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The reasons and emotional processes of people who self harm: An exploratory study

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He who does not accept and respect those who want to reject life does not truly accept and respect life itself.

Thomas Szasz, (1920-)

There is but one truly serious philosophical problem and that is suicide. Judging whether life is or is not worth living amounts to answering the fundamental question of philosophy.

Albert Camus, Philosopher (1913-1960)

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A bird does not sing because it has an answer. It sings because it has a song.
Chinese Proverb

To the participants who allowed me to witness their stories; it was a privilege to meet with you.

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ABSTRACT

People who harm themselves present a number of clinical challenges for staff in managing the risks associated with their behaviours, providing appropriate interventions and preventing repetition.

This research explored the reasons individuals have and the changes in emotions they experience, when they self-harm and attend hospital for treatment. It investigated the role of emotional regulation and experiential avoidance. The research included people who had self-poisoned or engaged in both self-poisoning and self-injury.

Study 1 involved ten out-patients from a Self-Harm Service who took part in a semi-structured interview. Using Interpretative Phenomenological Analysis, twelve themes emerged from the data which were grouped into four super-ordinate themes. These highlighted the difficulty participants had in experiencing and regulating their emotions and the use of self-harm as a strategy to avoid or regulate their emotions. They emphasised the important role of interpersonal, and not just, intrapersonal reasons for self-harm. The final super-ordinate theme explored the experience of becoming a self-harmer and the struggle with publicly acknowledging and accepting self-harm.

Study 2 collected questionnaire data from 60 participants who attended hospital following self-harm. The results suggested that following self-poisoning, participants experienced a decrease in their emotions (particularly negative emotions e.g. anger at other people). Although positive emotions increased, shame also significantly increased. The results also suggested that people who had self-poisoned and self-injured, significantly differed from those who had only ever self-poisoned showing higher emotional dysregulation and experiential avoidance.

The clinical implications for assessing self-harm and developing interventions for emotional regulation difficulties are discussed.

CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1 INTRODUCTION

We shall not cease from exploration and the end of all our exploring will be to arrive where we started... and know the place for the first time.

T. S. Eliot, Poet (1888-1965)

1. Overview

Self-harm is a term which encompasses a wide variety of behaviours, such as self-poisoning and self-injury. Reducing repetitive self-harm is a clinical necessity given the number of people involved and the risks of subsequent self-harm, including suicide (Hawton et al., 2004b). Unfortunately, the underlying emotional processes and functions of self-harm are poorly understood (Gratz, 2003). This study aims to explore the reasons why people choose to harm themselves and the emotional processes associated with using different methods of self-harm.

This chapter initially considers the challenges which self-harm presents in terms of both the risks and the difficulties of managing people who self-harm. The subsequent sections explore the complexity of classifying and measuring the prevalence of self-harm. The different theoretical approaches to understanding self-harm are then examined before the evidence for differing intentions and functions is considered. The role of emotions and emotional regulation, and the application of research into experiential avoidance in self-harm are then explored. Finally, the rationale for the study and consideration of epistemological issues is presented.

2. The challenge of self-harm

"...The emotional pain was so overpowering I just couldn't stop myself from self-harming. I took tablets, alcohol and cut both my wrists. I was found and taken to

hospital. I was put on a psychiatric unit where I found doctors were very unsympathetic and not very understanding of why I was self-harming. They told me I was wasting their time..." (Harris, 2000, p.166).

As this quote illustrates, people who deliberately harm themselves present a significant clinical challenge to the National Health Service, both because of the risks they present to themselves and the difficulties staff have with working with this client group.

Self-harm is a risk factor for completed suicide (Sampson et al., 2004). Between 0.5% and 1% of people who attend hospital with an incident of self-harm will complete suicide in the following year, which is between 50 to 100 times greater than the suicide rate for the general population (Owens, Horrocks & House, 2002). Of those who attend hospital, one in six will have a further episode of self-harm in the following year (Owens et al., 2002). On average, a person dies as a result of suicide every two hours in England. It is the commonest cause of death in men under 35 and is the main cause of premature death in people with mental illness (Department of Health, 2002).

The National Institute of Clinical Excellence (NICE) commissioned guidelines to manage the short-term physical and psychological issues and prevent further self-harm. These state that "the experience of care for people who self-harm is often unacceptable" (National Collaborating Centre for Mental Health, 2004, p. 50). Unfortunately, staff attitudes towards people who self-harm are frequently poor and are often based on opinions that self-harm is a 'manipulative act' (Jeffery & Warm,

2002). Reports of poor treatment in Accident and Emergency departments include withholding anaesthetic when repairing injuries and not reinforcing behaviour by showing emotion or giving care (Jeffery & Warm, 2002; Mackay & Barrowclough, 2005; Smith, 2002). In particular, self-injurers are often seen as 'attention seekers' by medical staff (Smith, 2002). Although it has been suggested by a number of authors that self-injury may be protective against further suicide attempts (Babiker & Arnold, 1997), or as Yates (2004) suggests a "compromise that prevents or delays suicide" (p.38), there is no evidence to support the view that those people who are actively self-injuring are less likely to commit suicide (National Collaborating Centre for Mental Health, 2004).

It has been demonstrated that staff who perceive themselves as skilled in working with self-harming clients have more positive attitudes towards self-harm (Anderson, Standen & Noon, 2003; McAllister, Creedy, Moyle & Farrugia, 2002). Hawton (2001) points out that, clinically, self-harm patients are very challenging. They are often poorly motivated to engage in therapy and the reasons underlying their self-harm are frequently unclear, which presents a difficulty for psychological intervention.

However, poor staff attitudes are not simply the result of a skill deficit which can be resolved by further training. There is a lack of evidence to indicate what the most effective forms of treatment for people who harm themselves are. A number of interventions have been evaluated, including Brief Solution-Focused Therapy (problem-solving), (Milnes, Owens & Blenkiron, 2002), conventional psychiatric care (risk assessment/management approach), crisis cards (Evans, Morgan, Hayward &

Gunnell, 1999), drug treatment (Hawton et al., 1998) and intensive psychological therapy such as Dialectical Behavioural Therapy (DBT) (Linehan, 1993). However, very few treatments have led to clinically significant reductions in repetition (Hawton, 2001; Kapur, 2005; Sharkey, 2003). Even the results from a large multi-centre randomised controlled study using manual assisted cognitive behaviour therapy (MACT), were disappointing (Tyrer et al., 2004). No significant differences in repetition of self harm were found between the MACT group and the treatment as usual (TAU) controls.

Given this lack of success, it is not surprising that the need for further research has been highlighted. The NICE guidelines (National Collaborating Centre for Mental Health, 2004) suggest research is required to help clinicians gain a better understanding of self-harm and of the comparability of different methods such as self-injury and self-poisoning. The National Inquiry into Self-Harm Among Young People (Mental Health Foundation, 2006) focused on people aged between 11 and 25, and found relatively little research into the reasons why young people self-harm. They highlight the need for a number of studies, including a qualitative exploration of different forms of self-harm behaviour in order to develop the understanding of the feelings and meanings that motivate and arise from self-harm.

3. The classification of self-harm

One of the initial difficulties in accurately defining self-harm is the quantity of terminology being used to describe the behaviour. Multiple terms have been applied, including *self-harm, self-injury, deliberate self-harm, self-destructive behaviour, self-mutilation, self-poisoning, self-inflicted injury* (Webb, 2002), *focal suicide, attempted*

suicide, suicidation, suicidal gestures, parasuicide (Yates, 2004), *self-inflicted violence, non-fatal suicidal behaviour* and *intentional self-harm* (National Collaborating Centre for Mental Health, 2004). The World Health Organisation multicentre study defines parasuicide as:

> an act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes which the subject desired via the actual or expected physical consequences (World Health Organisation, 1986).

The NICE guideline adopts a more succinct, though broader, definition of self-harm as "self-poisoning or self-injury, irrespective of apparent purpose of act" (National Collaborating Centre for Mental Health, 2004, p.16). They suggest that most self-harm can be divided into either self-poisoning or self-injury. Using this definition, methods such as burning, hanging, shooting and jumping from heights or in front of vehicles could be considered as self-injury. This significantly differs from other definitions of self-injury, which exclude any acts with suicidal intent (see below section 3.3 below).

Even within the academic literature, there is some confusion of terminology. In the American literature, *deliberate self-harm* generally refers to self-injury excluding self-poisoning; whilst *self-harm* in the United Kingdom includes both behaviours (Kapur, 2005; Kapur & Cooper, 2005). The standard prefix of *deliberate* or *intentional*, which is still applied within the American literature, has been removed in the UK in

response to service user objections, particularly from those who self-harm during a dissociative state (Kapur & Cooper, 2005; National Collaborating Centre for Mental Health, 2004; Sutton, 2005). Within this thesis, the definition of self-harm adopts the definition of the NICE guidelines: "self-poisoning or self-injury, irrespective of apparent purpose of act" (National Collaborating Centre for Mental Health, 2004, p.16) which includes both self-poisoning and self-injury behaviours regardless of suicidal intent.

3.1 What is defined as self-harm?

The complexity of classifying self-harm is not just an issue of terminology; there are also difficulties in defining which behaviours can be classed as harmful. Historically, self-harm and suicide behaviours have been viewed very differently at different times. *Mors vountaris* in early Roman culture was occasionally recommended to people and considered acceptable. However by the Middle Ages those who harmed themselves were put on trial for committing a criminal act (De Leo et al., 2006). These cultural differences remain: in Japanese culture, self-harm in response to shame is still commonly accepted (Stack, 1996).

Within western society, certain self-harm behaviours can be culturally acceptable (e.g. smoking, alcohol consumption and overeating). They can also occur as part of religious practice or social protest (e.g. self-flagellation or hunger strike) (Babiker & Arnold, 1997; National Collaborating Centre for Mental Health, 2004). Favazza (1996) makes the distinction between ritualised self-harm (e.g. piercing, tattooing and branding) and pathological self-harm. It has been suggested that some self-harm behaviours may have a protective function. In a study of people with an eating

disorder, Claes, Vandereycken, and Vertommen (2005) found that piercing and tattooing seemed to be motivated by self-care rather than by self-harm. They suggested this self-care served the opposite function to self-harm. Interestingly, 65% of this sample also engaged in self-injury, which is not unsurprising given that the behaviours associated with eating disorders could also be defined as self-harm. As Sutton (2005) points out, eating distress, drug misuse, extreme risk taking, gambling, getting into debt, overworking and staying in an abusive relationship could all be included as self-harm behaviours. However, generally these behaviours are excluded from the current classification of self-harm (National Collaborating Centre for Mental Health, 2004).

3.2 Is self-harm a mental illness? –The Mental Health Act

Despite the fact that some self-harm behaviours can be culturally acceptable, high rates of psychiatric morbidity have also been found in this population (Haw, Hawton & Houston, 2001). Under the Mental Health Act, a person who poses a risk to his or her own health and safety can be admitted to hospital on a voluntary basis, if they agree, or involuntarily under the Mental Health Act (1983). Three conditions must be fulfilled for admission and treatment under the Act: it must be believed that the person suffers from a mental disorder; that they pose a risk to the health and safety of themselves or others; and that alternative methods of treatment are inappropriate (Burgess & Hawton, 1998). Generally, in relation to self-harm, the Mental Health Act is used with the intention to prevent suicide. However, as Burgess and Hawton (1998) point out, this area is contentious:

> If all suicides were unambiguously the result of treatable mental illness, there would be no problem here. Suicidal wishes could be considered as merely

another symptom of mental illness and reversed, to the relief of all, by the institution of a simple treatment. However, whether all those who consider committing suicide are indeed mentally ill is questionable, and mental illness is often not clearly distinguishable from 'normal' distress (p116).

Under the Mental Health Act, mental disorder is defined as "mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind" (Department of Health, 1983, section 1). Mental illness is not defined specifically within the Act; the bounds of the definition of the concept of "mental illness" is a complex ground (Warnock, 1988). It is not clear whether undertaking an act of self-harm in itself can be accepted as evidence of mental illness. Burgess and Hawton (1998) argue that suicide is not a defined mental illness and that suicidal ideation does not necessarily arise directly from the effects of a treatable mental illness (e.g. depression). However, as Warnock (1988) points out, it leaves psychiatrists in the unenviable position of either saying "You're sick, so I don't believe you want to die. I will try to cure you," or, "There's nothing wrong with you. You're just unhappy. Go put your head in a gas oven" (Warnock, 1988, p.128).

Barr, Leitner & Thomas (2004) found that 36.3% of people who harmed themselves and presented at hospital were not deemed to have a mental illness. This significantly impacted on the standard of care they received; they were significantly less likely to be admitted to an inpatient bed of any sort (psychiatric, surgical, medical or short-stay observational beds) or to receive referral for community support on discharge from hospital. The lack of a diagnosable mental illness may also partially explain the poor

staff attitudes towards this client group, with the implicit message being "there is nothing wrong with you".

Self-harm is not, in itself, classified as a mental illness within the diagnostic classification systems. However, self-harm is often observed as a secondary symptom to other diagnoses of mental illness, such as depression, eating disorders, post traumatic stress disorder (PTSD) and borderline personality disorder (BPD) (Haw et al., 2001; Haw, Houston, Townsend & Hawton, 2002; Sampson et al., 2004) and appears to be associated with emotional distress (Chapman, Gratz & Brown, 2006). However, as self-harm is part of the diagnostic criteria for BPD, this in itself may exaggerate the observed relationship (Yates, 2004). Although research has investigated self-harm within the context of BPD, self-harm occurs across non-psychotic, cognitively normal, adult populations and is not limited to people with a personality disorder (Chapman et al., 2006).

3.3 Self-injury

Definitions of self-injury are also problematic; over 33 separate terms have been used to describe the behaviour (Muehlenkamp, 2005). Self-injury has been classified in a number of different ways (Yates, 2004). The Behavioural-Descriptive approach contrasts *direct* methods (cutting, biting, burning, hitting, constricting etc.) with *indirect* methods (overeating, substance abuse, refusing medical treatment etc.) (Ross & McKay, 1979). The definition of *indirect* methods includes behaviours which are usually excluded from definitions of self-harm. Pattison and Kahan (1983) use a dimensional approach to measure the *directness, lethality* and *repetitive* nature of the

act. An alternative approach divides self-injury into categories: *Stereotypical*, *Major*, *Compulsive* and *Impulsive* (Simeon & Favazza, 2001).

Recent definitions of self-injury have excluded 'suicidal intent to die' from their criteria and it has been argued that repetitive self injury should be defined as a clinical syndrome distinct from suicidal behaviour and borderline personality disorder (Muehlenkamp, 2005; Muehlenkamp & Gutierrez, 2004). Muehlenkamp (2005) argues that there is a case for adopting 'Repetitive Self-Harm Syndrome' (Favazza & Rosenthal, 1993) within the next version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association. Favazza & Rosenthal (1993) suggest defining self-harm as an Axis I impulse-control syndrome (similar to OCD), not an Axis II personality disorder. For the case to be made, self-injury (without intent to die) would need to have a clear symptom pattern and presentation of biological and other features (age, onset, course and precipitants) to differentiate it from other types of self-harming behaviour (Muehlenkamp, 2005). However, as Horrocks, Price, House, & Owens (2003) point out, there is a significant level of overlap between people who self-poison and self-injure and, in fact, many people engage in both behaviours.

4. Prevalence

Given the difficulties in classifying self-harm, it is unsurprising that there is some variation in prevalence estimates. The National Inquiry into Self-Harm among Young People (Mental Health Foundation, 2006) found that self-harm affects at least 1 in 15 young people between 11 and 25. Some of the evidence suggests that rates of self-harm in the UK are higher than anywhere else in Europe at 400 per 100,000

population (Horrocks, 2002). There have been parallel increases in completed suicide in men and self-harm in women over the last 20 years (Hawton, Rodham, Evans & Wetherall, 2002; Kerkhof, 2000; Webb, 2002) which is likely to be due to the lethality of the chosen method. In relation to hospital attendances, self-poisoning is far more frequent than self-injury. Of admissions to hospital between 1985 and 1997 in the UK, 87.4% were due to self-poisoning, 8.9% were due to self-injury, and 3.7% were both self-poisoning and self-injury. There is some evidence that the degree of suicidal intent may also influence the choice of method (e.g. self-poisoning with gas is associated with high suicidal intent) (Townsend et al., 2001). However, rates recorded from only those who attend hospital are an underestimate of the prevalence of self-harm as many people may not seek or require treatment.

A national interview survey suggested that 4.6% to 6.6% of people in the UK have self-harmed (Meltzer et al., 2002) and 4% of a general population sample and 21% of a clinical sample report self-injury (Briere and Gil, 1998). However, this may be an underestimate as Hawton et al. (2002) found rates of 13% for any episode of self-harm and 7% in the previous 12 months in a survey of 15 and 16 year olds. Lifetime prevalence of impulsive self-injury is 10% to 15% and 5% to 10% engage in repeated episodes (Yates, 2004). The incidence rates are comparable to incidences of schizophrenia and bi-polar disorder (Jeffery & Warm, 2002). Rates vary depending on whether they are inclusive of self-poisoning, hanging or gunshot injuries or exclusive (e.g. self-injury only) (Yates, 2004). For example, if the definition of self-injury specifically includes self-battery (hitting self) then one study found rates of 14% for women and 33% for men (Nada-Raja et al., 2004).

The typical onset of self-harm is in adolescence (as high as 40-60% in clinical adolescent populations) and it diminishes in middle adulthood (Yates, 2004). Self-harm is more likely to affect women, with girls being up to three times more likely to self-harm in adolescence (Hawton et al, 2002).

5. The measurement of self-harm behaviours

Given the difficulties in classifying self-harm, it is not surprising that the definitions of self-harm in research studies are also inconsistent: some specifically exclude self-injury and restrict the samples to self-poisoning, whilst in others no clear differentiation is made. Some self-harming behaviours (e.g. reckless behaviour, alcohol, drugs) are usually excluded. However, as many acts of deliberate self-harm occur under the influence of alcohol or drugs, this frequently remains an extraneous variable.

Researchers often ask participants to state whether they have previously harmed themselves without defining what is meant by self-harm. This approach uses a dichotomous response which is clearly impacted by the participants own conceptualisation of self-harm (Gratz, 2001). This concern has led to the development of behaviourally based measures of self-harm.

Interestingly, the development of these self-report measures has also mirrored the difficulties in defining self-harm behaviours. The Self-Harm Inventory (SHI) (Sansone & Wiederman, 1998) was developed as a scale for identifying self-destructive behaviours and borderline personality disorder. Although it includes both self-injury and self-poisoning, it also includes behaviours such as starvation, laxative

and alcohol abuse, reckless driving and promiscuity which broadens the definition of self-harm. The Self-Harm Behavior Questionnaire (SHBQ) (Gutierrez, Osman, Barrios & Kopper, 2001) was designed to assess a full range of non-lethal self-harm and suicide-related behaviours. However, it only includes a single open ended item asking about intentional self-harm that the individual did not identify as suicidal and also includes a section on suicidal ideation, which is not specifically related to previous behaviour. In contrast, the Deliberate Self-Harm Inventory (DSHI) (Gratz, 2001) is a behaviourally-based measure which only includes self injurious behaviours, with no suicidal intent.

Flege et al. (2006) compared the use of the SHBQ with the DSHI and found a satisfactory concordance between the measures. However, the DSHI shows a higher sensitivity, which they suggest is due to the under-reporting of specific self-harm behaviours unless prompted (Zlotnick et al., 1996). They conclude that the DSHI may be the preferred measure when researching different forms of self-harm behaviour (Fliege et al., 2006). Although the DSHI does not include items relating to self-poisoning or self-injury, it does include an open-ended item to allow the participant to nominate further behaviours

Overall, this area is beset with difficulties, both in classifying and measuring self-harm. While a consensus is needed, at this time the research literature appears divided, particularly in relation to the classification of self-injury. Unfortunately, these difficulties remain present as the backdrop to attempts to explain and understand self-harm.

6. Theoretical explanations of self-harm

Self-harming behaviour has been considered from a number of different theoretical perspectives. Psychodynamic theorists have conceptualised various motivational explanations. Freud (1925) understood self-harm as resulting from the conflict between wanting to destroy an introjected loved-and-hated object and the guilt of this wish. Similarly, Jung (1957) recognised the importance of the tension of the internal conflict but also viewed self harm as one alternative path following on from a number of linked decisions. Each decision is made depending on thresholds of tension and affect of the individual.

Self-harm has been viewed interpersonally as a purposive strategy by Adler (1958) to impact other people; the person believes that they will gain by the effect on significant others, even if this results in their own death. A behavioural perspective suggests that a person may harm themselves (aversive action) if, by doing so, they avoid more aversive consequences (Skinner, 1953).

Researchers have presented a number of models of self-harm behaviour. The psychobiological stress–diathesis model views suicidal behaviour as an interaction between acute life events, genetic factors, childhood negative experiences and biological factors. Increasing evidence for a biological component implicates dysfunctions in both the hypothalamic-pituitary-adrenal (HPA) axis and the serotonergic systems in self-harm (Träskman-Bendz & Westrin, 2001). Dysfunctions in the serotonergic system are associated with dysregulation of both anxiety and aggression. Increases in stress leading to greater cortisol production can further increase these serotonergic disturbances, which can be viewed as biological risk

factors for self-harm (van Praag, 2001). Research focusing on self-injury has also identified the endogenous opioid system in the aetiology and maintenance of self-injury (Symons, 2002, cited in Yates, 2004).

Those theorists who support the differentiation of self-injury from other self-harm have proposed specific self-injury explanatory models. Yates' (2004) developmental psychopathology framework brings together psychoanalytic, neo-analytic, biological and behavioural paradigms. It focuses only on repetitive self-injury and proposes that self-injury is seen as a compensatory regulatory strategy in post-traumatic adaptation. A number of other models of self-injury also focus on self regulation. The 'affect regulation model' suggests that self-injury regulates overwhelming emotions. Similarly, the 'dissociation model' suggests that regulation of emotions occurs by an interaction with dissociative behaviour, while the 'boundaries model' proposes that self-injury re-affirm the boundaries of the 'self' (Chapman et al., 2006). In a similar line to the regulation models of self-injury, 'escape models' of suicidal behaviour explain suicide as a permanent escape from problems in life; suicide will bring final relief from their painful emotions (Baumeister, 1990; Brown, 2006).

Models of suicidal behaviour include the 'suicide pyramid', with different layers describing non-fatal and fatal self-harm. The 'suicidal career' is a concept used to explain the way individuals follow a pathway through the layers of the pyramid. However, a limitation of this approach is that it presumes a stepwise progression of self-harming behaviours towards suicide (van Heeringen, 2001). In the 'suicidal process' model, self-harm behaviours are also accompanied by an increasing desire to end life. However, the development of suicidality involves an interaction between the

individual and their environment, a process which is unlikely to be linear (Neeleman, de Graaf & Vollebergh, 2004). These models include all modes of self destructive behaviour, whether or not death is intended (van Heeringen, 2001), which suggests a link between different types of self-harm.

Owens et al. (2002) found a strong link between self-harm and suicide. Subsequent suicide occurs in 1 in 200 to 1 in 40 self-harm patients in the first year of follow-up and in approximately 1 in 15 people after 9 or more years. Fliege et al. (2006) also found a high co-morbidity between self-harm behaviour and suicide attempts. However, despite the strong association between self-harm and suicide (Cooper et al., 2005), many authors do not view them synonymously (Sutton, 2005). Stengel (1962) makes a distinction between those people who 'attempt' and those who 'complete' suicide, suggesting that these are different populations. Aldridge (1998) argues that this separation of populations is an "artefact of the research methodology" (p. 13) as the populations are not static – as researchers we are missing the dynamic process of "becoming suicidal" (p. 13). Given this, Fliege et al. (2006) questioned whether a theoretical distinction between self-harm and suicidal behaviours can be upheld and on what clinical or empirical criteria this could be based.

7. Self-harm: intentions, motives and functions

A key theoretical issue appears to be whether self-harm can be conceptualised as a single entity or as a continuum of behaviours or whether different types of self-harm (e.g. self-poisoning, self-injury without suicidal intent) should be considered separately. The self-injury literature, in arguing that self-injury occurs without conscious suicidal intent, suggests that it is functioning as a process not to end life,

but to end either emotional overload or dissociation (Chapman et al., 2006; Gratz, 2003; Sutton, 2004, 2005). Gratz (2003) contrasts the function of a suicide attempt (to end life) with self-injury (to regulate emotions). However, for this distinction to be made there must be clarity about the level of suicidal intent a person reports.

7.1 Suicidal intent

The major aspect of distinguishing between suicide and self-harm has been the severity of suicidal intent. Maris, Berman, and Silverman (2000) defined intent as "the purpose a person has in using a particular means (e.g., suicide) to effect a result" (p.37).

This raises an interesting question of whether it is possible to accurately measure suicidal intent involved with self-harm behaviour. Unlike completed suicide, which ends in death, there are countless outcomes and levels of intent associated with non-fatal self-harm (Andriessen, 2006). Suicidal intent may be completely unrelated to the outcome of the act (De Leo et al., 2006). The relationship between the strength of an individual's intention to die and the nature and seriousness (lethality) of self-harm is ambiguous. Plutchik, van Praag, Picard, Conte & Korn (1989) found that the lethality (method used, degree of damage, degree of reversibility of effects, type of treatment required) was not related to the level of suicidal intent reported by the individual.

Self-reported intent may also differ from that rated by a clinician. For example Bancroft et al., (1979) found that, while 56% participants in their interview study reported suicidal intent, only 29% were judged to be suicidal by psychiatrists. However, when Varadaraj, Mendonca, and Rauchenberg (1986) compared the

perceptions of patients with those of key relatives or friends, as regards motives for self-poisoning and intent to die, they found a strong association. This is the opposite finding to that of James and Hawton (1985) who reported no agreement between patients and their families as to the presence of suicidal intent. Self-reported intent is often difficult to ascertain given that intent may change after self-harm, and people may be ambivalent about their intent to die or be unwilling to disclose their suicidal intention for fear of further consequences (Fliege et al., 2006).

7.2 Motivations for self-harm

Maris et al. (2000) define motive as "the cause or reason that moves the will and induces action," (p.37). Andriessen (2006) argues that motives and intentions are not synonymous; intentions are related to what the person wants to achieve (outcome) while motives are related to the reasons for the desired outcome (Hjelmeland & Knizek, 1999). However, when asked the reason for self-harm, the common response of 'I wanted to die' demonstrates the practical difficulty of separating motive from intention. Researchers have used approaches (interviews or checklists) which generally combine asking participants for both their reasons and intentions (Andriessen, 2006).

Studies have found that the reasons people give for self-poisoning vary. Bancroft, Skrimshire, and Simkin (1976) studied the reasons 128 self-poisoners gave for taking an overdose: 44% indicated that they had wanted to die; 33% were 'seeking help'; 42% 'escaping from the situation'; 52% 'obtaining relief from a terrible state of mind'; and 19% 'trying to influence someone'.

Schnyder, Valach, Bichsel and Michel (1999) compared patients', doctors' and nurses' attributions of the patients' reasons for attempting suicide by asking them to choose from 14 possible reasons. Intrapersonal reasons, such as to get relief from a terrible state of mind or from an unbearable situation, were most frequently chosen by patients, nurses and doctors alike. However, patients chose "loss of control" more often than the nurses and doctors did.

Brown, Comtois, and Linehan, (2002) compared the self-reported reasons for suicide attempts and nonsuicidal self-injury in a sample of women with BPD. They found that, although reasons for suicide attempts differed from reasons for nonsuicidal self-injury, almost all participants reported that both types of behaviours were intended to relieve negative emotions. This contradicted the view that individuals are simply either trying to die (or relieve emotional pain) or manipulate others; the reasons often overlap. They concluded that suicide attempts and nonsuicidal self-injury apparently involve similar and multiple motives.

Rodham, Hawton and Evans (2004) compared adolescent self-poisoners and self-injurers in a community sample. While more adolescents who took overdoses said that they had wanted to die (66.7%), a sizeable number of self-injurers also expressed suicidal intent (40.2%). More self-injurers (50.9 %) were impulsive (thought about the act of self-harm for less than an hour), although a subgroup of self-poisoners were also impulsive (36.1%). Neither study measured the strength of intention, which is a notable limitation. Nevertheless, the results suggest that the differences between self-injurers and self-poisoners may be less clear-cut than suggested by Gratz (2003). In fact, many self-poisoners who have a history of self-injury often underestimate the

lethality of their poisoning behaviour (Stanley, Gameroff, Michalsen & Mann, 2001). This is further supported by Nock and Kessler (2006) who found that those people who self-injure and express intent to die differ from self-injurers without such intent and have risk factors that resemble those at high risk for completed suicide even though they are engaging in a low lethality method. This also confirms the view that self-injury is not necessarily protective against suicide. Those who choose self-injury do not appear to be a homogenous population; a significant number of self-injurers report suicidal intentions. Conversely, self-poisoning is not indicative of a 'suicide attempt'; a significant number of self-poisoners report not intending to die.

7.3 Functions of self-harm

It is also important to make a distinction between intentions (or intended outcomes) and the function of self-harm behaviour. These also are not synonymous terms. A person may intend one outcome from harming themselves but the behaviour may function in a different way. For example, self-harm may function to influence other people, although this may not have been the original intention when the act took place (Linehan, 1993). Researchers have investigated the possible functions of self-harm by studying the reasons (and invariably the intentions) that people give.

It is not clear whether the functions of self-poisoning and self-injury are the same (Webb, 2002). While the function of self-injury (non-suicidal intent) has been considered in the literature, the function of self-poisoning has not been given the same attention, possibly as those authors who support a separate classification for self-injury presume that self-poisoning is synonymous with a suicide attempt which has the function of ending life.

Briere and Gil (1998) investigated the function of self-injury by asking self-injurers to indicate why they engaged in self-injury from a list of possible reasons. They identified nine different functions: to decrease dissociative symptoms, especially depersonalization and numbing; to reduce stress and tension; to block upsetting memories and flashbacks; to demonstrate a need for help; to ensure safety and self-protection; to express and release distress; to reduce anger; to disfigure self as punishment; and to hurt self in lieu of others. Although these results are important, the items did not measure the strength of the reasons, which limits the conclusions which can be drawn. Gratz (2003) criticised the study for using close-ended statements, although, interestingly, her own qualitative interview study found comparable results.

Gratz (2003) reviewed the clinical literature and concluded that a consistent number of functions for self-injury were being identified: to relieve anxiety; to release anger; to relieve unpleasant thoughts and feelings; to release tension; to relieve feelings of guilt, loneliness, alienation, self-hatred and depression; to externalise and concretize emotional pain; to provide an escape from emotional pain; to provide a sense of security; to provide a sense of control; to self-punish; to set boundaries with others; to terminate depersonalisation and derealisation; to end flashbacks; and to stop racing thoughts. She noted that the number of different ways in which self-harm may function for any individual had not been investigated, although it is likely to have multiple functions (Gratz, 2003).

The links between the suggested functions of self-injury and the theoretical explanations of self-injury have been considered by Klonsky (2007) in a review of 18

studies found overall support for an affect-regulation function, strong support for a self-punishment function and modest evidence for functions relating to anti-dissociation, anti-suicide, sensation seeking and interpersonal boundaries. Klonsky argues that there is limited evidence that self-injury serves an interpersonal function. Interestingly, in her qualitative interview study of young people, Spandler (1996) also argued that there was no evidence for an interpersonal function and highlighted the intrapersonal function. The research used a participatory approach which may have influenced the reflexivity of the researcher as she appeared to be focused on showing that self-harm was not a manipulative or attention-seeking behaviour. Methodologically this study is also limited by lack of a framework for the data analysis. Alternatively, Nock and Prinstein (2004) suggested that self-injury is performed because of the automatically reinforcing (i.e. reinforced by oneself; e.g emotional regulation functions) and/or socially reinforcing (i.e. reinforced by others; e.g., attention, avoidance/escape function). In their two studies of adolescent self-injurers they found that, although most adolescents engaged in self-injury for automatic reinforcement, a significant number endorsed social reinforcement functions as well (Nock & Prinstein, 2004; Nock & Prinstein, 2005). It is possible that the wish to separate self-injury from manipulative or attention-seeking behaviour has led to research which primarily focuses on the intrapersonal functions, and overlooks the interpersonal functions of self-injury.

In general it is difficult to draw conclusions, as the research into the reasons, intentions or functions of self-harm is limited by inconsistencies in the definition of self-harm used in studies (Claes & Vandereycken, 2007). Studies are also limited by only looking at the index incident (i.e. a person may be classified as a self-poisoner

from their last episode and, although they may have a previous history of self-injury, this is not further explored). However, there is a growing consensus in the literature that self-harm (and particularly self-injury) functions to change emotions.

8. Emotions

Parkinson, Totterdell, Briner and Reynolds (1996) distinguish emotion from mood in terms of duration (emotions are relatively brief experiences), time-pattern (emotions are acute with a definite beginning and end), relative intensity (emotions are stronger in intensity), specificity of cause (caused by a specific event) and directedness (emotions are directed at a specific object).

A number of different emotions have been reported prior to an episode of self harm. Schnyder et al. (1999) asked patients to recall, retrospectively, the presence of specific emotions from a list. Over half of the participants recalled the presence of anxiety/panic, despair and emptiness (mental vacuum). This differed from the responses of nurses and doctors who attributed powerlessness/hopelessness and despair to be the most prevalent emotions for the patients. The number or type of emotions present for any individual was not investigated and there was no consideration of changes in emotion.

Briere and Gil (1998) presented self-injurers with a list of emotions which the researchers had compiled. Participants were asked to retrospectively identify which emotions had been present before and after their last episode of self-injury. They found that post self-injury there was a significant reduction in the number of people reporting *anger at self, anger at others*, *loneliness* and *sadness*. Following self-injury,

there was also significant increases in the number of people reporting *relief* and *shame*. As with the items relating to function, the researchers only measured whether the emotion was present and not the intensity of the emotions, which limits the statistical analysis and understanding of specific emotional changes. Nevertheless, the increase in shame is worthy of note as shame has been found to have a specific role in relation to depression (Andrews, Qian & Valentine, 2002; Cheung, Gilbert & Irons, 2004) suicidal ideation (Lester, 1998) and indirect self-harm (e.g. eating disorders), but not direct self-injury. However, the presence of shame has been found to predict the presence of dissociation (Irwin, 1998), which may then be involved in precipitating further self-harm.

Narrative accounts of suicide attempts often describe a dissociative state prior to the act (Harris, 2000) and the dissociation-pain-analgesia-suicide hypothesis states that intolerable life events can lead to dissociation, analgesia and self-harm (Michel and Valach, 2001). Dissociation has also been identified as present prior to self-injury (Gratz, 2003; Yates, 2004). Vunerability to dissociation may be due to negative childhood experiences. Indeed, some evidence links childhood sexual abuse, physical abuse, neglect, childhood loss/separation, security of attachment to caregivers, emotional reactivity and intensity to self-harm (Gratz, 2003; Sansone, Gaither & Barclay, 2002). It has been hypothesised that dissociation is a mediating factor between negative early experiences and self-harm (Yates, 2004) and a pilot study found a strong association between high levels of dissociation and increased frequency of self-harm. Dissociation was also shown to mediate the relationship between childhood sexual abuse and self-harm (Low et al., 2000).

Michel and Valach (2001) suggest that dissociation and self harm, if used to regulate emotions, can become a pattern of coping which is positively reinforced and thus is likely to be repeated in further unbearable situations. This may explain why the repetition rate of self-harm is high. The research exploring emotions in self-harm points to an important role for emotional regulation.

9. Emotional regulation

Emotional regulation refers to how people influence the emotions they have, when they have them and how they express these emotions (Richards & Gross, 2000). Traditionally, emotional regulation has been viewed as the second part of a two factor process involving, firstly, the generation of emotions and, secondly, a separate process which regulates or controls these emotions (Campos, Frankle & Camras, 1994; Gross, 1999). Emotion regulation is then conceptualized as the control of emotional experience and expression and the reduction of emotional arousal (particularly of negative emotions) (Gratz & Roemer, 2004). However, some theorists have argued that the two factor process is a false dichotomy and that emotion-generative processes and emotion-regulation are the same process; emotion does not exist in an unregulated form (Campos et al., 1994; Gross, 1999). Gross (1999) argues that, while it is difficult to draw a distinction between emotion and emotional regulation, the question " 'Is emotion ever not regulated?' is misleading, in that it suggests an all-or-none affair. A conception of relative regulation seems more appropriate" (p.565). Gross and John (2003) maintain that particular emotion regulation strategies can be differentiated beside the developing emotional response.

Applying a consensual model of emotion, Gross (1998) differentiates when different emotion regulation strategies have their primary impact on the emotion-generative process. Antecedent-focused emotion regulation (e.g. cognitive reappraisal) intervenes before the emotion response has been fully generated, while response-focused emotion regulation (e.g. expressive suppression) occurs afterwards. Emotional regulation is then, not only defined as emotional control, but also involves the ability to experience (and discriminate) the full range of emotions and respond appropriately. Gratz and Roemer (2004) conceptualise emotion regulation as involving the:

> (a) awareness and understanding of emotions, (b) acceptance of emotions, (c) ability to control impulsive behaviours and behave in accordance with desired goals when experiencing negative emotions, and (d) ability to use situationally appropriate emotion regulation strategies flexibly to modulate emotional responses as desired in order to meet individual goals and situational demands. The relative absence of any or all of these abilities would indicate the presence of difficulties in emotion regulation, or emotion dysregulation (p. 42-43).

9.1 Measuring emotional regulation

There are a limited number of measures of emotional regulation and, often, closely-related constructs are used as a substitute. One such measure is the Generalized Expectancy for Negative Mood Regulation Scale (NMR) (Catanzaro & Mearns, 1990), which primarily assesses emotional avoidance and does not assess the awareness, understanding and acceptance of emotions. It also should be noted that the scale was originally aimed at measuring mood regulation, rather than emotional regulation. The Emotion Regulation Questionnaire (ERQ) (Gross & John, 2003) was

developed to measure emotional regulation and includes both positive and negative emotional regulation. However, it is limited by measuring only two strategies: appraisal and suppression of emotions. The Difficulties in Emotional Regulation Scale (DERS) (Gratz & Roemer, 2004) was developed, to assess difficulties regulating emotions during times of distress more comprehensively than existing measures, although one limitation is that it only assesses the regulation of negative emotional states.

9.2 Emotional regulation in self-harm

Michel and Valach (2001) argue that self-harm and suicidal actions are part of a system of behaviours related to repeated problems of emotional regulation. People who repeatedly self-harm have been shown to be high in impulsivity and have deficits in both coping and problem-solving (Haines & Williams, 1997). Mood fluctuation has been identified as a risk indicator for self-harm (Sampson et al., 2004). It has also been suggested that self-harm results from a failure of the capacity for self-soothing in the presence of intense emotions (Gallop, 2002). It has been argued that the goal of self-harm is to reset the emotional system and is an attempt at self-regulation (Van der Kolk, 1996, cited in Michel and Valach, 2001).

Linehan (1993) supports this view and proposes that an emotionally invalidating environment during childhood contributes to emotional dysregulation by failing to provide effective regulating strategies. Childhood trauma increases the risk of hyperarousal and increased affective dysregulation (Gratz, 2003). Self-harm can then be viewed as an emotional regulation strategy reinforced by the avoidance or reduction of negative emotions (Chapman, Specht & Cellucci, 2005).

However, while initial work (Gratz, 2003) showed that those people in a community sample with a history of self-injury have more difficulties in emotional regulation, this hypothesis has yet to be explored in other clinical groups, including self-poisoners. In a sample of female college students, Gratz (2006) found that those who self-harmed had higher levels of affect intensity/reactivity (global and negative). Among women with a history of self-harm, emotional inexpressivity was associated with more frequent self-harm.

There is also growing evidence that interventions which target emotional regulation decrease self-harm. Gratz and Gunderson (2006) found preliminary evidence that a short-term emotion regulation group intervention, for self-harming women with BPD, led to a reduction in the frequency of their self-harm behaviour. While a number of studies have shown that Dialectical Behaviour Therapy, a cognitive behavioural treatment developed to treat suicidal clients meeting the criteria for BPD which targets emotional regulation, also reduces self-harm (Linehan et al., 2006).

10. Experiential avoidance

One specific type of emotional regulation strategy is experiential avoidance (Gratz, 2003), which refers to more than just emotional avoidance. The construct of experiential avoidance has been defined as a person's aversion to experiencing thoughts, feelings and physiological sensations, particularly those which are appraised negatively, such as anger or fear. The person will attempt to decrease or avoid these experiences. It has been suggested that psychopathology results, not from these experiences, but from the active attempts to avoid, contain or control these

experiences (Hayes et al., 1996; Sloan, 2004). Experiential avoidance has been acknowledged, implicitly or explicitly, among most therapeutic approaches. For example, repression in psychoanalysis, increasing awareness of feelings in client-centred therapy and completing 'unfinished business' by full experiencing in Gestalt Therapy (Hayes et al., 2004). Hayes et al. (2004) state that:

> Like many concepts drawn from the behavioural tradition, experiential avoidance is not meant to be treated as an underlying trait. Rather, experiential avoidance is conceptualized as a functional response category that relates several more specific behavioural phenomena into a theoretically coherent perspective (p.565).

Initially, experiential avoidance leads to short-term decreases of emotional experience. However, paradoxically, attempts to decrease these experiences may increase both the severity and frequency of the experiences (Hayes et al., 1996). As such, experiential avoidance is a type of behaviour which is maintained primarily through negative reinforcement. Sloan (2004) states that "the pattern of a short-term reduction leading to a long-term increase results in a self-amplifying loop that appears to be fairly resistant to change" (p.1258). A similar pattern has also been shown for people who use the emotional regulation strategy of suppression. Gross and John (2003) found that high emotional suppressors experience more negative emotions than individuals who use suppression less frequently. Their suppression was partly successful as they expressed less negative emotion than they experienced, although they still expressed as much as individuals who suppress less frequently.

Research has also suggested that experiential avoidance increases psychological symptoms (Wenzla & Wegner, 2000). High scores of experiential avoidance have been correlated with general psychopathology, trauma, depression, anxiety, and a lower quality of life (Kashdan, Barrios, Forsyth & Steger, 2006). Furthermore, they have been shown to mediate the relationship between childhood sexual abuse and psychological distress over and above emotional expressiveness (Hayes et al., 2003, cited in Sloan, 2004; Marx and Sloan, 2002, cited in Sloan, 2004).

10.1 Measuring experiential avoidance

As with emotional regulation, a number of related concepts and measures have been used to assess aspects of experiential avoidance including the White Bear Suppression Inventory (WBSI), (Wegner & Zanakos, 1994) which measures thought suppression, and the Dissociative Experiences Scale (DES), (Bernstein & Putnam, 1986). As experiential avoidance is a relatively new construct there has been only one measure The Acceptance and Action Questionnaire (AAQ) (Hayes et al., 2004) has been developed to specifically measure the construct. The psychometric properties of this scale have shown a single overarching factor structure that is strongly correlated with indicators of general psychopathology including depression and anxiety (Hayes et al., 2004; Kashdan et al., 2006) .

10.2. Experiential avoidance and self-harm

Gratz (2003) suggested that self harm may function as a behavioural form of emotional avoidance. Chapman, Gratz, and Brown (2006) have further proposed the Experiential Avoidance Model (EAM) of deliberate self-harm which applies only to self-injury without suicidal intent. They argue that self-injury is quite functional in

that it is successful at stopping unwanted emotions. According to the EAM, (see Figure 1) self-injury is maintained via escape conditioning and negative reinforcement.

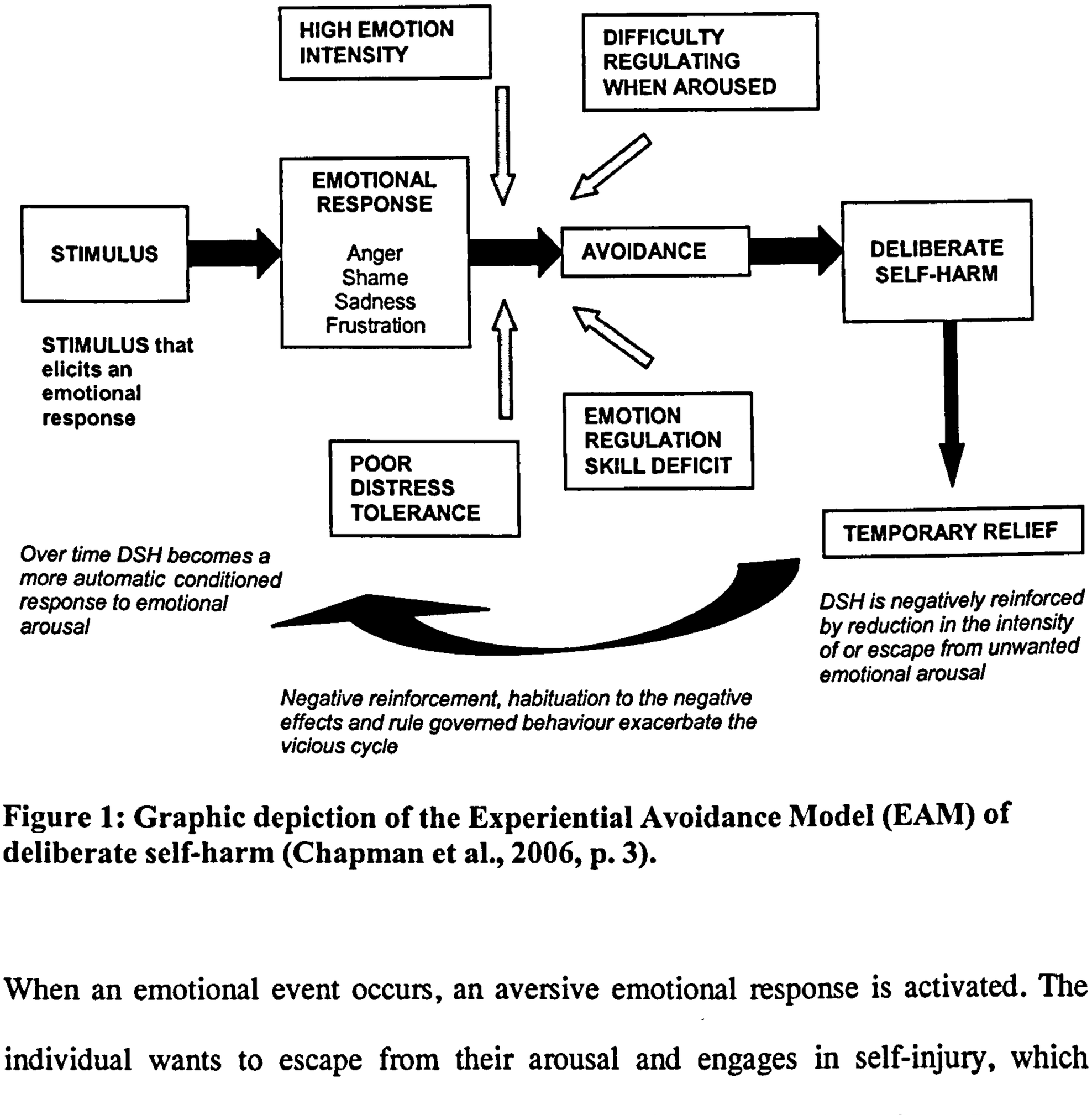


Figure 1: Graphic depiction of the Experiential Avoidance Model (EAM) of deliberate self-harm (Chapman et al., 2006, p. 3).

When an emotional event occurs, an aversive emotional response is activated. The individual wants to escape from their arousal and engages in self-injury, which reduces the emotional arousal and negatively reinforces the behaviour. Repeated negative reinforcement increases the association between aversive emotional arousal and self-injury, and self-injury becomes an automatic escape response (Chapman et al., 2006).

Few studies have examined the link between avoidance tendencies and self-injury and none, as yet, within people who self-poison. In their study of the relationship between BPD, experiential avoidance and self-harm, Chapman et al. (2005) found no significant relationship between experiential avoidance (measured by the AAQ) and frequency of self-harm. However, emotional dysregulation (DERS) has been found to be significantly correlated with experiential avoidance (AAQ) and with frequency of self-injury (Gratz & Roemer, 2004) and high levels of experiential avoidance have been found in those who self-injure (Chapman et al., 2006).

The EAM is a model specific to self-injury without suicidal intent. However, given the overlap in populations, it would be useful to explore whether difficulties in emotional regulation and experiential avoidance are also present in people who self-poison. This would be an initial step in considering the application of this model to self-harm in general. Further empirical research into the utility of both the emotional regulation and experiential avoidance theoretical frameworks is needed.

11. Rationale and implications of present study

People who self-harm can present a significant risk to themselves, and are a difficult group to intervene with successfully. The variation between people who use different types of self-harm (self-injury, poisoning etc.) is not understood, which may explain the lack of convincing evidence for an intervention.

Research literature on people who self-harm has often focused on the method they choose (i.e. self-poisoning or self-injury). This has led to a theoretical discussion about whether those people who self-injure represent a clinically different group from

those who self-poison. A review of the literature suggests that people who choose different methods overlap in terms of their intentions, reasons and the emotional changes or processes they go through when they decide to hurt themselves. Gratz (2003) concludes that self-harm may function to regulate emotions, via a process of experiential avoidance, particularly for people who self-injure repetitively. However, it is not clear whether this is true for all types of self-harm behaviour. Gratz identifies the need for more research to gain a better understanding of people's different intentions and the varied functions of self-harm and to explore the role of emotional dysregulation and experiential avoidance in all forms of self-harm. A greater understanding of the relationship between people's intentions and emotional processes across different methods of self-harm may assist in targeting interventions to specific client groups and improve clinical outcomes. In particular, there is a need to measure the extent of emotional dysregulation and experiential avoidance in self-poisoners who have yet to be studied and are excluded from the Experiential Avoidance Model of self-harm.

There is a limited qualitative literature, which has thus far considered the experience of care for people who have self-harmed (Harris, 2000), interpersonal processes of in-patient adolescents who self-harm (Crouch & Wright, 2004) and a follow-up study of people who had self-poisoned but had not harmed themselves in the last two years (Sinclair & Green, 2005). A qualitative exploration of the emotional processes people go through when they decide to harm themselves may broaden the understanding of the variation between people who self-harm. In addition, the use of quantitative scales also enable the further investigation of intentions, experiential avoidance and

emotional regulation in the current study, although the use of this approach is exploratory at this stage.

As intentions and reasons for self-harm can change over time, a study within a hospital setting enables access to participants who have recently self-harmed. A hospital setting will increase the numbers of participants who have self-poisoned but will also enable the exploration of previous self-injury in this population. However, it is recognised that the participant characteristics of a hospital population may be different from those who self-harm in a community setting and do not seek medical intervention. This will be considered in discussing the findings of the study.

13. Research aims and questions

This research primarily aims to explore the different reasons people give, and the changes in emotions they experience, when they harm themselves and subsequently attend hospital for treatment. It will look at whether, and how, they have harmed themselves previously. It will also investigate how they manage their emotions when they are distressed (emotional regulation) and whether they routinely try to avoid thoughts or feelings as a way to cope with them (experiential avoidance). Although primarily focusing on self-poisoners, it will be inclusive of different methods of self-harm.

The present study will aim to answer the following research questions:

- What reasons do people give for attending Accident and Emergency following an incident of self-harm?

- What perceived emotions and emotional changes are associated with self-harm?
- What reasons are associated with self-harm?
- What history of self-harm behaviour (including self-injury) do people present with?
- How commonly do people who self-harm have a difficulty in emotional regulation and experiential avoidance?
- What are the relationships between: a) types of reason and emotions; b) emotional regulation, experiential avoidance, previous history of self-harm and attendances at hospital?
- What are the differences between people who use different methods of self-harm in terms of emotional regulation, experiential avoidance, previous history of self-harm, current intent to die, number of attendances at hospital and length of time thinking about self-harm[1]?

12. Epistemological considerations

This section will consider in more detail the epistemological position of this research. In evaluating the quality of qualitative research, it is usual that the researcher's epistemological assumptions are explicitly considered (Finlay, 2005a). This is particularly important when a mixed qualitative / quantitative approach is chosen as it involves reconciling potentially different epistemologies and ontologies (Mason, 2006). A mixed method approach can be used for the triangulation of data, explanation or exploration (Bryman, 2006; Todd, Nerlich & McKearn, 2004) and this

[1] It was anticipated that a significant number of participants would have self-poisoned, some of whom may have also self-injured and/or have a history of self-injury, which may allow a comparison between self-poisoners only and self-poisoners/self-injurers. It was not expected that participant numbers would enable a self-injury only comparison group.

involves "an integrated framework, where we use each method and form of data to tell us about a specific part of 'the picture'" (Mason, 2006, p.20). By taking a multi-dimensional perspective, different levels of the same problem can be studied to explore the macro/micro divide (Todd et al., 2004). Mason (2006) argues for mixing methods in a qualitatively driven way, given that integrating knowledge from different sources requires the acceptance of a relativist epistemology and a high level of reflexivity. As Bryman (2006) points out, qualitative approaches are comparatively open-ended and frequently generate unexpected results and new directions; in using a qualitatively driven mixed method it is also necessary to accept that the overall outcomes may not be predictable.

12.1 Phenomenology

Phenomenology is the "systematic study of people's experiences and ways of viewing the world" (Barker, Pistrang & Elliot, 2002, p.76). It is both a philosophical approach and a collection of research approaches. The phenomenological movement was developed by Husserl in 1936 (Husserl, 1970) as a new approach to philosophy. The aim of phenomenological research was to describe the world as it is subjectively experienced (Finlay, 2005a; Giorgi & Giorgi, 2003). Other theorists, such as Heidegger in 1927 (Heidegger, 1962), took a more hermeneutic position, which subsequently moved the focus of phenomenological research from not only describing conscious experience, but also to include both existential and interpretive dimensions (Finlay, 2005a).

12.2 Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) is a relatively recent qualitative approach stemming from phenomenology developed specifically within psychology in the UK (Smith & Osborn, 2003). IPA is more idiographic in nature than empirical phenomenology, focused on the individual's cognitive, linguistic, affective and physical being (Finlay, 2005a). It is, however, phenomenological and assumes that there is some (although not transparent) relationship between what a participant says and the beliefs they hold (Smith, 1995). It takes a hermeneutic position, in that an understanding of the participants' experiences is gained through the interpretations of the researcher. It also recognises that meanings are negotiated in a social context and can be understood as a symbolic interaction (Smith, 1995). With regard to this, IPA necessitates reflexivity from the researcher. As Finlay (2005a) argues, "we need to strive, explicitly, to understand some of the connections by which subject and object influence and constitute each other. We need to acknowledge both our experience and our experiencing" (p.3). The researcher is asked to elucidate their perspective explicitly, with the aim not of bracketing it (as is empirical phenomenology) but to understand and accept its influence (Willig, 2001). A reflexive statement and a summary of the research process can be found in appendix 1.

CHAPTER 2 METHOD

If we knew what it was we were doing, it would not be called research.

Albert Einstein, Physicist (1879 - 1955)

1 Overview

This study used a mixed qualitative and quantitative approach to explore the different intentions and the changes in emotions that people experience when they harm themselves and subsequently attend hospital for treatment. The study collected data from a small number of current out-patients attending a self-harm service and a larger group of people attending hospital after a recent incident of self-harm.

2 Design

An exploratory study using qualitative and quantitative methodology was carried out. The research assumed a phenomenological position using a discovery approach to describe and understand the meanings, relationships and differences between people's reasons for self-harm and the emotional changes when they harm themselves, previous self-harm, experiential avoidance and emotional regulation.

A qualitative exploration of the emotional processes people experience when they harm themselves was chosen as it supports a greater understanding of the process issues. The additional use of quantitative measures was exploratory, although it is noted that this approach assumed that people were able to access their thoughts and feelings and quantify the strength of them.

There were two parts to the study. Study 1 (qualitative) collected retrospective data from a small group of people using an interview and a questionnaire. Study 2

(quantitative) collected retrospective and current questionnaire data from a larger group of people following an incident of self-harm.

3 Setting

The present study took place within an Accident and Emergency Mental Health Liaison Team which covers a General Hospital and related Minor Injuries Units (the team provide a service for people who self-harm and will herein be referred to as the Self Harm Service). The team operates from Monday to Friday 9am – 8pm. Outside of these times, the Crisis Resolution Service are available to provide a service. The Crisis Resolution Service was not involved in this present study. There are approximately 1500 incidences of self-harm per year in the area covered by these services.

3.1 Psychosocial assessment

Following admission to hospital with an incident of self-harm, all patients are offered a psychosocial assessment once they are deemed medically fit by a doctor for discharge. Approximately half of the patients have used alcohol or drugs, which delays their medical fitness for assessment. A number of patients also choose to leave hospital without participating in a psychosocial assessment. The psychosocial assessment is carried out by staff from the Self Harm Service or the Crisis Resolution Service (depending on the time of day of admission). A psychosocial assessment includes an evaluation of the social, psychological and motivational factors specific to the act of self-harm, current suicidal intent and hopelessness, as well as a full mental health and social needs assessment (National Collaborating Centre for Mental Health, 2004).

3.2 Outpatient clinics

Following psychosocial assessment, patients may be offered further outpatient appointments for individual therapy and/or psychoeducational group interventions.

4 Participants

4.1 Participants (Study 1)

Potential participants were identified as all those who were currently attending outpatient appointments with the Self Harm Service, between the months of April 2006 and January 2007 inclusive. Participants were recruited on a voluntary basis using a purposive sampling strategy, according to the study's inclusion and exclusion criteria (Barker et al., 2002). It was anticipated that participants who had self-harmed in different ways (e.g. self-poisoned and/or self-injured) would be included. No gender breakdown was specified, although it was expected that there would be a representation from both men and women.

In drawing from this population the inclusion criteria were as follows:

- Over 18 years of age and under 65 years of age.
- Presented to Hospital or Minor Injuries Unit with an incident of self-harm. Self-harm was defined as any behaviour carried out with the intent to self-harm irrespective of suicidal intent (e.g. self-poisoning, self-injury).
- Able to consent to participation in the study.
- Able to complete the questionnaire in English.

Individuals were excluded if they were:

- Under 18 years of age and over 65.
- Unable to consent to participation in the study.

- Unable to complete the questionnaire in English.
- A prisoner.
- Detained under the Mental Health Act.
- Judged by the clinical member of staff to be too highly distressed to be recruited into study.

4.2 Response rate and demographic information (Study 1)

During the data collection period, 10 people (4 men and 6 women) consented to take part in Study 1. The overall age range was 19 - 53 years (mean =32.0 years; SD = 13.0 years); the range for men was 19 - 53 years (mean =29.0 years; SD =16.3 years) and for women was 19 - 48 years (mean =34.7 years; SD =10.7 years).

Demographic data (age and gender) was collected on those people who did not agree to participate in the study to monitor any sampling bias (see Appendix 9). One woman refused to participate. Two women consented to take part in the study but did not attend the arranged interview appointments. It was presumed that they had withdrawn their consent when they did not respond to follow-up contact. All three had a history of both self-poisoning and self-injury.

Seven participants agreed to be involved in a participant validation meeting following analysis of the data. Of these, two were available to attend for a meeting with the researcher.

4.3 Participants (Study 2)

A naturalistic cohort of people attending an Accident and Emergency department following an episode of self-harm were invited to participate in Study 2.

In drawing from this population the same inclusion and exclusion criteria as study 1 were applied. There were two further exclusions:

- Patients who refused, or left hospital before a psychosocial assessment was carried out.
- Patients who presented for psychosocial assessment at a time when a member of staff from the Self Harm Service was not available.

4.4 Response rate and demographic information (Study 2)

During the data collection period, 60 participants consented to take part in Study 2 and completed the questionnaire: 28 men (46.7%) and 32 women (53.3%). The overall age range was 18 – 60 years (mean =32.3 years; SD =13.0); the range for men was 18 – 60 years (mean =34.9; SD =13.6) and for women was 18 – 55 years (mean =29.7; SD =11.2).

Although it was intended to collect demographic data on the people who were approached and did not agree to participate, in order to monitor any sampling bias, only very limited data was collected (for three people). This was due to data collection by a number of different staff, who were under time pressure and did not complete the demographic information sheet (Appendix 9).

4.5 Demographic data: comparison to all attendees at hospital

During the data collection period, demographic information (gender and age) was routinely collected for all attendees at hospital for treatment following a recent incident of self-harm and who were referred for a psychosocial assessment, which allows a comparison to be made with the study's participants (see Table 1). Overall 670 people were referred for assessment following self-harm: 300 men (44.8%) and

370 women (55.2%). The data showed a comparable gender distribution in both studies. However, both Study 1 and 2 included a greater percentage of 18-25 year olds than the target population and a decreased number of both 26-35 year olds and 35-50 year olds.

Table 1: Age range: percentage of Study 1 and 2 participants and all hospital attendees for self-harm

Age Range	Study 1 participants Percentage	Study 2 participants Percentage	All hospital attendees for self-harm Percentage
Age 18-25	40.0	40.0	23.7
Age 26-35	20.0	21.7	29.8
Age 35-50	30.0	26.7	35.0
Age 51-65	10.0	11.7	11.7
Total	100.0	100.0	100.0

5 Pilot study

Prior to the data collection period, a pilot study for Study 2 was carried out over 1 week. During this time staff approached people attending hospital, following an incident of self-harm, and asked them to complete the study questionnaire. Three people consented to participate. It was found that while patients were willing to complete the questionnaire, it was taking approximately 30 minutes to finish, which was considered too long. As a result of this, it was decided to remove the supplementary items asked from the Deliberate Self Harm Inventory (see below Section 6.1.4). The data from the pilot study were not included in the results.

6 Measures

6.1 Questionnaire (Study 1 and 2)

6.1.1 Demographic and qualitative information

Participants were asked about:

- how they had harmed themselves on this occasion
- their choice of method of self-harm
- the reasons for self-harm
- the reasons for attending hospital
- the number of times they had attended hospital following self-harm
- the length of time since the incident occurred
- the length of time they had thought about harming themselves before acting
- their consumption of alcohol or drugs prior to harming themselves
- where they would seek help in the future if they harmed themselves again.

For Study 1, the questions related to their last incident of self-harm which led to an attendance at hospital. For study 2, the questions related to their current incident of self-harm.

6.1.2 Emotions list

The emotions list was used to assess retrospectively participants' self report of specific emotions and changes in these emotions just before they harmed themselves, just after they harmed themselves and currently, as they were completing the questionnaire. In contrast to previous studies, which had used dichotomous items, participants were presented with a list of emotions which they were asked to rate in intensity on a 5-point scale (from 'not feeling this' to 'overwhelming'). The emotions list included the feeling states used by Briere and Gil (1998): (*Anger at Others, Anger at Self, Fear, Emptiness, Excitement, Guilt, Hurt, Loneliness, Pleasure, Relief, Sadness and Shame*) and by Schnyder et al. (1999) (*Anxiety/Panic, Despair, Self-contempt, Disappointment / Insult, Powerlessness / Hopelessness and Emptiness [mental vacuum*]). These lists were selected as they had been previously used in

studies of self-harm and were combined to ensure the inclusion of a range of different emotions.

6.1.3 Motives for Parasuicide Questionnaire

The Motives for Parasuicide Questionnaire (Kerkhof et al., 1989) was developed for the European Parasuicide Study Interview Schedule (EPSIS) for the WHO (Euro) Multicentre Study on Parasuicide and was based on earlier work (Bancroft et al., 1979; Bancroft et al., 1976). It consists of 14 possible reasons for self-harm. The person is asked to rate '*To what extent did the following reasons influence your decision to harm yourself*' on a 3-point scale (major influence, minor influence or no influence). Four factors have been identified for this scale (Hjelmeland, Hawton, Nordvik & Bille-Brahe, 2002):

- *Care Seeking* relates to seeking care and attention from others or testing of love (items 2, 6, 8 and 9)
- *Influencing Others* deals with revenge, punishment or manipulation of others (items 10-12)
- *Temporary Escape* deals with wanting short-term relief (items 5 and 14)
- *Final Exit* deals with unbearable thoughts and situations, the intention to die and the wish to make things easier for others (items 1, 4, 7 and 13).

Item 3 is a separate item called 'loss of control' which was viewed, not as an intention, but as a description of what people experience. Internal consistency for the subscales is 0.53 – 0.73, and although *Temporary Escape* and *Final Exit* have less than adequate alpha values, lower alpha scores can be expected on scales with a small number of items (Nunnally, 1978).

Grøholt, Ekeberg, and Haldoran (2000) used two subscales *Intrapersonal Motives* (Items 1, 3-5. 7, 14) and *Interpersonal Motives*. However their items differed slightly in using the second person form of personal pronouns and not the first person which has been more routinely used in previous studies (Bancroft et al., 1979; Bancroft et al., 1976; Hjelmeland et al., 2002).

The current study adopted the more traditional style of wording (Bancroft et al., 1979; Bancroft et al., 1976) and used the first person form of personal pronouns. An additional item '*I wanted to punish myself*' which was adopted by Rodham et al. (2004) was also included in this study. The data in Study 2 was analysed using both approaches to divide the scale into subscales (Grøholt et al., 2000; Hjelmeland et al., 2002).

6.1.4 Deliberate Self Harm Inventory (DSHI)

The Deliberate Self Harm Inventory (DSHI) (Gratz, 2001) is a 17-item behaviourally based self report measure to assess deliberate self-harm. It is based on a definition of deliberate self-harm as the deliberate, direct destruction of body tissue without conscious suicidal intent. It assesses type and frequency of self-harming behaviours and includes supplemental measures of duration and severity of self-harming behaviours.

The DSHI asks about a range of self-harming behaviours including cutting, burning, scratching, biting, punching, breaking bones and preventing wounds from healing. It does not include an item on self-poisoning but it has a free response item: '*Have you done anything else to hurt yourself that was not asked about in this questionnaire*'. Although originally developed to measure self-harm without conscious suicidal intent,

given the nature of the participants it was felt likely that responses to this item would reflect behaviours with conscious suicidal intent. In view of this, in addition to keeping the free response item, a further 3 items were included:

- Have you ever intentionally (i.e. on purpose) cut your wrist, arms or other area(s) of your body (with the intention to kill yourself)?
- Have you ever intentionally (i.e. on purpose) poisoned yourself (without intending to kill yourself) e.g. taken an overdose?
- Have you ever intentionally (i.e. on purpose) poisoned yourself (with the intention to kill yourself) e.g. taken an overdose?

The item: 'Have you ever intentionally (i.e. on purpose) used bleach, comet or oven cleaner to scrub your skin' was reworded to remove the word *comet,* which was unknown to a UK sample.

It is possible to derive two measures from the scale; a continuous measure of the frequency of reported self-harm behaviour; and a dichotomous (yes/no) measure of previous self-harm. As all participants had harmed themselves the dichotomous measure was redundant in the present study. A further measure was created by summing the total number of different self-harm methods a person had used. The DSHI includes supplemental questions to measure severity and duration of self-harming behaviours. As these questions are not incorporated in the scoring, they were excluded from this study.

In Gratz's (2001) study high internal consistency was reported for the dichotomous DSHI items (α =.82) and test-retest reliability over two to four weeks was adequate (.68). The total number of self-harming behaviours endorsed on the first and second

administrations of the DSHI were also highly correlated (r = .92, p <001) (Gratz, 2001).

6.1.5 Acceptance and Action Questionnaire (AAQ)

The Acceptance and Action Questionnaire (AAQ) is a short 9-item general self-report measure of experiential avoidance, developed from the longer 32-item measure (Hayes et al., 2004). This measure of experiential avoidance is theoretically based on Relational Frame Theory, which has been incorporated into Acceptance and Commitment Therapy (ACT) (Hayes, Strosahl & Wilson, 1999). Items in the AAQ were designed to assess: the ability to take action in the context of inhibitory thoughts (Item 1) or feelings (Item 3); the presence of worry, anxiety or negative evaluations associated with private events (Items 4 and 5), and resulting attempts to control or eliminate them (Items 4 and 9); the ability to distance oneself from the literal content of negative evaluations (Item 6); and the use of worry or day-dreaming as a method of behavioural regulation (Item 2). Negative comparisons as to how others handle their lives was also assessed (Item 8).

Internal consistency was considered adequate for a new scale (α =.70) and test-retest reliability over four months was reported as .64 (Hayes et al., 2004).

It has been used in a range of studies examining the relationship of experiential avoidance to psychopathology including depression (Hayes et al., 2004), anxiety (Roemer, Salters, Raffa & Orsillo, 2005) , PTSD (Tull, Gratz, Salters & Roemer, 2004), drug addiction (Forsyth, Parker & Finlay, 2003) and BPD (Chapman et al., 2005).

6.1.6 Difficulties in Emotional Regulation Scale (DERS)

The Difficulties in Emotional Regulation Scale (DERS) (Gratz & Roemer, 2004) is a 36-item self-report measure designed to assess clinically relevant emotional regulation difficulties in adults. The DERS has six subscales:

- Nonacceptance of Emotional Responses (*Nonacceptance*) is the tendency to have negative secondary emotional responses to one's negative emotions, or to have nonaccepting reactions to one's distress;
- Difficulties Engaging in Goal-Directed Behaviour (*Goals*) reflects difficulties concentrating and accomplishing tasks when experiencing negative emotions;
- Impulse Control Difficulties (*Impulse*) reflects difficulties remaining in control of one's behaviour when experiencing negative emotions.
- Lack of Emotional Awareness (*Awareness*) reflects an inattention to, and lack of awareness of, emotional responses.
- Limited Access to Emotion Regulation Strategies (*Strategies*) reflects the belief that there is little that can be done to regulate emotions effectively, once a person is upset.
- Lack of Emotional Clarity (*Clarity*) reflects the extent to which individuals know (and are clear about) the emotions they are experiencing.

The DERS has high reported internal consistency both for the full scale (α =.93) and adequate internal consistency for the subscales (α = .80). The overall DERS score showed good test-retest reliability (.88) over four to six weeks and adequate to good test-retest reliability for the subscales (.57 - .89) (Gratz & Roemer, 2004) .

6.2 Information from medical records (Study 1 and 2)

Where available the previous attendances at Hospital following incidences of self-harm were obtained from hospital records.

6.3 Semi-structured interview (Study 1)

Semi-structured interviews enable the participant to provide a richer account of their experiences than a purely quantitative approach allows. This approach also enables the researcher greater flexibility in exploring new areas which arise (Smith & Osborn, 2003). The interview is seen as "a co-determined interaction in its own right" (Smith, 1995 p. 12) and therefore a semi structured interview schedule was constructed to guide rather than dictate the interview process.

The interview schedule was structured around the research questions (see Table 2 above) and the questions were designed to be neutral and open-ended. Prompts were included to remind the interviewer to ask about specific areas (Smith, 1995). The interview also provided the opportunity to explore further individual questionnaire responses.

Table 2: Interview Schedule

Topic Area	Questions	Prompts
History of self-harm	Can you talk about how you have harmed yourself in the past?	How often? Which method? Planning?
Time planning	Can you tell me about the last time you harmed yourself?	Which method? Planning? Alcohol?
Emotions and emotional changes	What were you thinking and feeling before you harmed yourself?	
Intentions	What were you thinking and feeling after you harmed yourself?	
	What did you intend (want?) to happen when you harmed yourself?	
Reasons for attending hospital	What happened after you harmed yourself *	Medical treatment? Responses from other people?
Difficulties in emotional regulation and experiential avoidance	How do you normally react when you feel upset?	How would someone else know you were upset? How long does it last? What do you do to feel better?
Difficulties in emotional regulation and experiential avoidance	Some people find it difficult to cope with their thoughts and feelings. Are there any thoughts or feelings you find are difficult to cope with?	Positive and negative examples of emotions.
Relationships between intentions, emotional changes, emotional regulation, experiential avoidance	What sort of relationship are you aware of between how you think or feel and when you harm yourself?	Do certain things go together, particular types of situation, or feelings.
	Is there anything else about self-harm that you feel is important to talk about? Can you tell me a bit about it?	Treatment at hospital? Other people's reactions? Feelings about death

**All participants attended hospital.*

7 Procedure

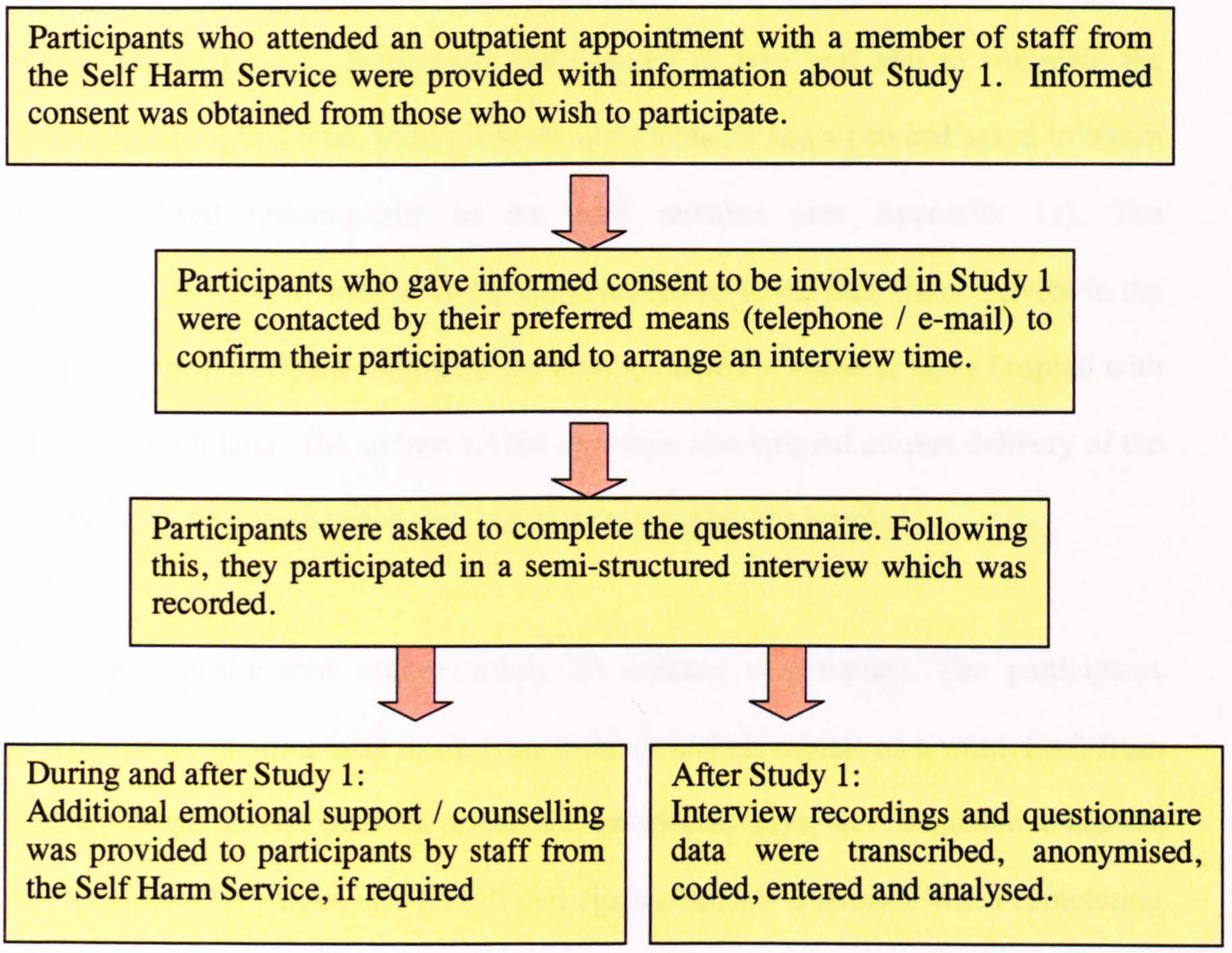
Ethical approval was sought and gained from the local research ethics committee (See Appendix 2). Approval was also gained from the relevant NHS Trusts (See Appendix 3 & 4) and an honorary contract agreed.

7.1 Procedure (Study 1)

The procedure is presented in Figure 2 (below). Participants were identified by their keyworker who approached them with an information sheet about the study which detailed the purpose, procedure and ethical considerations of the study (See appendix 5) and consent form (See appendix 6). They also had the opportunity to ask their keyworker any questions about their participation. Participants who agreed to take part were asked to complete a consent form and to nominate their preferred contact method (letter / telephone / e-mail) to arrange an interview appointment with the researcher at a convenient time. Interviews took place at the Self Harm Service, in a confidential interview room. Where possible, it was arranged for the participant's key worker to be available in the Service during and after the interview.

The interviews lasted between 60 and 90 minutes. The participant was asked to complete the questionnaire (see Appendix 10) and then to participate in the interview. The interview was digitally-recorded. The interviewer ascertained how the participant was feeling before they left the interview. Additional psychological support, including counselling, was provided by the participant's keyworker from the Self Harm Service following the interview if required. At the end of the interview the participant was invited to a further meeting to enable participant validation of the themes derived from their interview (see below section 9.1.4).

Figure 2: Study 1 Flow diagram of procedure



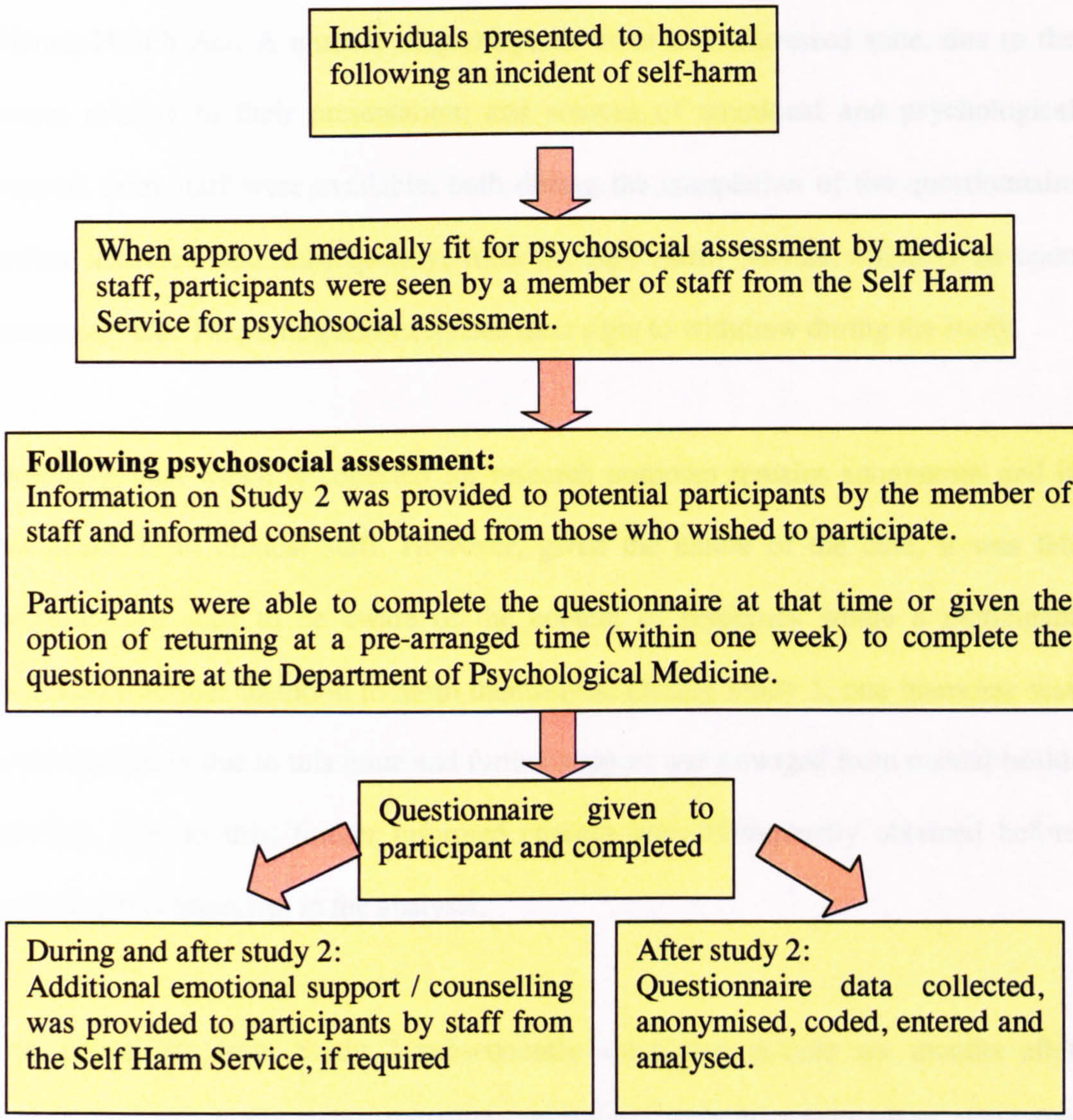
7.2 Procedure (Study 2)

The procedure is presented in Figure 3 (below). Potential participants who had attended hospital following an incident of self-harm were approached about the study by a member of staff from the Self Harm Service. They were approached after they were deemed medically fit for discharge by a doctor and following the psychosocial assessment. They were given an information sheet about the study (See appendix 7) and consent forms (See appendix 8) which detailed the purpose, procedure and ethical considerations of the study. They had the opportunity to ask the staff member any questions about their participation.

Participants were given the option of completing the questionnaire at that time or arranging an appointment to complete the questionnaire at the Self Harm Service within the next week. Participants who agreed to take part and to complete the questionnaire at that time, were given the questionnaire and a pen and asked to return the completed questionnaire to the staff member (see Appendix 11). The questionnaire was provided in an envelope addressed to the Self Harm Service in the event that the participant completed the questionnaire but chose to leave hospital with it and return it later. The address on the envelope also ensured correct delivery of the envelope, if the questionnaire was left anywhere within the hospital.

The questionnaire took approximately 20 minutes to complete. The participants completed the questionnaire in a private room or in their cubicle on a ward. Staff from the Self Harm Service (and the researcher, on specific days, were available to answer any questions the participants had. If participants became distressed when completing the questionnaire, additional psychological support could be directly provided, if required, by staff from the Self Harm Service. Following participation in the study, the Self Harm Service offered on-going psychological support including counselling to participants or referral to other support services, as required.

Figure 3: Study 2 Flow diagram of procedure



8 Ethical considerations

A key consideration in this study was ensuring informed consent was obtained from participants. All participants were over 18 and only when individuals were deemed medically fit and had completed a psychosocial assessment were they approached. Potential participants were given an information sheet describing the study, with contact information for the Self Harm Service, and written informed consent was

obtained. One participant who was approached with information about the study was subsequently excluded as, following further assessment, they became subject to the Mental Health Act. A number of participants were in a distressed state, due to the issues relating to their presentation; and sources of emotional and psychological support from staff were available, both during the completion of the questionnaire and/or interview and subsequently, from the Self Harm Service which is an open access service. No participants exercised their right to withdraw during the study.

Normally, data which is collected for research purposes remains anonymous and is not available to clinical staff. However, given the nature of the data, it was felt necessary for staff to be aware of the content of responses where a participant indicated a further intention to harm themselves. During Study 1, one interview was concluded early due to this issue and further support was arranged from mental health services. Due to this, further informed consent was subsequently obtained before including this transcript in the analysis.

One participant from Study 2 subsequently completed suicide six months after completing the questionnaire. Following discussion with their keyworker, their data continued to be included in the sample.

The interviews were recorded, transcribed and then destroyed following transcription. The transcripts were kept under the same conditions as the questionnaire data. Any written information which left the hospital was anonymous; individuals were given a unique identifying number and the master list was kept separately from the data. Questionnaire data was scored and stored on an anonymous password protected

computer record. The questionnaire data and interview transcripts are held in a locked cupboard in the Department of Clinical Psychology for the required length of time following the study and then will be appropriately destroyed. There was no relationship between the primary researcher and any of the participants involved in the study. One potential participant in Study 1 was excluded from the study, due to a prior therapeutic relationship with the primary researcher. Participants did not receive any payment or incentive for their participation in the study.

9 Data analysis

9.1 Data analysis (Study 1)

9.1.1 Questionnaire

The data from the questionnaire was described descriptively within and across cases and reported with the demographic data with the aim of 'situating the sample' (Elliot, Fischer & Rennie, 1999) and triangulating with the interview data.

9.1.2 Interpretative Phenomenological Analysis

The data from the interview study was transcribed and initially coded on paper and subsequently using the computer software NVIVO 7. The data were analysed using Interpretative Phenomenological Analysis (IPA) (Smith & Osborn, 2003) to explore the participants' experiences whilst remaining mindful of the research questions. While encouraging the spontaneous development of themes, IPA privileges the use of systematic procedures to support the analysis of qualitative data (Smith, 1995; Smith & Osborn, 2003; Willig, 2001).

Primarily the IPA is an ideographic process, in that the researcher is engaging individually with the individual case before cases are integrated (Willig, 2001). The researcher used accepted procedures for IPA (Smith, 1995; Smith & Osborn, 2003; Willig, 2001). During the first stage, notes were produced which encompassed initial thoughts, associations and responses to the text. In the second stage, the researcher then approached the transcripts in a more systematic way to identify and label themes throughout each section of text. Further structure was then added at the third stage, exploring the reciprocal and hierarchical relationships between themes to enable themes to be clustered, integrated and labelled across transcripts. The clusters were then considered in the context of the transcripts to ground them in the original data. The final stage involved constructing a summary table of clustered themes and subordinate themes supported by quotations. The final stage involving the integration of the subordinate themes was difficult and a number of different possible solutions were considered before the summary table was finalised (see Appendix 1). The researcher reflected on the importance of the themes, their representation within the text and the relevance to research questions before completing the analysis (Smith, 1995; Smith & Osborn, 2003; Willig, 2001).

9.1.3 Additional researchers

Additional researchers were involved in the process of analysis at various stages including identifying initial themes, coding of transcripts and reviewing the thematic structure to ensure that the interpretations were grounded in the research data and to increase reflexivity of the interpretation (Barker et al., 2002; Elliot et al., 1999).

9.1.4 Participant validation

A summary of interview themes was fed back to participants to provide participant validation. Two participants attended follow-up sessions to explore the development of the themes. Although participant validation was seen as a useful tool in providing a credibility check (Elliot et al., 1999), it was also recognised that the implicit power imbalance in the researcher/participant relationship may negate the opportunity for participants to challenge the themes (Ashworth, 1993).

9.2 Data analysis (Study 2)

The questionnaire data were analysed using SPSS software (version 14.0). Descriptive statistics and analysis of frequencies were used to describe the data including percentages, mean and standard deviation. The internal consistency of the measures was assessed using Cronbach's Alpha. The data was assessed for a normal distribution and non-parametric statistical analyses were considered necessary because the data was not normally distributed. Correlational analysis using Spearman's Rho, were used to explore the magnitude and degree of relationships between variables. Differences between variables were explored using the Mann-Whitney test. Content analysis was used to analyse the open ended questions. An additional researcher was involved in coding the open ended questions to provide validation of the analysis.

9.3 Reflective diary

Throughout the data collection period the researcher completed a reflective diary of her experiences, reflections, beliefs, values and interests (Willig, 2001). When assuming a phenomenological position in research, the focus is on exploring and

understanding the participants' world from their viewpoint; however the interpretation the researcher brings to the data will be influenced by their own conceptual framework (Smith, 1995; Willig, 2001). The reflexivity of this process is aided by the researcher's self reflection. As Hertz (1997) argues, "To be reflexive is to have an ongoing conversation about the experience while simultaneously living in the moment" (p. viii). The researcher wanted to reflect on the intersubjectivity of the research process; exploring both the impact of herself on the construction of research meanings and the impact of the research on her own personal and professional development (Willig, 2001). As Finley (2005b) argues, "Through the web that is intersubjectivity, we come to understand that self-understanding and other-understanding are intimately interwoven" (p. 288).

A summary of the research process derived from the reflective diary is presented in Appendix 1.

CHAPTER 3 RESULTS (STUDY 1)

All meanings, we know, depend on the key of interpretation.

George Eliot, Writer (1819-1880)

1. Overview

This chapter presents the analysis of qualitative data collected from Study 1. Firstly, the ten participants are described using the data from their questionnaires and then the themes from their interviews are presented with illustrative quotes.

2. Description of participants

Table 3 presents summary information for the ten participants from their questionnaires. It shows the current method of self-harm (index episode), the number of self-harm episodes resulting in hospital attendance, the total number of self-harm episodes and their types of previous self-harm (from DSHI).

Table 4 shows the length of time (in weeks) since the index event, length of time the person had thought about self-harm and their estimated amount of alcohol. It also presents their strongest reported emotions before and after the index episode, their strongest reported reasons and their scores for emotional dysregulation (DERS) and experiential avoidance (AAQ).

The index episodes involved self-poisoning (by overdose or carbon monoxide) and/or self-injury (cutting or burning). Only participant J had no history (previous or current) of self-poisoning. Apart from participant F, they all had a previous history of self-harm. Participant C reported previous self-harm with suicidal intent only, while the remainder reported self-harm both with and without suicidal intent. There appeared to be a trend that those participants who reported increased frequencies of self-harm engaged in a greater number of different types of self-harm.

Half of the participants had consumed alcohol prior to their self-harm. Participants were asked to estimate how much they had been drinking and, where possible, this figure was converted to units of alcohol using a unit converter. All participants who had been drinking would be classified as having been binge drinking prior to their self-harm (British Medical Association, 2005). The time spent thinking about self-harm before the index episode ranged from less than an hour to more than a month.

Prior to and after the self-harm many different feelings were reported. The commonest before self-harm were: *Despair, Detached, Anger at self* and *Powerlessness / Hopelessness,* whereas afterwards they were *Powerlessness / Hopelessness, Relief, Fear*, *Despair* and *Detached.* For the index episode, only participants D, E and F did not choose '*I wanted to die'* as a reason/intention. All the self-injurers reported intent to die, although only one of them cut in a location which increased the risk of this occurring (I). The commonest expressed reasons for self-harm were intrapersonal: '*I wanted to escape for a while from an impossible situation'*; '*I wanted to get relief from a terrible state of mind'* and '*I wanted to die'.*

All participants (except F) were in the clinical range for emotional dysregulation and all participants were scoring above the upper quartile cut-off for experiential avoidance (Hayes et al., 2004).

Table 3: Participant summary information (Study 1)

Person	Gender	Age range	Index self harm (SH)	No of SH at hospital	Total no of SH	Types of previous self-harm (not including Index Self Harm) (* = suicidal intent; ^ = without suicidal intent)
A	F	35-50	Poisoning	30	115	Cutting*^, Burning (match & cigarette), Scratching, Hitting head, Sticking sharp objects, Rubbed glass, Preventing wounds from healing, Poisoning*^
B	F	35-50	Carbon Monoxide	2	118	Cutting*^, Burning (fire), Carving words & designs, , Hitting head, Sticking sharp objects, Punched self, Hit self with object, Poisoning*^
C	M	51-65	Carbon Mono. & Poisoning	3	3	Poisoning*
D	F	18-25	Poisoning	1	33	Cutting^, Carving designs, Poisoning*^
E	F	26-35	Poisoning Cutting & Burning	100	1662	Cutting^, Carving words, Biting, Burning with iron, Scratching, Dripped acid on skin, Used bleach to scrub skin, Hitting head, Sticking sharp objects, Preventing wounds from healing, Poured boiling water over self, Stopped medication, Poisoning*^
F	M	18-25	Poisoning	1	1	None
G	M	18-25	Poisoning	1	21	Cutting^, Burning (cigarette), Scratching, Sticking sharp objects, Poisoning*
H	F	26-35	Cutting	30	109	Cutting*^, Carving words, Scratching, Hitting head, Burning with iron, Poisoning*
I	F	35-50	Cutting	20	93	Cutting*^, Scratching, Punching, Sticking sharp objects, Preventing wounds from healing, Poisoning*^
J	M	18-25	Cutting	3	68	Cutting*^, Burning (match & cigarette), Rubbing glass, Punching, Sticking sharp objects.

Table 4: Participant summary information (Study 1)

Person	Time since	Planning	Alcohol units	Strongest emotions before	Strongest emotions after	Strongest reasons	Emotional Regulation (DERS)	Experiential Avoidance (AAQ)
A	4	<1 hour	11.4*	Despair, Detached, Disappointment, Emptiness, Powerless / Hopeless	Detached, Relief, Powerless / Hopeless	Unbearable situation, Escape from impossible situation, I wanted to die.	133**	47***
B	16	1 month +	14.1*	Despair, Detached, Excited, Loneliness, Pleasure, Relief, Self-contempt, Emptiness, Powerless / Hopeless	Despair, Fear, Loneliness, Emptiness, Powerless / Hopeless	Relief from state of mind, Show love, Unbearable situation, I wanted to die, Easier for others.	116**	44***
C	12	1 month +	13.5*	Despair, Detached, Relief	Despair, Disappointment, Relief	Relief from state of mind, Unbearable situation, Escape from impossible situation, I wanted to die.	99**	42***
D	6	<1 hour	0	Anger at others, Despair, Disappointment, Fear, Guilt, Loneliness, Powerless / Hopeless	Anxiety, Detached, Fear, Guilt, Shame, Powerless / Hopeless	Relief from state of mind, Unbearable situation, Escape from impossible situation, Make people understand, Seek help.	134**	55***
E	4	1 hour - 1 day	0	Anger at self, Loneliness, Powerless / Hopeless.	Detached	Relief from state of mind, Lost control, Unbearable situation, Make people understand, Seek help, Sleep.	101**	39***

Person	Time since	Planning	Alcohol units	Strongest emotions before	Strongest emotions after	Strongest reasons	Emotional Regulation (DERS)	Experiential Avoidance (AAQ)
F	8	1 hour - 1 day	0	Anger at self and others.	Shame	Show love, Lost control, Unbearable situation, Escape from impossible situation, Make people understand.	95	39***
G	4	1 month +	yes (units not known)	Anger at self, Anxiety, Despair, Fear, Loneliness	Despair, Detached	Relief from state of mind, Lost control, Unbearable situation, I wanted to die, Find out if loved, Frighten someone.	126**	48***
H	1	1 hour - 1 day	0	Anger at self, Relief, Self-contempt, Emptiness	Anger at self, Fear, Relief	Make people understand, I wanted to die, Punish self.	128**	44***
I	32	1 week - a month	0	Anger at self, Fear, Guilty, Self-contempt, Powerless / Hopeless	Anger at self and others, Despair, Disappointment, Fear, Guilt, Self-contempt, Powerless / Hopeless	Relief from state of mind, Unbearable situation, Escape from impossible situation, I wanted to die, Easier for others, Sleep, Punish self.	129**	47***
J	5	<1 hour	10.0*	Anger at self and others, Detached, Fear, Guilt, Shame, Powerless / Hopeless	Excitement, Loneliness, Relief, Shame, Emptiness, Powerless / Hopeless	Relief from state of mind, Unbearable situation, Escape from impossible situation, I wanted to die, make people sorry, Punish self.	154**	49***

* Meets criteria for binge drinking (eight or more units for men and six or more units for women) (British Medical Association, 2005)
** Score considered in clinical range
*** Score above upper quartile of non-clinical sample

3. Interpretative phenomenological analysis: overview of themes

Twelve themes emerged from the interpretative phenomenological analysis of the interview transcripts. These were organized into four super-ordinate themes (See Table 5). Following this, an overview of each super-ordinate theme is presented and each sub-theme subsequently described with illustrative quotes from the participants. Both similarities and variations between participants are considered in the descriptions.

Table 5: Summary of super-ordinate themes

Super-ordinate theme 1: "I'm not good with feelings"
Theme 1 – Difficulty understanding and expressing emotions
Theme 2 – "My feelings just spiral out of control"
Theme 3 – Hiding emotions from others / struggling to cope alone
Super-ordinate theme 2: "You can't put a plaster on emotional pain" – Trying to make it feel better
Theme 4 - Physical expression of emotional distress
Theme 5 - Make a feeling stop v. make all feelings stop
Theme 6 – "What I want to do is dice with death"
Super-ordinate theme 3: Self-harm as an interpersonal process
Theme 7 - Feeling invalidated by others
Theme 8 - Do I want to seek help from others?
Theme 9 - Loss of personal agency
Super-ordinate theme 4: Living with self-harm
Theme 10 - Being an amateur self-harmer
Theme 11 - Becoming an experienced self-harmer
Theme 12 - The private and the public - accepting and acknowledging self-harm

4. Super-ordinate theme 1: "I'm not very good with feelings" (H)

This theme reflects the difficulty that the participants described in managing their emotional life. They found it hard to understand and express emotions and when they did express negative emotions, they felt overwhelmed and out of control. They were ashamed of other people being aware of their negative feelings and, though they actively sought to distract themselves from these feelings, they were not always successful.

4.1 Theme 1: Difficulty understanding and expressing emotions

Emotions were described as difficult to understand. Participants talked about not knowing how they were feeling and finding it hard to use the right words to describe their emotional experience. They were often unable to pinpoint the reason for a particular negative feeling and this seemed to increase their distress, as they felt they had no control over the cause.

> *I'm not very good with feelings and quite often I find it really hard to know how I'm feeling and why it is that I feel that way (H:443-445).*

> *I don't think to talk to anybody because I don't know what to say , I don't know how to say how I feel or, because for me it's just, I feel really crap and that's it, I don't know what else to say. It's just like, 'Well yes I do feel really crap' but I don't know what else, what other words to use to say why it is because I just do (H:184-188).*

> *Whereas when I'm feeling really down and crappy and it's not a particularly tangible reason, I don't have any reason for it, that's when it gets on top of me more that when I have actually got something to get upset about because I don't know what to do about it (G:333-337).*

Expressing emotions was very difficult, with people talking about disliking being upset and, particularly, the experience of crying or feeling anger. They felt that expressing emotions did not provide them with relief.

I don't know what to do with myself...well I do know what to do with myself - I cut myself. If I didn't have that I would be sort of very confused about how to express it. I'm not a crier (D:277-279).

I'm not much of a crier. I can't...I don't...it just makes me tired. It doesn't make me feel any better (laugh) (D:254-255).

A number of people talked about being upset as too time-consuming and just wanting something to make the feelings go away quickly.

So I used to use self-harm as a quick way of doing that especially at university that I can take myself out of whatever conversation it was, cut my arms, and be back within five minutes, whereas if I was going to cry and be upset and that was going to take so much longer (E:422-429).

4.2 Theme 2: "My feelings just spiral out of control" (J)

All of the participants talked about experiencing overwhelming emotions, which they described as having an uncontrollable quality. They depicted their emotions as feeling out of proportion to their current situation. This particularly appeared to be related to anger, which a number described as "boiling up" inside them.

If I can't get out of it things get from bad to worse. Then it interacts with everything else . . comes forward . . so then everything is on your mind all at once. It feels like your head's going to explode (A:702-705).

Only one participant talked about feeling overwhelmed by their positive emotions. Although the others described strong positive emotions, this seemed less of a problem for them. Several people felt that, after feeling so positive, it made a subsequent experience of negative emotions feel worse.

I don't tend to describe them as overwhelming but in practice I do do the same with them, so that if I'm enjoying something, I have a good time, then I'm totally focused on that, and I'm not looking ahead for the time I'm going to feel sad again. I do tend to be in whatever I'm doing at that minute (E:488-491).

But then it's kind of like if I do that, then I have to find something else to do afterwards, because what happens is, if I get really down and then I distract myself from it and go in the opposite direction, then feel really happy and good about myself, then completely crash even worse afterwards (G:416-420).

4.3 Theme 3: Hiding negative emotions from other people / struggling to cope alone

Participants talked about not wanting people to see their true feelings – of putting on a happy mask to cover up negative feelings:

> *She said, 'I thought you were getting better'. I said, 'No, I was just covering up'. I've learnt to do that. Just because I might laugh or chuckle or tell a funny joke people might think, 'Oh she's okay' (B:247-249).*

One participant said that, when other people saw her being upset, they would pressure her to feel better. She would prefer to leave the situation, rather than be seen to be upset (E). Implicit within the accounts was a sense of the shame of being seen by others to be upset and a strong need to hide away:

> ***Interviewer:*** *What helps when you are feeling upset?*
> ***H:*** *I don't know, because I don't really do it. What I really prefer is hiding under a blanket. Just lying on the floor and being under the blanket, against the wall where nobody can see me (H:428-432).*

The participants choose to try to manage their difficult feelings alone. They described engaging in distraction strategies, such as listening to music, going to sleep, watching TV (particularly comedies) but that these were not always successful and they had to work very hard to continue to maintain the distraction.

> *But I've had it when I've refocused on something and someone's said something and you have to restart or you end up self-harming (A:789-791).*

Only participant F focused on other people to help him: "*like when I have a laugh with mam and dad it makes me feel better*" (F:283-284).

5. Super-ordinate theme 2: "You can't put a sticking plaster on emotional pain"[(D)] -Trying to make it feel better

The participants described using self-harm as a way to make their emotional pain and distress go away. By turning it into something physical, it could be expressed and, for

some people, soothed. Self-harm was a way of stopping the emotional pain and although it could result in death, that was a risk worth taking.

5.1 Theme 4: Physical expression of emotional distress

Self-harm, and particularly self-injury, enabled the emotional pain to be turned into something physical which provided the opportunity for people to show their distress without using words, to show how bad they were feeling. This in turn seemed to provide a validation of those feelings and a number of participants talked about the scars representing their emotional pain and feeling soothed by them.

> *Okay, I started harming about six years ago and what I realised is that, I punched the wall, and all, some of the hurt I was feeling inside I could see something physical on me to say 'Look I'm hurting' (I:28-30).*

> *There's something about if I use cutting then it has to be a deep enough cut for stitching and for it to scar so that it's a message to me. You know like it gets really bad up there because, look I don't need it to show someone else or for someone else 'Look this is how much I hurt'. It's all for me, my benefit (I:247-251).*

The physical aspects of self-injury (seeing the blood, feeling pain, the scars) were seen as important. However, there were different experiences of pain; some people felt no pain at the time and wanted to feel pain to feel alive, while others felt that the physical pain distracted or relieved their emotional pain. By turning emotional distress into something physical it seemed to allow the person to care for themselves and, when they chose to, to seek care from other people. It gave a practical way for others to intervene, by dressing a wound or by being cared for in hospital after an overdose.

People described making a physical 'mess' and then being able to 'tidy it up'.

> *I find that the physical pain of self harm helps me deal with the mental pain of whatever is going on around me that made me want to do it and obviously like I said like when I cut myself I will wash it and bandage it, put cream on and whatever it needs, its easier to deal with but you can't sort of stick a plaster on emotional pain can you? (D:270-274).*

When I was really coming apart and cutting a lot, and there were times when she stuck them back together and that was comforting. And times when I went into hospital and sometimes it almost felt like it gave the other person something they could do, that I kept coming to people saying, 'I'm really hurting here, I'm really upset' and they were like, 'But what can we do', and when I came to them with cuts and blood everywhere and everything then they could clean it up and make it tidy (E:206-211).

5.2 Theme 5: Make a feeling stop v. make all feelings stop

Participants talked about self-harm as a way of making a specific feeling stop. This was often in relation to self-injury and seemed to be about continuing to cope with life.

> *It's more often, it wants whatever feeling I'm stuck in to stop but it's not about stopping everything in the same way. It's almost the opposite but when I do cut I've usually got in my mind something that I'm going to do next, that cutting and getting out of this upset is going to make possible (E:537-540).*

In relation to self-poisoning it could also sometimes be about stopping specific, often painful, feelings.

> *And so I can stay stuck for hours or even days sometimes but I don't get out of it until I've overdosed and that's broken all the feelings (E:266-267).*

However, individuals described times when self-harm was about stopping all their feelings and this was often accompanied by a change in their self-harm behaviour.

> *But this one, the carbon monoxide was for different reasons. It was to stop feeling the pain (B:502-503).*

> *Because actually if I had have done I knew it was a consequence, I knew almost that at least if I died then all the feelings and all the hurt and everything else that I get inside me, that would stop and that would be nice (I:74-77).*

Participants described this as primarily being about stopping all their feelings, rather than dying although several individuals did explicitly link this to being dead.

5.3 Theme 6: "What I want to do is dice with death"[I]

The accounts reflected a strong ambivalence in relation to intent to die. For some, making a decision to self-harm became synonymous with making a decision to die. Even where the decision was fairly impulsive the ambivalence was evident:

> *Like I said when I was taking the overdose I wanted to go and I didn't. I wanted to see if, I always think my future's going to be bad but just sometimes it's just like, 'It might be alright and I'll stick through it'. But then I just realise it might not be so I took the chance (F:165-168).*

Although some people were very clear about their intention to die, they would often seek help from others after their self-harm while continuing to maintain their intent to die. Their accounts also reflected the changing nature of intent:

> *But then things changed and I started cutting on my wrist because, actually, I didn't mind if I died. I was quite prepared to take that risk (I:41-43).*

A number of people described the death as a risk they were prepared to take if the outcome resulted in them feeling better:

> *Like I said it was like either get help and be alright or like die, and well I wouldn't have to worry about getting help because I wouldn't have to worry about anything. It was like win win either way for me (D:375-377).*

However, in taking the risk, they also seemed to minimise or underestimate the lethality of their self-harm. Participant E, who self-injured and self-poisoned, talked about seeing her self-injury as normal, which led to her underestimating the effect of her self-poisoning:

> *Because a lot of the time it* [self-poisoning] *doesn't feel that different, because I tend to assume, like when I was cutting, to me that was very normal and I was doing it all the time. And I knew if I showed it* [self-injury] *to other people, a lot of them would respond with a lot of shock and fear and see it as a lot more, a lot bigger and a lot more dangerous than it was and I tend to apply that to everything with self-harm* [including self-poisoning] *(E:508-512).*

6. Super-ordinate theme 3: Self-harm as an interpersonal process

The interpersonal processes of self-harm were very apparent, even when self-harm occurred in secret and no-one was aware of it. The overwhelming feelings often arose in response to interactions with others and this could lead to self-harm. The responses of others could lead to further invalidation and this led to fears about presenting their harm to medical staff. The response of others often led to a loss of personal agency, which some participants wanted but also struggled to accept.

6.1 Theme 7: Feeling invalidated by others

Self-harm often occurred subsequent to the person feeling invalidated by others or feeling that they had failed interpersonally. These feelings seemed to be either externalised, where self-harm was almost a way of attacking others, or internalised, where self-harm was about punishing the self without the other person knowing.

> *All I saw was like, my mam and dad and sister like having a go at me, so every time I was taking them* [tablets] *I was thinking of them. This is why I'd done it. Hope you are proud of themselves (F:41-43).*

> *...it was like paying for being a horrible person. If I did that it made me okay. And I did it if I felt I'd upset anybody or I was angry at myself at the way I'd acted to somebody I'd go and cut as well. I'd go and cut but they never had to know that it was anything to do with them (E:195-198).*

Following self-harm people talked about further invalidation from their friends and family and a sense of failing to make an impact.

> *It was like I said it just felt a lot like after I had got out of hospital everything just suddenly went back to normal and everyone forgot that I had just blatantly taken an overdose and had spent nearly a week in the hospital and sort of everyone got back to normal and no-one mentioned it and it was like 'that was it, she didn't die' and 'woo hoo that's the end – we don't have to worry about it anymore' and like it was hang on a minute. Something was supposed to happen (D:420-426).*

In general, participants were very aware of the potential negative effect of other people and described feelings of shame:

> *I'm almost ashamed of who I am. Because everywhere I go I just keep my head down and not keep it up and be proud of who I am (J:406-408).*

6.2 Theme 8: Do I want to seek help from others?

Seeking help for their self-harm involved participants showing their self-harm to others. They were very anxious about being seen as attention seekers and being taken seriously.

> *"I'm anxious about how my harm is going to, in presenting my harm to the hospital, how are they going to react" (I:202-203).*

> *What the hospital would say when I turned up. Like people turn up in car crashes and stuff and I had turned up deliberately taking an overdose and making it not kill me kind of thing, everyone will hate me for causing lots of hassle (D:174-177).*

Given this fear, individuals were ambivalent about making a decision to seek help.

> *I've taken overdoses and I don't go to hospital and that, it always is that weighing up, 'Do I want to go to hospital and get the help dealing with this, more than I want to avoid going to hospital' (E:64-67).*

For those participants who regularly attended hospital, the previous response of others had led to an increase in the severity of their self-harm to ensure that they were taken seriously.

> *So I cut myself and ended up with twelve stitches so because somebody said once that that wasn't that bad so, one of my cuts wasn't that bad so I thought, 'Okay I can do a bit more so' (H:26-28).*

> *I think it's more the response people are going to give, so I kept taking Paracetamol because if I came to A&E having taken Paracetamol, nobody is going to say 'Why did you bother us with that' (E:118-120).*

6.3 Theme 9: Loss of personal agency

Participants often experienced a loss of personal agency when they went into hospital. Medical professionals were perceived as very powerful and a number of people went to hospital because another medical professional had told them to go, often with a sense that they had been forced to go.

> *I got dragged back into hospital (A:606).*
>
> *They got hold of an ambulance and dragged me off to hospital (C:199-200 .*

Although some participants were resentful of this, they also expressed a sense of wanting others to take control. They described it as feeling like a 'small child' and wanting someone to contain them and keep them safe.

> *Then I kind of thought I just well...like....I just sort of wanted someone to help me and make everything better again and just make this feeling go away (D:82-84).*

Participant E explicitly recognised the interaction between the way in which she was behaving and the response from medical professionals.

> *But here I'd had people ask me if I wanted my parents informed. I'd say 'No' and they rang anyway...I was in my twenties then, but because of the way I was behaving I didn't seem adult (E:595-600).*

7. Super-ordinate theme 4: Living with self-harm

This super-ordinate theme reflects the relationship people have with self-harm. Initially people feel scared and unsure about self-harm but also somewhat curious. As they become more experienced, their self-harm becomes more routine, although it can still change. Their relationship with self-harm is often contradictory. Privately some people are able to accept their self-harm but publicly they struggle with wanting their self-harm to remain hidden and not wanting to be acknowledged as a self-harmer.

7.1 Theme 10: Being an amateur self-harmer

Participant F, who had only self-harmed on one occasion, compared himself to people who repetitively self-harm and recognised that he felt different: *"you're just an amateur compared, I don't know just an outsider" (F:421-422)*. The sense of being an amateur was reflected in some participants' descriptions of starting to self-harm and involved feeling like they didn't know what they were doing or which method to choose:

> *I would ring my friend up, xxx [friend] because she does it all the time. Well she used to, she used to slit her wrists. I was going to ask the best way, but I know she'd sussed me out in trying to get through to stop me. So, I didn't ring her up (F:131-134).*

People talked about not knowing what would happen next, particularly after self-poisioning. This was often accompanied by feeling scared:

> *I was scared, I was panicking. I had never seen anyone take an overdose. I didn't know what would happen to me. Is it going to hurt? Am I going to spontaneously combust? Or what? I had no idea what was going to happen (D:171-173).*

Being an amateur also involved a sense of trying out self-harm or experimenting with it. This occurred equally to both self-poisoners and self-injurers. There seemed to be a strong sense of curiosity, which seemed at odds with the fear.

> *What will it do? I don't know because some of the time when I took...I haven't taken the sleeping tablets since I've been xxx [name of illness] but when I did the sort of effect it had I was quite fascinated by that (E109-111).*

> *So I used fisting the wall for a short while. I don't know why I moved on to it but I guess I experimented cutting myself, just a small cut to see how it felt (I30-32).*

7.2 Theme 11: Becoming an experienced self-harmer

Becoming an experienced self-harmer involved developing rituals relating to the method of self-harm. For self-injury this could involve the implements used, location where harm took place and the location on the body. Rituals also developed in relation to self-poisoning:

> *And so the only times now that I cut really are when I've already overdosed and when I'm going to A & E, I sometimes still cut then. The rest of the time I don't cut. There have even been times when I've been thinking about overdosing and I've had in my head 'Well if you overdose you're going to have to cut as well' and really not wanting to cut (E:167-170).*

Where the person then attended hospital, the ritual also seemed to extend to the hospital and included which wards people went to:

> *A: Most of the staff know me, I've got a clocking on card on ward 21, I've got my own rent book. But most of the staff know me now anyway (A:920-921).*

Becoming an experienced self-harmer also involved changes to the methods over time:

> *All the way through it seems to have changed, the way I've done it to why I've done it (H: 221-222).*

Although most people were clear that they used different methods of self-harm at different times and for different reasons, for people who used multiple methods there was also a sense of movement between the methods:

> *One way or the other, if it's self harm . . . then cutting. Cutting nine times out of ten will stop me from taking tablets or other such things as . . . but there's been times when I've gone from one to another at the same time, because nothing's worked (A:520-523).*

However, some people would describe themselves as experienced in one form of self-harm (e.g. self-injury) but an amateur in another (e.g. self-poisoning). Being

experienced appeared to relate specifically to each method and the most repetitive self-harmers seemed to be experienced in multiple methods.

7.3 Theme 12: The private and the public - accepting and acknowledging self harm

Participants talked about self-harm as not being a problem for themselves, particularly self-injury. They accepted it as coping mechanism which was the safest option available to them. A number of people struggled with the dilemma of doing something which helped them but also harmed them. This was more evident when they talked about how they felt about other people who harm:

> *I'd stop anybody doing it. I hate it. Every time I try and stop other people, they end up calling me a hypocrite because I've done it, but I wouldn't want anybody else to do it. I wouldn't want anybody to go through what I've been through. It's not a good place to be at (J:327-330).*

However, several participants strongly maintained their own right to self-harm:

> *It's like my body and I'm allowed to do what I want to it. And even if I do want to kill myself who are they to stop me (D:210-211).*

In contrast, some people found it difficult to acknowledge privately that they had harmed themselves. They talked about finding it difficult to quantify the amount of self-harm, as this involved remembering it. They found it hard to come to terms with what they had done: *"Quite extreme but I did it. Sometimes I can't believe that I did it" (F:180).*

Publically, all the participants struggled with other people seeing their self-harm and needing to keep it hidden. Repetitive self-injurers talked about trying to get away with further self-harm, without others finding out. There was a fear of being judged and shamed by others, which in some cases led to denial of their self-harm.

> *Like I said it is awkward when people ask questions about it. I think some people do sort of twig. But they don't say anything and even if they do I just lie and say I'm not a self-harmer (D:217-219).*

One participant was able to reflect on the public separation of their self-harm as a way of managing the contradictions:

> *I kind of separate it, the self harm from everything else. In my mind, and I know it's not true, the kind of picture in my mind, is that nobody outside the hospital and medical profession actually knows that I self harm. And while it's not as black and white as that, it's very split so that I don't tell anyone when I go into hospital (E:572-576).*

8. Participant validation

Two participants were available to attend for a follow-up session to discuss the themes. They both identified with, but were surprised by, the contradictions and strong ambivalences within the themes. One participant explained that "*when you are in it you can't take a step back it from it, it depends which head you have on at the time*". She felt that this left her living a double life, which she felt was reflected in *The private and the public - accepting and acknowledging self harm.* One participant challenged the first part of *Being an amateur self-harmer,* feeling that she had known exactly what she was doing at the time, although it was possible that this was because she had self-injured. However, the participant identified with trying out self-harm and felt that this was the transition to becoming a more experienced self-harmer. Overall, both participants were satisfied with the themes as a reflection of their different experiences of self-harm.

CHAPTER 4 RESULTS (STUDY 2)

There is nothing like looking, if you want to find something. You certainly usually find something, if you look, but it is not always quite the something you were after.

J.R.R. Tolkien Writer (1892-1973)

1. Overview

This chapter presents the analysis of data collected from sixty participants in Study 2 (the questionnaire study). Both quantitative and qualitative findings are detailed and an explorative analysis of the relationships and group differences is undertaken.

2. Missing data

Sixty people completed the questionnaire following an incident of self-harm. There was a high level of missing data: 29 participants (48.3%) had some data missing in the questionnaire. However, in only three cases did the participant stop completing the questionnaire. The sections with missing data were not located at the end of the questionnaire, which suggests that participant fatigue was not a factor. An analysis of the missing data was conducted. Although a number of participants missed specific motives (6 people) and items in the AAQ (6 people), the areas where most data was missing was in rating the strength of their emotions (23 people) and quantifying the amount of self-harm behaviours (11 people). It was not that participants failed to complete the whole of the emotions section, but that they missed particular items within that section. In the DSHI, they were able to indicate if they had ever engaged in a particular self-harm behaviour but a group of people then did not quantify the amount of that behaviour. Where this occurred, they then tended to miss all the quantification items for that section. It was decided to exclude participants with missing data for each item rather than exclude all of their data.

3. Attendance at hospital

Thirty five people (58.3%) were first attendees at hospital, while 23 people (38.3%) were repeat attendees and 2 people (3.3%) were unknown. The number of times people reported that they had attended hospital ranged from 1 - 20 occasions (mean 3.40, median 1.00; SD =4.67; Interquartile Range=2.50). This variable was positively skewed as shown by the One-Sample Kolmogorov-Smirnov Test, which was highly significant (Z =2.36; p <0.001). Where possible, hospital records were consulted to validate the self-reported figure. However, records were often incomplete or difficult to access, so a full validation was not possible. Of those records accessed (n =15), the self-report was shown to be valid for seven. The remainder were incomplete.

4. Method of self-harm (index episode)

The method of self-harm for this current episode (index episode) was recorded (100% response rate) and is shown in Table 6. The most prevalent method was self-poisoning (85.0%) which was as expected, given the study population. Overall, rates of self-poisoning in attendees at the hospital during the study were slightly lower (71.4%) However this may be an underestimate as the classification of 'other' is regularly used.

Table 6: Method of self-harm frequency and percentage

	Study 2 Frequency	Study 2 Percent	All hospital attendees for self-harm: Percent
Self-poisoning	51	85.0	71.4
Self-injury	5	8.3	6.1
Hanging	1	1.7	0.8
Mixed method	2	3.3	-
Fire	1	1.7	-
Other	-	-	21.7
Total	60	100.0	100.0

5. Choice of self-harm method (index episode)

Participants were asked why they chose their method of self-harm. There was a 93.3% response rate (56/60 responses) and this was analysed using content analysis (see Table 7). The most frequent response (33.9%) related to the accessibility of the method. Other responses related to the expectations of using the particular method (e.g. easiest, painless, previous experience), the outcomes of using the method (e.g. stop difficult feelings or wanted to die), their reasons for harming themselves (e.g. personal problems) or an impulsive choice.

Table 7: Choice of self-harm method

Theme	Reason	Count	Example Quote
Accessibility	Accessibility	19	*"Tablets were there at the time"*
Expectations of method	Easiest	14	*"Easiest way"*
	Painless	5	*"It seemed to be the most painless"*
	Previous experience	3	*"Have used it before"*
	Simple	2	*" I found it a simple way out really"*
	Quick	2	*"Quick"*
	No scars	1	*"It leaves no visible marks or scars"*
	Other people have used it	1	*"I've heard many people use this method"*
	Believed it will work	1	*"Cause other things don't work"*
Intended outcomes of method	Stop difficult feelings	5	*"Thought it was a simple way to resolve the way I was feeling at that time"*
	Death	4	*"The outcome should have been suicide"*
	Wanted to go to sleep	4	*"I wanted to go to sleep and not wake up"*
	Reduce pain	2	*"Numb pain"*
	Way to seek help	2	*"It was the easiest way to be rescued"*
	Didn't want to die	2	*"But not with the intention of death"*
Reasons for self-harm	Because of personal problems	3	*"Because I have problems"*
Impulsive choice	Impulsive decision	2	*"Just the first thing that came into my head"*
Don't know	Don't know	5	*"Don't know-wasn't thinking clearly at time"*

6. Length of time since self-harm

Participants were asked how long ago it was since they had harmed themselves. The length of time since the self-harm episode ranged from 4 hours to 168 hours (7 days) (mean =39.35 hours; median and mode =24 hours; SD =53.64 hours; interquartile range=33 hours) (95.0% response rate). 70.2% of the sample completed the questionnaire within 24 hours of harming themselves and 91.2% within 72 hours.

7. Alcohol and drugs

Thirty three people (55.0%) reported that they had consumed alcohol prior to harming themselves. Participants were asked to estimate how much they had been drinking and, where possible, this figure was converted to units of alcohol using a unit converter. The mean number of units for those that had consumed alcohol was estimated as 16.25 units (Median 12.00 units; SD =1.9 units; Range 1 - 53 units). The Office for National Statistics (ONS) definition of 'heavy' drinking is eight or more units for men and six or more units for women on at least one day in the week. This has been used as a proxy for binge drinking (British Medical Association, 2005). Of those people who had been drinking, 76.7% would have been classified as binge drinking prior to their self-harm. Twelve participants (20.0%) reported that they had also used drugs prior to their self-harm.

8. Length of time participants had thought about harming themselves

Participants were asked how long they had thought about harming themselves. There was a 98.3% response rate. The results are shown in Table 8 and it can be seen that 59.3% had thought about self-harm for less than a day, whilst 16.9% had thought about self-harm for a month or more.

Table 8: Length of time participants had thought about self-harm

Length of time	Frequency	Percent
Less than an hour	21	35.6
More than an hour but less than a day	14	23.7
More than a day but less than a week	6	10.2
More than a week but less than a month	8	13.6
A month or more	10	16.9
Total	59	100.0

9. Why did you come to hospital?

People were asked why they had attended hospital. There was a 91.7% response rate *(55/60 responses)* and this was analysed using content analysis (see Table 9). The most frequent responses related to other people and seeking medical help.

Table 9: Reason for attending hospital

	Reason	Count	Example Quote
Other People	Other people contacted emergency services	15	*"An ex partner knew what I had done and called the police"*
	Other people took them	13	*"My flatmates alerted the authorities"*
	Other people found them	4	*"My family found me"*
	Other people asked them to go	2	*"Because a friend made me promise to."*
	Impact on others / feeling guilt	2	*"The pain I was suffering and also visions of my daughters finding me"*
Seek medical help	Because of what they had taken	7	*"Because I had taken an overdose"*
	For medical help	6	*"I came to hospital for help"*
	Feeling unwell/in pain	5	*"I set myself on fire and I was burning like hell"*
	Didn't want to die	4	*"Because I didn't want my life to end"*
	Scared of what would happen	3	*"I felt unwell and became scared of what was going to happen to me, would I feel anything."*
	Because of self injury	2	*"knew had cut too deep in moment of 'madness'"*
Other	Changed mind	1	*"Because I came to my senses"*
	Self contacted services	1	*"I called an ambulance"*
	Get to safe place / No responsibility	1	*"I knew I would have to be in a safe place and not have to worry about anything"*
	Don't know	1	*"Don't know can't remember"*

10. Presence of emotions (self-poisoners)

Participants were asked to rate how they were feeling just *before* they self-harmed, just *after* and *now* as they were completing the questionnaire. *Before*, *after* and *now* were treated as different time points, although the data was collected retrospectively at a single time point. Table 10 shows the percentage of self-poisoners,[2] indicating the presence of a specific emotion.

Table 10: Percentage of self-poisoners reporting the presence of a specific emotion

	Before	After	Now
Anger at others	82.2	46.3	46.3
Anger at self	80.4	78.0	88.0
Anxiety / panic	72.7	71.4	60.0
Despair	77.8	78.0	64.1
Detached / cut off	84.8	74.4	64.4
Disappointment / insult	84.4	76.2	71.8
Excitement	14.3	26.8	7.7
Fear	72.7	72.5	70.0
Guilt	59.1	61.0	70.7
Loneliness	91.3	87.8	84.6
Pleasure	9.8	19.5	10.0
Relief	53.5	67.5	50.0
Self-contempt	55.3	48.6	60.0
Shame	65.1	65.0	73.8
Emptiness (mental vacuum)	75.0	72.5	71.8
Powerlessness / hopelessness	93.3	85.0	66.7

The most reported emotion prior to self-poisoning was *powerlessness/hopelessness*, while the least reported emotion was *pleasure*. There were increases in the amount of people reporting *excitement*, *pleasure*, *relief* and *guilt* (*despair* increased slightly) *after* self-harm, while the number of people reporting all other emotions stayed the same or showed decreases. This section was poorly completed: the response rate for each emotion ranged from 71.7% to 91.7%. It was noted that participants often asked

[2] People who had engaged in self-injury (9 people) were excluded from this analysis to enable conclusions to be drawn about one specific method.

for further clarification of the meaning of *self-contempt* and that this had the lowest response rate suggesting that this term was poorly understood by participants.

11. Strength of emotions (self-poisoners)

Participants were asked to rate the strength of each emotion just *before*, just a*fter* and *now* as they were completing the questionnaire. Figures 4 to 7 show the mean strength of each emotion at each recalled time point for self-poisoners and it can be seen that they reported different emotion strengths at the other time points from their current emotional state. After self-poisoning, *anxiety* and *fear*; *excitement*, *pleasure* and *relief*; and *guilt* and *shame* increased, while the other emotions reduced in strength. For most emotions the reported strength reduced at the *now* time point apart from for *guilt*, *self-contempt* and *shame* which slightly increased in strength.

Figure 4: Changes in strength of emotions (self-poisoners)

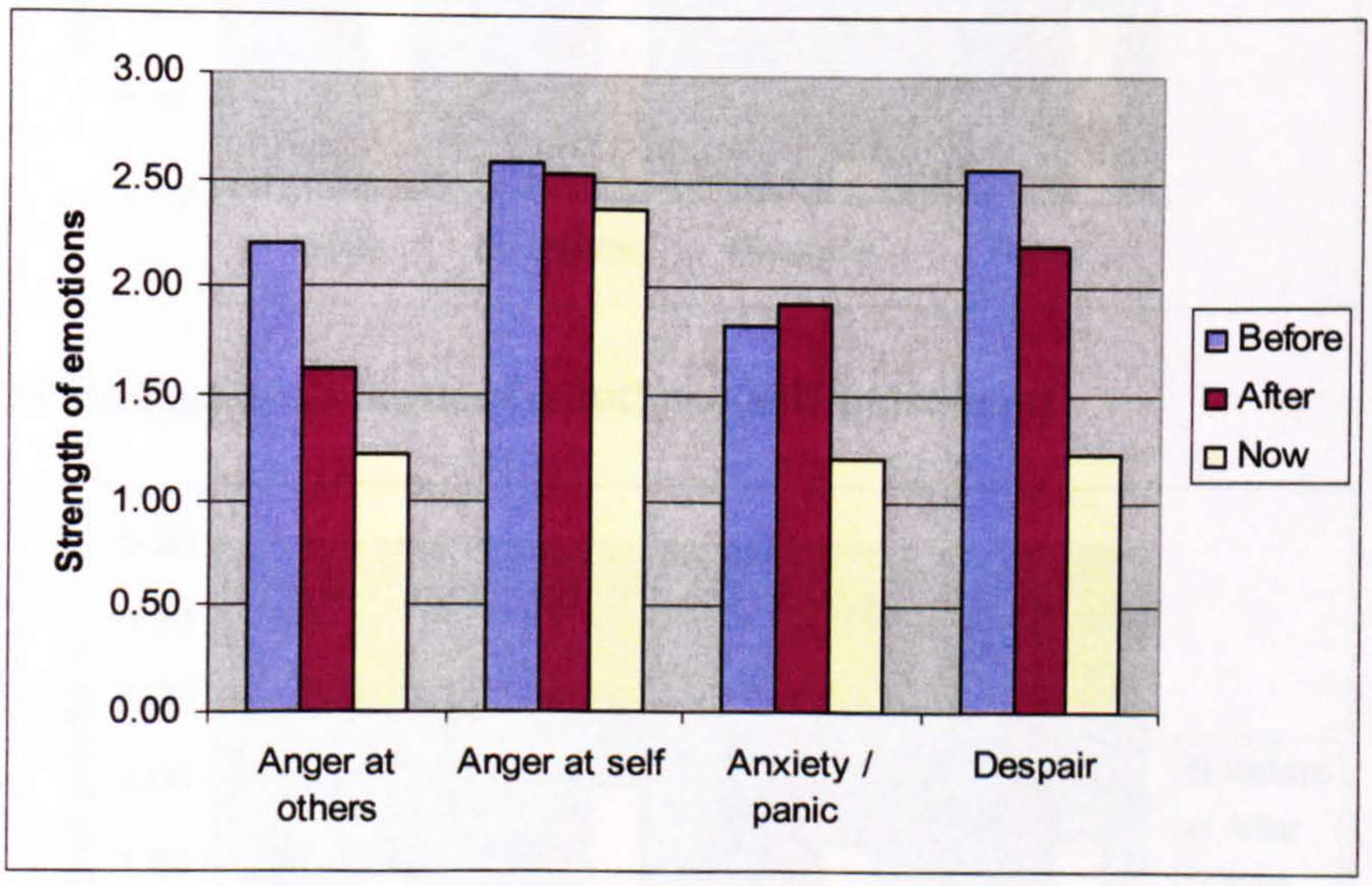


Figure 5: Changes in strength of emotions (self-poisoners)

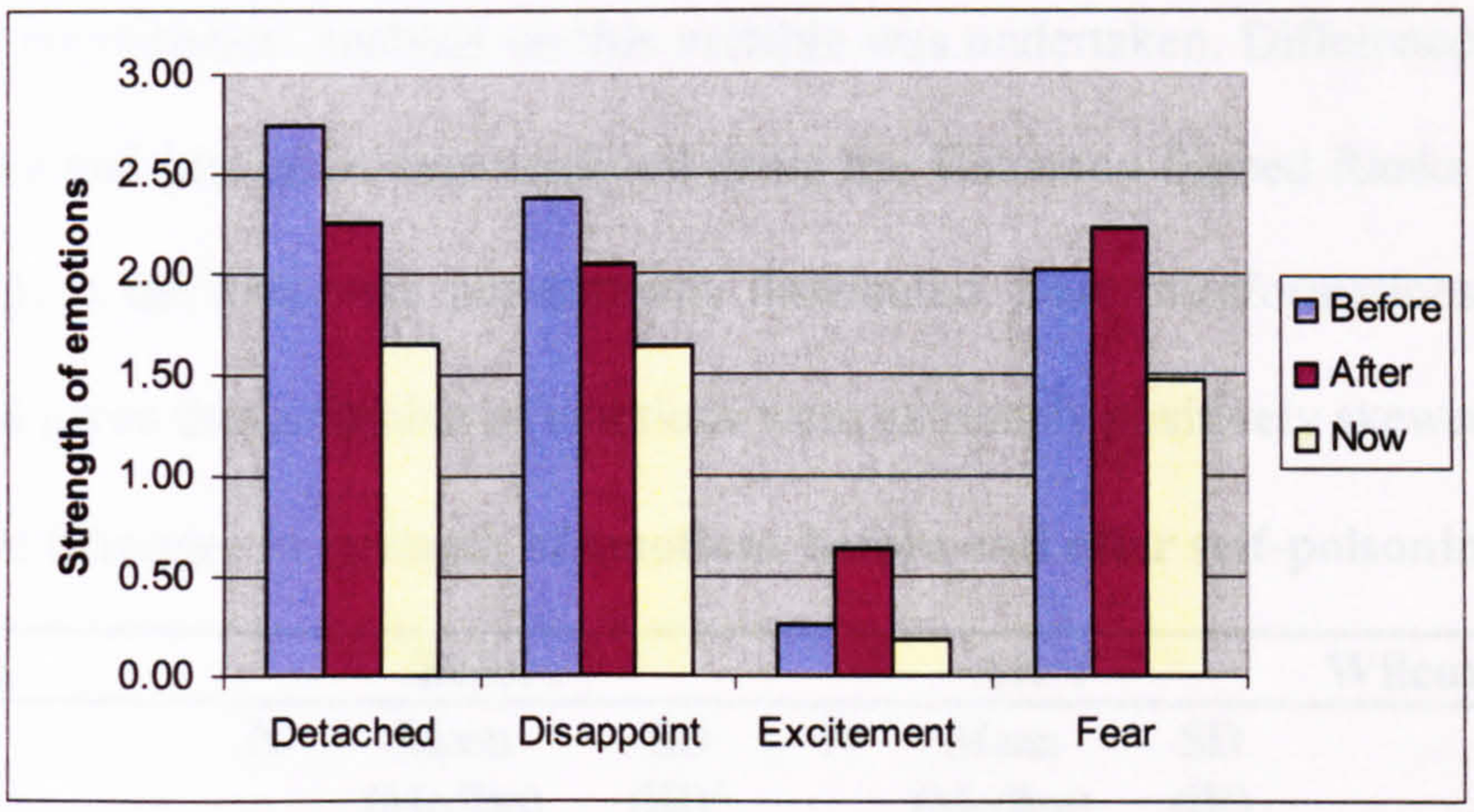


Figure 6: Changes in strength of emotions (self-poisoners)

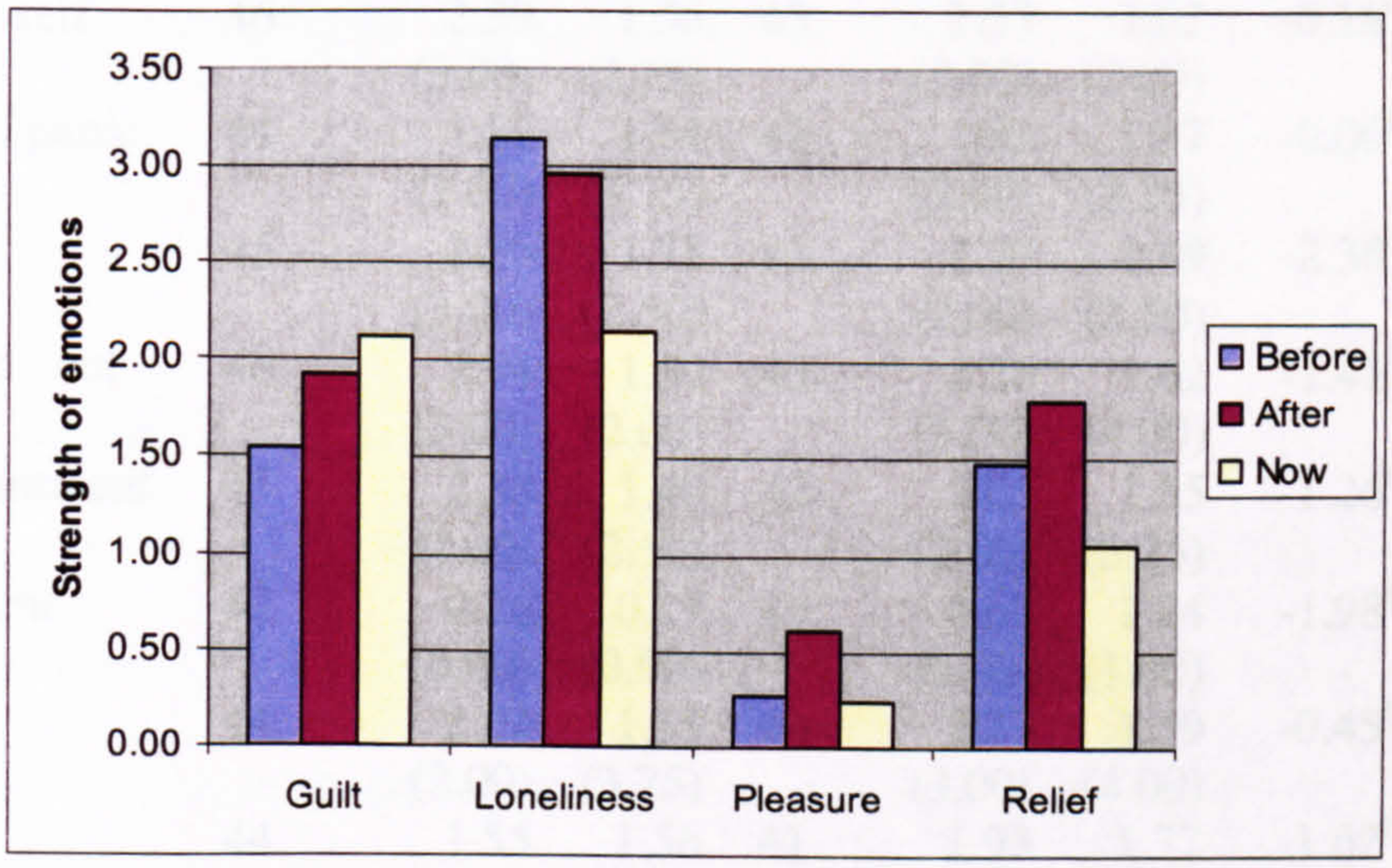
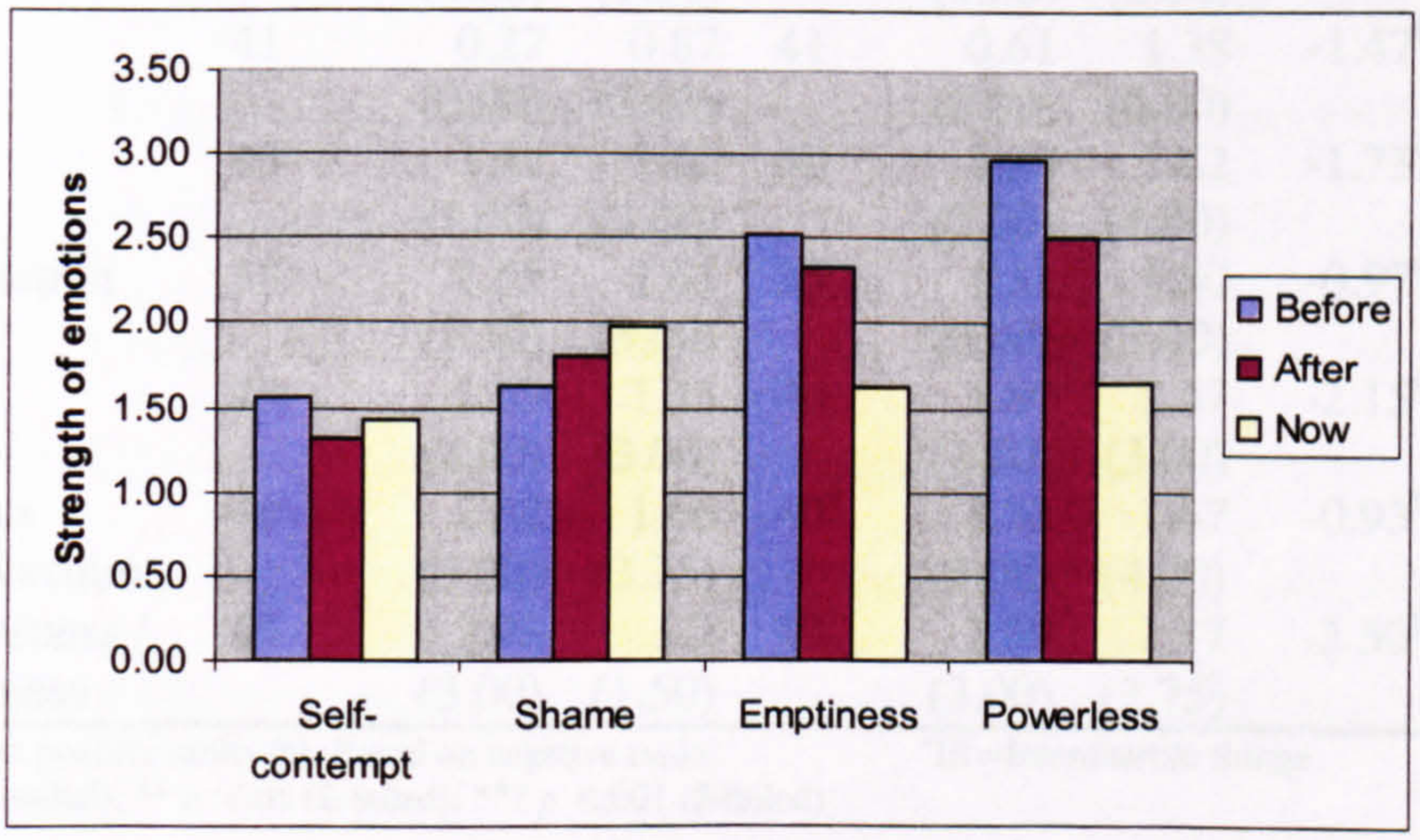


Figure 7: Changes in strength of emotions (self-poisoners)



Given that *now* involved differing lengths of time since the self-poisoning had occurred no statistical analysis on this variable was undertaken. Differences between just *before* and just *after* were analysed using the Wilcoxon Signed Ranks Test (See Table 11), as the data were not normally distributed. Data transformations were not attempted given that a number of emotions were extremely positively skewed.

Table 11: Changes in strength of emotions before and after self-poisoning

Emotion	Before			After			Wilcoxon Test
	N	Mean (Median)	SD (IR)^	N	Mean (Median)	SD (IR)	F
Anger at others	45	2.20 (2.00)	1.41 (2.50)	42	1.62 (1.00)	1.51 (3.00)	-2.92[(a)]***
Anger at self	46	2.59 (3.00)	1.56 (2.25)	43	2.53 (3.00)	1.62 (3.00)	-0.18[(a)]
Anxiety / panic	44	1.82 (2.00)	1.54 (3.75)	42	1.93 (2.00)	1.57 (3.25)	-0.06[(a)]
Despair	45	2.56 (3.00)	1.53 (2.50)	41	2.20 (2.00)	1.49 (2.50)	-2.38[(a)]**
Detached / cut off	46	2.74 (3.00)	1.50 (2.00)	43	2.26 (3.00)	1.62 (4.00)	-1.41[(a)]
Disappointment / insult	45	2.38 (2.00)	1.40 (2.50)	42	2.05 (2.00)	1.55 (3.25)	-1.26[(a)]
Excitement	42	0.26 (0.00)	0.77 (0.00)	41	0.63 (0.00)	1.24 (1.00)	-1.98[(b)]*
Fear	44	2.02 (2.00)	1.55 (3.75)	40	2.23 (3.00)	1.59 (4.00)	-0.45[(b)]
Guilt	44	1.55 (1.00)	1.56 (3.00)	41	1.93 (2.00)	1.72 (4.00)	-1.62[(b)]
Loneliness	46	3.13 (4.00)	1.22 (1.00)	41	2.95 (4.00)	1.41 (2.00)	-1.43[(a)]
Pleasure	41	0.27 (0.00)	0.87 (0.00)	41	0.61 (0.00)	1.38 (0.00)	-1.47[(b)]
Relief	43	1.47 (1.00)	1.62 (3.00)	40	1.80 (2.00)	1.62 (4.00)	-1.73[(b)]
Self-contempt	38	1.55 (1.50)	1.61 (3.00)	35	1.31 (0.00)	1.60 (3.00)	-0.97[(a)]
Shame	43	1.63 (2.00)	1.45 (3.00)	40	1.80 (2.00)	1.57 (3.00)	-2.15[(b)]*
Emptiness (mental vacuum)	44	2.52 (3.00)	1.66 (3.75)	40	2.33 (3.00)	1.67 (4.00)	-0.93[(a)]
Powerlessness / hopelessness	45	2.98 (3.00)	1.2 (1.50)	40	2.50 (3.00)	1.47 (2.75)	-2.50[(a)]*

(a) Based on positive ranks (b) Based on negative ranks. ^IR=Interquartile Range

* p <.05 (2-tailed); ** p <.01 (2-tailed); *** p <.001 (2-tailed)

Anger at others significantly decreased following self-harm, although no change was observed in *Anger at self. Despair* and *Powerlessness / Hopelessness* also significantly decreased in reported strength. There were also significant increases in *Excitement* and *Shame*.

12. Reasons for self-harm

12.1 Reasons for self-harm – free response

Participants were asked why they had tried to harm themselves on this occasion. There was a 95% response rate (57/60 responses) and this was analysed using content analysis. The most frequent responses involved specific *feelings* (43.9%) and *other people* (35.1%). Responses relating to emotions were involved within all the categories and particularly in *escape/relief from problems* (Table 12).

12.2 Reasons for self-poisoning - ratings

Participants were asked to rate how much each reason had influenced their decision to harm themselves. Data transformations were not attempted given that a number of emotions were extremely positively skewed. Table 13 shows the mean and median response for self-poisoners for each item. The percentage of self-poisoners indicating that the reason had an influence is shown graphically in Figure 8. Forty people (64.7%) of self-poisoners expressed some intent to die. The three most indicated reasons suggest a role for emotional regulation and experiential avoidance in self-poisoning: '*The situation was so unbearable that I had to do something and didn't know what else to do*', '*I wanted to get relief from a terrible state of mind*'; '*I wanted to escape for a while from an impossible situation*'. The least reported reasons involved interpersonal reasons, particularly in relation to making an impact on others:

'I wanted to frighten someone or to get my own back on someone' 'I wanted to make people sorry for the way they have treated me'.

Table 12: Reasons for self-harm

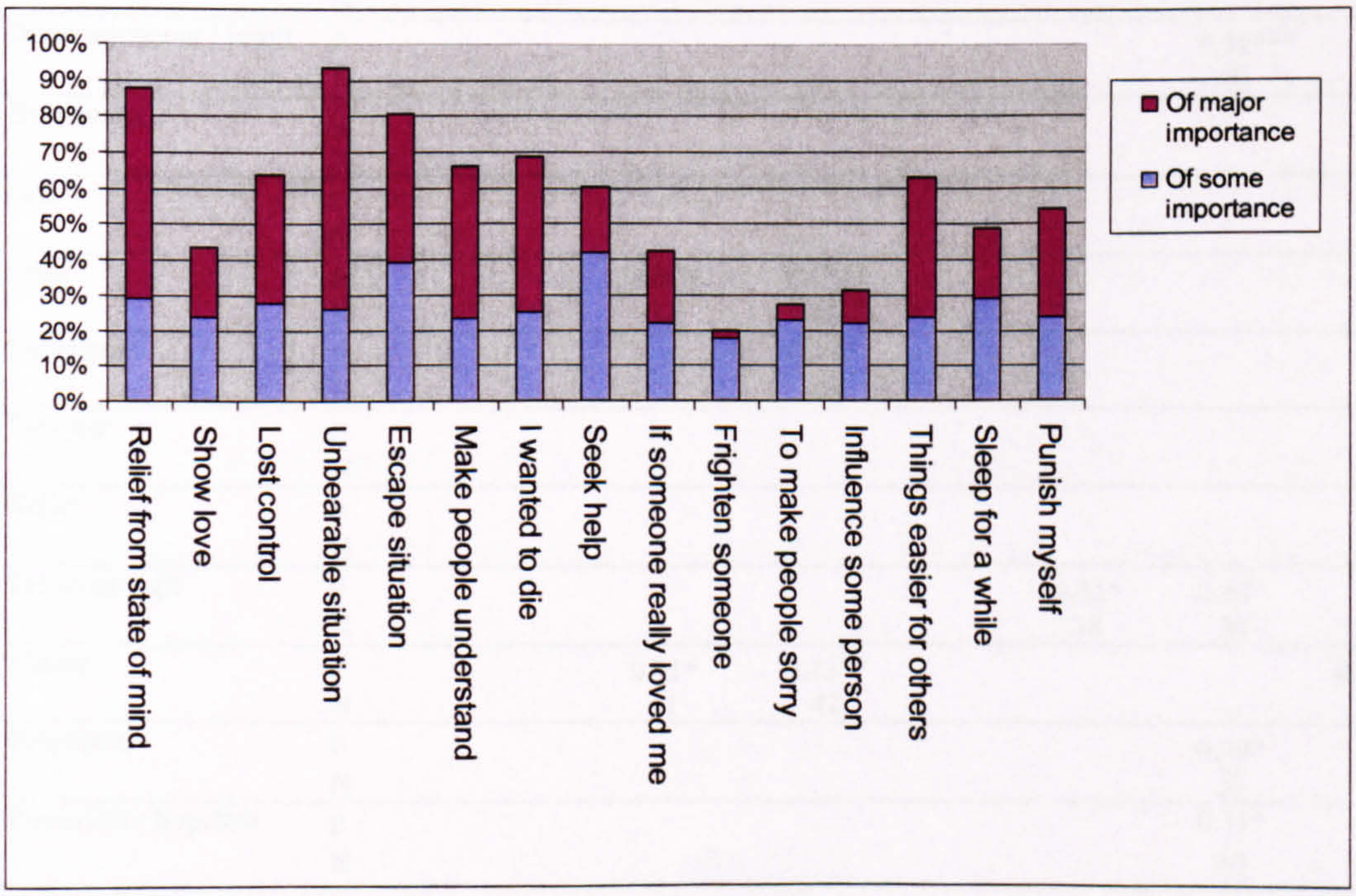
Theme	Reason	Count	Example Quote
Other people	Close relationship problems	15	*"Because my partner took herself and kids away from me without no explanation as to why"*
	Better off for others	3	*"I felt that everyone else would be better off without me"*
	Impact on others	2	*"To prove a point"*
Feelings	Overwhelmed	7	*"Because all my problems piled on top of me"*
	Not coping	6	*"Cause I can't cope anymore."*
	Experiencing difficult feelings	4	*"I was angry or frustrated."*
	Hopelessness	3	*"Because I feel as though I am never going to recover. Hopelessness."*
	Feeling like no choices	2	*"Because I felt there was no other way"*
	Loneliness	1	*"Felt lonely"*
	Shame	1	*"Feeling low and ashamed"*
	Punishment	1	*"To punish myself"*
Illness / addiction	Depression	8	*"I'm also suffering with depression"*
	Other mental health problems	3	*"I was finding things too difficult and couldn't handle my panic disorder."*
	Alcohol	3	*"Because I had been drinking"*
	Health	1	*"Sick of having fits"*
Outcome of harm	Escape/relief from problems	8	*"I wanted to switch off from the world"*
	Wanted to die	5	*"I don't think I could continue living"*
	Seeking help	1	*"It was a cry for help"*
Specific life events	Stress (Work, finance, worries)	4	*"Stress levels high"*
	Bereavement	2	*"Death of mum"*
Impulsivity	Impulsive	1	*"I didn't think I just did it"*
Don't know	Don't know	2	*"I can't think of anything why I did it this time "*

Table 13: Reasons for self-poisoning

	N	Mean*	Median	SD	IR
I wanted to get relief from a terrible state of mind	48	1.46	2.00	0.71	1.00
I wanted to show how much I loved someone	46	0.63	0.00	0.80	1.00
I seemed to have lost control of myself and have no idea why I behaved that way	47	1.00	1.00	0.86	2.00
The situation was so unbearable that I had to do something and didn't know what else to do	46	1.61	2.00	0.61	1.00
I wanted to escape for a while from an impossible situation	46	1.22	1.00	0.76	1.00
I wanted to make people understand how desperate I was feeling	47	1.09	1.00	0.88	2.00
I wanted to die	48	1.13	1.00	0.87	2.00
I wanted to seek help from someone	48	0.79	1.00	0.74	1.00
I wanted to find out if someone really loved me	45	0.62	0.00	0.81	1.00
I wanted to frighten someone or to get my own back on someone	45	0.22	0.00	0.47	0.00
I wanted to make people sorry for the way they have treated me	44	0.32	0.00	0.56	1.00
I wanted to influence some particular person or get them to change their mind	45	0.40	0.00	0.65	1.00
I wanted to make things easier for others	46	1.02	1.00	0.88	2.00
I wanted to sleep for a while	45	0.69	1.00	0.79	2.00
I wanted to punish myself	46	0.85	1.00	0.87	2.00

**Max possible score = 2 (Variable recoded from 1-3 to 0-2 as per Hjelmeland et al (2002))*

Figure 8: Percentage of self-poisoners indicating the influence of each reason



The reasons were recoded into reason types for self-poisoning: Intrapersonal reasons (Mean=6.93, SD=2.05) and Interpersonal reasons (Mean=4.93, SD=3.42). They were also further recoded into *Careseeking* (Mean=3.02, SD=2.20), *Influencing* (Mean=0.95, SD=1.44), *Escape* (Mean=1.89, SD=1.25), *Final exit* (Mean=5.09, SD=1.86) and *Loss of control* (Mean=1.00, SD=0.86).

I wanted to punish myself was treated as a separate variable and was found to correlate with *anger at self* ($\rho = 0.46$, $p < 0.01$), *shame* ($\rho = 0.53$, $p < 0.001$), *anxiety/panic* ($\rho = 0.39$, $p < 0.05$) and *fear* ($\rho = 0.46$, $p < 0.01$).

Table 14: The relationship between reported emotions prior to self-poisoning and reason types

		Intrapersonal	Interpersonal	Care seeking	Influen-cing	Escape	Final exit	Loss of control
Anger at others	ρ				0.35*			
	N				42			
Anger at self	ρ							
	N							
Anxiety / panic	ρ	0.49**				0.32*	0.44**	
	N	41				43	41	
Despair	ρ						0.36*	
	N						40	
Detached / cut off	ρ							
	N							
Disappointment / insult	ρ						0.51***	
	N						40	
Excitement	ρ							
	N							
Fear	ρ							
	N							
Guilt	ρ		0.44**	0.48**				
	N		42	43				
Loneliness	ρ			-0.31*				
	N			43				
Pleasure	ρ							
	N							
Relief	ρ							
	N							
Self-contempt	ρ					0.32*	0.38*	
	N					38	36	
Shame	ρ		0.31*	0.42**				0.45**
	N		41	42				42
Emptiness	ρ						0.39*	
	N						38	
Powerless / hopeless	ρ						0.31*	
	N						40	

* p <.05, ** p <.01, *** p <.001 (2-tailed)

The relationships between reported emotions prior to self-poisoning and the specific reason types were explored using correlations (Spearman's Rho) and the results are shown in Table 14. Intrapersonal reasons were significantly associated with the presence of *anxiety* prior to self-poisoning. Interpersonal reasons, were associated with *shame* and *guilt,* and *shame* was also associated with loss of control. Specifically careseeking was associated with *guilt* and *shame*, while influencing others was related to *anger at others*.

13. Self-harm behaviours (previous and current)

13.1 Type of self-harm

Table 15 shows the percentage of all participants indicating that they had engaged in a specific self-harm behaviour (including the index episode). No one had dripped acid on their skin but all other categories were affirmed by someone within the sample. All but three participants had engaged in self poisoning (current or previous), although there was a differentiation as to intent to end life.

The mean number of different types of self-harm engaged in by all participants was 3.28 (n=54; Median=2.00; SD=2.84; Interquartile Range=3.25). The distribution was positively skewed with 38.9% of participants engaging in only one type of self-harm. This is further evidenced by the One-Sample Kolmogorov-Smirnov Test, which was found to be significant ($z=1.56$; $p<0.05$). Although a logarithm transformation was conducted, the variable remained significantly positively skewed following transformation. As such, the analysis used the non-transformed scored.

Table 15: Percentage of individuals endorsing the DSHI Items

Type of self-harm	N	Yes %
Poisoned yourself (with the intention to kill yourself)	58	69.0
Poisoned yourself (without intending to kill yourself)	58	50.0
Cut your wrist, arms or other area(s) of your body (without intending to kill yourself)?	58	34.5
Banged your head against something, to the extent that you caused a bruise to appear?	58	29.3
Punched yourself, to the extent that you caused a bruise to appear?	57	28.1
Prevented wounds from healing?	56	19.6
Other (hanging, burning with tongs, burning with boiling water, hit self with object, set self on fire using other substance, pierced skin with glass)	56	19.6
Severely scratched yourself, to the extent that scarring or bleeding occurred?	58	19.0
Cut your wrist, arms or other area(s) of your body (with the intention to kill yourself)?	57	15.8
Stuck sharp objects such as needles, pins, staples, etc. into your skin, not including tattoos, ear piercing, needles used for drug use or body piercing?	57	14.0
Carved words into your skin?	58	12.1
Rubbed glass into your skin?	57	10.5
Burned yourself with a lighter or a match?	58	8.6
Burned yourself with a cigarette?	58	6.9
Broken your own bones?	56	5.4
Used bleach or oven cleaner to scrub your skin?	57	5.3
Bit yourself, to the extent that you broke the skin?	58	5.2
Rubbed sandpaper on your body?	57	1.8
Carved pictures, designs or other marks into your skin?	58	1.7
Dripped acid onto your skin?	57	0.0

13.2 Number of occasions of self-harm behaviour

The mean and median number of reported occasions for each self-harm behaviour is shown in Table 16.

Table 16: Number of occasions of self-harm behaviour

Type of self-harm	N	Mean Occasions	Median	SD	IR
Poisoned yourself (with the intention to kill yourself)	49	2.21	1.00	5.25	2.00
Poisoned yourself (without intending to kill yourself)	47	0.70	0.00	1.30	1.00
Cut your wrist, arms or other area(s) of your body (without intending to kill yourself)?	52	8.88	0.00	31.53	2.00
Banged your head against something, to the extent that you caused a bruise to appear?	49	1.61	0.00	5.19	0.50
Punched yourself, to the extent that you caused a bruise to appear?	48	1.35	0.00	5.84	0.00
Prevented wounds from healing?	50	1.12	0.00	4.51	0.00
Other	52	1.00	0.00	3.66	0.00
Severely scratched yourself, to the extent that scarring or bleeding occurred?	51	3.39	0.00	15.53	0.00
Cut your wrist, arms or other area(s) of your body (with the intention to kill yourself)?	51	0.24	0.00	0.86	0.00
Stuck sharp objects such as needles, pins, staples, etc. into your skin, not including tattoos, ear piercing, needles used for drug use or body piercing?	52	0.75	0.00	2.62	0.00
Carved words into your skin?	53	0.57	0.00	2.81	0.00
Rubbed glass into your skin?	52	0.23	0.00	0.83	0.00
Burned yourself with a lighter or a match?	52	0.12	0.00	0.58	0.00
Burned yourself with a cigarette?	53	0.19	0.00	0.92	0.00
Broken your own bones?	53	0.09	0.00	0.41	0.00
Used bleach or oven cleaner to scrub your skin?	52	0.13	0.00	0.69	0.00
Bit yourself, to the extent that you broke the skin?	53	0.09	0.00	0.49	0.00
Rubbed sandpaper on your body?	53	0.02	0.00	0.14	0.00
Carved pictures, designs or other marks into your skin?	54	0.74	0.00	5.44	0.00
Dripped acid onto your skin?	53	0.00	0.00	0.00	0.00

The overall mean number of occasions of self-harm engaged in by participants was 26.64 (Median=3.5; Interquartile Range=18.75; SD=68.43; n=44). The distribution was also positively skewed with 30.0% of participants reporting only one occasion of self-harm. This is further evidenced by the One-Sample Kolmogorov-Smirnov Test, which was found to be significant ($z=2.35$; $p<0.001$). Although a square route

transformation was employed, the One-Sample Kolmogorov-Smirnov Test, remained significant so the non-transformed scores were used.

13.3 Previous self-harm (excluding index)

Overall, 18 participants (30.0%) had no previous history of self-harm (excluding the index episode), 41 participants (68.3%) reported a previous history of self-harm and one person was unknown.

14. Difficulties in emotional regulation

Table 17 shows the means and median scores for the DERS total and subscales.

Table 17: DERS mean and median scores, interquartile range and standard deviations

	N	Mean	Median	Std. Deviation	Interquartile Range
DERS Total Score	54	115.15	117.50	24.08	30.25
DERS non-acceptance	56	18.95	20.00	6.89	11.75
DERS goals	56	18.04	19.00	4.92	7.75
DERS impulse	55	18.42	18.00	6.23	10
DERS awareness	54	18.89	18.00	5.43	8.25
DERS strategies	56	27.16	29.00	7.60	11.75
DERS clarity	56	13.91	14.00	4.22	6

The variable was normally distributed (One-Sample Kolmogorov-Smirnov Test was found to be insignificant; (z =0.67, n/s). Cronbach's alpha was calculated to determine the internal consistency of the DERS. The full scale was found to be 0.92 and the subscales ranged from 0.69 – 0.89.

Scores above 1 SD of the mean for nonclinical samples (Gratz & Roemer, 2004) have been used as a cut-off for high or non-normative levels of emotional dysregulation (Gratz & Gunderson, 2006) (See Appendix 12 for population means and SD). High scores were observed for 79.6% of all participants: ≥2SD =44.4%; ≥3SD = 14.8%. (see Appendix 12 for scores for individual subscales). Lower levels were observed in

individuals who had only ever engaged in self-poisoning (23 people; full data available for 22 people) 59.1% showed high levels of emotional dysregulation (≥2SD = 27.3%; ≥3 SD = 9.1%) (See section 16 for further statistical analysis of the difference between self-poisoners only and self-poisoners/self-injurers).

15. Experiential avoidance

Experiential avoidance was measured by the AAQ. The mean score was 41.70 (Median=41.50; SD=7.02; Interquartile Range=9.50) and scores ranged from 27 - 56 (n=50), which is similar to reported AAQ mean total scores in clinical populations of between 38 and 40 (Hayes, Masuda & De Mey, 2003). The variable was normally distributed (One-Sample Kolmogorov-Smirnov Test was found to be insignificant; (z=0.64, n/s). Cronbach's alpha was calculated to determine the internal consistency of the AAQ (α =0.41). Hayes (2004) has reported that the alpha is sometimes marginal, or even unacceptable, due to item complexity. Item analysis suggested that the four reverse scored items were contributing to the low alpha score (α=0.67 when these items were removed), which suggests that participants may have found it difficult to respond to the items due to their verbal complexity.

Scores of 38 and above represent scores in the upper quartile of a non-clinical sample (Hayes et al., 2004). Within this sample, 76% of participants had scored above this cut-off and can be considered to have a high score. In people who had only ever engaged in self-poisoning (23 people; full data available for 22 people), 57.1% showed high scores.

Relationships between emotional dysregulation, experiential avoidance (using the condensed AAQ) and self-harm (number of types, occasions and hospital attendances) were explored using Spearman's Rho correlations (see Table 18). The AAQ was only

significantly associated with the DERS, but not with the self-harm measures (see Figure 9). The DERS was significantly associated with all measures of self-harm. The self-harm measures were all significantly related with each other.

Figure 9: Scatterplot for DERS Total x AAQ Total

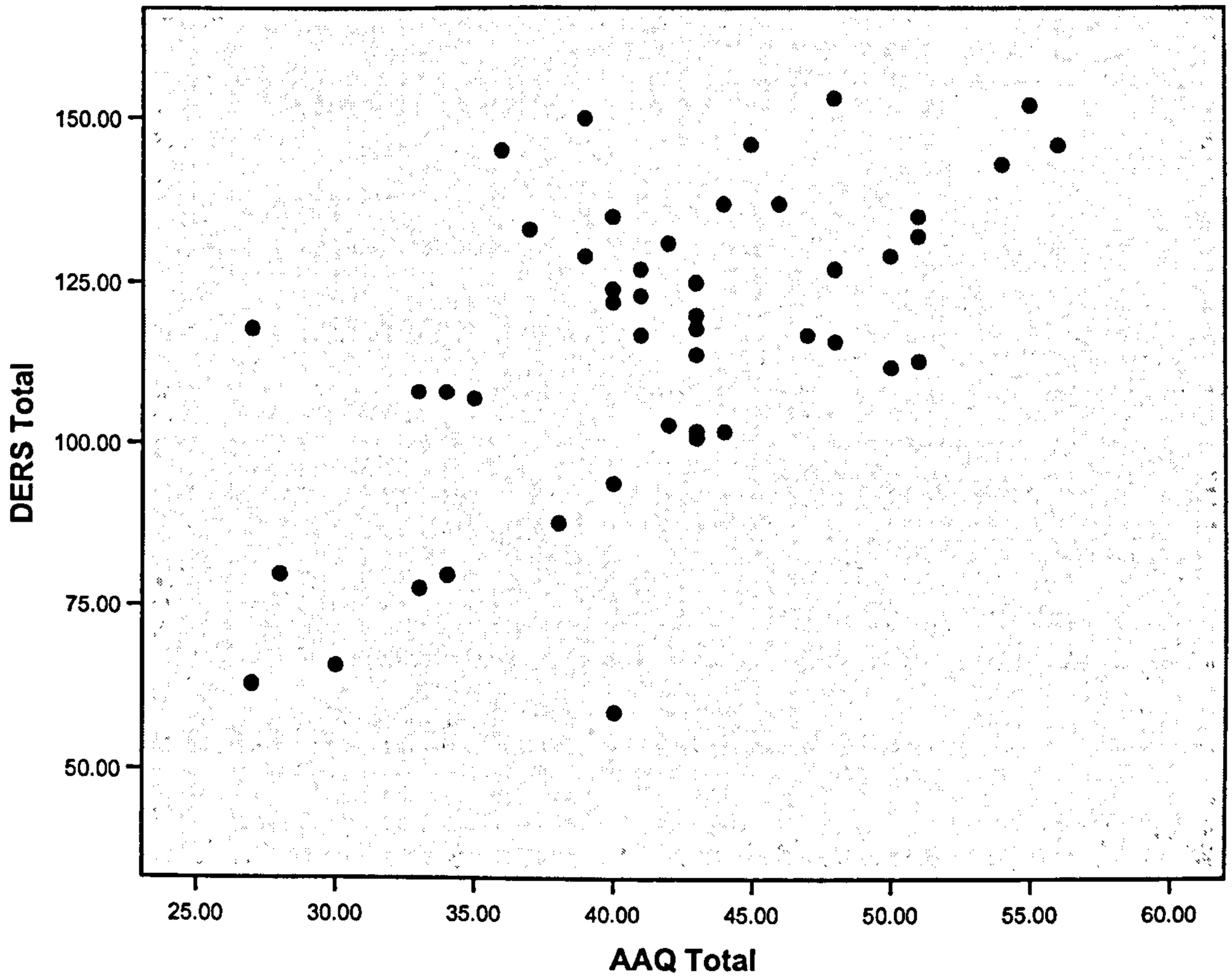


Table 18: Correlation matrix for DERS, AAQ^ and self-harm

		DERS Total	AAQ Total	Harm-total no of types	Harm total no of occasions	No of times attended hospital
DERS Total	ρ	---				
	N					
AAQ Total	ρ	.53***	---			
	N	47				
Harm total no of types	ρ	.49***	.26	---		
	N	53	47			
Harm total no of occasions	ρ	.52***	.17	.88***	---	
	N	44	40	44		
No of times attended hospital	ρ	.30*	.09	.55***	.63***	---
	N	54	48	54	44	

* p <.05 (2-tailed); *** p <.001 (2-tailed) ^ 5 item AAQ

16. Differences between self-poisoners and self-poisoners/self-injurers

Twenty three participants (38.3%) had only ever engaged in self-poisoning (including index episode), 32 people (53.3%) reported both self-poisoning and self-injury, three people (5%) reported self injury only and two people: (3.3%) were unknown. All participants in the self-poisoning/self-injury group had engaged in self-injurious behaviours without the intent to end life. Only two participants in this group had also engaged in self-injurious behaviours with the intent to end life.

Table 19: Differences between self-poisoners and self-poisoners/self-injurers

	Self-poisoning only			Self-poisoning and Self-injury			Z
	n	Mean (Median)	SD (IR)	n	Mean (Median)	SD IR	
DERS Total	22	102.45 (105.00)	26.04 (42.75)	30	126.45 (127.00)	15.14 (21.50)	-3.46***
DERS Non-acceptance	23	16.17 (18.00)	6.75 (12.00)	31	21.27 (22.00)	6.07 (9.25)	-2.54*
DERS Goals	23	15.70 (15.00)	5.11 (9.00)	28	20.03 (21.00)	3.97 (5.00)	-3.02**
DERS Impulse	23	15.74 (16.00)	6.57 (9.00)	30	20.90 (20.00)	5.12 (9.50)	-2.91**
DERS Awareness	22	19.14 (18.00)	4.59 (5.50)	30	19.00 (19.00)	6.09 (10.00)	-0.21
DERS Strategies	23	23.26 (24.00)	8.04 (16.00)	31	30.60 (31.00)	5.49 (5.25)	-3.16**
DERS Clarity	23	13.17 (13.00)	4.07 (5.00)	31	14.63 (15.50)	4.06 (7.00)	-1.29
AAQ Total	21	39.14 (39.00)	7.53 (9.50)	28	43.44 (43.00)	6.32 (8.00)	-2.30*
Self-harm - Total no of types	23	1.17[3] (1.00)	0.39 (0.00)	29	5.18 (4.00)	2.80 (4.75)	-6.13***
Self-harm - Total no of occasions	19	1.32 (1.00)	1.00 (0.00)	23	50.41 (11.50)	91.47 (36.50)	-5.48***
Number of times attended hospital	24	2.00 (1.00)	3.40 (0.00)	31	4.83 (2.50)	5.25 (6.25)	-3.09**
Intent to die	22	0.73 (0.50)	0.51 (1.00)	32	0.84 (1.00)	0.76 (0.00)	2.77**
Length of time thinking	23	1.91 (1.00)	1.35 (1.00)	32	2.84 (2.00)	1.49 (2.00)	2.47*

p <.05; ** p <.01, *** p <.001

[3] Self-harm - Total number of types mean is 1.17 as self-poisoning with and without suicidal intent are considered 2 separate types.

Group differences were explored on the DERS, AAQ, DSHI, number of hospital attendances, expressed intent to end life at index episode and time thinking about harm prior to episode. Significant differences were tested for by using the Mann-Whitney U test (see Table 19).

The self-poisoning/self-injury group scored significantly higher on the DERS (except the Awareness and Clarity subscales), AAQ and the self-harm measures. For their current self-harm episode they were expressing a higher level of intent to die and had reported thinking about their self-harm for a longer length of time.

As DERS is a correlate of DSHI total occasions, it must be considered whether differences between groups are due to the self-poisoning/self-injury group engaging in a greater frequency of self-harm. Using an analysis of covariance, the significance of differences between the self-poisoning and self-poisoning/self-injury group, while controlling for total number of occasions, could be examined. While DERS is normally distributed, the transformed DSHI total occasions scores remained positively skewed and kurtotic (skewness $=2.53$, kurtosis $=6.87$). However, as Kline (1998) argues, non-normality is not problematic unless skewness >3 and kurtosis >10 (Gratz & Roemer, 2004). Given the exploratory approach of this research, in this analysis, the transformed DSHI total occasions score was used as a covariate.

The DSHI total occasions score was chosen as a measure of self-harm frequency as it provides a better estimate of frequency than the number of hospital attendances which underestimates overall self-harm frequency. When DSHI total occasions were statistically controlled in an ANCOVA, differences between these groups on DERS Total Score continued to be significant, $F(1, 41) = 5.71$, $p < .05$. These findings

suggest that the differences in emotional regulation may not simply be as a result of the self-poisoning/self-injury group engaging in a greater frequency of self-harm.

CHAPTER 5 DISCUSSION

The most important thing in science is not so much to obtain new facts as to discover new ways of thinking about them.

Sir William Bragg, physicist and chemist (1862 - 1942)

1. Overview

This research aimed to explore the different reasons people have and the changes in emotions they experience following self-harm, principally after self-poisoning. It also investigated their history of previous self-harm and difficulties with emotional regulation and experiential avoidance.

The findings are integrated to discuss the research questions and emergent issues from the analysis. The strengths and weaknesses of the research are critiqued. Finally, clinical implications and suggestions for further research are discussed.

2. Summary of key findings

Participants in both studies had predominantly engaged in at least one episode of self-poisoning. Rates of self-injury in Study 2 were higher than the general population estimates of self-injury. The most frequent response as to why participants chose their method of self-harm was accessibility. Both studies showed that, following self-harm, changes occur to the type and strength of emotions which people report they experience. The results suggested that following self-poisoning, participants experienced a decrease in their emotions (particularly negative emotions e.g. anger at other people). Although positive emotions increased, shame also significantly increased. People gave both intrapersonal and interpersonal reasons for their self-harm. The super-ordinate theme from Study 1: *Self-harm as an interpersonal process*

particularly highlighted these interpersonal processes and the role of shame both precipitating and maintaining their self-harm.

The super-ordinate theme from Study 1: *"I'm not very good with feelings"* highlighted the difficulties participants had with emotional regulation and *"You can't put a sticking plaster on emotional pain" - Trying to make it feel better* demonstrated their use of self-harm as a way to manage or avoid emotions. The participants in Study 2 reported high rates of difficulties in emotional regulation and experiential avoidance. Those people who engaged in both self-injury and self-poisoning showed differences in the type of emotional dysregulation difficulties, greater experiential avoidance, attended hospital more frequently and expressed higher levels of intent to die.

3. Method of self-harm

3.1 Type and frequency of self-harm

The majority of participants in both studies had engaged in at least one episode of self-poisoning. Rates of self-injury in Study 2 were 53.3%, which is much higher than the general population estimates for self-injury and more similar to clinical populations. However, these estimates are based on responses to a single survey item asking about previous self-harm. Lundh, Karim and Quilisch (2007) question whether a single screening item is a sufficiently strong cue for the retrieval of all relevant types of self-harm, including self-injury. Using the DSHI, Gratz (2001) found that 35% of an undergraduate student population (mean age 23) had self-injured (excluding suicidal intent), although she specifically recruited for a study into self-harm which may have biased the sampling. However, a recent community study of

adolescents (Lundh et al., 2007), which also used the DSHI, showed that 65.9% of adolescents reported having engaged in some kind of self-injury at least once; 41.5% reported at least one kind of self-injury more than once; and 13.8% reported at least one kind of self-injury behaviour 'many times'. This suggests that rates of self-injury may be higher than previously reported and, given this finding, the rate within Study 2 may be more reflective of the prevalence rates in the wider population. Given the rates found by Lundh et al. (2007), the current finding adds support to the view that self-harm, and specifically self-injury, are not simply behaviours associated with borderline personality disorder but constitute a wider phenomenon (Chapman et al., 2006).

Study 1 also indicates that, without explicit definitions, people include a much wider range of behaviours as self-harm, particularly eating disorders. As participant E stated:

> *I think one thing I'd like to say is how in my mind it's never that clear, there isn't actually a clear distinction between what's self harm and what's not...because almost anything you can construe as self harm (E:554-555).*

A strength of using the DSHI is that the behaviours are clearly defined and it does not depend on using a personal definition of self-harm. However, while participants could indicate whether they had engaged in a specific behaviour, they found it difficult to quantify the amount of self-harm they had engaged in on the DSHI:

> *I couldn't put it in numbers. I was guessing, but yes, it's just, and I guess even when this happens in hospital, when they ask how many times and I say I can't remember how many. I've never made any effort to, once it went above ten, to remember how many (E:609-611).*

This may represent the participants' difficulties in accepting self-harm, as reflected in the final theme from Study 1 *The private and the public - accepting and*

acknowledging self-harm. Alternatively, individuals may not actually be able to recall this specific information.

Interestingly, Gratz (2007; personal communication) states that this had not been a problem in her studies. However, given the responses of the interviewees and the fact that 18.3% of participants in Study 2 failed to quantify the amount of self-harm, it is probable that participants reporting a greater frequency of self-harm may be subject to an increased level of error.

Lundh et al. (2007) avoided this difficulty by adapting the DSHI. Instead of asking for the actual frequency of self-harm, they used a categorical response choice of *never*, *once*, *more than once* or *many times*. As with Study 1 and 2, Lundh et al. also adapted the DSHI by including behaviours irrespective of expressed suicidal intent and not including the supplementary questions. These studies demonstrate that the DSHI can be expanded to measure behaviours with suicidal intent, rather than being limited to self-injury without intent to die. The DSHI is a useful measure, although it may require further revision to address the issue of frequency before it can have more widespread clinical use. Overall, both studies highlight the importance of using a behaviourally-based measure of previous self-harm to accurately identify the prevalence and extent of the behaviour, both within a clinical and general population.

3.2 Choice of method

The most frequent response as to why participants chose their method of self-harm was accessibility. This finding supports the introduction of limits on packet size for non-prescription pain medication, as a way of reducing the potential lethality of overdoses (Morgan & Majeed, 2005), and reflects the often impulsive nature of self-

harm. Method choice also seemed to depend on how participants wanted self-harm to function, with for example, self-poisoning being seen as an easy, painless and quick way to stop emotional pain. The choice of method for self-injury also involved accessibility but often reflected a different way to achieve the same outcome (e.g. feeling physical pain to stop emotional pain).

Participants in Study 1 who repeatedly self-harmed often tried a number of methods before settling on a particular approach, for example, self-injury with a specific object or self-poisoning with a particular substance. The idea of 'trying out' or 'experimenting' with self-harm was present even within those people who were using a method for the first time. It is important to recognise that this did not apply to everyone in the sample but, even within circumstances of intense distress was a sense of individuals being interested or curious about the outcome. One possibility is that this reflects some form of novelty-seeking. Chapman et al (2006), in reviewing the literature, suggest that higher levels of impulsivity or novelty-seeking may be associated with a greater likelihood of experiential avoidance. Interestingly, one person in study 1 (Participant C) specifically linked his engagement in extreme sports to managing his emotional life. Chapman et al.'s proposal for future research to examine a link between repetitive self-injury, behavioural systems of inhibition and harm avoidance, and temperament characteristics of novelty-seeking and impulsivity, may be helpfully extended to self-poisoning. It is possible that impulsivity and/or novelty-seeking may contribute to the repetition of self-harm.

Those participants who repeatedly self-harmed seemed to have developed rituals which appeared to be rule-governed. Chapman et al. (2006) suggest that the

persistence of self-injury can be explained by rule-governed behaviour, where a verbal rule links a behaviour (self-injury) with a consequence (feeling better). The person continues to engage in the behaviour for the short-term consequences, despite the presence of more negative long-term consequences. This is operating in the same way as the negative feedback loop in experiential avoidance (Hayes et al., 1996) and may reduce a person's ability to learn from the concrete environmental contingencies (Hayes, Kohlenberg & Melancon, 1989; cited in Chapman et al., 2006). The results from Study 1 suggest that this process may be operating for both repetitive self-injury and self-poisoning. The effect of rule-governed behaviour in both self-injury and self-poisoning would be likely to decrease the flexibility of available responses, particularly where self-harm has become a habitual response to emotional distress.

In Study 1, the theme '*becoming an experienced self-harmer'* highlights the risks associated with the rule-governed behaviour of self-injury being generalised to self-poisoning. The finding in Study 2 that those people who engage in both self-injury and self-poisoning attend hospital more frequently and express higher levels of intent to die clearly adds to that risk, particularly given that self-poisoners who have a history of self-injury often underestimate the lethality of their poisoning behaviour (Stanley et al., 2001). This may explain the finding that previous self-injury is a risk factor in those who complete suicide following hospital attendance (Cooper et al., 2005) and also adds to Joiner's (2005) theory that the likelihood of suicide attempts is increased when individuals habituate to self-injury. Furthermore, the results support those of Nock et al. (2006) who found that a longer history of self-injury, the use of more methods of self-injury, and the absence of physical pain during self-injury are all associated with a higher rate of lifetime suicide attempts.

Both studies show that, following self-harm, changes occur to the type and strength of emotions which people report they experience. In Study 1, participants talked about feeling upset, and being angry at themselves or others prior to self-harm. These emotions were experienced as feeling overwhelming. The theme '*You can't stick a plaster on emotional pain - making it feel better'* reflects self-harm functioning as a way of making people feel better. Self-injury accomplished this by a physical expression of emotional distress, which participants felt reduced the strength of their emotions. Self-poisoning could have a similar effect, although often the intention was not just to reduce one feeling but to stop all feelings.

In Study 2, the emotions and emotional changes were explored in those people who had engaged in self-poisoning. The most reported emotions prior to self-poisoning were *powerlessness/hopelessness*, *loneliness, detached, disappointment*, *anger at self* and *others*. Overall, following self-poisoning there was a reduction in all these emotions except *anger at self.* Although increases occurred in the positive emotions (*excitement, pleasure and relief*), the number of people reporting these emotions and their relative strength was low. It is also particularly interesting that a number of these emotions have an interpersonal focus. In their study, Ellsworth & Tong (2006) found that *anger*, *shame*, and *guilt* are social emotions and almost always involved other people (about 98% of the time for all three). They found that self-anger was not simply anger with a different agency appraisal, directed internally, as about half the time, other people were also involved in self-anger. *Anger at self* overlaps in terms of its cognitive appraisals to *anger, shame* and *guilt*, even when it is not related to other

people. They also found strong links between *anger at self*, *shame* and *guilt* (Ellsworth & Tong, 2006).

In Study 2, following self-poisoning both shame and guilt increased although only the increases in shame were statistically significant. This supports the findings of Lester (1998) who found that feelings of shame were a stronger correlate of suicidality than feelings of guilt. The results were also similar to the finding of Briere and Gil (1998) in self-injurers who showed reductions in negative emotions apart from shame and guilt which increased (although only shame was significant).

In Study 1, shame was associated with being seen expressing emotions, being invalidated by other people, seeking help from others and being seen publicly as a self-harmer. As an emotion, shame has been differentiated from guilt:

> The experience of shame is directly about the self, which is the focus of evaluation. In guilt, the self is not the central object of negative evaluation, but rather the thing done or undone is the focus. In guilt, the self is negatively evaluated in connection with something but is not itself the focus of experience (Lewis, 1971, p. 30).

Shame is generally associated with feeling powerless, involves a sense of exposure and motivates either avoidance (e.g. running away) or defensive actions (e.g. retaliatory anger). In contrast, guilt tends to motivate reparative behaviour (Tangney, Miller, Flicker & Hill, 1996).

It has been suggested that shame is a self-conscious emotion (Tangney et al., 1996) which develops later than the primary emotions (e.g. anger, anxiety, sadness, happiness) and can be considered a secondary or higher-order emotion (Gilbert,

2002). Shame can join with other emotions such as anger or anxiety which then change the way it is experienced (Gilbert, 2002). Gilbert (2002) views shame as a multifaceted experience with five components: (a) a social or external component - shame often occurs in a social environment involving a negative comparison to others; (b) an internal self-evaluative component - a global negative self-evaluation is made; (c) an emotional component - where shame is possibly associated with a sudden loss of positive emotions; (d) a behavioural component - involving either avoidance or defensive actions and (e) a physiological component - related to the stress response possibly via heightened parasympathetic activity (Gilbert, 2002).

Although self-harm as a behaviour extends beyond people who have BPD, recent research into the role of shame in BPD is pertinent, given the association between BPD and self-harm (Crowe, 2004; Rüsch et al., 2007). Crowe (2004) argues that the mental distress that is characteristic of BPD could be defined as an overwhelming shame response. She suggests that self-harm is frequently directed towards the body as both a source of, and expression of, shame. Rüsch et al. (2007) found higher levels of shame- and guilt-proneness and state shame in women with BPD; they suggest that shame is the central emotion in BPD. This supports the importance of shame within the self-harm process. Further work is needed to explore shame as both a precipitating and perpetuating factor in self-harm, both within people with BPD and, more generally, in people who engage in self-harm.

The results from both studies together suggest that both self-injury and self-poisoning can be used to stop or decrease an emotion or all emotions. Although the results from Study 2 and Briere and Gil's (1998) study suggest that similar changes in emotions occur for people engaging in self-injury or self-poisoning, there was one area of

difference; following self-injury, *anger at self* reduces while it remains high in self-poisoning. It may be that self-injury provides a more immediate outcome, which results in a reduction of *anger at self*. It is also possible that, if self-injury occurs to self-punish (Klonsky, 2007), then it may also reduce the distress associated with negative thoughts and anger towards oneself (Chapman et al., 2006).

6. Reasons for self-harm

6.1 Intrapersonal and interpersonal reasons

Both studies suggest that the reasons for self-harm relate to difficulties with regulating emotions and seeking relief from overwhelming feelings. However, the reasons people gave for self-harm highlight the role of both intrapersonal and interpersonal motivations for self-harm. The most frequent free responses in Study 2 involved responding to feelings within the person or involved reasons related to other people. Conversely, the least rated reasons for self-poisoning were interpersonal, specifically those relating to the impact of their behaviour on others which is similar to the finding of Schnyder et al (1999). In Study 1, interpersonal reasons were also given for self-harm, although these were in the context of feeling invalidated by other people, which could lead to feelings of shame. In Study 2, as the participants were completing the questionnaire, they reported a higher level of shame than both before and after their self-harm. One possible reason that people talked about interpersonal reasons but did not respond to them in a rating scale is the wording of the statements. For example, acknowledging '*I wanted to frighten someone or get my own back on someone*' within a questionnaire may in itself provoke a shame response.

A further explanation for this disparity in the rating of interpersonal reasons is the way in which interpersonal reasons are conceptualised. For example, in Spandler's (1996) study she states that:

> the young people interviewed for this study tended to see self-harm and attempted suicide more as intrapersonal than interpersonal acts – that is, as having more to do with what it does for them than the effect the behaviour has on other people (p.25).

However, this suggests that an interpersonal reason relates only to the impact on another of the behaviour. As Study 1 highlights, the interpersonal processes of self-harm are more complex. The person may report an intrapersonal reason following an interpersonal event. Self-harm can also occur for an interpersonal reason without the person wanting to make a specific impact on other people. For example, a person may want to punish themselves or validate their own feelings by self-harm following an argument with another person, but not intend their self-harm to affect the other person. Conversely, while a person's motives and intentions may be intrapersonal, the way in which the behaviour functions could be interpreted by others as interpersonal. The distinction between intrapersonal and interpersonal reasons is artificial and these are clearly related processes.

The difficulty of acknowledging interpersonal reasons for self-harm may also, in part, relate to the fear of people to be identified as attention-seeking. This is shown by one participant's interview:

> *Interviewer:* *It doesn't feel like it's about attention for you?*
> *J:* *No, and I'm scared if somebody said that to my face that it was. Because I don't want to be in this place, where I am in my head. But I am and I've got to deal with it. I don't think it's for that, but I'd be afraid if, even if one of my friends said it was for that reason. I would end up losing it (J:347-351).*

Warm, Murray and Fox (2003) found that repetitive self-injurers view the statement 'self-harm is a manipulative act' as completely false. Given the association between attention-seeking and self-harm, it is perhaps more useful to take the approach of Clark (2002) who conceptualises self-harm as attachment-seeking rather than attention-seeking or manipulative behaviour. Clark points out that everyone engages in attachment-seeking behaviour and within this context, self-harm may function to avert abandonment or conversely, increase distance from other people.

6.2 Intention to die

The theme '*Dicing with death*' highlights that the purpose of self-harm cannot be understood simply in terms of the absence or presence of intent to die. Intent is not a static phenomenon; it changes over time and often involves ambivalent and contradictory feelings. This has an impact on both the use of self-report measures, and on assessments made by medical professionals, which are taken at one time-point. This may explain the mixed findings regarding the predictive value of measuring intent and the ambiguous relationship between intent and lethality of the self-harm method (Plutchik et al., 1989).

It is also interesting that the self-injurers in Study 1 were expressing intent to die even when they were not injuring in a location which would increase the likelihood of this happening. This may have been due to these self-injurers having a high intent to die or may correspond to self-injury being used as a safer expression of suicidal feelings (Babiker & Arnold, 1997). In Study 2, 25.0% of self-poisoners indicated that the reason 'I wanted to die' had some importance and a further 43.6% indicated that it was of major importance in their decision to self-harm. This corresponds to the findings of Bancroft et al.(1976), Bancroft et al.(1979), and Rodham et al. (2004) that

people who engage in self-poisoning or self-injury express varying levels of intent to die. As Brown et al. (2002) found there is an overlap between the intentions of both self-poisoners and self-injurers, which cannot be differentiated by method choice.

6.3 Reasons and emotions

Intrapersonal reasons for self-harm (specifically *escape* and *final exit*) were significantly associated with presence of *anxiety* prior to self-poisoning. Interpersonal reasons, specifically *care-seeking* were associated with *shame* and *guilt,* and *shame* was also associated with *loss of control*. This provides further evidence for the role of shame following self-harm, particularly in seeking care from other people. The association between the desire to punish one self and *anger at self* and *shame* in self-poisoning is also interesting, given the hypothesised links between these variables.

It is, however, important to note that as Study 2 was exploratory, multiple correlations were made and this will inflate the probability of a Type 1 error occurring. Given this these findings need to be interpreted with some caution. The study does not demonstrate causality, although this would be a further avenue to explore in understanding the emotional processes of self-harm.

6.4 Reasons for self-harm: the role of alcohol

It is important to reflect on the role of alcohol when considering the reasons why people self-harm. Alcoholism was identified directly by only two participants in Study 2 as a reason for self-harm although 50% of participants in Study 1 and 55% of people in Study 2 had consumed alcohol prior to self-harm. Cherpitel, Borges, and Wilcox, (2004) found an increased risk of suicide during or shortly after use of alcohol. Hufford (2001) suggests that there are four mechanisms by which alcohol

increases the risk of self-harm: (1) increasing psychological distress; (2) increasing aggressiveness; (3) impel suicidal ideation into action; and (4) constrict cognition, which impairs the use of alternative coping strategies. There was evidence in Study 1 of alcohol being involved prior to making a decision to self-harm:

> *You know I'd gone out, I'd got drunk, smashed this glass and for some reason the thought kind of entered my head. I started and then I realised I couldn't stop (J:21-23).*

However, for others it was used following the decision to support the process of 'impelling suicidal ideation into action' (Hufford, 2001):

> *On the last occasion with a 24 ounce t-bone, mushrooms, chips, smoked salmon and a bit of salad to start off with. One nice bottle of red wine was just about right. Then I took a second bottle with me in the car just to wash the pills down with. So I probably got about half way through that. It was just something to wash the pills down after I'd already made the decision (C:461-466).*

Alcohol may act as a disinhibitor before a decision to self-harm is made and also subsequently, to support the person to take action on the decision. It is important to consider the effect of this where people also have a difficulty in regulating emotions.

7. Emotional regulation

In these studies, emotional regulation was measured quantitatively by the Difficulties in Emotional Regulation Scale (DERS) (Gratz & Roemer, 2004). The DERS was shown to have high overall consistency, with acceptable alpha levels for the subscales. In Study 1, only participant F did not score in the clinical range on the DERS. This was particularly interesting as he defined himself as an '*amateur self-harmer*', who had only ever self-poisoned once. In Study 2, 79.6% of all participants showed DERS levels within the clinical range. Of those participants who had only ever self-poisoned, lower levels of DERS were observed, with 59.1% scoring in the clinical range.

The DERS was significantly positively correlated for all participants with total number of self-harm occasions and number of different methods of self-harm which supports the finding of Gratz and Roemer (2004). The results also showed that increased difficulties in emotional regulation were related to increased hospital attendances for self-harm, which has not been previously examined.

People who had a history (current and previous) of both self-poisoning and self-injury scored significantly higher on the DERS than those who had only engaged in self-poisoning. The self-poisoners and self-injury group scored significantly higher on four DERS subscales: *Impulse* (controlling behaviour when upset), *Goals* (difficulty accomplishing tasks when upset), *Strategies* (belief in the use of strategies to regulate emotion) and *Nonacceptance* (not accepting the emotional reaction or experiencing a negative secondary emotional response). The first three of these scales involve response-focused emotional regulation (Gross, 1998). *Nonacceptance* includes the concept of experiential avoidance. No differences were shown on two DERS subscales: *Awareness* (inattention or lack of awareness of emotional response) and *Clarity* (the extent to which emotions are clear), which can be viewed as antecedent-focused regulation strategies (Gross, 1998). This suggests that there may be differences in the type of emotional dysregulation experienced by people who engage in self-poisoning and self-injury as opposed to those who engage in self-poisoning only.

In comparison to the general population norms for the DERS (Gratz & Gunderson, 2006) (see Appendix 12) apart from *Goals, Strategies* and *Clarity,* the self-poisoning group mean was at least 1 SD above the population mean for DERS *Total Score* and

remaining subscales. For the self-poisoning/self injury group the mean score was at least 1 SD above the population mean for all DERS mean scores and at least 2SD above the population mean for DERS *Total score, nonacceptance, impulse* and *strategies*. Although conclusions are limited by the absence of a control group, this suggests that both the self-poisoning and self-poisoning/self-injury groups are showing clinical differences in their emotional regulation and that the self-poisoning/self injury group are showing increased emotional regulation difficulties.

In Study 1, participants also described difficulties in both antecedent and response-focused emotional regulation. *'Difficulty understanding and expressing emotions'* reflected difficulties in *Awareness*, *Clarity* and *Non-acceptance* of emotions, whilst *"My feelings just spiral out of control"* includes aspects of *Impulse*, *Goals* and *Non-acceptance* of emotions. *'Hiding emotions from others / struggling to cope alone'* particularly reflects aspects of *Strategies*. This theme reflected not participants' inability to use strategies per se, but their limited success in applying them. They felt that the strategies did not provide relief or they had to work very hard to use them, which suggests that this is a conscious process. The theme *'Hiding emotions from others'*, suggests that participants were primarily using emotional suppression as a strategy. The use of emotional suppression has been shown experimentally to have no effect on emotional expression and to actually increase physiological activation as a result of effort spent in reducing emotional expression (Gross, 2001). Emotional suppression can be considered as an emotional form of experiential avoidance (Kashdan et al., 2006). It has also been shown to require self-monitoring and self-corrective action throughout the emotional event, which carries a high cognitive load

that interferes with cognitive processing, such as memory (Richards & Gross, 2000). This appears to reflect the participants' description of their experiences.

The use of distraction and concentration as strategies is also evident in participants' descriptions. The participants required an external focus to support this process (e.g. watching a comedy), rather than being able to do this as at a cognitive level (e.g. changing internal focus such as remembering a happy event). These can be considered *Attentional Deployment* strategies and have been viewed as, primarily, antecedent-focused activities. However, for these participants the use of these strategies occurred after the full experience of the emotion and so were being used in the response phase. Gross and John (2003) suggest that response-focused strategies are always less effective than adjustments at an earlier stage. Interestingly, there were no descriptions of participants using cognitive re-appraisal as a strategy, which has been shown to effectively reduce emotional expression. It is possible that this absence reflects difficulties in the *Awareness* and *Clarity* of emotions, which limits people's ability to engage antecedent-focused strategies at an earlier stage within the emotional process.

It is not clear whether emotions are regulated in the same way as other self-regulatory processes, e.g. stress, mood, attention, hunger and pain (Gross & Thompson, 2007). There is evidence that the neural systems of emotional regulation overlap with the systems responsible for pain regulation, which is unsurprising given the linkage between emotional and physical pain in self-injury. Theoretically and experimentally, exploring the links between emotional regulation and other regulation processes may support the further understanding of whether the deficits are primarily specific or reflective of more widespread deficits. It is also important, given the evidence that emotional regulation processes continue to change in adulthood, with older people

increasingly using cognitive appraisal rather than emotional suppression as their primary strategy (Charles & Carstensen, 2007; John & Gross, 2004).

8. Experiential avoidance

The themes of '*Difficulty understanding and expressing emotions'* and '*Stop a feeling v. Stop all feelings'* reflect the use of emotional suppression. Emotional suppression is also a form of emotional avoidance, which is included within the concept of experiential avoidance. Emotional avoidance is seen in the accounts in people's aversion to emotions and their physiological sensations (particularly in relation to anger or crying); participants described actively trying to decrease or avoid these experiences. It has been suggested that experiential avoidance, paradoxically, leads to an increase in the severity of negative emotional experiences (Hayes et al., 1996). The participants in Study 1 described their emotions as increasing in severity (my feelings spiral out of control) and this finding corresponds with that of Gross and John (2003) that high emotional suppressors experience more negative emotions. All participants in Study 1 scored highly on the AAQ and, in Study 2, 76% of participants scored highly on the AAQ. The number of people who had only ever self-poisoned and who scored in the clinical range on the AAQ was smaller (57.1%), which mirrors the pattern found on the DERS results.

Study 2 found the DERS to be significantly correlated with the AAQ, which supports the finding of Gratz and Roemer (2004) and would be expected, given that the constructs measured by the DERS includes experiential avoidance. However, experiential avoidance involves avoidance of all negative private experiences, not just emotional avoidance. No relationship was found between AAQ and measures of self-harm, which reflects the findings of Chapman (2005) who also failed to find a

relationship between the 16-item version of the AAQ and frequency of self-harm. Chapman suggested that one explanation for this unexpected result was that the length of time between the participant's last self-harm episode and the administration of the AAQ may have reduced the association between them. However, in Study 2, 91.2% completed the AAQ within 72 hours of self-harm and still no relationship was observed with self-harm.

Hayes et al. (2004) report that the alpha level for the 9-item version was acceptable but could become unacceptable in some studies, due to the verbal complexity of the items. In both Gratz and Roemer's (2004) and Chapman's (2005) studies the published reliability levels were relied on and they did not report the alpha levels for their own studies. The participants in Study 2 had recently self-harmed and were in a distressed state. Given that it was the reverse scored items which reduced the overall consistency, it is possible that these items are too complex. Using only the remaining AAQ five items increases the correlations, but no significant associations are seen with self-harm. This leaves two explanations for the lack of association: the AAQ is not reliably measuring experiential avoidance or experiential avoidance is not associated with self-harm. Chapman (2005) found that the AAQ was strongly associated with other measures which include aspects of experiential avoidance (avoidant coping and thought suppression). He also found that, although thought suppression was associated with self-harm, the subscales of the COPE measuring avoidance were not associated. Interestingly, the AAQ-II is currently in development, with the aim of improving the reliability of the measure which should enable further investigation. It is important to note that, as yet, a direct link between experiential avoidance (as measured by AAQ) and self-harm has not been established.

Experiential avoidance was proposed as a functional diagnostic dimension, which would allow the functional classification of individuals as an alternative to syndromal classification. Experiential avoidance is conceptualised as a conscious process. The AAQ attempts to measure it by examining a person's acceptance and avoidance of negative private experiences. The acceptance of experiences is measured by examining a person's high need for emotional and cognitive control, inability to take needed action in the face of private events and forms of cognitive entanglement, such as excessively negative evaluations of private experiences or negative self-references (Hayes et al., 1996). Although the AAQ also attempts to measure avoidance by exploring a person's avoidance of negative private events, it should be noted that self-report measures are only ever likely to reflect response-focused avoidance (e.g. thought suppression and emotional suppression). If antecedent-focused avoidance is successful, the person may not be aware of it taking place, which makes it difficult to measure via self-report questionnaires.

8.1 Experiential Avoidance Model (EAM) of deliberate self-harm

Chapman et al. (2005) proposed that self-harm may function as a behavioural form of experiential avoidance. From Study 1 the theme '*Stop a feeling v. Stop all feelings*' reflects the functional nature of self-harm. Participants felt that it was a successful strategy in stopping unwanted emotion. Self-injury was often focused on reducing particular emotions. Those who repetitively self-poisoned also seemed to use it to reduce a particular emotion. However, for others, self-poisoning could also focus on stopping all feelings. The language that the participants used was primarily about stopping feelings, rather than death, even though this was a potential outcome.

According to the EAM model (Chapman et al., 2006), self-injury enables a person to escape from their negative emotional arousal. Study 1 and 2 did not aim to test this model of self-injury specifically. However, it is useful to consider the applicability of this model to all methods of self-harm. Although the EAM was proposed in relation to self-injury (without suicidal intent), its application to self-poisoning, particularly the role of rule-governed behaviour, may help explain the process by which a small number of people become repetitive self-poisoners who attend hospital on multiple occasions. This group may be using self-poisoning in the same way as the model proposes people use self-injury.

Although a relationship between experiential avoidance and self-harm has been observed clinically and qualitatively, an established link between self-harm and experiential avoidance (as measured by the AAQ) has not been shown. However, given the limitations of the AAQ, it is important that the model is explored further and not discounted primarily on the basis of studies using one specific measure. Further work is needed to explore the relationship between experiential avoidance and self-harm, and for this to be a quantitative exploration, the measurement of experiential avoidance will also need to be developed further.

Both study 1 and 2 also highlight specific areas which the EAM does not explicitly consider. The EAM does not make any reference to the role of other people within the self-harm process, although the emotion 'shame' is included as a precipitating factor. Throughout this discussion, the role of shame and the impact of other people have been highlighted. It is not clear whether the absence of interpersonal processes from the EAM is a reflection of the need for a solely intrapersonal explanation of self-

harm. Nevertheless, the EAM may benefit from a consideration of interpersonal factors, both in relation to the precipitation and perpetuation of self-harm.

9. Self-poisoning and self-injury

A number of studies have suggested that people who self-poison have different characteristics than people who self-injure (Chapman & Gratz, Submitted for publication; Hawton et al., 2004a; Muehlenkamp & Gutierrez, 2004; Rodham et al., 2004). However, such studies often conclude that there are differences between people who self-poison or self-injure by dividing them on the basis of their last episode (index episode) or their previous hospital attendances and not their overall history of self-harm (Hawton et al., 2004a; Rodham et al., 2004). Given the high rates of self-injury within people who self-poison in Study 2, dividing people only on the basis of their index episode will not result in pure comparison groups. Just because someone is currently classified as a self-poisoner does not mean that they could not also be classified as a self-injurer on the basis of their previous history. This is particularly important, given the finding that suicide attempts and low-lethal self-harm behaviour often co-exist within the same person (Sansone, Songer & Sellbom, 2006).

When previous history is taken into account, the evidence is growing that the differences between groups are not clear cut. For example, Muehlenkamp and Gutierrez (2004) compared adolescents who had attempted suicide (self-poisoning and/or self-injury) and those who engaged in self-injury only without suicidal intent. Comparisons between the self-injury group and the suicide attempt group failed to find significant differences in suicide ideation and depressive symptoms. The only significant difference was on attitudes toward life. Muehlenkamp and Gutierrez

suggest that the differences between the two behaviours are actually more subtle than initially thought and may relate only to differences in the individual's attitude toward life or death. Again, this study did not look at those individuals with a history of both behaviours.

At their extremes, self-injury (with the aim of coping and feeling better), and self-poisoning (with the aim of stopping all feelings and dying) are different behaviours. However, they appear to be linked by the underlying emotional processes, with the same motivation to eliminate difficult feelings. The differentiation of self-injury from self-poisoning and other forms of self-harm with suicidal intent is contentious, both in terms of validity and utility. Defining people who self-injure without intent to die as a separate clinical group is only valid if the person does not engage in self-harm with intent to die. Given the ambiguous nature of intent to die, it is questionable whether this differentiation can actually be made, particularly given that there is a group of people who in engage in both types of behaviour. While there are differences between people who engage in different types of self-harm, before these are defined within formal classification systems, further work is needed to explore the similarities and underlying processes, particularly given the possibility that self-injury and self-poisoning may represent different ends of a continuum of self-harm behaviour (Stanley et al., 1992) .

10. Living with self-harm

The final super-ordinate theme '*Living with self-harm'* explored the participants' experiences of, and difficulties in accepting, self-harm. Again, the emotion of shame was present, particularly in '*The private and the public - accepting and acknowledging self-harm'*. This theme highlights the cognitive dissonance (Festinger,

1957) evoked by their own and others self-harm. For many participants, the only way to accept this dissonance was to separate their self-harm from the rest of their lives, allowing the contradictory feelings to co-exist separately. This links to the work of Adams, Rodham & Gavin (2005) who found evidence of the conflict between '*the accepted or denied self*' in their qualitative study of self-injurers who use on-line discussion forums.

The difficulties participants have in accepting self-harm are also reflected in the way they feel others perceive it. The medical profession, in separating self-harm from 'mental illness', seems to have left the participants struggling to make sense of what their self-harm is:

> *I struggle with it as who am I to cause them any problems or any difficulties because people will say 'It's just an inappropriate coping strategy, you're not mentally ill'. Well this is how it feels when you've supposedly got no illness but I struggle all the time with (I:392-395) .*

> *And in my mind a lot of the time it seems like self harm is anything that means that medical people actually have to do something. And as long as I don't come to hospital the same action won't be self harm. But what they are actually saying is, 'Stop asking for our attention' (E:563-566).*

Implicit within this is a sense that, in harming themselves, participants are doing something wrong, which seems to add to their need to keep it hidden from other people.

The data includes a number of contradictions both within and between themes. These highlight the strong ambivalent feelings, which were often expressed by the participants:

- wanting a feeling to stop so that they can live and feel better, but wanting all their feelings to stop and possibly die;

- wanting to punish themselves with self-harm, but allowing themselves self-care and care from others following self-harm;
- wanting to seek help from others, but wanting to keep their emotions and self-harm hidden from others;
- maintaining their right to self harm, but wanting to stop others and, for some, to be stopped themselves from self-harming.

Overall, this highlights the complexity of reasons and emotions relating to self-harm. Given the different messages, it is not surprising that staff find this a difficult client group to work with and often express negative attitudes towards people who self-harm (Friedman et al., 2006).

11. Strengths and limitations

The use of a mixed method design is a significant strength of this research. It enabled the qualitative exploratory approach to drive the research and provide further insight into the interpretation of the quantitative results. The studies provides different types of information and, particularly, highlighted the difficulties of using a quantitative approach to studying the reasons for self-harm. A quantitative only approach would have overlooked the subtleties of the interpersonal processes within self-harm and, particularly, the role of shame. However, a qualitative only study of self-harm would not have identified the differences between those who self-poison only and those who self-poison and self-injure.

Studying self-harm is a difficult area in which to carry out research as a prospective design is precluded on ethical grounds (Briere & Gil, 1998). Although this study used a retrospective design, Study 2 attempted to collect data shortly following an incident

of self-harm (91.2% within 72 hours). Unfortunately, the participants' emotional state is likely to have exacerbated the difficulties they had with the complexity of the AAQ reverse scored items, which resulted in only a small number of items being included in calculating the measure of experiential avoidance.

Previous research has used the index episode to compare different people who use specific methods of self-harm. One strength of the current research was the use of a behavioural-based measure of previous self-harm to group participants on the basis of their previous self-harm behaviour and not just the current index episode. Analysing the missing quantitative data also provided additional evidence as to the difficulties that participants experienced. The research was carried out over a 10 month period. During this period the researcher was able to shadow the Self Harm Service, which enabled the researcher to reflect on the experiences of this client group and added to the overall reflexivity of the research process.

However, this research had a number of key limitations, which need to recognised when interpreting the results. The studies were hospital based, primarily due to the focus on emotional regulation and experiential avoidance within self-poisoners and the need to see people as soon as possible after the self-harm episode. Sampling via Accident and Emergency departments increases the number of self-poisoners in samples (Webb, 2002) but limits possible generalisations to all self-harmers. While differences are shown between people who had self-poisoned and people who had self-poisoned and self-injured, generalisations cannot be made to those people who only self-injure, and those that do not attend hospital.

All age groups are represented in both studies, which improves the overall validity of the data. However, it must also be considered whether there was an inherent sampling bias by staff in approaching participants. Study 2 included a larger proportion of 18-25 years olds than in the overall population of people referred to the Self-Harm Service. It is possible that staff implicitly felt that this group were more willing to take part in the research. Unfortunately, the non-collection of statistics on those participants who did not consent to the study limits further consideration of any inherent sampling bias.

The research used self-report measures of behaviour and, although attempts were made to substantiate the number of hospital attendances for self-harm, this aim was not achieved because of practical restrictions. Internal experiences are not easily verified through other methods than self-report without using physiological measures, which would not have been appropriate to use immediately following self-harm. Self-report measures only describe what a person is willing (or able) to report (Fliege et al., 2006).

It is also important to recognise that the participants in Study 2 completed the questionnaires after psychosocial assessment. This, in itself, may have changed the way in which participants perceived and attributed the reasons for their self-harm. However, as Fliege et al (2006) argue, many people are more comfortable divulging information about self-harm through self-report than clinician interview.

Significant numbers of participants in both studies experienced difficulties with experiential avoidance, emotional dysregulation and, specifically, with antecedent emotional regulation. This will clearly have impacted on the completion of the

questions relating to differentiating and reporting strength of emotions. Within the emotions list, the use of the word *self-contempt* was poorly understood by participants and the use of an alternative term (such as self-hatred) may have been more appropriate.

Although the sample in Study 1 was homogenous, in that the participants had all experienced self-harm, their heterogeneity of experience was reflected in the large number of initial themes. The data was difficult to integrate and the final four themes did not easily emerge from the data. IPA presumes that people are able to use language to represent their experiences (Willig, 2001) but, given the difficulties participants had in describing their emotions, this may have impacted on their descriptions of their internal experience.

12. Clinical implications

Self-harm is hard to prevent. Given that self-harm is often an impulsive act, particularly in the case of self-injury, it is difficult to intervene with an individual to prevent self-harm, unless that individual is already known to be at risk and in contact with professionals. This study supports the general prevention strategies to reduce access to the means to self-harm, e.g. by reducing pack size of medication and encouraging people not to keep unused medication (Morgan & Majeed, 2005). It also supports the need for greater public awareness of the role of alcohol, and particularly binge drinking, in precipitating self-harm episodes. Further research into the effectiveness of an alcohol reduction programme following self-harm is underway and should inform clinical practice in this area (Crawford, Touquet & Reid, 2007).

The results also highlight the clinical importance of fully exploring a person's previous history of self-harm within a psychosocial assessment. The use of a general question such as 'have you self-harmed before?' is dependant on the definition of self-harm being used by the person and the clinician. There is a need to use a behavioural questionnaire to ensure that people are clear about what self-harm includes and to accurately identify those people who have previously self-injured. The use of a questionnaire may increase the likelihood that people will acknowledge previous self-harm, given the difficulties that people have in doing this. This study suggests that those people who self-poison and self-injure attend hospital more frequently, have increased frequency of self-harm and express greater suicidal intent. Identifying this group is particularly important, given that previous self-harm is one of the strongest predictors of future self-harm (Johnston, Cooper, Webb & Kapur, 2006) and that self-injury has specifically been identified as a risk factor in those who complete suicide following hospital attendance (Cooper et al., 2005).

Overall, brief interventions, which aim to reduce the likelihood of repetition of self-harm among people who attend hospital, have been ineffective. Although longer-term interventions for people with BPD have been shown to reduce the rate of repetition of self-harm, these are only available via specialist services (Crawford & Kumar, 2007). This study suggests that there are high rates of experiential avoidance and emotional dysregulation in people who self-harm and, particularly, those who use multiple methods of self-harm. Within this group, those identified with BPD could be referred to specialist services. However, this diagnosis would not apply to all self-harmers and it is outside the bounds of the current discussion to consider the advantages/disadvantages of taking such an approach. Nevertheless, it is possible that

those people who use multiple methods of self-harm would benefit from the interventions applied to people with BPD, such as DBT (Linehan, 1993; Linehan et al., 2006) and ACT (Hayes et al., 1999), which both include a focus on accepting emotional responses rather than actively attempting to change them. Although further research into clinical efficacy would be necessary, the use of shorter-term interventions (such as a 14-week emotion regulation group intervention, designed to teach self-harming women with BPD more adaptive ways of responding to their emotions) (Gratz & Gunderson, 2006) should be considered.

Clinically, work is needed to further develop and evaluate interventions which target emotional regulation difficulties. This research suggests that it may be useful to focus particularly on supporting different emotional regulation strategies (e.g. antecedent and/or response-focused) for different people, given that they may have a differing pattern of deficits. It appears important that people are not just encouraged to adopt general strategies e.g. distraction without considering their specific deficits. The timing of the strategies people use is significant; for example, in someone who is unaware of their emotions, they are less likely to be able to use distraction at an early stage. If distraction is used after the full experience of an emotion, it is likely to be less effective, and may actually increase the experience of the emotion rather than reduce it.

Finally, Study 1 has highlighted the contradictions and ambivalences which are present within people who self-harm and attend hospital and the potential negative consequences of invalidation by hospital staff. Mackay and Barrowclough (2005) found that, where staff perceive self-harm to be caused by a factor potentially controllable by patients, they express higher levels of irritation and less helping

behaviour. They also found that medical staff showed expressed higher levels of irritation and less willingness to help than nursing colleagues. It has also been shown that senior and more experienced staff may have more unhelpful attitudes (Friedman et al., 2006). It is possible that the contradictions and ambivalences reflected within people who self-harm result in further negative staff attributions towards self-harm. Clinically, it is vital that staff who have contact with individuals who self-harm have the training and supervision which enables them to explore and challenge their own beliefs about self-harm. It is important that they understand both their own personal responses to self-harm and the impact that these responses may have on others. This is necessary in order to engage this challenging client group and prevent further self-harm.

13. Further research

These studies have highlighted the need for further research in a number of areas. Further work could usefully explore the reasons for and intentions of self-harm. The current approach to research in this area is limited by the available measures which result in people being more likely to indicate intrapersonal reasons than interpersonal reasons for self-harm. Due to the potential impact of invalidation prior and following self-harm, the challenge is to develop a measure of the reasons for self-harm which asks about interpersonal reasons in a non-shame provoking way.

The theme *Dicing with death* highlights that intent to die is not a static phenomenon. The measurement of suicidal intent is clearly important in the assessment of future suicide risk (Harriss, Hawton & Zahl, 2005). Kumar (2005) argues that measuring suicide intent is more useful than measuring the lethality of the attempts, particularly where there is no correlation between the expected and actual outcome of the method.

It would be helpful for research to develop a measure of intent to die which conceptualises intent as a process. Such a measure would explore intent at different time-points (e.g. before and after self-harm) and measure strength of intent rather than presence or absence. This would aid researchers understanding of whether people who self-injure without suicidal intent are in fact a separate group from those who engage in other forms of self-harm.

Further research into the group of people who engage in both self-poisoning and self injury is important. Study 2 has shown differences, particularly in types of emotional regulation, between self-poisoners and those who self-poison and self-injure. The next step would be to explore whether those differences are present between people who only engage in self-injury and those who engage in both self-injury and self-poisoning. It is likely that such a study would need to be community-based to enable access to those people who self-injure but who do not seek medical treatment.

Research into the use of different emotional regulation strategies for people who self-harm and the relationship between emotional strategies and general self-regulation is also needed. Theoretically, this would aid understanding of the relationship between emotion and self-regulation, particularly given that, conceptually, emotional regulation is a developing area (Gross, 2007). Clinically, this would also enable interventions to specifically focus on the areas of deficit that people have. The use of the DERS as a measure of difficulties in emotional regulation is limited by its primary focus on negative emotional dysregulation. Study 1 indicates that participants may also have difficulties regulating positive emotions (although this caused less distress). Therefore, differences in positive emotional regulation strategies could also be explored further.

These studies highlight the importance of shame within self-harm, both as a possible precipitating and perpetuating factor. Given this, further research specifically exploring the level of shame-proneness and state shame is needed. This could expand on research with involving individuals with BPD. However, it is important that it is not only restricted to BPD but is expanded to consider those who self-harm within the general population.

14. Conclusions

This research explored the reasons and emotional processes underlying self-harm. The data from both studies highlight the difficulties that participants have in experiencing and regulating their emotions. Although individuals tend to give intrapersonal reasons for their self-harm, the interpersonal processes are significant in understanding why people self-harm. The results suggest that, following self-poisoning, participants experience a decrease in their emotions (particularly negative emotions) and although positive emotions increase, shame also significantly increases. Both studies highlight the potential role of a shame-driven process underlying self-harm. The results indicate that people who have both self-poisoned and self-injured, significantly differ from those who have only ever self-poisoned. The former group show higher emotional dysregulation, higher experiential avoidance and expressed intent to die for their current self-harm episode. They also appear to show deficits in both antecedent and response-focused emotional regulation.

People who self-harm are a complex and diverse client group to work with and developing effective interventions remains a clinical priority. As these studies

highlight, this will only be possible with a greater understanding of the different reasons and emotional processes that underlie self-harm.

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APPENDIX 1: REFLEXIVE STATEMENT

"...when researching something like attempted suicide or self-harm, such objectivity is a myth. For, what this inevitably involves is one set of human beings confronting and then striving to understand the intentions of other human beings" (Davies, 1996, p.6).

1. Figure and ground

In seeking to describe my own reflexive process, I am aware of both the immediate figures (that which is most dominant in drawing my interest) and the ground (or background to that which is figural). At various points within the research process, different issues have been more or less figural and this can only be understood within the context of my own field (the relationship between my own internal world and my external environment) (Clarkson, 2004; Joyce & Sills, 2001). The use of a research diary has helped me track this process and reflect on what, of myself, I bring to this research.

My own interest in self-harm developed in my previous employment, prior to my clinical training, from my experiences of supporting people who were thinking about or who had self-harmed. I had varied experiences, both positive and negative. I experienced deep compassion, frustration, fear and sadness in my work. I observed difficult and often negative attitudes towards this client group and was left with a curiosity about what self-harm was about, why for some individuals it continued and how they could best be helped.

My ground also included my developing skills as a psychologist, my current training which encouraged me to look at information from different perspectives; my own experiences of depression; and my belief in the benefit of talking and expressing difficult feelings.

2. Reflections on the research process

In working with the Self Harm Service to recruit interviewees and collect questionnaires, a number of issues became very figural for me. I was aware of entering 'self-harm world' and

initially being shocked at seeing so many people who had self-harmed. The initial emotional impact of interacting with individuals who had self-harmed reduced over the time I was there, and it seemed to become more normal. I was very aware of the teams' and my own sense of humour being used as a defence against the emotional impact of this work. I really struggled with the lack of confidentiality on hospital wards and encountered very different and sometimes negative feelings from hospital staff towards the clients. I witnessed the impact on staff of a number of completed suicides and of my own emotional response to the two people I came into contact with who completed suicide. I observed the difficult balance between promoting self-determination and trying to prevent further self-harm, and questioned whether this aim was an impossible goal.

During the interviews, although I felt comfortable talking about self-harm, I was struck by the often powerful content and difficult feelings I was left with after the interviews. I worked to balance my activity in interviews between asking questions and actively listening. In this I sought to privilege my role of researcher but remained aware in the ground of my clinician's role.

I delayed re-reading my literature review and writing the introduction chapter until analysis was underway in an attempt to limit the influence of other work and allow the themes to emerge from, and be grounded in, the data. I also spent time reflecting on the process of the interviews, within my experience of being in 'self-harm world'. At times, I felt overwhelmed by the transcripts and found the process of integration challenging but I felt supported by the methodological structure. It was difficult to group the themes into super-ordinate themes. A number of different solutions were considered which focused on the different types of ambivalence people were expressing and their difficulty with control. These solutions were not satisfactory as they resulted in the exclusion of a number of themes which had been

strongly expressed within the transcripts. The final thematic structure represented the best fit for the overall data. Given these difficulties, I spent a lot of time considering whether the initial themes were a product of questions and was satisfied that they were data driven.

I was anxious before the participant validation meetings, particularly in relation to managing the issues around power and trying to enable a dialogue to occur. I was surprised by constructiveness of the process and encouraged that the two participants could identify their differing experiences with the emerging themes.

Throughout the research, I was aware of my often parallel process to the participants. At the end of the research process I noticed that I was left with ambivalent feelings about the research. This was something I actively reflected on in my diary, recognised and incorporated in my writing. I remain interested in this area theoretically, and clinically as a client group I would like to further work with.

APPENDIX 2: ETHICS APPROVAL

NHS
Local Research Ethics Committee

Telephone: (
Facsimile: (

10 March 2006

Mrs Emma Coyne
Trainee Clinical Psychologist

Dear Mrs Coyne

Full title of study: **An exploratory study into deliberate self harm: people's intentions, emotional functions and processes**

REC reference number: **06/Q1104/13**

Thank you for your letter of 01 March 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered by the chair of the committee.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The favourable opinion applies to the research sites listed on the attached form.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Application	1	19 January 2006
Investigator CV	Emma Coyne	19 January 2006
Investigator CV	Supervisors CV	
Protocol	4	01 January 2006
Protocol	Flow Chart v 2	01 December 2005
Covering Letter	Covering letter	19 January 2006
Peer Review	University Review Form	24 January 2006
Peer Review	University Review Form	
Statistician Comments	20/07/2005	20 July 2005
Interview Schedules/Topic Guides	1	13 January 2006
Questionnaire	1	15 January 2006
Questionnaire	Study 1 version 3	15 January 2006
Questionnaire	Study 2 version 3	15 January 2006
Participant Information Sheet	Information sheet 1 version 3	21 February 2006
Participant Information Sheet	Information sheet 2 version 3	21 February 2006
Participant Consent Form	Consent form 3 version 1	28 February 2006
Participant Consent Form	Consent form 1 version 2	05 December 2005
Participant Consent Form	Consent form 2 version 2	05 December 2005
Response to Request for Further Information	Letter addressing all concerns of the committee	01 March 2006

Research governance approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final research governance approval from the R&D Department for the relevant NHS care organisation.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/Q1104/13	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Mr Graeme Duthie
Chair

Email: I

Enclosures:

Standard approval conditions

Site approval form

Copy to: IHS Trust.

APPENDIX 3: TRUST APPROVAL 1

NHS
Teaching NHS Trust
Research & Development Department
Trust Headquarters

Our Ref: SW-22/03/06-Emma Coyne.doc

22 March 2006

Emma Coyne

Dear Emma Coyne

Re: An exploratory study into deliberate self harm: peoples intentions, emotional functions and processes.

I am please to notify you formally that this study has been approved by the Trust and may now proceed.

The NHS Trust conducts all research in accordance with the requirements of the Research Governance Framework, and the NHS Intellectual Property Guidance. In undertaking this study you agree to comply with all reporting requirements, systems and duties of action put in place by the trust to deliver research governance, and you must comply with the Trust information management and data protection policies. In addition, you agree to accept the responsibilities associated with your role that are outlined within the Research Governance Framework as follows:

- The study follows the agreed protocol
- Participants should receive appropriate care while involved in the study
- The integrity and confidentiality of clinical, other records and data generated by the study will be maintained
- All adverse events must be reported to the Trust and other authorities specified in the protocol
- Any suspected misconduct by anyone involved in the study must be reported

The Trust is required to return information on the progress of studies to the National Research Register, and to report research findings. We will, therefore, ask you every 6 months for such updates. This includes full reference of any publications arising from the project.

I would like to wish you every success with this project

Yours sincerely

Mr Duncan Courtney
Senior Projects Officer

APPENDIX 4: TRUST APPROVAL 2

NHS Trust

20.03.2006

Ms Emma Coyne
Clinical Psychology

Dear Ms Coyne,

REC reference number 06/Q1104/13
Re: An exploratory study into deliberate self harm: peoples intentions, emotional functions and processes.

I am pleased to notify you formally that this study has been approved by the Trust and may now proceed.

NHS Trust conducts all research in accordance with the requirements of the Research Governance Framework, and the NHS Intellectual Property Guidance. In undertaking this study, you agree to comply with all reporting requirements, systems and duties of action put in place by the Trust to deliver research governance, and you must comply with Trust information management and data protection policies (see intranet Policies Nos: 134, 135, & 192). In addition, you agree to accept the responsibilities associated with your role that is outlined within the Research Governance Framework as follows:

- the study should follow the agreed protocol;
- all potential subjects should have enough information to make a free and informed decision about participation;
- participants should receive appropriate care while involved in the study;
- the integrity and confidentiality of clinical and other records and data generated by the study will be maintained;
- all adverse events must be reported forthwith to the Trust and other authorities specified in the protocol;
- any suspected misconduct by anyone involved in the study must be reported;

I would like to wish you every success with this project.

Yours sincerely

N. Dunham

Nina Dunham
Research and Development Manager

APPENDIX 5: INFORMATION SHEET STUDY 1

Title of project: An exploratory study into deliberate self harm

INFORMATION SHEET (Study 1)

- You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

- **What is this research about?** This research is looking at the reasons why people harm themselves and the different emotions they experience. This research may help us find better ways to help people. This research is being undertaken as part of an educational qualification.

- **Do I have to take part?** No. It is up to you to decide whether or not to take part. If you agree to take part in the study you will be asked to give your permission by answering the five questions on the next page and signing the sheet. You can change your mind about taking part at any time. Your treatment will be the same, whether or not you choose to take part in the study. You can keep this information sheet to take away with you.

- **What will happen to me if I take part?** A researcher will then contact you to arrange an appointment to meet with you. This will be at the [redacted]. When you get there you will be asked to fill in a questionnaire about why you harmed yourself and how you had been feeling. The questionnaire also asks you about whether you have harmed yourself before and how you cope generally when you are feeling upset. You will then be asked to talk more about these issues in an interview with the researcher. The interview will be recorded. The questionnaire and interview will take up to 1 hour 30 minutes.

- Some people find filling in the questionnaire or talking about their experiences can be upsetting. If this happens to you, you can talk to a member of staff about how you feel.

- **Will my taking part in the study be kept confidential?** All information which is collected about you during the research will be kept strictly confidential. The exception to this is if you indicate in your answers that you are intending to harm yourself again; this information will be shared with the staff involved in your care. Staff will then talk to you to find the best way to support you with these thoughts and feelings.

(Continued on next page)

- **What will happen to the results of the research study?** All information from the study which leaves the hospital will be anonymous so you cannot be recognised from it. The interview will be transcribed and the recording will then be destroyed. The results of the study will be presented in a thesis and published reports. You will not be personally identifiable in any information which is published

- **Any questions?** If you have any questions now please speak to the member of staff who gave you this sheet.

- **Contact Information and complaints** Further information about the research or if you want to make a complaint please contact:

Emma Coyne, [redacted]

If after you leave the hospital, you feel you need additional support please contact the Self Harm Service on: [redacted]

APPENDIX 6: CONSENT FORM STUDY 1

CONSENT SHEET (Study 1)

Title of Project: **An exploratory study into deliberate self harm**

Name of Researchers: **Emma Coyne / Dr Lesley Glover / Patrick Scott**

1.	I confirm that I have read and understood the information sheet dated *(21/02/06) Version 3* for the above study and have had the opportunity to ask questions.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason, without my treatment or legal rights being affected.	☐
3.	I understand that sections of any of my medical notes may be looked at by the researchers where it is relevant to my taking part in the research. I give permission for these individuals to have access to my records.	☐
4.	I agree to take part in the above study.	☐
5.	I would prefer to be contacted to arrange an appointment by: **letter / telephone / e-mail** (Please delete as appropriate) **Name** _____ **Contact details** _____ _____ _____	

_____ _____ _____

Name of patient Date Signature

_____ _____ _____

Name of researcher
or staff member taking consent Date Signature

Consent Form 1 (05/12/05) Version 2

APPENDIX 7: INFORMATION SHEET STUDY 2

Title of Project: An exploratory study into deliberate self harm

INFORMATION SHEET (Study 2)

- You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

- **What is this research about?** This research is looking at the reasons why people harm themselves and the different emotions they experience. This research may help us find better ways to help people. This research is being undertaken as part of an educational qualification.

- **Do I have to take part?** No. It is up to you to decide whether or not to take part. If you agree to take part in the study you will be asked to give your permission by answering the six questions on the next page and signing the sheet. You can change your mind about taking part at any time. Your treatment will be the same, whether or not you choose to take part in the study. You can keep this information sheet to take away with you. You can choose whether to complete the questionnaire before you leave the hospital today or to come back to hospital in the next week to complete the questionnaire.

- **What will happen to me if I take part?** Taking part will involve you filling in a questionnaire about why you harmed yourself and how you have been feeling. It also asks you about whether you have harmed yourself before and how you cope generally when you are feeling upset.

- Some people find filling in the questionnaire or talking about their experiences can be upsetting. If this happens to you, you can talk to a member of staff about how you feel.

- **Will my taking part in the study be kept confidential?** All information which is collected about you during the research will be kept strictly confidential. The exception to this is if you indicate in your answers that you are intending to harm yourself again; this information will be shared with the staff involved in your care. Staff will then talk to you to find the best way to support you with these thoughts and feelings.

(Continued on next page)

- **What will happen to the results of the research study?** All information from the study which leaves the hospital will be anonymous so you cannot be recognised from it. The results of the study will be presented in a thesis and published reports. You will not be personally identifiable in any information which is published.

- **Any questions?** If you have any questions now please speak to the member of staff who gave you this sheet.

- **Contact Information and complaints** Further information about the research or if you want to make a complaint please contact:

Emma Coyne, [redacted]

If after you leave the hospital, you feel you need additional support, please contact the Self Harm Service on: [redacted]

APPENDIX 8: CONSENT FORM STUDY 2

Title of Project: **An exploratory study into deliberate self harm**

Name of Researchers: **Emma Coyne / Dr Lesley Glover / Patrick Scott**

1.	I confirm that I have read and understood the information sheet dated 21/02/06 (version 3) for the above study and have had the opportunity to ask questions.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason, without my treatment or legal rights being affected.	☐
3.	I understand that sections of any of my medical notes may be looked at by the researchers where it is relevant to my taking part in the research. I give permission for these individuals to have access to my records.	☐
4.	I agree to take part in the above study.	☐
5.	I would like to complete the questionnaire now.	☐
6.	I would like to come back in the next week to complete the questionnaire. I would prefer to be contacted to arrange an appointment by: **letter / telephone / e-mail** (Please delete as appropriate) **Name** _____ **Contact details** _____ _____ _____	☐

_____	_____	_____
Name of patient	Date	Signature
_____	_____	_____
Name of researcher or staff member taking consent	Date	Signature

APPENDIX 9: CONSENT AND RECORDING FORMS

CONSENT SHEET DEMOGRAPHIC DETAILS ONLY

Title of Project: **An exploratory study into deliberate self harm**

Name of Researchers: **Emma Coyne / Dr Lesley Glover / Patrick Scott**

1.	I confirm that I do not wish to take part in the study.	☐
2.	I agree to the following information being recorded anonymously: my gender, my age group and the way I have harmed myself in the last year (e.g. self-poisoning or injury). I understand that no other information will be recorded.	☐

Name of patient _____ Date _____ Signature _____

Name of researcher or staff member taking consent _____ Date _____ Signature _____

Consent Form3 (28/02/06) Version 1

Recording sheet
Staff member to complete

For people who do not agree to take part please complete demographic information:

Gender Male Female

Age _____

Type of Self Harm which has occurred in the last year (ring as many as appropriate)

Self-poisoning Self-injury Other_____

APPENDIX 10: QUESTIONNAIRE STUDY 1

Please answer all the questions as honestly as you can. Please do not miss any questions out.

1) Please circle your gender Male Female

2) How old are you? _____**years old**

3) How many times have you attended hospital for treatment because you have harmed yourself?

_____**time(s)**

Please answer questions 4 - 15 in relation to the last time you harmed yourself and attended hospital afterwards.

4) Please describe in your own words how you harmed yourself on that occasion?

_____

_____

_____

5) Please explain why you chose this method of self-harm?

_____

_____

_____

6) How long ago was it that you harmed yourself?

_____days / weeks / months
(delete as appropriate)

7) Did you consume any alcohol prior to harming yourself? If yes can you say how much?

No Yes how much?_____

8) Did you use any non-prescription drugs prior to harming yourself?

No Yes

9) How long before you tried to harm yourself had you started to think about doing it?

☐ less than an hour ☐ more than an hour but less than a day

☐ more than a day but less than a week ☐ more than a week but less than a month

☐ a month or more

10) Please explain in your own words why you think you tried to harm yourself on that occasion?

_____

_____

_____

11) How were you feeling <u>just before</u> you harmed yourself? For each feeling can you rate how strong the feeling was?

1----------2----------3----------4----------5
Not feeling this — Overwhelming

Anger at others	1——2——3——4——5	**Anger at self**	1——2——3——4——5
Anxiety / panic	1——2——3——4——5	**Despair**	1——2——3——4——5
Detached / Cut off	1——2——3——4——5	**Disappointment/insult**	1——2——3——4——5
Excitement	1——2——3——4——5	**Fear**	1——2——3——4——5
Guilt	1——2——3——4——5	**Loneliness**	1——2——3——4——5
Pleasure	1——2——3——4——5	**Relief**	1——2——3——4——5
Self-contempt	1——2——3——4——5	**Shame**	1——2——3——4——5
Emptiness (mental vacuum)	1——2——3——4——5	**Powerlessness/ hopelessness**	1——2——3——4——5

12) How were you feeling <u>just after</u> you harmed yourself? For each feeling can you rate how strong the feeling was?

1----------2----------3----------4----------5
Not feeling this — Overwhelming

Anger at others	1——2——3——4——5	**Anger at self**	1——2——3——4——5
Anxiety / panic	1——2——3——4——5	**Despair**	1——2——3——4——5
Detached / Cut off	1——2——3——4——5	**Disappointment/insult**	1——2——3——4——5
Excitement	1——2——3——4——5	**Fear**	1——2——3——4——5
Guilt	1——2——3——4——5	**Loneliness**	1——2——3——4——5
Pleasure	1——2——3——4——5	**Relief**	1——2——3——4——5
Self-contempt	1——2——3——4——5	**Shame**	1——2——3——4——5
Emptiness (mental vacuum)	1——2——3——4——5	**Powerlessness/ hopelessness**	1——2——3——4——5

13) How are you feeling <u>now</u>? For each feeling can you rate how strong the feeling is?

1----------2----------3----------4----------5
Not feeling this — Overwhelming

Anger at others	1——2——3——4——5	**Anger at self**	1——2——3——4——5
Anxiety / panic	1——2——3——4——5	**Despair**	1——2——3——4——5
Detached / Cut off	1——2——3——4——5	**Disappointment/insult**	1——2——3——4——5
Excitement	1——2——3——4——5	**Fear**	1——2——3——4——5
Guilt	1——2——3——4——5	**Loneliness**	1——2——3——4——5
Pleasure	1——2——3——4——5	**Relief**	1——2——3——4——5
Self-contempt	1——2——3——4——5	**Shame**	1——2——3——4——5
Emptiness (mental vacuum)	1——2——3——4——5	**Powerlessness/ hopelessness**	1——2——3——4——5

14) Please explain in your own words why did you go to hospital?

_____

_____

_____

15) If you self-harmed again in the future where would you go for help? (You can pick more than one answer).

☐ Family
☐ Friend
☐ Hospital
☐ Minor injuries Unit
☐ G.P
☐ Community Mental Health Team
☐ Telephone help line
☐ Nowhere
☐ Other (Please specify)

_____

16) To what extent did the following reasons influence your decision to harm yourself?

1——————2——————3
Of no importance Of some importance Of major importance

1. I wanted to get relief from a terrible state of mind	1——2——3
2. I wanted to show how much I loved someone	1——2——3
3. I seemed to have lost control of myself and have no idea why I behaved that way	1——2——3
4. The situation was so unbearable that I had to do something and didn't know what else to do	1——2——3
5. I wanted to escape for a while from an impossible situation	1——2——3
6. I wanted to make people understand how desperate I was feeling	1——2——3
7. I wanted to die	1——2——3
8. I wanted to seek help from someone	1——2——3
9. I wanted to find out if someone really loved me	1——2——3
10. I wanted to frighten someone or to get my own back on someone	1——2——3
11. I wanted to make people sorry for the way they have treated me	1——2——3
12. I wanted to influence some particular person or get them to change their mind	1——2——3
13. I wanted to make things easier for others	1——2——3
14. I wanted to sleep for a while	1——2——3
15. I wanted to punish myself	1——2——3

17) For each of the statements below please rate how true they are for you.

1 Never True	2 Very rarely True	3 Seldom True	4 Sometimes True	5 Frequently True	6 Almost Always True	7 Always True

1. I am able to take action on a problem even if I am uncertain what the right thing is to do.	1---2---3---4---5---6---7
2. I often catch myself daydreaming about what I have done and what I would do differently next time.	1---2---3---4---5---6---7
3. When I am depressed or anxious I am unable to take care of my responsibilities.	1---2---3---4---5---6---7
4. I rarely worry about getting my anxieties, worries and feelings under control	1---2---3---4---5---6---7
5. I'm not afraid of my feelings.	1---2---3---4---5---6---7
6. When I evaluate something negatively, I usually recognise that this is just a reaction and not an objective fact.	1---2---3---4---5---6---7
7. When I compare myself to other people, it seems that most of them are handling their lives better than I do.	1---2---3---4---5---6---7
8. Anxiety is bad.	1---2---3---4---5---6---7
9. If I could magically remove all the painful experiences I've had in my life I would do so.	1---2---3---4---5---6---7

18) This part of the questionnaire asks about a number of different things that people sometimes do to hurt themselves. Please be sure to read each question carefully and respond honestly. Often, people who do these kinds of things to themselves keep it a secret, for a variety of reasons. However, honest responses to these questions will provide us with greater understanding and knowledge about these behaviours and the best way to help people.

Please answer yes to a question only if you did the behaviour intentionally, or on purpose, to hurt yourself. Do not respond yes if you did something accidentally (e.g., you tripped and banged your head accidentally).

If you answer yes for a question, please state how many times you done this behaviour? Please write an actual number (e.g., 1, 5, or 15 NOT some, many, or few).

Have you ever intentionally i.e., on purpose:		**No of Times:**
1. cut your wrist, arms, or other area(s) of your body (without intending to kill yourself)?	Yes No	
2. cut your wrist, arms, or other area(s) of your body (with the intention to kill yourself)?	Yes No	
3. burned yourself with a cigarette?	Yes No	
4. burned yourself with a lighter or a match?	Yes No	
5. carved words into your skin?	Yes No	

Have you ever intentionally i.e., on purpose:			No of Times:
6. carved pictures, designs, or other marks into your skin?	Yes	No	
7. severely scratched yourself, to the extent that scarring or bleeding occurred?	Yes	No	
8. bit yourself, to the extent that you broke the skin?	Yes	No	
9. rubbed sandpaper on your body?	Yes	No	
10. dripped acid onto your skin?	Yes	No	
11. used bleach or oven cleaner to scrub your skin?	Yes	No	
12. stuck sharp objects such as needles, pins, staples, etc. into your skin, **not including** tattoos, ear piercing, needles used for drug use, or body piercing?	Yes	No	
13. rubbed glass into your skin?	Yes	No	
14. broken your own bones?	Yes	No	
15. banged your head against something, to the extent that you caused a bruise to appear?	Yes	No	
16. punched yourself, to the extent that you caused a bruise to appear?	Yes	No	
17. prevented wounds from healing?	Yes	No	
18. poisoned yourself (without intending to kill yourself)	Yes	No	
19. poisoned yourself (with the intention to kill yourself)	Yes	No	
20. done anything else to hurt yourself that was not asked about in this questionnaire? If yes, can you tell us what did you do to hurt yourself and the number of times?	Yes	No	

Please continue on to Question 19 on the next page.

19) Please indicate how often the following statements apply to you by circling the appropriate number from the scale below on the line beside each item:

1——————2——————3——————4——————5

almost never (0-10%) | sometimes (11-35%) | about half the time (36-65%) | most of the time (66-90%) | almost always (91-100%)

1) I am clear about my feelings.	1——2——3——4——5
2) I pay attention to how I feel.	1——2——3——4——5
3) I experience my emotions as overwhelming and out of control	1——2——3——4——5
4) I have no idea how I am feeling.	1——2——3——4——5
5) I have difficulty making sense out of my feelings.	1——2——3——4——5
6) I am attentive to my feelings.	1——2——3——4——5
7) I know exactly how I am feeling.	1——2——3——4——5
8) I care about what I am feeling.	1——2——3——4——5
9) I am confused about how I feel.	1——2——3——4——5
10) When I'm upset, I acknowledge my emotions.	1——2——3——4——5
11) When I'm upset, I become angry with myself for feeling that way.	1——2——3——4——5
12) When I'm upset, I become embarrassed for feeling that way.	1——2——3——4——5
13) When I'm upset, I have difficulty getting work done.	1——2——3——4——5
14) When I'm upset, I become out of control.	1——2——3——4——5
15) When I'm upset, I believe that I will remain that way for a long time.	1——2——3——4——5
16) When I'm upset, I believe that I'll end up feeling very depressed.	1——2——3——4——5
17) When I'm upset, I believe that my feelings are valid and important	1——2——3——4——5
18) When I'm upset, I have difficulty focusing on other things.	1——2——3——4——5

1——————2——————3——————4——————5 almost never (0-10%) sometimes (11-35%) about half the time (36-65%) most of the time (66-90%) almost always (91-100%)
19) When I'm upset, I feel out of control. 1——2——3——4——5
20) When I'm upset, I can still get things done. 1——2——3——4——5
21) When I'm upset, I feel ashamed with myself for feeling that way. 1——2——3——4——5
22) When I'm upset, I know that I can find a way to eventually feel better 1——2——3——4——5
23) When I'm upset, I feel like I am weak. 1——2——3——4——5
24) When I'm upset, I feel like I can remain in control of my behaviours. 1——2——3——4——5
25) When I'm upset, I feel guilty for feeling that way. 1——2——3——4——5
26) When I'm upset, I have difficulty concentrating. 1——2——3——4——5
27) When I'm upset, I have difficulty controlling my behaviours. 1——2——3——4——5
28) When I'm upset, I believe that there is nothing I can do to make myself feel better 1——2——3——4——5
29) When I'm upset, I become irritated with myself for feeling that way. 1——2——3——4——5
30) When I'm upset, I start to feel very bad about myself. 1——2——3——4——5
31) When I'm upset, I believe that wallowing in it is all I can do. 1——2——3——4——5
32) When I'm upset, I lose control over my behaviours. 1——2——3——4——5
33) When I'm upset, I have difficulty thinking about anything else. 1——2——3——4——5
34) When I'm upset, I take time to figure out what I'm really feeling. 1——2——3——4——5
35) When I'm upset, it takes me a long time to feel better. 1——2——3——4——5
36) When I'm upset, my emotions feel overwhelming. 1——2——3——4——5

Thank you for completing this questionnaire.

APPENDIX 11: QUESTIONNAIRE STUDY 2

Please answer all the questions as honestly as you can. Please do not miss any questions out.

1) Please circle your gender Male Female

2) How old are you? _____ **years old**

3) How many times have you attended hospital for treatment because you have harmed yourself (including today)?

_____ **time(s)**

4) Please describe in your own words how you harmed yourself on this occasion?

_____

_____

_____

5) Please explain why you chose this method of self-harm?

_____

_____

_____

6) How long ago was it that you harmed yourself on this occasion?

_____ hours/ days
(delete as appropriate)

7) Did you consume any alcohol prior to harming yourself? If yes can you say how much?

No Yes how much?_____

8) Did you use any non-prescription drugs prior to harming yourself?

No Yes

9) How long before you tried to harm yourself had you started to think about doing it?

☐ less than an hour ☐ more than an hour but less than a day

☐ more than a day but less than a week ☐ more than a week but less than a month

☐ a month or more

10) Please explain in your own words why you think you tried to harm yourself on this occasion?

_____

_____

_____

11) How were you feeling <u>just before</u> you harmed yourself? For each feeling can you rate how strong the feeling was?

1——————2——————3——————4——————5
Not feeling this — Overwhelming

Anger at others	1——2——3——4——5	**Anger at self**	1——2——3——4——5
Anxiety / panic	1——2——3——4——5	**Despair**	1——2——3——4——5
Detached / Cut off	1——2——3——4——5	**Disappointment/insult**	1——2——3——4——5
Excitement	1——2——3——4——5	**Fear**	1——2——3——4——5
Guilt	1——2——3——4——5	**Loneliness**	1——2——3——4——5
Pleasure	1——2——3——4——5	**Relief**	1——2——3——4——5
Self-contempt	1——2——3——4——5	**Shame**	1——2——3——4——5
Emptiness (mental vacuum)	1——2——3——4——5	**Powerlessness/ hopelessness**	1——2——3——4——5

12) How were you feeling <u>just after</u> you harmed yourself? For each feeling can you rate how strong the feeling was?

1——————2——————3——————4——————5
Not feeling this — Overwhelming

Anger at others	1——2——3——4——5	**Anger at self**	1——2——3——4——5
Anxiety / panic	1——2——3——4——5	**Despair**	1——2——3——4——5
Detached / Cut off	1——2——3——4——5	**Disappointment/insult**	1——2——3——4——5
Excitement	1——2——3——4——5	**Fear**	1——2——3——4——5
Guilt	1——2——3——4——5	**Loneliness**	1——2——3——4——5
Pleasure	1——2——3——4——5	**Relief**	1——2——3——4——5
Self-contempt	1——2——3——4——5	**Shame**	1——2——3——4——5
Emptiness (mental vacuum)	1——2——3——4——5	**Powerlessness/ hopelessness**	1——2——3——4——5

13) How are you feeling <u>now</u>? For each feeling can you rate how strong the feeling is?

1——————2——————3——————4——————5
Not feeling this — Overwhelming

Anger at others	1——2——3——4——5	**Anger at self**	1——2——3——4——5
Anxiety / panic	1——2——3——4——5	**Despair**	1——2——3——4——5
Detached / Cut off	1——2——3——4——5	**Disappointment/insult**	1——2——3——4——5
Excitement	1——2——3——4——5	**Fear**	1——2——3——4——5
Guilt	1——2——3——4——5	**Loneliness**	1——2——3——4——5
Pleasure	1——2——3——4——5	**Relief**	1——2——3——4——5
Self-contempt	1——2——3——4——5	**Shame**	1——2——3——4——5
Emptiness (mental vacuum)	1——2——3——4——5	**Powerlessness/ hopelessness**	1——2——3——4——5

14) Please explain in your own words why did you come to hospital?

_____

_____

_____

15) If you self-harmed again in the future where would you go for help? (You can pick more than one answer).

☐ Family
☐ Hospital
☐ G.P
☐ Telephone help line
☐ Other (Please specify)

☐ Friend
☐ Minor injuries Unit
☐ Community Mental Health Team
☐ Nowhere

_____

16) To what extent did the following reasons influence your decision to harm yourself?

1 — 2 — 3
Of no importance — Of some importance — Of major importance

16. I wanted to get relief from a terrible state of mind	1——2——3
17. I wanted to show how much I loved someone	1——2——3
18. I seemed to have lost control of myself and have no idea why I behaved that way	1——2——3
19. The situation was so unbearable that I had to do something and didn't know what else to do	1——2——3
20. I wanted to escape for a while from an impossible situation	1——2——3
21. I wanted to make people understand how desperate I was feeling	1——2——3
22. I wanted to die	1——2——3
23. I wanted to seek help from someone	1——2——3
24. I wanted to find out if someone really loved me	1——2——3
25. I wanted to frighten someone or to get my own back on someone	1——2——3
26. I wanted to make people sorry for the way they have treated me	1——2——3
27. I wanted to influence some particular person or get them to change their mind	1——2——3
28. I wanted to make things easier for others	1——2——3
29. I wanted to sleep for a while	1——2——3
30. I wanted to punish myself	1——2——3

17) For each of the statements below please rate how true they are for you.

1	2	3	4	5	6	7
Never True	Very rarely True	Seldom True	Sometimes True	Frequently True	Almost Always True	Always True

10. I am able to take action on a problem even if I am uncertain what the right thing is to do.	1—2—3—4—5—6—7
11. I often catch myself daydreaming about what I have done and what I would do differently next time.	1—2—3—4—5—6—7
12. When I am depressed or anxious I am unable to take care of my responsibilities.	1—2—3—4—5—6—7
13. I rarely worry about getting my anxieties, worries and feelings under control	1—2—3—4—5—6—7
14. I'm not afraid of my feelings.	1—2—3—4—5—6—7
15. When I evaluate something negatively, I usually recognise that this is just a reaction and not an objective fact.	1—2—3—4—5—6—7
16. When I compare myself to other people, it seems that most of them are handling their lives better than I do.	1—2—3—4—5—6—7
17. Anxiety is bad.	1—2—3—4—5—6—7
18. If I could magically remove all the painful experiences I've had in my life I would do so.	1—2—3—4—5—6—7

18) This part of the questionnaire asks about a number of different things that people sometimes do to hurt themselves. Please be sure to read each question carefully and respond honestly. Often, people who do these kinds of things to themselves keep it a secret, for a variety of reasons. However, honest responses to these questions will provide us with greater understanding and knowledge about these behaviours and the best way to help people.

Please answer yes to a question only if you did the behaviour intentionally, or on purpose, to hurt yourself. Do not respond yes if you did something accidentally (e.g., you tripped and banged your head accidentally).

If you answer yes for a question, please state how many times you done this behaviour? Please write an actual number (e.g., 1, 5, or 15 NOT some, many, or few).

Have you ever intentionally i.e., on purpose:		No of Times:
1. cut your wrist, arms, or other area(s) of your body (without intending to kill yourself)?	Yes No	
2. cut your wrist, arms, or other area(s) of your body (with the intention to kill yourself)?	Yes No	
3. burned yourself with a cigarette?	Yes No	
4. burned yourself with a lighter or a match?	Yes No	
5. carved words into your skin?	Yes No	

Have you ever intentionally i.e., on purpose:			No of Times:
6. carved pictures, designs, or other marks into your skin?	Yes	No	
7. severely scratched yourself, to the extent that scarring or bleeding occurred?	Yes	No	
8. bit yourself, to the extent that you broke the skin?	Yes	No	
9. rubbed sandpaper on your body?	Yes	No	
10. dripped acid onto your skin?	Yes	No	
11. used bleach or oven cleaner to scrub your skin?	Yes	No	
12. stuck sharp objects such as needles, pins, staples, etc. into your skin, not including tattoos, ear piercing, needles used for drug use, or body piercing?	Yes	No	
13. rubbed glass into your skin?	Yes	No	
14. broken your own bones?	Yes	No	
15. banged your head against something, to the extent that you caused a bruise to appear?	Yes	No	
16. punched yourself, to the extent that you caused a bruise to appear?	Yes	No	
17. prevented wounds from healing?	Yes	No	
18. poisoned yourself (without intending to kill yourself)	Yes	No	
19. poisoned yourself (with the intention to kill yourself)	Yes	No	
20. done anything else to hurt yourself that was not asked about in this questionnaire? If yes, can you tell us what did you do to hurt yourself and the number of times?	Yes	No	

Please continue on to Question 19 on the next page.

19) Please indicate how often the following statements apply to you by circling the appropriate number from the scale below on the line beside each item:

1——————2——————3——————4——————5
almost never (0-10%) | sometimes (11-35%) | about half the time (36-65%) | most of the time (66-90%) | almost always (91-100%)

1) I am clear about my feelings.	1——2——3——4——5
2) I pay attention to how I feel.	1——2——3——4——5
3) I experience my emotions as overwhelming and out of control	1——2——3——4——5
4) I have no idea how I am feeling.	1——2——3——4——5
5) I have difficulty making sense out of my feelings.	1——2——3——4——5
6) I am attentive to my feelings.	1——2——3——4——5
7) I know exactly how I am feeling.	1——2——3——4——5
8) I care about what I am feeling.	1——2——3——4——5
9) I am confused about how I feel.	1——2——3——4——5
10) When I'm upset, I acknowledge my emotions.	1——2——3——4——5
11) When I'm upset, I become angry with myself for feeling that way.	1——2——3——4——5
12) When I'm upset, I become embarrassed for feeling that way.	1——2——3——4——5
13) When I'm upset, I have difficulty getting work done.	1——2——3——4——5
14) When I'm upset, I become out of control.	1——2——3——4——5
15) When I'm upset, I believe that I will remain that way for a long time.	1——2——3——4——5
16) When I'm upset, I believe that I'll end up feeling very depressed.	1——2——3——4——5
17) When I'm upset, I believe that my feelings are valid and important	1——2——3——4——5
18) When I'm upset, I have difficulty focusing on other things.	1——2——3——4——5

1 almost never (0-10%)	2 sometimes (11-35%)	3 about half the time (36-65%)	4 most of the time (66-90%)	5 almost always (91-100%)
19) When I'm upset, I feel out of control.				1-----2-----3-----4-----5
20) When I'm upset, I can still get things done.				1-----2-----3-----4-----5
21) When I'm upset, I feel ashamed with myself for feeling that way.				1-----2-----3-----4-----5
22) When I'm upset, I know that I can find a way to eventually feel better				1-----2-----3-----4-----5
23) When I'm upset, I feel like I am weak.				1-----2-----3-----4-----5
24) When I'm upset, I feel like I can remain in control of my behaviours.				1-----2-----3-----4-----5
25) When I'm upset, I feel guilty for feeling that way.				1-----2-----3-----4-----5
26) When I'm upset, I have difficulty concentrating.				1-----2-----3-----4-----5
27) When I'm upset, I have difficulty controlling my behaviours.				1-----2-----3-----4-----5
28) When I'm upset, I believe that there is nothing I can do to make myself feel better				1-----2-----3-----4-----5
29) When I'm upset, I become irritated with myself for feeling that way.				1-----2-----3-----4-----5
30) When I'm upset, I start to feel very bad about myself.				1-----2-----3-----4-----5
31) When I'm upset, I believe that wallowing in it is all I can do.				1-----2-----3-----4-----5
32) When I'm upset, I lose control over my behaviours.				1-----2-----3-----4-----5
33) When I'm upset, I have difficulty thinking about anything else.				1-----2-----3-----4-----5
34) When I'm upset, I take time to figure out what I'm really feeling.				1-----2-----3-----4-----5
35) When I'm upset, it takes me a long time to feel better.				1-----2-----3-----4-----5
36) When I'm upset, my emotions feel overwhelming.				1-----2-----3-----4-----5

Thank you for completing this questionnaire.

APPENDIX 12: DIFFICULTIES IN EMOTIONAL REGULATION SCALE (DERS) GENERAL POPULATION NORMS

Table 20 Means and Standard Deviations for DERS Scales Among Women (n =260) and Men (n = 97) (Gratz & Roemer, 2004)

Scale	Women Mean	*SD*	Men Mean	*SD*
DERS Total	77.99	20.72	80.66	18.79
NONACCEPTANCE	11.65	4.72	11.55	4.20
GOALS	14.41	4.95	14.34	5.16
IMPULSE	10.82	4.41	11.55	4.59
AWARENESS	14.34	4.60	16.26	4.61
STRATEGIES	16.16	6.19	16.23	6.26
CLARITY	10.61	3.80	10.74	3.67

Table 21 Frequency and percentages by gender for scores on DERS Scales 1 standard deviation above population mean

Scale	Women *Frequency*	%	Men *Frequency*	%	**Total** %
DERS Total	24/30	80.00%	19/24	79.17%	79.63%
NONACCEPTANCE	22/31	70.97%	18/25	72.00%	71.43%
GOALS	12/31	38.71%	16/25	64.00%	50.00%
IMPULSE	21/31	67.74%	11/24	45.83%	58.18%
AWARENESS	24/30	80.00%	10/24	41.67%	62.96%
STRATEGIES	22/31	70.97%	19/25	76.00%	73.21%
CLARITY	17/31	54.84%	10/25	40.00%	48.21%