difficult, to know what to do (A - yeah, yeah, ……) but I think, it, … if I can work out how to properly say what's going on, they're more likely to help me… but its sometimes you don't' know,… how to like express what you're … what you're going through without it like being, … sounding as if you're threatening them [with self-injury]"*

Here Harriet describes a Catch-22 situation, whereby she has been encouraged to seek help before she self-injures, but feels that her requests for help are ignored or downplayed because she hasn't "*done anything*." Further, if she tries to communicate that she wants to injure herself, she is accused (or feels accused) of being

"*threatening*". Ultimately, this can result in it being more straightforward for Harriet to not seek help for her (non-visible) anxiety, and simply seek and receive help once she has injured herself. In this case she would not be threatening anything, as she has already carried out the injury, and there can be no doubt that there is something wrong, since she has injured herself.

Belinda's and Harriet's stories illustrate situations where emotional distress is either not recognised, or certainly not taken as seriously as physical injuries. There are several possible explanations for this. Firstly, it could be that if an individual self-injures they are understood to be in greater mental anguish than a person who has not self-injured, because people who self-injure are understood to be irrational, crazy and even possibly dangerous. Secondly, physical injuries are more visible than emotional distress, they are, in Belinda's words more 'believable' – others cannot dispute the existence of cuts, burns or bruises, whereas they could dispute the extent or severity of unseen emotional or mental pain. Thirdly, it has been argued that in general physical injuries, symptoms and conditions are taken more seriously than mental or emotional complaints (Bendelow, 2009). Thus, self-injury in this sense could be understood as a logical attempt by individuals in emotional distress to signal more clearly the pain they are in. Both Belinda and Harriet appeared to argue in this manner, suggesting that they felt that they had to injure themselves in order to properly communicate their emotional pain. In summary, in some cases, self-injury can be understood as a method of signalling to others the authenticity of the emotional pain that an individual is feeling. This reflects a general bias/preference towards visible, physical symptoms over and above unseen, emotional/mental symptoms. This analysis again highlights the continued preponderance of dualist understandings of mind and body, whilst also indicating their insufficiency in representing lived experience.

8.3.3 Self-injuring authentically

The idea that some people might self-injure in ways that were not 'authentic' was first raised by Anna, after our first interview and unfortunately after I had stopped

recording. She talked about the issue specifically in relation to the experience of pain during self-injury. She related a specific instance to me, whereby someone who had been in a psychiatric hospital with her had apparently 'copied' her self-injury. Anna said that she could not understand how they had been able to do this: surely the self-injury must have hurt. Anna implied that, because the person was copying her, they could not possibly be in the same 'mental state' that Anna herself was in when she self-injured. It was this 'mental state' that, Anna suggested, explained her own lack of pain during self-injury. Several other participants presented ambivalent stories about 'copying' self-injury from other people, and I would suggest that this ambivalence reflected a concern with being seen as an 'authentic self-injurer'. Both Milly and Belinda, for instance, were clear that they had 'learned' about self-injury from someone else, and both expressed some concern about this.

Belinda suggested that the reasons she had self-injured gave her behaviour some credibility, contrasting this with other people at her school who had self-injured for less credible reasons - to be "*cool*." "*I hated to think that I was doing it for attention, even though I was doing it for attention. But I wasn't doing it for attention to be cool*." Belinda's narrative regarding attention seeking was discussed in section 6.4.2. However, it is worth reiterating here that for Belinda, as well as for other participants, attention seeking was viewed negatively, and there appeared to be some suggestion that people who self-injured and 'displayed' their self-injury were somehow being inauthentic. This would relate to wider socio-cultural attitudes regarding the appropriate expression of pain, and the suggestion that it should be done in 'private'.

Milly related how the girl from whom she had 'learned' about self-injury "*turned round and told me that I was being an idiot because I was copying her*." Milly reacted to this accusation by emphasising earlier self-injurious behaviour she had engaged in. By locating her own self-injury in an earlier time, Milly claimed authenticity for her behaviour. Similarly, both Francis and Mark initially said that they had not come across self-injury at all prior to starting the behaviour themselves. For instance when I asked Mark about this he said: *"have I ever come across self-*

harm before?(A – yeah) ***absolutely not****."* . In both cases, throughout the course of our interviews, Mark and Francis worked out or realised that in fact they must have known about the behaviour before they started.

8.4.1 Motivation, accounts and self-injury.

In this section I will more fully draw out themes relating to motivation and morality. I follow Mills (1940), Scott and Lyman (1968) and Crossley (2006), in examining motives and accounts as social artefacts in and of themselves, rather than indications of internal/inner intentions[18]. As Crossley (2006: 27) has suggested, "motivation talk is a technique for organizing, controlling and judging action" – therefore talk of motivations incorporates moral messages regarding the action being discussed. Examining the vocabularies of motive associated with self-injury illuminates the social and moral nature of the behaviour, side-stepping the issues which more usually concern literature on self-injury, which tends to focus on internal and individual causes. I have raised the moral nature of participants' descriptions and evaluations of self-injury at several points throughout the preceding chapters, this section will therefore consolidate and further emphasise the importance of this aspect of participants' understanding of their behaviour.

Mills argued that the "long acting out of a role, with it's appropriate motives, will often induce a man (sic) to become what at first he merely sought to appear" (1940: 908). This relates to his assertion that motives are not 'merely' stating reasons or describing action, but influencing the future behaviour of the self and often of others (ibid: 907).

This frame of analysis also highlights the importance of the setting in which the account is given – in this case, interviews with someone else who participants knew to have also self-injured (see Monaghan, 2002 for a similar 'insider' study on steroid use among bodybuilders.). In this section I further consider the ways that this knowledge may have affected the accounts given.

[18] I use the terms account and motivation interchangeably here.

8.4.2 Accounting for self-injury

I have demonstrated that self-injury was understood and explained by participants in a wide variety of ways. What I will now show is that although the differences and nuances between these explanations are important, there are some important similarities in terms of the way that the narratives were framed. Following Scott and Lyman, I will first examine those accounts that might be viewed as *excuses* – which they term "socially approved vocabularies for mitigating or relieving responsibility" (1968: 47). I then highlight those accounts which can be viewed more as *justifications* – whereby an individual accepts responsibility for an act, but attempts to re-frame the negative associations the act is understood to have (ibid). I note that justifications were far more commonly given than excuses, and I tentatively suggest that this may lead from my own position as someone else who had self-injured. Thus, participants may have been both reluctant to condemn a behaviour they knew I had also carried out, and also may have found it easier to justify the behaviour, and less likely to feel the need to excuse it. I further argue that the bodily marks that self-injury so often leaves may also affect the types of accounts that participants were likely to give.

8.4.2.1 Excuses

As I note above, excuses for self-injury were given far less frequently than justifications. Nevertheless, almost all participants provided me with excuses for their self-injury, and there were overlaps and similarities. These excuses were sometimes given rather glibly, and further, they occasionally directly contradicted justifications given by participants at other points in the interviews. I suggest that these contradictions indicate that participants will draw on a variety of both justifications and excuses which they will employ in different situations.

Biological Mechanisms

Biological mechanisms were noted by several participants in their attempts to explain, or I would argue, excuse their practice of self-injury. Harriet and Rease both implicated endorphins in their explanations of why self-injury did not cause much pain. Mark and Justin suggested that the efficacy of self-injury – why it worked – was related to bio-chemical mechanisms. Justin suggested that adrenaline was involved in the 'buzz' that he felt when he self-injured as a teenager.

All of these accounts attempt to excuse self-injury by appealing to widely held beliefs regarding the biological mechanisms of the body. Importantly, each participant spent more time talking about various other explanations for the feelings that they got from self-injury. In Harriet's case, she only mentioned the bio-chemical understanding of self-injury in the context of talking about her self-injury with school children:

"its like, cos like when I was trying to explain it to a group of, of like school kids I was like, explaining about how like there was like, like all these chemicals in your brain that get released […] so that it acts as like as a pain killer"

This episode was part of her involvement in 'training days' whereby people who had self-injured spoke to school children about their experiences in an attempt to increase awareness and help-seeking about the behaviour. It is perhaps suggestive of the greater esteem given to biochemical explanations that Harriet chose to emphasise this type of explanation in this context.

It is important to contrast these biochemical explanations for self-injury with other possible interpretations, this emphasises further why participants might chose to use such explanations in favour of others. For instance, the claim that self-injury feels good because of endorphins might help to mediate against the charge of being 'masochistic'. This issue was also raised by Craig, Rease and Mark – in all cases to claim that they were *not* masochistic. There is something problematic about being seen to 'enjoy' pain, whether in a sexual or non-sexual manner, though it is likely that the sexual connotations of masochism play a large part in its negative framing. However, in order to explain their continued practice of self-injury, Rease, Mark,

Francis and Justin emphasised the pleasurable feelings associated with self-injury. It is possible that in order to excuse these feelings, bio-chemical explanations are employed, giving legitimacy to the feelings.

Psychological/Psychiatric terminology

Participants also drew on less biological, but nevertheless, authoritative clinical/medical terminology to excuse their behaviour. This was a problematic stance, however, given that mental illnesses are stigmatised. However, in some contexts such terminology may also provide an acceptable excuse for inappropriate or otherwise incomprehensible behaviour. For those participants who were heavily involved in psychiatric services – Anna, Emma and Harriet – these explanations were a key aspect of their broader narrative. Anna and Emma were both rather ambivalent and sometimes critical about their involvement in psychiatric services and with psychiatric diagnoses. In contrast, Harriet was less ambivalent, and seemed the most accepting of the explanations and treatment she had been given for her behaviour. Belinda, Dinah, Robert and Milly had all had much more limited involvement in psychiatric services, but nevertheless at times framed their self-injury in terms of psychiatric terminology. Belinda, for example, described her early self-injury as "*impulsive*". Other participants talked of their self-injury in terms of "*impulses*" (Mark, Harriet) or "*urges*" (Harriet, Milly). These types of description can be seen as locating the motivation for self-injury outside of the conscious control of the participant. Similarly, Harriet said that she sometimes dissociated to such an extent that she did not even know she had self-injured until later.

Although several participants talked about madness in relation to self-injury, few directly attributed their self-injury to insanity. Rather, most references to madness were in relation to participants' suggestions about how *other* people might view their self-injury. In this sense, participants acknowledged what they understood to be wider cultural/social understandings about the type of people who injured themselves: mad people. There appeared to be some ambivalence regarding this issue

however. Participants did not directly contradict or dispute this suggestion, though similarly, they did not tend to endorse it.

None of the participants talked about addiction, which may be significant. I had expected at least some participants to frame their self-injury as an addiction, as this is a common explanation on some self-injury websites, for instance, one refers to self-burning as "a huge addiction, just like any other form of self-injury" (Scar-Tissue, 2009). However, Anna, Harriet, Emma and Justin did all describe their self-injury as being, at times, habitual. This could be seen as a comparable 'excuse' for their behaviour, in that to some extent it downplays the agency of the individual.

8.4.2.2 Justifications

The accounts which can be viewed as justifications were those which sought to (re)frame self-injury in a more positive light, affirming and accepting the individual's responsibility for the behaviour. This is in contrast with the accounts above, which tended to accept more readily the negative framing of self-injury as an undesirable behaviour, downplaying individual agency.

Control and release

One of the more dominant accounts, which I have returned to throughout the thesis, focuses around control and release. As I have already demonstrated, whether this control and release is bodily or emotional is unclear, what is important is that the concepts are recognisable. They are recognisable because they reflect wider concerns and discourse regarding the moral virtue of being 'in control' and the simultaneous need for 'release' in order to be healthy (Lupton, 1998b). This is a justification rather than an excuse, because the individual employing this account is accepting responsibility and agency in enacting the behaviour, and in order to legitimate this they are drawing on pre-existing understandings of emotion and health. The legitimacy of this account can be seen in that it is often accepted – it is certainly rarely questioned in the existing literature on self-injury.

Explaining self-injury as being a way of transforming emotional pain into physical pain is another of the more common accounts my participants gave me, and similarly, it can also be viewed as a justification rather than an excuse. In this case, participants draw on socio-cultural references regarding the primacy of physical pain over and above emotional pain (Bendelow, 2009). Again, with this explanation participants are drawing on existing socio-cultural understandings (of pain) to explain their behaviour, whilst simultaneously accepting responsibility for the behaviour.

Self-injury as a coping mechanism

Another, related, way in which self-injury was justified was to refer to it as a 'coping mechanism'. Again, this explanation involves the individual accepting responsibility for their actions, but framing self-injury in a more acceptable manner – as an almost innocuous 'coping mechanism'. This was expressed particularly strongly in Rease's narrative, where she argued that self-injury could be seen as a successful coping mechanism, because otherwise she would have killed herself. Rease's argument parallels one of the earliest explanations for self-injury, where it was understood as a 'proxy' for suicide (Shaw, 2002):

"I was very, em, kind of prone to suicidal thoughts, and, self-harm was, kind of a way, … to deal with that, and kinda, keep myself alive. I mean I've always said, if I hadn't have self-harm I wouldn't be here, I'd be dead. Em, and I don't say that lightly, I mean that's really true. ….. so, em, so it was a big deal. And even though like the self harm, obviously you can't keep doing it, or using it as a coping mechanism, ahm, I do kinda see it as a positive thing"

Rease explicitly states that her self-injury was a positive coping mechanism, though she accepts that it cannot be continued indefinitely. In this way Rease justifies her past behaviour, whilst acknowledging and partly explaining that she no longer carries out this 'positive' behaviour. Emma talked in a similarly ambivalent manner about her self-injury. In the following excerpt in particular, Emma struggles to reconcile her past behaviour, with the continued presence of the scars she created:

Evie once asked me, if, … if I could, go back again, … you know, if I was actually embarrassed by, … my scars and things and, … .. and if, it, …. Em, … … …. … …. You know if I would do it again if I went back (A – mm) and I said, ***I probably would, still do it but, ... I do kind of regret having done it****, at the same time, em, … … … … …. .. but, … .. … ..regret having done it, at the same time, em, … … … … …. .. but, … .. … .. it was a part of my life for, … … a good, … 10 years, so, … em, …. … . well, a very bad 10 years actually not a very good 10 years (A – heheheh) hehe, em, … .. but em, … …. …. … …* ***… it was just a way of, … …. a way of coping****, … … …. .. because I didn't know how to, how to talk about it"*

Emma's narrative here is complex. She simultaneously claims that she would still self-injure, even with hindsight, whilst also saying she regrets what happened. She concludes, however, by suggesting that what she did was "*just*" a way of coping. In doing this, Emma draws on a common cultural motif – the need to cope, and the need for mechanisms to enable this. Self-injury was "*just*" one possible method of doing coping. I would suggest that Emma's scars play an important role in her struggle to reconcile her behaviour. The visibility and permanence of her scars make a justificatory account of their creation more desirable. Emma maintains that she would still "*do it again*", it was "*just*" a coping mechanism – this account implies a level of agency, control and responsibility. However, she acknowledges wider socio-cultural understandings by acknowledging some level of regret.

Self-injury as 'attention seeking'

Those participants who described their self-injury as 'attention seeking' can also be said to have provided justificatory accounts. These explanations for self-injury were complex and often detailed justifications regarding why the 'attention seeking' was necessary. These drew on, and sometimes challenged, broader socio-cultural understandings regarding emotions and display. Importantly, participants employing these types of account accepted responsibility for their actions.

Belinda and Harriet in particular provided lengthy narratives regarding their 'attention-seeking' self-injury. Belinda was clear that she had tried many other ways of seeking attention and help, but that these had been ignored. Similarly, Harriet

explained how she now struggled to be taken seriously unless she had self-injured. In each of these cases, the visible nature of self-injury (in contrast to in-visible emotional distress) was paramount. As I argued in Chapter 6, this appears to relate to more widely held understandings regarding the relative importance and believability of physical versus emotional pain.

8.4.3 Considering the nature and contexts of accounts

Justificatory vocabularies of motive for self-injury were more commonly expressed than excuses. As I noted above, this could be for several reasons. Firstly, given the context in which these accounts were given, participants may have been more inclined to provide justifications than excuses. Excuses are more likely to accept and reinforce negative judgements about the behaviour in question, and as participants knew that I had also self-injured, they may have been less inclined to discuss self-injury in such a manner.

Secondly, because self-injury often leaves permanent marks (and most of my participants had some permanent scars from their behaviour), the individual providing an account of their self-injury has to account for their continued and visible status as 'someone who has self-injured'. This too may lead them to be more inclined to account for the behaviour in a manner which does not reinforce negative judgements. The importance of the continued corporeal visibility of self-injury in mediating the nature of accounts again emphasises the centrality of bodies and embodiment to an understanding of self-injury.

Finally, justifications also allow the individual to present themselves as a coherent and active 'self'. It may be significant that none of the participants excused their self-injury entirely. Despite some having long histories of involvement with psychiatric services, narratives relating to madness were only ever referred to through 'other' people. In comparison then, excuses might indicate some moral weakness. This may be advantageous in some contexts, such as in a court of law defending oneself

against a murder charge. However, in the context of a research interview, this is less desirable.

8.5 Conclusions

This chapter has demonstrated three key sociological perspectives through which self-injury can be viewed. Each of these illustrates the necessity of accounting for the embodied and social nature of self-injury.

A focus on self-injury as a method of emotion work highlights the ways in which self-injury can be seen to function within interpersonal social contexts. My discussion here demonstrated the variety of means through which self-injury can be seen to operate as a form of emotion work – eliciting, removing, distracting from and releasing emotions. Examining self-injury in this manner also serves to problematise the concept of emotion work as it is increasingly used, by clearly showing the ways that emotion work and emotions are experienced as embodied.

The concept of authenticity was shown to be key in understanding both participants' practice of self-injury and also the meanings they associated with their own and other people's self-injury. Again, the body was central to this, as I argued that the self-injured body could be viewed as a site upon which participants could demonstrate 'authentic' pain. This was important whether the results of this were displayed or not. Indeed, I noted that participants' views on the authenticity of others' self-injury (especially when it was displayed) was problematic and contradictory.

Finally, examining the nature of the accounts that participants gave for self-injury demonstrated the importance of the context in which they were given – the interview. Further, a focus on accounts in the form of both justification and excuses, highlighted the broader socio-cultural discourses that participants employed when narrating their experiences with self-injury. Many of these accounts were explicitly embodied, and thus incorporated socio-cultural understandings of bio-medical bodies with chemicals and hormones, and emotional bodies with ebbs and flows.

Overall, this chapter has demonstrated the importance of bodies and socio-cultural contexts to understandings of self-injury, as well as showing the usefulness of sociological theories in illuminating these issues.

Chapter 9

Pain Incarnate: Conclusions and Implications

9.1 Introduction

This thesis set out to explore the lived experience of self-injury. In particular, a focus on the embodied nature of self-injury has highlighted the importance of attempting to locate understandings of self-injury within biographical, interpersonal and socio-cultural contexts. In this concluding chapter I will provide a final discussion of methodological and theoretical issues raised by the thesis. Following this, I discuss the implications of these findings for the practice of those working with people who self-injure. Finally, I make some suggestions regarding future avenues for research into self-injury.

9.2 Exploring self-injured bodies: Methodological reflections

9.2.1 Life stories and the lived experience

This research began as an exploration into the lived experiences of people who had self-injured. I aimed to investigate the ways in which people narrated their self-injury, and through this, to examine how self-injury was understood, the meanings it had. By focusing in the first instance upon the life-stories of participants, I was able to provide background biographical context in which to locate these meanings and understandings. This approach also allowed me to avoid exaggerating the importance of self-injury in participants' lives. Reflecting the diverse sample, participants did indeed narrate widely different biographies and correspondingly different understandings of their self-injury. These differences were further reflected in the various self-injurious practices which participants described.

A narrative approach to both data collection and analysis has allowed me to critically investigate the understandings and meanings participants gave their self-injury. Throughout my analysis, I have attempted to acknowledge and attend to the constructed and situational nature of participants' accounts. I have taken a subjective position within the research, whereby I have similarly acknowledged my part in the creation of the narratives of my participants. This reflected my ethical, feminist position in relation to the research, as a result of which I sought to conduct research in a collaborative and power neutral manner. Although my attempts at this were far from successful, I nevertheless retained some of the spirit of this approach in my analyses and treatment of the data. I make my truth claims tentatively, and readily accept that these conclusions may not be the ones that my participants would draw.

9.2.2 Limitations

As I have criticised previous research on self-injury for providing partial and limited interpretations of self-injury, it is appropriate that I acknowledge the limitations of my own work.

9.2.2.1 The sample

The research findings may have been strengthened had my sample been larger and more diverse. Practical and emotional constraints led to me ending data collection after recruiting 12 participants. Although some research has indicated this is the average number at which data saturation occurs (Guest et al., 2006), it would have been beneficial to include more participants. In particular, the sample would have benefited from a properly balanced gender ratio and from a more diverse spread of ages and socio-economic backgrounds. The voices of people from deprived backgrounds tend to be significantly absent from much existing research on self-injury, which has tended to privilege educated and eloquent informants. Although my sample did include some people from less affluent backgrounds (Anna, Robert and Rease), the sample was certainly skewed towards those who had been educated to degree level (with the exception of Justin and Belinda, all participants had or were

studying for a degree). Further, research with much older people who self-injure is almost entirely absent, and I hoped to recruit a sample with a wide age range. However, my sample was relatively homogeneous in terms of age. Despite these limitations, however, the sample did include important and hitherto under-researched groups: males who had self-injured; and those who had not sought help for self-injury. The sample was also diverse in terms of sexuality, household type, involvement in psychiatric services and methods of self-injury.

9.2.2.2 Participation, ethics and safety

I suggested in Chapter 3 that a participatory and collaborative style of research was the most ethical approach I could have taken, even if it was not entirely successful. Recent research has questioned the extent to which researchers should engage in this type of research, suggesting that more than any other style it may leave researchers open to emotional and psychological damage (Sampson et al., 2008). Whilst I accept these concerns, I remain convinced that the approach I took to the study was both appropriate and safe. By attending to my emotional safety at all stages of the research, I was able to successfully negotiate many potential problems that I faced when engaging with participants. Although the research was emotionally challenging and at times upsetting, with a strong supervision team, a good relationship with a therapist, along with invaluable interpersonal support from friends and family, helped me to 'cope with' these challenges, (thankfully) with no major psychological trauma.

How far my research may have impacted upon my participants is less clear. I remain in contact with some of my participants, and I attempted to be open and accessible to all who wanted to maintain contact. Nevertheless, and reflecting the problems I faced when trying to involve participants in analysis, I am no longer in contact with most of the participants. Due to the two stage nature of the data collection, I was able to 'check up' on participants' well-being during and between the interviews. However, it is perhaps a limitation of my research design that I did not plan in a more formal checking back process following the second interview. This might have enabled me

to assess the impact of the research, adjust my practice if any negative effects were identified, as well as allowing another chance for participants to challenge my analyses. Such an approach would then have strengthened the ethical foundations of the study even further.

9.2.2.3 Researching bodies

I did not begin this project with an intention to focus explicitly upon the embodied nature of self-injury. I was conscious from the start that previous research had not really engaged with the practical aspects of self-injury, generally overlooking what people who self-injured 'actually did'. However, my concern with embodiment and self-injury arose organically through my ever deeper engagement with the topic, my conversations with my research participants, and my increasing interest in sociological approaches to the study of bodies and emotions.

Leading from this later emergence of bodies as an explicit focus of analysis, my research practice was not as well designed or applied as it could have been. For instance, I took no comprehensive, rigorous notes regarding participants' visible scars or methods of display. I did keep field notes, and these sometimes referred to participants' scars, but I did not consistently attend to this aspect of my participants' appearance. This omission is especially incongruous given my increasing concern with the visible aspects of self-injury, and indeed may well be reflective of the more general trends I discuss in this thesis: that is that visible signals of distress are simultaneously powerful and yet frequently ignored or overlooked.

9.3 Discussion of findings

9.3.1 The importance of practice

Throughout the thesis, I have engaged with the embodied and practical nature of self-injury. Previous work on self-injury has tended to overlook the matter of 'what

people do' when they self-injure, and after their injuries 'what they do' with the scars or wounds that are created. In contrast, this work has shown that an examination of individual narratives concerning 'what they do' can illuminate important aspects of how self-injury is understood. Participants' narratives about how they started to self-injure suggest that, for some, there is a need to claim authenticity for the behaviour by locating their early self-injury in a distant past. Whilst others (Adler & Adler, 2005; Hodgson, 2004) have previously highlighted the importance of learning in the development of self-injury, my work had suggested that narratives about the learning of self-injury are difficult and morally complex. Participants expressed some ambivalence about having 'learnt' their behaviour from someone else. Others were adamant that they had 'learnt' the behaviour themselves, while some initially said this but later altered their narrative. This indicates the sensitive and morally charged nature of narratives around learning or self-learning self-injury, and mirrors other work on authenticity and subcultures (Riley & Cahill, 2005; Williams, 2006).

A focus on the practical, material, corporeal nature of self-injury also provides important findings regarding the allure of self-injury. For many participants, although for different reasons, self-injury was intensely satisfying. How this was understood and experienced did appear to vary, though there were some common themes. Several participants' narratives suggested that the sensations associated with self-injury were both satisfying and pleasurable. This appeared to relate to understandings of self-injury as a form of immediate control as well as a 'release' – of blood, emotions, tension or all three. These narratives of satisfaction tended to relate to an understanding of self-injury as effective.

A detailed examination of participants' understandings of pain associated with self-injury further demonstrated the ways in which participants drew upon dominant, yet contradictory, socio-cultural understandings of bodies and emotions in their explanations for their behaviour. For many participants, self-injury was described as not causing physical pain. Despite this, some of these participants also said that self-injury allowed them to deal with emotional pain by causing physical pain. My analysis of stories around pain and self-injury suggests that these narratives may

draw on dominant discourses regarding the functions of self-injury. In particular, describing self-injury as a way of transforming emotional pain into physical pain may be seen as a justification for self-injury. This draws on wider socio-cultural understandings regarding the appropriate management and expression of emotions. Participants' stories around pain, emotions and expression suggested that self-injury did far more than 'transform' emotional pain into physical pain. Frequently, participants did not differentiate between emotional and physical pain. Some participants used self-injury to create sensations or feelings when they were feeling numb. Other participants used self-injury to 'distract' from emotional pain. Tying these explanations together was the importance of the embodied practice of self-injury: the act of self-injury, of cutting, burning, or bruising the flesh, was framed as successful – either in distracting from, creating, or releasing problematic or absent emotional states.

9.3.2 Attending to the wounds: the importance of visibility and feeling

A key conclusion is that attending to the visible and sensate nature of self-injury should be central to any attempt to understand the behaviour in socio-cultural context. I have demonstrated that the visible and felt nature of both the initial injuries caused by self-injury, as well as any lasting marks or scars are important both to individuals' understandings and interpretations of their behaviour, and how they then negotiate social life with these marks. These negotiations are closely related to understandings about the 'assumptions' of others.

A key aspect of some participants' practice of self-injury was the visual, material and felt nature of the wounds they created. The cuts, burns or bruises themselves were important in participants' practice – for some they needed to be of a sufficient 'depth' or 'bad' enough for the self-injury to 'work'. For other participants, the healing of their wounds was an equally important aspect of the meaning that self-injury had for them. Some emphasised that caring for and nurturing their wounds helped to distract them from negative mood states, or to symbolically heal emotional

wounds. Others indicated that wound interference was a way in which they exacted further control over their injuries: re-opening wounds and picking scabs enabled the immediate, bodily control of self-injury to be maintained over days, if not weeks.

How and where self-injury was practised, and how wounds were concealed or revealed afterwards, was sometimes affected by participants' attendance to the 'assumptions' of others. Many participants attempted to limit their self-injury to areas of their bodies that could be easily covered. Others felt less able or willing to do this, and were happier to fend off comments about inappropriate clothing than they were to injure elsewhere. Understandings about this differed.

Questions and comments about scars or marks, or the awareness that such questions and comments might arise were an integral part of the lived experience of being someone who has self-injured. How these were dealt with and experienced varied however. Some faced comments or questions defiantly, choosing not to hide their arms, and challenging negative comments and questions. Others preferred to avoid such questioning, either by hiding scars, lying about them, or fending off comments. Still others reported little direct questioning, yet nevertheless expressed concern regarding what they thought others must think about their scars.

The sensate aspects of self-injury – how it felt, whether it was painful – were equally central to participants' explanations for their self-injury. I have demonstrated that these understandings drew upon wider socio-cultural beliefs concerning bodies and emotions. In particular, I have suggested that bio-medical models of the body are used in participants' narratives around pain and self-injury. The embodied, emotional, feeling elements of self-injury, following Lupton (1998a) and Williams' (1998b) work, were described frequently in terms of release and control. My findings contrast with some interpretations of control as negative/denial, with several participants indicating that control was a positive state that self-injury helped them to achieve. The way in which several participants framed self-injury – as a way of gaining control through release – may relate to theoretical work on intoxication, which has similarly suggested that certain modes of intoxication might take the form

of controlled release. These theoretical strands need further development and exploration, but this work suggests that analyses of self-injury might make a useful contribution.

9.3.3 Authenticity, self-injury, bodies and emotions

Authenticity has emerged as a dominant theme in my analyses of participants' narratives. Some participants claimed that self-injury might be more or less authentic depending upon how and when it was practised. The narratives of Milly, Dinah, and Mark each implied, in different ways, that self-injury could be a primordial aspect of a 'self', manifesting itself in early childhood initially, before gradually finding a different outlet in the form of 'real' self-injury. Anna and Belinda's narratives suggested that some people self-injured for inauthentic reasons, with Anna further implying such people were not 'really self-harmers'. Whether self-injury was 'self-learned' or 'other-learned' (Hodgson, 2004) was another important way in which people might claim authenticity for their behaviour. The narratives of Francis and Mark, each of whom initially, and quite strongly, claimed to have 'self-learned' indicated this. A concern with authenticity was further evident in the narratives of Milly and Belinda, who were both clear that they had learned about self-injury from another person, but who struggled to justify this both to me and to themselves.

Authenticity was important for different reasons in the narratives of Harriet and Belinda. Both explained in detail the lengths they felt they had to go (self-injury) in order to have their distress recognised and attended to. Harriet in particular illuminated the particular problems she faced trying to do this when she was known to self-injure, finding that she was not taken seriously unless she had 'done something'. This only served to reaffirm the understanding that unseen emotional distress was not viewed as important as the more visible wounds caused by self-injury.

Some participants indicated, however, that people who 'showed off' their self-injury were not 'real' self-harmers. Belinda said that she 'hated' such people, though she

admitted that she herself had often not hidden her behaviour. This impression was also implied in Anna's narrative, where she emphasised the secretive and hidden nature of her self-injury. Several other participants (Craig, Dinah, Emma, Justin and Mark) were at pains to suggest that their self-injury had been kept secret, at least when it was a recent activity.

However, in several participants' narratives their self-injury or other self-harm was described as being overlooked or ignored. This paints a particularly problematic and contradictory picture. Self-injury might be understood as a form of expressing and attempting to have recognised unseen or invisible emotional distress. However (and as previously noted by Crouch and Wright (2004)) if people are seen to display their injuries they may be understood as in-authentically trying to 'seek attention' (perhaps rather than 'help'). Further, in many cases, even such an apparently explicit display of distress might be ignored, overlooked or minimised. Thus, wider socio-cultural understandings of emotions and self-injury could be seen to encourage hiding behaviour. A person who injures themselves discreetly and privately might be understood to be coping alone, and such behaviour might be seen as more valued than those who seek 'attention' (or help?) from others.

9.4 Implications and future directions

9.4.1 Implications for practice

Leading from my conclusions, I make a number of suggestions for those working with people who self-injure, whether in clinical or non-clinical contexts.

Non-judgemental reactions

My research has demonstrated that judgemental, angry, negative reactions to an individual's self-injury are experienced as extremely damaging and hurtful. Further, rather than inhibiting self-injury, such reactions are more likely to encourage people to hide their self-injury from others. Those working with people who self-injure

should certainly receive training to support them in providing reactions that are nurturing, supportive and caring. Such training should involve education and awareness-raising among staff regarding the problems associated with negative interpretations of self-injury. Indeed, some published work has suggested that medical staff who have received some educational training about self-harm are better able to respond to patients presenting with such behaviours (McCann et al., 2006). Such training should be developed and delivered with input from people who self-injure. This recommendation supports the best practice guidelines by the Royal College of Psychiatrists (2006). I would suggest that such education and awareness-raising should be extended to a wide range of professionals who might work with people who self-injure, including teachers, social workers and counsellors.

Attending to self-injury appropriately

My participants indicated that on many occasions, their self-injury was overlooked or ignored. While some felt this was appropriate, others did not. Self-injury should not necessarily be ignored: however, equally, it is not always appropriate to question someone who appears to have self-injured. Particularly where scars are evidently old there is perhaps less reason to address the matter. If a decision is made to attend to the self-injury this should be done sensitively and carefully. Again, educating professionals who come into contact with people who self-injure would help them to do this. Such education should focus upon the damaging effects of inappropriate attention, as well as providing better ways of responding to self-injury. As above, any training should be developed with the input of people who have self-injured.

The importance of practice

In clinical practice with people who self-injure, attention should be paid to developing diverse ways of doing emotion management. It should be recognised that self-injury can be powerfully effective and 'substitutes' – especially those that are largely cognitive – may be difficult to adopt. Thus, I would support 'harm reduction' strategies when working with people who self-injure, as opposed to 'no-harm'

contracts. However, any strategy should be discussed and negotiated with the individual concerned. My research found that 'no-harm' contracts could be experienced both positively and negatively.

Motivations for self-injury

Participants related a wide range of motivations for their self-injury. Their diverse stories suggest that assumptions regarding motivation should be avoided. Nevertheless, there were some important commonalities. Communication, especially regarding emotions, was implicated by most participants as being a factor in their self-injury. The person who has self-injured should then, above all else, be listened to and encouraged to talk.

Socio-cultural meanings

Throughout this thesis I have suggested that wider socio-cultural understandings regarding emotional expression and pain are important in explaining how self-injury is interpreted. The stories of some of my participants show that these socio-cultural understandings can have potentially damaging effects. Some reported not being taken seriously *unless* they had injured themselves, pointing to the more general tendency to privilege visible, tangible 'pain' over invisible, emotional 'pain'. Ironically, this may be a reason why some self-injure in the first place, as well as being a reason why self-injury may be experienced as effective. Self-injury works, in some cases, by either getting 'attention' or 'help', or by clearly signalling 'pain', whether to the self-injuring individual or to 'others'.

However, self-injury was also described as 'hidden' and I have suggested that more often it is 'ignored'. This may be related to the negative connotations attached to mental ill health. Although self-injury is 'physical', it is understood to signal 'emotional' distress. Thus, people who have self-injured may be caught in complicated moral negotiations. Emotional pain is invisible, and easily ignored. However, by manifesting this emotional pain in the form of 'physical' self-injury, the

individual is (in some understandings) creating an 'inauthentic' physical injury. It is seen as inauthentic both because it is a 'proxy' for 'emotional' pain, and because it is 'visible' and thus, 'displayed'.

It is essential that these socio-cultural assumptions and understandings around self-injury, pain and emotions are addressed in training targeted at those working with people who self-injure. Indeed, although an ambitious project, challenging such assumptions should certainly be engaged with in any large scale attempt to reduce or prevent self-injury in general populations.

9.4.2 Future directions for research

This exploratory study can point to a number of possible future directions that could be taken by sociological research into self-injury.

There is a need for better information regarding the prevalence of self-injury in non-clinical, general adult populations. Very little is currently known about this, and research on clinical and adolescent populations continues to dominate. Research is especially needed to ascertain whether self-injury does indeed tend to cease in early adulthood (as is widely assumed). s

This study has demonstrated the usefulness of taking a life-story, narrative approach to the study of self-injury. Future studies should apply such techniques with larger and more diverse samples. This might permit the development of a more comprehensive picture of the different ways that self-injury is used and understood, including methods, length of time and type of involvement with self-injury, functions and meanings.

More research is needed that addresses the potentially different ways that different methods of self-injury and self-harm are practised, and how these may relate to different meanings and understandings. Research is beginning to address this – for instance, some recent studies have begun to examine different methods of self-harm

separately; and this concern is also reflected in the calls for a distinction between suicidal and non-suicidal self-injury (e.g. Nock, 2009b). I would suggest, however, that this latter concern with motivation should be avoided. It would be more beneficial if attention were paid to material practices and understandings of self-injury and self-harm, rather than the motivations which are (as I discussed in Chapter 1) extremely liable to be influenced – and altered – by contextual factors.

In particular, more research is needed which engages with the potentially diverse ways that self-injury is used by members of different social groups. As this research was based on a relatively limited sample, it was difficult to contribute to this topic. Future qualitative research should focus in particular on self-injury among older people, those from deprived socio-economic backgrounds, and people from more ethnically diverse geographical areas. This thesis has raised a number of different explanations and ways of accounting for self-injury. Further research is needed to ascertain how widespread these explanations and understandings are among different social groups.

Research on the relationship between self-harm and suicide is currently limited. Further research is needed to ascertain whether different methods of self-harm are equally associated with increased risk of suicide. Currently, understandings tend to conflate all methods of self-harm and assume that all methods and modes of self-harm increase the risk of suicide. These understandings are limited due to their reliance upon clinical samples, and clinically recorded cases of self-harm. Very little is known about a relationship between medically untreated self-harm and suicide. Further research would improve understandings and enable better targeted intervention and care. For instance, it is currently unknown whether any one method of self-harm is more likely to increase risk of suicide. Existing qualitative research into self-injury has suggested that self-injury may in fact be protective of suicide. Quantitative studies are needed to corroborate this.

Finally, research which examines the ways and means by which individuals stop self-injuring is needed. Very little research engages with this at present. In particular, such research should involve non-clinical as well as clinical populations.

9.5 An ending

This thesis has demonstrated the possibility and necessity of an embodied, sociological perspective on self-injury. Through an exploration of the life-story narratives of people who self-injure, I have shown that the ways in which self-injury is described are mediated by wider socio-cultural understandings regarding emotions and bodies. In particular, I have highlighted the importance of pain and authenticity in participants' narratives about their self-injury. Self-injury, in some cases, might be understood as a way of 'being in pain' 'authentically'. This understanding only comes about through an engagement with the embodied nature of self-injury, and indeed, of social life. This engagement emphasises the importance of the visible and felt aspects of self-injury, each of which contributes to the lived experience of those who practise self-injury. Whether felt, seen, or both, self-injury, both to the practitioner and those observing, can be seen to represent pain, incarnate. In common with pain (Bendelow & Williams, 1995), self-injury highlights the importance and necessity of an embodied, anti-dualist perspective on lived experience. Examining these experiences and behaviours allows an interrogation of the inter-connected nature of emotions, bodies and social life. Pain, self-injury and indeed experience are all 'incarnate'. Attending to this allows for a more nuanced, sensitive and socially situated understanding of the lived experience of those who have practised self-injury.

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Appendix A

Spring / Summer 2007

Self-Injury?

I don't have all the answers but I'm trying to find out, and I need your help.

If you are over 18 and have ever self-injured - especially if you've never sought help - I'd like to hear from you.

As part of my PhD research at the University of Edinburgh, I'm holding interviews with people who self-injure to record their life-stories.

For more information visit: www.tardis.ed.ac.uk/~amy/

Call: 0131 650 4681

Write: Amy Chandler, Sociology, School of Social and Political Studies, University of Edinburgh, EH8 9LL

Appendix B

Self-Injury Study: Confidentiality and Consent Form

Check the boxes that describe how you would like your interview to be carried out and treated.

Part A

- I agree for the interview to be recorded ☐
- I do not want the interview to be recorded. ☐

Part B

- I am happy for quotes from my interview to be published, so long as they do not identify me. ☐
- I would prefer not to be quoted in anything that is published. ☐

Please read each statement below carefully, and tick the box next to it if you agree.

✓ I have read the information sheet provided, and have had the study described to me by the researcher. ☐

✓ I understand the purpose of this study and that anything I say will be treated in the strictest confidence. ☐

✓ I understand that the interview might bring up sensitive topics, and that I can discuss with the researcher some ways that I might address this. ☐

✓ I agree to be interviewed. ☐

.....	.....
Participant's Signature	Date
.....	.....
Researcher's Signature	Date

Appendix C

Self-Injury: Information Sheet

Thanks for your interest in taking part in my study. The focus of the study is the lives of people who have self-injured. This information sheet will answer some of the questions you might have about the study.

What do you mean by self-injury?
'Self-injury' in this study means any kind of harm to the outside of your body that leaves a mark. This includes cutting your skin with something sharp, punching objects, punching yourself, burning yourself, or any other kind of injury that you do to yourself, even if only temporarily. In this study, self-injury DOES NOT mean taking too many pills (an overdose), drinking too much alcohol, or taking too many illegal drugs.

If I have taken an overdose of pills or other substances, but I have also self-injured, do you still want to talk to me?
ABSOLUTELY! I'm interested in talking to anyone who has self-injured, whether or not you have also taken an overdose.

Why are you doing this study?
There is only a limited amount of information about people who self-injure. This study is trying to fill the gap in our knowledge and understanding of self-injury.

Who is doing this study?

I am! My name is Amy Chandler, and I am a student at the University of Edinburgh. This study forms part of my PhD. in sociology. It is being paid for by the Economic and Social Research Council, a government funded body that supports social research.
One of the reasons I'm interested in researching self-injury is that I have self-injured since I was 14. However, I can't do my research on myself, that's why I need to talk to you about your own experiences and opinions about life and your own self-injury.

What does the study involve?

- The study will involve two interviews. These will be carried out at a time and place of your choice. You will decide how long each interview will be, which could last up to 2 hours. If it is OK with you, I will record these interviews. But if you want me to stop recording at any time, that is fine – just let me know.

- There won't be any set questions, but we will be talking mainly about your life and experiences. A lot of what we discuss will be up to you. You don't have to talk about anything that you don't want to.

- You will also be asked to have a look at a summary of the first interview (where I have typed out our discussion), but again, this is up to you – you don't have to.

Appendix D

Ages:	1 – 5	6	7	8	9	10	11	12	13	14	15	16
School & Education												
Work/ Employment												
Where you lived, who you lived with												
Family, Friendships, Relationships												
Personal Interests, Leisure Activities												
Health and Ill-health.												

Appendix E

Anna

- Pain - None at all? Different methods affect?
- Privacy
- Telling others - How soon after, at all, depends on severity of injury?
- Copying
- Transition from hitting to cutting
- Have there been times when she wasn't harming that much/that often?
- Power
- Control
- Being taken seriously – by mother, especially when brother is taken seriously. Wanting acknowledgement – wanting to be noticed.
- Suffering illness alone as a child – just get on with it
- Feeling depersonalised – not knowing who I am.

Belinda

- Responsibility/feeling responsibility/guilt
- Mood management
- Self-harm: hiding it vs. attention seeking.

Themes to explore:

- Being heard/people not listening/people 'not knowing' when things are not OK.
- Self-injury as punishment – self-injury as other things:- What does self-injury 'do'?
- Experience of pain/no pain issue.
- Self-injury and mental health and ill health.
- Self-injury and emotions.
- Self-injury and the body/ practical issues (where, what with, rituals?)

Craig

- Drinking – how far this was implicated in the self-harm, drinking as a *method* of self-harm. With the people I've spoken to so far, about 50% drank to excess, and 50% don't drink at all, so I think there might be something in this?
- What it was like when you were self-harming – practical aspects e.g. how often, what you used – why and how cigarette burning happened! Only if you feel comfortable discussing it though – just let me know if not!
- Anger seemed to come up a lot, and I wondered whether other emotions ever seem/ed relevant e.g. sadness/anxiety etc. Also, is anger less of a problem now, or do you deal with it better – or both?!

- Pain – not sure what to say on this, but it is a big part of how people talk about self-harm – some people feel it, some people don't, some people like it, some people don't, so it could be useful to try and think about that.

Dinah

Responsibility – Self-blame - Caring
Feeling responsible for other people/things seems to have been a theme that started from a young age. It seems almost like a double edged sword in that on one hand you feel more stable when you are busy, and have people to look after; but on the other hand, it seems people have taken advantage of this in the past – but then you have beaten yourself up for that – continued to feel responsible for a situation. This also seems to relate to the feelings you have had that you were to blame for everything, your good memory about all the things you had done that could have hurt other people. I felt a great sense of your responsibility for other people, which appears to have been both a positive and a negative presence in your life.

Control*/Body-control*
You mentioned a few times the issue of control, and often this related to your body – especially as regards training. We talked about how you have increasingly used training as a way of regulating your moods, especially when you are feeling 'hyper'. In earlier years, you didn't do this so much (?), and drank, often with consequences where you did something 'silly' which you then felt very guilty (responsible?) about. 'Control' comes up in a lot of the existing literature, so it would be interesting to talk more about it.

Thinking too much vs. keeping busy
Body modification/tattooing
The above themes aren't really talked about in the literature, but they have come up in other people's interviews, so it might be useful to talk about these?
Other things:

- Drinking
- Eating
- Other people who do it.
- Explaining scars. Telling partners.
- Pain

Emma

- Drinking, a subject close to my own heart, as you know! This has also cropped up in other peoples interviews and is an issue I'd like to explore further, both as regards health, life etc. and self-harm more specifically.
- Mental health and illness.
- Not talking – this seemed to be a big issue when you were younger, and the theme of *families* not talking is one that's come up a lot.

- Practicalities of self-harm – mundane aspects e.g. how often, how much, where etc.

Milly

- Drinking; especially as you have stopped drinking now!
- Responsibility/feeling responsible/guilt.
- Mood management.
- Self-harm – hiding it vs. attention seeking.

Harriet

- School/Bullying – did parents know? Did anyone know? Teachers/other students etc. If not, why not? If yes, how did they react?
- Tension – how to explain self-harm to younger kids? Why the tension? Don't want to encourage it?
- People not knowing when everything isn't OK. – Related to people not listening?
- What does she think about the hormone/chemical issue – does that describe her experiences? Does it fit? No pain? Perhaps introduce my story here, that I do feel some pain.
- Relationship with parents/dad in particular – perfectionism.
- (what do parents do??)
- Status of self-harm as a mental health problem. Any other diagnoses?
- What self-injury does – talked of relief, punishment – anything else, and how does it relieve? Punish?
- What used to happen at school when she got suspended? Did she actually harm herself? Or did they find out she wanted to? And if so – how did they find out?
- What was the therapy she was in for all those years – try to get a clearer picture of 'help' received and sought.
- Ever been to A&E?
- Practicalities – what, when, where, how often – different stages?
- The first time – remember? Idea came from?

Robert

- Drinking
- Responsibility/feeling responsibility/guilt
- Mood management
- Self-harm: hiding it vs. attention seeking.

Themes to explore:

- Being heard/people not listening/people 'not knowing' when things are not OK.
- Self-injury as punishment – self-injury as other things:- What does self-injury 'do'?
- Experience of pain/no pain issue.
- Self-injury and mental health and ill health.
- Self-injury and emotions.
- Self-injury and the body/ practical issues (where, what with, rituals?)

Mark

Had you heard about SH before you did it?
Themes to explore:

- Being heard/people not listening/people 'not knowing' when things are not OK.
- What does self-injury 'do'?
- Experience of pain/no pain issue.
- Self-injury and mental health and ill health.
- Self-injury and emotions.
- Self-injury and the body/ practical issues (where, what with, rituals?)

Francis

- Times when self-injury happened – review.
- Emotions and feelings about self-injury – at the time and around the time.
- Talking to people about self-injury – friends, family, doctor.
- Self-injury, the body and risk-taking.
- Not having problems/reasons for self-injury.
- Early 'self-injury'?
- Control?
- Parents.

Justin

From interview:

- Drinking/working – addiction?
- Parents
- Social aspects re. schooling -> later life/relationships/
- 'emotional stuff'

Themes to explore:

- Communication.
- What does self-injury 'do'?
- Experience of pain/no pain issue.
- Self-injury and mental health and ill health.
- Self-injury and emotions.

- Self-injury and the body/ practical issues (where, what with, rituals?)
- Self-injury and other people.

Appendix F

(1)	**/Body**
(1 1)	**/Body/Pain**
(1 1 1)	**/Body/Pain/**Emotional pain into physical pain
(1 1 2)	**/Body/Pain/**Medical model of pain
(1 1 3)	**/Body/Pain/**Pain and tattooing
(1 1 4)	**/Body/Pain/**Pain as distraction
(1 1 5)	**/Body/Pain/**Gender & Pain
(1 2)	**/Body/Self-injury**
(1 2 1)	**/Body/Self-injury/**Practice
(1 2 2)	**/Body/Self-injury/**Comparison to non-self-injury
(1 2 3)	**/Body/Self-injury/**Changes over time
(1 2 4)	**/Body/Self-injury/**Physical sensations
(1 2 5)	**/Body/Self-injury/**The wound/injury
(1 3)	**/Body/Hiding/**revealing
(1 4)	**/Body/Healing**
(1 5)	**/Body/Scars**
(1 5 1)	**/Body/Scars/**Attitudes towards
(1 5 2)	**/Body/Scars/**Reduction/minimisation/concealment
(1 6)	**/Body/Body image**
(1 7)	**/Body/Exercise**
(1 8)	**/Body/Sleep**
(1 9)	**/Body/Drugs**
(1 9 1)	**/Body/Drugs/**Alcohol
(1 9 2)	**/Body/Drugs/**Medication
(1 10)	**/Body/Bio-medical**
(2)	**/Emotion**
(2 1)	**/Emotion/Emotional Expression**
(2 2)	**/Emotion/Invalidation of emotion/feeling**
(2 3)	**/Emotion/Emotions and Control**
(2 4)	**/Emotion/SI as response to emotion**
(2 5)	**/Emotion/Emotional authenticity**
(2 6)	**/Emotion/Release**
(2 7)	**/Emotion/Relief**
(2 8)	**/Emotion/Impulsivity**
(2 9)	**/Emotion/Feel something**
(3)	**/Communication**
(3 1)	**/Communication/Help-Seeking**
(3 2)	**/Communication/Attention seeking**
(3 3)	**/Communication/Communicating about SI**
(3 4)	**/Communication/Family**
(3 5)	**/Communication/Other people who SI**
(3 6)	**/Communication/Problems with communication.**