A Portfolio of
Academic, Therapeutic Practice,
and Research Work

Including an investigation of
‘Attitudes towards Self-Injurious-Behaviour among
Mental Health Professionals and Adolescent Self-
Harmers’

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Introduction to the Portfolio

This portfolio consists of a selection of work that has been carried out in part fulfilment of the PsychD in Psychotherapeutic and Counselling Psychology at the University of Surrey. It is comprised of three sections that represent the academic, practice, and research components of the training.

Statement of Anonymity:

The confidentiality of clients and participants has been protected throughout this portfolio. Whenever client or participant material is referred to, names have been replaced with pseudonyms and any identifying information has been changed or omitted to preserve the anonymity of those involved.

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Academic Dossier

This dossier contains a selection of academic papers and reports submitted during the three years of my psychotherapeutic training. The first two papers are concerned with ‘Theoretical Models of Therapy’ and ‘Advanced Theory and Therapy’ respectively, and address issues relating to the integration of theory into therapeutic practice. The former explores the psychoanalytic theories and clinical implications of anger, and the latter explores the therapist’s and the client’s use of silence in the therapy room. A paper from the final year ‘Advanced Theory and Therapy’ explores the cognitive-behavioural therapeutic system of delivery alongside recent advances in research and practice.

Finally, a report that addresses ‘Issues in Counselling Psychology’ is submitted. This report explores some of the ethical issues I encountered in qualitative research with a group of adolescent inpatients who engaged in self-injurious behaviours. The paper was published in *Counselling Psychology Review*. 
COMPARE AND CONTRAST THE THEORETICAL ASPECTS AND CLINICAL IMPLICATIONS REGARDING ANGER ACCORDING TO THE FOLLOWING ANALYSTS: KLEIN AND WINNICOTT

This paper focuses on Melanie Klein and Donald Winnicott’s conceptualisation of the roots and functions of anger and aggressive behaviour in mental life. Clinical examples from both their works will illustrate the relative influence case material had on their theorising over the course of their lives. Some close comparison of theory can be made since both were undisputedly heavily influenced by Freud’s work, yet chose to base their theories grounded in the direct observation (even if subjectively interpreted) of young children. Both appear to eschew an attitude of understanding the individual as a person interacting in their environment (more than the sum of their presenting ‘medical’ or ‘pathological’ disturbance), than the abstract theoretical hypothesising of Freud. As the idiom goes: you can fit a person to a model, but must allow them more than one possible ‘script.’ While this may feel to be a wild sweeping statement with regards to Freud’s theories, this paper will attempt to illustrate how much further our understanding of primary aggressive (as opposed to sexual) impulses, has impacted on therapeutic practice with clients in counselling psychology today.

Having said this, from a personal and philosophical outlook on life, Klein and Winnicott appear to come from opposite extremes. Winnicott is consistent throughout his writings about the very nature of ‘goodness’ or inborn curiosity and joy of living in the young infant. Klein on the other hand, is often associated and remembered for her more depressive view of the young infant: as constantly struggling with ‘bad’ or ‘negative’ destructive internal and external impulses. From a Kleinian point of view Winnicott is to be criticised for making the baby too benign and for idealising motherhood, which even feminists have held against him (see Chodorow, 1978; 1989). And from a Winnicottian perspective, Klein only tended to see the positive side of individuals as a ‘reaction formation’ against aggression and destruction, placing the latter rather than the former at the core of the personality.

Mrs Klein developed her play technique in the 1920’s, which permitted working with much younger children than had previously been dreamed possible. On closer
inspection of the roots of aggression, she isolated early anxieties in the very basic notion that a child acts and dramatises its thoughts and unconscious phantasies through play. This could be equated with Freud’s ‘free association’ of adults. Having provided her children with the freedom to manipulate and interact with small toys and figures, she linked their fate in the play to the child’s worries about what would happen in reality between the child and the important figures in his or her life. She found repeatedly, that interpretations (if she was correct in what the play ‘meant’) provided significant alleviation of anxiety and relief for the child. This meant the child was then ‘free’ for further less constrained play and phantasy life (Klein, 1932b; 1955). The interpretation of persecutory anxieties remains a crucial mark of a Kleinian approach today (see Hanna Segal, 1981; 1988).

She saw these aggressive impulses as instinctual in the child, arising from Freud’s ‘death instinct,’ which was in conflict with its opposite the ‘life instinct’ from the very beginning. The effect of the life instinct was to redirect aggression from life itself towards an external object. The original fear of the death instinct was then transformed into a fear of a persecuting object. Through this process of projection, in an attempt to preserve the internal goodness and ward off the destructive impulses of envy, ‘splitting of the good and the bad breast’ was necessary. Termed projective identification, this was seen as having manifold aims. It could be directed towards the ideal object to avoid separation, or it could be directed towards the bad object to gain control of the source of danger. Klein later called this the paranoid-schizoid position (1946). Clinically, when the death instinct is said to predominate, this can be seen in forms of perversion, masochism, and various other states of pathological aggression.

Insight came with Klein’s analysis of her youngest patient ‘Rita’, aged two years and nine months, and the discovery of the harshness of her super-ego. The case was instrumental in highlighting the importance of an introjected object that came to terrorise the child. Klein was able to elucidate the phantasy involved in her bedtime rituals: the “fear that a mouse or butty might come through the window and bite off her butty (genital)” (Klein, 1926: 132). Klein thus developed the concept of young children introjecting their parents as part-objects (firstly the mother and her breast), in a phantastic way. This was confirmed in another little girl, aged six years. Klein was
also quite perturbed and startled by the intensely destructive nature of this child’s phantasies:

“Erna often made me be a child, while she was the mother or teacher. I then had to undergo fantastic tortures and humiliations... I was constantly spied upon, people divined my thoughts, and the father or teacher allied themselves with the mother against me – in fact, I was always surrounded by persecutors. I myself, in the role of the child, had constantly to spy upon and torment others.” (Klein, 1929: 199-200).

She found that to progress and overcome these tendencies in young children, the way forward lay in analysing their sadistic phantasies and impulses (Klein, 1922, 1927a, 1948). She noted the link between the excessive violence of the sadistic impulses, then the deep form of depression that would set in. This was to culminate in Klein’s notion of the depressive position (1935). Here, the ego was integrated enough for the infant to experience a whole-object relation involving ambivalence, dread of loss, guilt, and the urge to regain and restore the object. She did not blame the parents for the type of provision they might provide for their child, believing that it was inherent in the ‘selves’ of both parties. Like Winnicott, she believed that even if the early environment were good the child would experience anxiety, fear, and aggressive and destructive emotions. She related this to the notion that envy is unavoidable. Even if the symbolic or real breast is gratifying, the baby envies the flow of goodness, wishing hopelessly to own it; whereas if the experience is unsatisfactory, the baby hates and envies it, as a grudging and mean breast object.

Hence, Klein stipulated that it was vital to recognise the normality of aggressive feelings in both the baby and also in the mother, and the ‘active’ way in which the child (and eventually the adult) maintains and creates these splits in the ego and internal world. In her paper ‘Notes on Some Schizoid Mechanisms’ (Klein, 1946), she takes up Winnicott’s view that the baby at first is ‘unintegrated,’ whilst going on to discuss alternating states of ego- ‘disintegration’ and ‘integration.’ From a Winnicottian perspective however, the aggressive impulses would be a representation of a more ‘passive’ needing to be seen, or needing to be held and contained. He
agreed on the process of how it may be expressed, but not in the origins of aggression (i.e. directed at envy), as I shall go on to describe.

Winnicott did not like the term depression, let alone Klein’s ‘depressive position,’ preferring instead to define it as the ‘Stage of Concern’ (1950-1955). Here, he also considered the ego-integration of the child to be sufficient enough to recognise the personality of the mother figure, and hence the capacity to feel guilty about perceived damage done to the loved person. In clinical terms, he describes this aggression often expressed as grief, guilt or some physical equivalent like vomiting. More specifically, in relation to the frustration experienced by the child (which is inevitable in some degree in all experience), his view of splitting involves innocent aggressive impulses towards ‘frustrating’ objects, and guilt-productive aggressive impulses towards ‘gratifying’ objects. This also results in a defence mechanism whereby love and hate are separated down different paths. Through this dichotomy he also saw the splitting of objects into good and bad as alleviating feelings of guilt.

Winnicott started from the premise and observation that small children of 3 and 4-years were preoccupied with introversion and living largely in their own inner phantasy world. In order to do this, relationships had to be re-arranged so that the good could be concentrated within, and the bad could be projected towards external reality. Where he differed from Klein, Winnicott viewed the management of inner world phenomena localised in body parts (e.g. the belly or the head) to explain aggressive behaviour. He also referred to the skin as a ‘limiting membrane’ (1988b: 68) which acts as a type of container for the state of ‘being’ (see also Esther Bick, 1968).

He went even further however, in the search for the origins of aggression, by turning to the very early stages of development where ego growth was only just considered to be starting. In the language of structural theory: we are born pure ‘id’ and the ‘ego’ develops through frustrating encounters with external reality. At the stage prior to sufficient ego-integration – where it was not considered possible to take responsibility for actions without subjective or objective distinction, he found ‘primitive love’ was still evident. Winnicott recognised that aggressive elements (whether destructive by chance), were operant in the earliest id satisfaction experiences. By this, he meant the
very basic evolutionary ‘instinct’ to survive mitigated by ‘primitive love impulses’ (id) could be viewed as a form of aggression, though with no intent on the infant’s behalf to destroy. Whereas Klein saw ‘aggression’ in the child’s want to ruthlessly to eat up everything that is good in mother, Winnicott’s term ‘primitive love impulse’ is less pejorative. Like Klein however, (equivalent in her paranoid-schizoid position) he placed the consequential origins of guilt in the first year of life: “Ruthlessness gives way to ruth, unconcern to concern” (Winnicott, 1965b: 23-24).

From this, Winnicott went on to develop his notions on the defensive clinical presentations of the false self. He viewed this as having one very powerful and important function, namely to hide the true self, which is alleviated by compliance with the demands of the mother. Originating in the stage of ‘absolute dependence’ – this (undifferentiated ego-id) primary narcissistic state of Me – the child begins to develop a sense of himself as Not-Me. This is the growing sense of I Am in existence facilitated by the ‘environment-mother.’ Winnicott considered that it was opposition from the environment or external forces (in this sense represented by the frustrating ‘object-mother’), that drove the child to recognise a differentiated external reality. This was seen as a natural growth towards maturity, provided there was correct provision or a ‘good-enough facilitating environment’ (1971a: 139). Thus, Winnicott’s concept of ‘good enough mothering’ is seen as a necessary condition for healthy development, and with this, passing through a stage of aggression, as a positive achievement. Particularly helpful to the child’s sense of object relations, the shock of recognising the existence of an external world that is outside of their control, challenges their ‘magical thinking:

“If time is allowed for maturational processes, then the infant becomes able to be destructive and becomes able to hate and to kick and to scream instead of magically annihilating that world. In this way actual aggression is seen to be an achievement ... Hate becomes a sign of civilization.” (Winnicott, 1964: 236).

So the Not-Me is recognised as external, or even externalised by projection. But the environment that is now outside can also be experienced as capable of, or actually attacking. Finally, in Winnicott’s developmental move ‘towards independence,’ came
“the change from relating to usage... The thing that that there is between relating and use is the subject’s placing of the object outside of the area of omnipotent control, that is, the subject’s perception of the object as an external phenomenon, not just as a projective entity, in fact recognition of it as an entity in its own right” (Winnicott, 1968: 156). Accordingly, the manner in which aggression contributes to object permanence, is when the ‘object-mother’ is seen to survive the destruction:

“If she survives, then the baby will find a new meaning to the word love, and new things turn up in the baby’s life which is fantasy. It is as if the baby can now say to the mother: ‘I love you because you have survived my destruction of you. In my dreams and in my fantasy I destroy you whenever I think of you because I love you.’ It is this that objectifies the mother, puts her in a world that is not part of the baby, and makes her useful.” (1988a: 32).

Winnicott could not look at destructiveness in terms of the death instinct, as Freud did, nor could he accept Klein’s view that it is envy of the good object (person or part-person) that leads to destructiveness from the beginning of life. He believed that aggression could be traced to the prenatal motility of the infant, “to the impulses of the foetus, to that which makes for movement rather than stillness, to the aliveness of tissues and to the first evidence of muscular eroticism. We need a term here such as life force” (1950-5: 216). He goes on to distinguish this form of aggression and opposition from that which is a reaction to instinctual frustration. Again, “At origin aggressiveness is almost synonymous with activity; it is a matter of part-function” (1949: 48). Thus seen, putting distance between oneself and others could be described as healthy assertiveness: “only those who have reached a stage at which they can make this assertion [of I Am] are actually really qualified as adult members of society” (1986: 141).

The clinical implications for Winnicott were although he believed the depressive position was reached in the healthy infant at around 6-9 months, in practice, this was not commonly seen in many of his subjects of analysis until they actually entered therapy. Still heavily influenced by supervision with Klein at the time – though clearly using his own descriptive language, he viewed reaching the depressive position and
negotiating Freud's Oedipus complex as the healthy "problem of life." One of the functions of therapy was therefore to help unhealthy individuals recognise they were hiding their 'true selves:"

"With regards to the more schizoid people and the whole mental hospital population of persons who have never reached true self life or true expression, the depressive position is not the thing that matters. It must remain to these like colour to the colour blind. By contrast, for the whole manic depressive group that comprises the majority of so-called normal people, the subject of the depressive position in normal development is one that cannot be left aside. It is, and remains, the problem of life, the problem of life except in so far as it is reached." (Winnicott, 1945: 265).

From a Kleinian perspective, the clinical implications of defused and split-off aggression can create obstacles to analysis, such as chronic resistance and negative therapeutic reactions (Rosenfeld, 1996). An expression of anger related to separation anxiety with a distinctly envious character, is one example. For instance, a client may regard the therapist's mind and body and the help and understanding received, as part of his/her own self. He/she is then able to attribute everything that is experienced as valuable in the analysis as being part of his/her own self (i.e., living in a state of omnipotent narcissism). As soon as the client begins to feel separate from the therapist the aggressive reaction appears, particularly after a helpful interpretation, which shows the therapist's understanding. The client reacts with feelings of humiliation and insignificance through being unable to provide this for him/herself. In envious anger, the client tries to destroy and spoil the therapist's interpretations by ridiculing or making them meaningless. The therapist may have the distinct experience in the counter-transference that he/she is meant to feel inadequate and has nothing of value to give to the client.

Winnicott wrote for different audiences (social workers, teachers, parents etc.), often mentioning the need to survive hate or anger without retaliation. Applied to the therapeutic hour he felt no therapist could provide a totally corrective experience, merely (hopefully) a 'good-enough' constant and reliable environment across sessions. Since therapists are human, and like parents, bound to fail or frustrate their
infants in some way, this experience means that “In the end we succeed [in therapy] by failing – failing the patient’s way” (1965a: 258). His contribution to psychoanalysis over the course of his life, was a movement from an over-emphasis upon phantasy to the centrality of the environmental provision. In other words, he began to ground his theories in reality and in the daily lives of his patients. He also increasingly advocated waiting before making interpretations, finding it more beneficial if clients should discover and gain insight for themselves (1971a). Klein on the other hand, came to recommend a much more rigorous view of making transference interpretations early in the analysis, with specific focus on the total transference situation:

“... transference originates in the same processes which in the earliest stages determine object relations. Therefore we have to go back again and again in analysis to the fluctuations between objects, ... external and internal, which dominate early infancy. We can fully appreciate the interconnection between positive and negative transferences only if we explore the early interplay between love and hate, and the vicious circle of aggression, anxieties, feelings of guilt and increased aggression, as well as the various aspects of objects towards whom these conflicting emotions and anxieties are directed.” (Klein, 1952: 53).

By this, Klein meant taking every association in a patient’s train of thought (from the past into the present) as referring unconsciously to the analyst (Klein, 1950). As mentioned earlier, the therapist may come to represent (in the transference relationship), both the introjected persecutor and the idealised figure at different times, as well as all the gradients in between (Klein, 1929). As these become gradually integrated, in coming together hate becomes mitigated by love, and the destructive impulses of greed and envy lose their power (Klein, 1957). Although not often acknowledged, Klein’s style of interpretation did change towards the end of her life, seemingly away from the immediate and routine symbolic concentrations on unconscious phantasies. The manner in which she used part-object language when she was analysing ‘Richard’ in 1941 (published 1961), seems to have been succeeded by the time she wrote Envy and Gratitude in 1957, by a language of interpretation based also on the patients’ present experience in the session (Klein, 1957; 1961). This shift
reflects a move towards a greater phenomenological understanding of the client's experiences.

In practice, whilst we don't tend to talk of a Winnicottian approach or 'school' in England, his influence is emphasised in the simplest intrinsic respect for the 'true self' of the individual, and a belief in the creative side of human nature to overcome adversity or mental illness. This is embodied by much of the subsequent work of Kohut (1977; cited in Strenger, 1997). Winnicott's basic techniques for working with children, in particular the 'squiggle game' and the 'spatula game' (the former as a means of approaching often heavily defended against aggression; 1971b), are still used as diagnostic and therapeutic tools in counselling and psychotherapy today. They are often used to break the ice, or to represent the state of the relationship between parent and infant.

The Kleinian 'school', however, is well established. This approach also focuses on bringing into consciousness the infantile roots of aggression. In practice, this is translated into confronting the painful phenomenon of destructiveness and examining what can be made of it (recognising the death instinct in terms of destruction of the 'good object' because it failed to gratify needs). This is done in a 'normalising' and 'educative' manner, to then look at how gratitude and other positive feelings in everyday lives are constructed (with emphasis on loving impulses of the life instinct). Through reparative processes, specific focus is placed on social interactions, and how 'healthier' relationships can be maintained in the face of envy and greed. The phantasy world is often accessed through free associations and dreams, and in the case of children, symbolic play. The reduction of persecutory anxieties and the integration of split off 'good and bad objects', is often taken as a sign that a client is ready for termination of therapy. This means they have learnt to live more comfortably with feelings of ambivalence, having successfully worked through the depressive position.
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DISCUSS AN ASPECT OF THE THERAPEUTIC RELATIONSHIP IN
RELATION TO PSYCHOANALYTIC IDEAS: THE THERAPIST’S AND THE
CLIENT’S USE OF SILENCE IN THE THERAPY ROOM

Many different kinds of silence are encountered in the clinical setting. This paper explores some of the different uses and functions of this non-verbal aspect of communication in the therapeutic encounter. It describes how silence may be manifest in the therapy room, and explores some of the differences in technical management according to various schools of thought. Differences in understanding and theoretical rationale based on the more traditional Freudian psychoanalytic approaches are discussed. Recent developments in psychodynamic and humanistic approaches argue for a more empathetic understanding and negotiation of both the therapist’s and the client’s use of silence during the course of therapy. Finally, the importance placed on the concepts of transference and countertransference in mediating difficulties in the therapeutic relationship are highlighted.

The therapist’s use of silence

In many schools of thought, silence plays a large part in overall therapeutic technique. A major aspect of Freudian therapeutic style is adhering to the rule of neutrality. Collectively, such attitudes are expressed in three main professional values (Dorpat, 1979): a caring commitment to the client, a respect for the client’s autonomy, and a devotion to the pursuit of truth. Freudian therapists go about this by being outwardly passive, spending most of their time listening to their clients, and attempting to formulate an understanding of the deeper implications of what has been said. This type of therapy has a somewhat formal or mannered quality because of the therapist’s strict, self-imposed discipline – mainly of sitting in silence. Accordingly, it has been criticised by the more humanistic schools of thought, on the basis of it being too impersonal, lacking in empathy, and non client-centered in its focus (see Rogers, 1951; Kahn, 1997).

Classical psychoanalytic therapists would argue that their methods are rooted in understanding rather than manipulation, and therefore eschew the more active, conversational or interventionist approaches. In their efforts to pursue unconscious meaning, Freudian therapists attempt to focus wholeheartedly on their clients
communications, avoiding interfering with their autonomy in any way. They abandon naturalistic attitudes and conventional social modes of interaction, and because of their exclusive focus on their client’s inner worlds, advocate non-self-disclosure according to the rule of anonymity. It could be argued that such a stance is so extreme and removed from social interaction ‘norms’, that in all likelihood it will have an effect on the client’s freedom and independence. This may originate from issues related to an insecure ‘frame’, or from both the therapist’s and the client’s false expectations or resistances. Such situations unfortunately appear to be frequently evident in NHS-based practice, where boundaries around the consistency of time, day, and even consulting room may be compromised. This often becomes plainly transparent in the unconscious (or otherwise) communications from the client to the therapist, with selective narratives representing deviations from the secured frame and its implications (Smith, 1991).

Freudian therapists break their silence in order to speak only infrequently, and when they do, it is almost always in order to share with their clients an interpretation of what may be going on in their clients’ unconscious mind (Freud, 1913). The aim of Freudian psychoanalytic intervention therefore, is to ‘make the unconscious conscious’ through the dissolution of ‘resistances’. There is a good deal of disagreement in the field over just what constitutes an acceptable psychoanalytic intervention. Some Freudian therapists believe that the rule of neutrality is consistent with a wide variety of interventions, including questions and ‘confrontations’. Others believe that the rule of neutrality, when taken quite seriously, permits only a very restricted range of interventions. Using the strict interpretation of the rule of neutrality there are only three types of interventions available to the Freudian therapist: silence, management of the environment and interpretation (see Smith, 1995; 1999 for the communicative approach).

The austerity and restrictions on the therapist’s behaviour is theoretically designed to create an ‘atmosphere of safety’ (Schafer, 1983) in which clients can authentically be themselves without fear of censure or interference. Hence, within the therapeutic encounter, silence can provide a space for the client in which to ‘roam’ or ‘free associate’ (Freud, 1904). Much evidence points to the fact that the most successful outcomes of therapy depend upon fostering strong working alliances and trust in the
therapeutic relationship (see Clarkson, 1995 for a review). On the other hand, some clients may find silence or space threatening, intrusive, and even persecutory. Kleinians argue that it is the very essence of such anxiety which they are trying to access or recreate in the total transference situation (Klein, 1952). In taking up both the positive and the negative feelings towards the therapist, Klein meant taking every association in the client’s train of thought (from the past into the present) as referring unconsciously to the analyst (Klein, 1950).

Silence therefore, is the most frequently used Freudian intervention in the strictest sense, and regarded as something that therapists actively do rather than a mere absence of speech. Management of the ‘analytic frame’ (Milner, 1952) or ‘holding environment’ (Winnicott, 1971), is also held as a fundamentally important intervention. If successfully maintained it reliably safeguards and encourages a therapeutic process. By creating an atmosphere of safety where clients can readily communicate and therapists can listen, these two forms of intervention create the preconditions for the interpretation of unconscious meanings (Langs, 1988).

There are occasions however, when clients may not be able to tolerate such firm holding and are said to be at risk of ‘acting out’. It is important for therapists to remain cautious about interpreting such anxieties as manifest resistance or defensive manoeuvring. Langs (1978) has suggested that it is possible to pay particular attention to the content of a client’s narrative as examples of unconscious supervision by the client. This is an imaginative extension of Margaret Little’s (1951) notion of the client as a ‘mirror’. For these reasons, it is of vital importance that the therapist remains aware of his/her own contribution to the therapeutic encounter and the need to monitor the effects of this on the analytic process.

It is worth considering what a client may find within the analytic encounter that is therapeutic in itself. In 1946, the psychoanalysts Alexander and French described successful therapy as a corrective emotional experience. Alexander believed that clients ‘got into trouble’ and sought therapy because their parental figures had not treated them well. What they needed was someone significant — namely their therapist — to treat them better. Some of the more traditional schools of thought criticise this notion for implying the ‘giving of milk and cookies,’ giving-in, or gratifying the
client’s wishes. The argument against gratifying a client’s needs is based on the
grounds that it only prolongs the problem by keeping the client from gaining insight
into how harsh the world really is. Thus objecting to an intentionally warm and
supportive experience presents the client with a frustrating situation – be that through
the therapist’s lack of feedback, use of silence, or by other means.

Casement (1990), writes that a corrective emotional experience cannot be provided for
a client by a therapist, and yet how needs from childhood inevitably do recur in the
course of analysis or therapy. These re-presentations of need by a client, are said to be
unconsciously in the service of a continuing search for attention to needs that have
remained unmet. Thus a client may have repeatedly been ignored, neglected or
marginalised in early life, and accordingly may find the experience of a ‘wholly
attentive therapist’ extremely gratifying. But as Casement points out: ‘the analytic
“good object” is not someone better than the original object: it is someone who
survives being treated as a “bad object”’ (1990: 87). Much of this thinking would
appear to derive from Winnicott’s (1965: ch.4) attention to ‘ego-needs’, which in
some respects, require frustrating in order to encourage emotional development and
growth.

Many schools of thought along the continuum from psychodynamic to humanistic
approaches readily acknowledge the adage that: no one gives up an old familiar
position without being motivated by some frustration. The question seems therefore to
be one of how therapists technically ‘deliver’ in order to facilitate insight or change in
their clients.

Kohut (1971, 1984) attempted to bridge some of the extremes of passive versus active
participation, arguing that a nonempathic therapist was merely recreating the original
trauma or environmental situation, which would therefore not be beneficial to the
client. He did however acknowledge that a certain kind of frustration is necessary for
psychological development. Nevertheless, this makes the assumption that a silent
therapist is equated with a non-empathic therapist, which once again may not
necessarily be the case. It may be more difficult to convey such implicit understanding
to the client though, if not through interpretation or some other form of verbal
response.
For the therapist, silence can be used for the purposes of internal supervision: an opportunity use trial identification (Fleiss, 1942) and really check out when an interpretation is warranted to help the client gain insight (Casement, 1985). In humanistic-phenomenological terms, silence may be used empathetically, for example in a bereaved person’s silence or tears, it may be sufficient to simply sit with this, reflecting empathy and congruence in the shared experience.

It would appear therefore that the psychotherapist who adheres rigidly to a ‘technique’ – without paying attention to the clues from the client about exactly what was enraging, frightening or demeaning in the original responses to their anger or silence – runs the risk of compounding the original trauma. The maintenance of a ‘blank screen’ persona is one obvious example of this. It is not enough for the client to understand that their hostility against their therapist derives from earlier experiences; they also need the experience of a different response in the present (Malan, 1979). Otherwise, if the traumatic similarity is too pronounced, there may be no analytic space within which to analyse this as transference. Such set-backs in therapy however, once understood and overcome by the therapist, usually signify a shift in the therapy often to both the client’s and the therapist’s advantage – i.e. one of having gained new insight (Kohut, 1977; Safran, 1993).

The use of silence by the client
Silence by the client has a tendency to be viewed negatively by therapists. When Freud first came upon the fact of unconscious resistance he saw it as an obstacle to analysis. Soon, however, he became aware that the resistance was actually a feature of unconscious activity which repeats patterns of behaviour disguised as a way of maintaining the repressions of the past. Hence, the elucidation of the new form of the ‘past into the present’ or analysis of the transference, is considered one of the central activities of the psychoanalyst. Any of a number of reactions that one learns and uses unconsciously to protect one’s internal psychic ‘structures’ (e.g., ego, self) from anxiety, conflict, shame etc. may be deemed to be a defence mechanism. Roughly speaking, psychoanalytic theory divides defence mechanisms into those that are neurotic and those which are normal (Freud, 1906). The difficulty with defence
mechanisms is that while they may function as effective protectors of self in some of life’s situations, they often prove counterproductive in others.

The theory of the defence mechanisms is that they maintain the division of the mind into reality or secondary processes on the one hand, and the pleasure principle or primary processes on the other. Far from just being a nuisance, they serve an essential function of resistance: the opposition to making what is unconscious conscious. The ‘pleasure principle’ dictates that gratification is sought at once, that the passage of time is not appreciated, that opposites exist together without clashing (splitting), and that a thing and its symbol are treated as the same (symbol formation). These features of the unconscious mean that repetition in the present continually occurs and that substitute gratifications can be just as satisfying as the original version. Hence the rationale for a lengthy psychoanalytic psychotherapy, where it is necessary to re-edit several times patterns of reworking the past into the present.

There has been a tendency in recent years to use the term ‘resistance’ over-inclusively. Although classical analysts do recognise alternative points of view, the term increasingly appears to be used somewhat more pragmatically to refer to the opposition against accepting an interpretation. In either case, the danger here is of attributing it as withholding or resisting on the client’s behalf, or falling into stereotypic ways of thinking on the therapist’s behalf, when trying to deal with prolonged silences. One of these stereotypes is to hold too strongly to the notion that the client should always be left to speak first. There are occasions when we need to recognise that a client has already started a session – be that with silence. It is therefore important to learn to ‘read’ a client’s silence, and sometimes to respond tentatively to what we sense is the underlying communication which is being conveyed in this.

Some forms of resistance, e.g. falling asleep and silence, may, at certain points in the analysis, be regarded not only as a resistance but as non-verbal forms of expression of repressed wishes, fantasies or memories (Ferenczi, 1914; Khan, 1963). In spite of the close link between resistance and defence, it has been repeatedly emphasised that resistance is not synonymous with defence (Lorand, 1958). Whereas the client’s defences are an integral part of his/her psychological structure, resistances represent
the client’s attempts to protect him/herself against the threats to his/her psychological equilibrium posed by the analytic procedure.

It would appear therefore, that there are two ways to look at a client’s prolonged silence during a session: either as communication or resistance. On a more positive usage, a client may be granted the analytic space which is so essential for the freedom to ‘play’ with various aspects of relating without having to be anxious about these becoming realised between him/her and the therapist. This is an important part of ‘working-through’. The client may be taking advantage of exploring just this: their capacity to be alone in the presence of another person (Winnicott, 1965, ch.2). The therapeutic silence may also be reinforcing of the boundaries for some people: something the client may need to test out for themselves. For the therapist, learning to read one’s own unconscious responses to this phenomenon is recognised as a reliable route to understanding the transference (Heimann, 1950; Little, 1951; Racker, 1982; Segal, 1986), and indeed has come to be seen as an excellent way to understand very obscure or very silent clients (Chassequet-Smirgel, 1985).

The ‘modern’ view sees transference not so much as the manifestations of unconscious mental forces, but rather as the emergence of latent meanings, stimulated by the intensity of real relationship with the therapist, but shaped and coloured by past experience. Thus, in ordinary relationships, or so called transference in general, people often tend to repeat their most painful early relational patterns, e.g. marrying or rejecting one man after another; or finding themselves repeatedly in triangular relationships and feeling left out and victimised.

Freud originally viewed countertransference as dangerous for the therapist to lose the ‘mirroring’ neutrality considered essential for making correct interpretations of the client’s unconscious conflicts. Jung (1953, 1971) was one of his first disciples to disagree, believing that a therapist could not help becoming at times deeply affected by a client, and therefore encouraged attempts to remain as aware of this as possible. The therapist’s countertransference: own responses or inclination to respond – emotionally or behaviourally, has been legitimised as a valuable source for identifying and choosing therapeutic interventions (Hynan, 1981; Little, 1986) – whether these be
sessions of silence, or sharing feelings of rejection or tenderness for the client, with the client, in a therapeutically enhancing way.

In the analytic therapies, directly examining the reactions and counter-reactions is the focus of the work. The term ‘countertransference’ is now commonly considered to encompass all of the therapist’s feelings and attitudes toward the client (Heimann, 1950), however it is used in two additional senses. It may refer to what the therapist ‘brings’ – what can be termed as proactive countertransference (situations where the client’s communications stir up unresolved problems of the therapist) – and that to which the therapist ‘reacts’ in the client, often termed reactive countertransference (Clarkson, 1995).

It is no longer assumed that countertransference is just a problem to be overcome. It may also be a positive advantage to be cultivated and used in the understanding of what may be going on in a session. Racker (1982) advocated that the emotional response of a therapist is often a more accurate clue to the psychological state of a client than the therapist’s conscious judgement. He distinguished between what he called concordant countertransference and complementary countertransference. Complementary countertransferences are emotions that arise out of the client’s treatment of the therapist as an object of one of his/her earlier relationships, and are closely linked to Klein’s notion of projective identification (Klein, 1946). Concordant countertransferences are empathetic responses, based on the therapist’s resonance or empathetic attunement with his/her client and are not solely a result of projective identification.

The question for the therapist is not usually how to recognise or establish a transference/countertransference relationship – as they are everywhere and unavoidable – but how to manage it. Counter-transference problems are signalled by intensification or departures from the therapist’s usual practice. At the time, they seem plausible, even justifiable; yet, when considered in supervision or in the routine self-scrutiny that is the mark of responsible psychotherapy, their obstructive nature can become apparent. What happens is that the therapist comes to feel something alien and strange to him/her. On checking for countertransference feelings, where nothing seems to fit, in Freudian terms this can be a good indicator that the client is ‘resisting’.
feeling the emotions experienced by the therapist and projecting them into or on to the therapist. In this way, the therapist feels it for the client – and as such, it can be used to gain insight into the experience and brought to the attention of the client in an appropriate way.

Conclusion

In summary, whatever orientation of the therapist, they are most likely to provide a genuinely therapeutic experience for the client when they demonstrate: respect for the person as an individual, a continuing interest in the relationship between themselves and the client, and a commitment to examine their own defensiveness in the face of criticism from the client. So whether using ‘silence’ as a interventionist tool, a space for the client to ‘move into’, or a means of communicating respectful listening to the client; its use will necessitate a degree of spontaneity, flexibility, open-mindedness and creativity incompatible with over-strict adherence to any rigid technique.

The use of silence may foster or hinder trust in the therapeutic relationship, which may also be dependent on not only the client’s expectations, but also personal preferences or personality characteristics of the therapist. In short, the use of silence may not be appropriate in all situations, regardless of professional orientation and theoretical preference of the therapist. In any given situation it remains the therapist’s task to be receptive to the client’s needs, and to learn how silences are used as part of their therapeutic relationship. As long as theoretical notions surrounding the use of silence (or lack thereof) may be reliably argued in light of clinical material, the debate on technical application may continue.
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IN COGNITIVE THERAPY, THERAPEUTIC CHANGE IS NOT DEPENDENT UPON THE SYSTEM OF DELIVERY BUT ON THE ACTIVE COMPONENTS WHICH DIRECTLY CHALLENGE THE CLIENT'S FAULTY APPRAISALS. 

DISCUSS.

It is the aim of the present essay to highlight what are generally considered to be some of the 'active components' or specific techniques of cognitive therapy, and appraise those factors commonly associated with 'therapeutic change'. The essay will also address the 'system of delivery' or characteristics of interpersonal behaviour between therapist and client which further seem to interact with the change process, and review any impact this has on treatment outcome. Research evidence will be presented throughout.

In the broadest sense, 'cognition' refers to the full range of processes and mechanisms that supports thinking, as well as the content or products of these processes, namely thoughts themselves. The basic premise of cognitive theories of emotional disorders is that dysfunction arises from an individual's interpretation of events. Moreover, behavioural responses emerging from particular interpretations are considered important factors involved in the maintenance of emotional problems (see Hawton et al., 1989).

Dysfunctional processing of this kind is likened to a stream of 'negative automatic thoughts' (NATS) that runs through an individual's mind, which reflects the operation of underlying beliefs and assumptions about themselves and the world. Beliefs and assumptions are considered to be relatively stable representations of knowledge stored in memory structures, which cognitive psychologists have termed 'schemas' (Bartlett, 1932). Once activated, schemas influence information processing, shape the interpretation of experience, and affect behaviour.

Ellis's (1962) cognitive approach is based on the principle that 'irrational beliefs' are the source of disturbed emotional and behavioural consequences. These beliefs predominantly consist of unconditional shoulds, musts, commands and demands which lead to illogical cognitions and emotional disturbances. Beck's cognitive theory of
emotional disorders (Beck, 1967, 1976) asserts that emotional disorders are maintained by a ‘thinking disorder’ in which anxiety and depression are accompanied by distortions in thinking. It is these ‘faulty appraisals’ where cognitive therapists have focused most of their attention, developing techniques to examine the impact of distorted thoughts on client’s mood, reality testing of false beliefs, reattribution, and searching for alternative interpretations (Beck et al., 1979).

Present day techniques for identifying and labelling cognitive distortions or ‘thinking errors’ are usefully summarised by Burns’ (1989) *Triple Column Technique*. The method is used for identifying distortions in NATS and for generating more realistic thoughts. Individuals are asked to write down automatic thoughts when they occur and rate belief in them on a scale of 0-100. The next step involves identifying distortions present in each thought such as *black-and-white thinking*, *personalising*, *catastrophising* and so on. The final step involves substituting a rational response for each thought followed by a rating belief in each alternative response. The technique can be used as a shorthand method of invalidating NATS and beliefs. It relies on educating clients about different thinking errors and training them to identify thinking errors in their NATS.

Behavioural experiments are also commonly used to challenge beliefs at the appraisal and schema level. In this context, they represent ‘reality testing’ procedures that offer a means of validating particular predictions derived from client’s appraisals and schemas. The use of behavioural experiments increasingly predominates in cognitive therapy, and is more commonly referred to as cognitive-behavioural therapy (CBT). Behavioural experiments are used to collect and assimilate data for replacement beliefs (psychoeducation), as well as used to modify affective experience. In this latter context, techniques such as *activity scheduling*, *distraction procedures*, and *relaxation* are used to provide temporary relief from symptoms and interrupt unhelpful cognitive, affective and behavioural cycles that interfere with engagement in cognitive therapy.

For instance, in therapeutic practice it can sometimes be difficult to ‘sell’ the cognitive model to a client. By way of example, in the treatment of depression, activity scheduling can be introduced as an experiment to illustrate how modifying behaviour...
and distraction from negative thoughts can influence mood. The outcome of which can be used as supporting evidence for the cognitive formulation of depression, whilst at the same time engaging in the procedure itself, may begin to challenge negative appraisals that can contribute to depressive inertia.

In this way, behavioural experiments can also be used to socialise clients in the model. However, methods of guided discovery through Socratic questioning are preferred over didactic presentations of the model. Client’s often believe they have good evidence to support their fears and can be initially reluctant to accept that their difficulties may primarily be with faulty appraisals (for example, negative self-evaluation in social phobia). The advantages of using Socratic dialogue include the maintenance of a collaborative framework, which allows the individual to be active in the modification of their behaviour and cognitions. In this way, guided exploration may be one vehicle of change as the client gains insight into their thought processes, and over time may test out these circular and dependent new beliefs through supporting behavioural experiments.

It should be noted, that studies investigating the link between certain techniques and treatment outcomes have obtained mixed results (see DeRubeis & Feeley, 1990; Luborsky et al., 1985). For instance, the adherence to homework has been linked to better outcome (Burns & Nolen-Hoeksema, 1991; Neimeyer & Feixas, 1990), as has the challenging of distorted cognitions (Teasdale & Fennell, 1982). However, there is some evidence that homework compliance is a rather isolated factor only moderately correlated to other motivational factors such as expectancy or preparedness to change (Lax et al., 1992; Startup & Edmons, 1994).

Other studies have specifically investigated the effect of interpretations and confrontations on CBT outcome. Interpretations may be helpful in that they precede new insights, understandings, and self-disclosure (e.g., Elliott et al., 1982; Hill et al., 1988). Nevertheless, Schaap and colleagues (1993) warn that they can also give rise to short responses, resistance, and rejection on the part of the client, which in turn, can impact negatively on the therapeutic relationship. With regards to confrontations, Orlinsky and Howard (1986) reported significant correlations with outcome in all seven
of the studies they reviewed. It has been put forward that such instances cause discomfort in the client, interrupting the client’s train of thought by presenting discrepancies or differing points of view, which may create the necessary foundation for change (Hill et al., 1988).

Traditionally, the technical aspects of therapy have been felt to be the ‘active components’ that facilitate therapeutic change. Cognitive therapy has nevertheless developed and refined its techniques considerably over the past 40 years, placing greater emphasis on the inter-personal processes of the therapeutic relationship, and how to use the relationship itself as an active ingredient in therapy (Beck et al., 1990; Safran & Segal, 1990; Young, 1999). For example, the relationship can provide an arena in which the client can practice alternatives or new behaviours, such as being angry with the therapist or expressing emotion rather than avoiding it. For clients who believe that people always let them down, the relationship in which the therapist does his/her best to be reliable and trustworthy can also begin the process of challenging the client’s beliefs. Nevertheless, it should be pointed out that given the structure of CBT and considering the client’s expectations of therapy, there may be occasions for the need to provide additional options/modifications to the cognitive-behavioural system of delivery where necessary, especially given differences in role across therapeutic milieus and/or settings.

One of the most comprehensive set of studies investigating therapist’s interpersonal behaviour or ‘system of delivery’, has been carried out by Shapiro and colleagues (1991). The first Sheffield Psychotherapy Project study used a crossover design to compare a psychodynamic-interpersonal treatment, termed exploratory therapy, with a cognitive-behavioural method, termed prescriptive therapy (Shapiro & Firth, 1987). The psychodynamic-interpersonal therapy condition was based on Hobson’s (1985; Goldberg et al., 1984) Conversational Model. Using psychodynamic, interpersonal, and experiential concepts, it focused on the therapist-client relationship as a vehicle for revealing and resolving interpersonal difficulties viewed as primary in the origins of depression. The method emphasised negotiation (therapist’s views expressed as tentative statements, open to correction, inviting elaboration and feedback), a language
of mutuality, the use of statements rather than questions, and the offering of hypotheses about the client’s experiences and their interconnections.

The CBT condition was a multimodal method somewhat more behavioural in emphasis than Beck et al.’s (1979) cognitive therapy. It emphasised the provision by the therapist of cognitive and behavioural strategies for application by the client. A wide range of techniques was available to the therapist, including anxiety-control training, self-management procedures, cognitive restructuring, and a job-strain package. Only a marginal superiority of CBT was reported. Criticisms prevailed that such findings may have been due to the study’s restriction to immediate effects of just eight sessions of each treatment. A second large-scale investigation was therefore undertaken.

The Sheffield Psychotherapy Project 2 (Shapiro et al., 1994), which again compared manualised psychodynamic-interpersonal therapy with CBT for depressed clients (stratified for severity), this time, assigned to either eight or sixteen sessions, interestingly, also controlled for investigators’ allegiances by equally balancing across the two treatments. This was to counter further criticisms by Robinson et al. (1990; see also Berman et al., 1985), who argued that the allegiance of the investigator, which can reliably be inferred from the manner in which each study is reported, should also be statistically controlled for to yield a true estimate of comparative effectiveness. The attempt was to abolish any apparent advantage to cognitive and behavioural methods.

On most measures, CBT and psychodynamic-interpersonal therapy were equally effective (Shapiro et al., 1994), irrespective of the severity of depression or the duration of therapy. However, there was evidence of some advantage to CBT on the Beck Depression Inventory (BDI; Beck et al., 1961). Given that the BDI is the most widely used self-report depression measure, this finding could be interpreted as revealing an advantage of cognitive-behavioural over psychodynamic-interpersonal approaches. Nevertheless, as the authors point out, the BDI may be seen as sufficiently grounded in a cognitive-behavioural model of depression to predispose this instrument to favour CBT (Shapiro et al., 1994, p.529).
Controversially, other randomly controlled trials have found little difference in improvement rates (or alleviation of symptoms) in the longer-term (say, 18 months follow-up) for people suffering from a moderate depressive disorder, when having received CBT versus a more supportive/less didactic method of psychotherapy (Gortner et al., 1998). Similarly, with different populations, in clinical work with children referred for aggressive and antisocial behaviour, therapeutic change and improvement was predicted by similar variables whether or not children completed treatment (Kazdin & Wassell, 1998). Such findings contribute to the growing body of evidence suggesting that there are perhaps only initial and/or short-term gains to CBT (Shea et al., 1992).

Despite some support for the effectiveness of cognitive therapy in the treatment of depression (Elkin et al., 1989; Robinson et al., 1990; Shapiro & Shapiro, 1982; Stiles et al., 1986), researchers are still confronted with a high degree of uncertainty about the underlying processes of therapeutic change (Whisman, 1993). Castonguay and colleagues (1996) set out to better understand some of these processes of change. They investigated two types of process variables, those that are unique to cognitive therapy and those factors that such an approach is assumed to share with other orientations. Client improvement was found to be predicted by two common factors measured: the therapeutic alliance and the client’s emotional involvement (experiencing). The alliance refers to the quality of the client-therapist interaction, and the client’s experiencing refers to the ability to focus on and accept affective reactions. Their results also indicated however, that a unique aspect of cognitive therapy (i.e., therapists’ focus on the impact of distorted cognitions on depressive symptoms) correlated negatively with outcome at the end of treatment.

This surprising result (upon informal post-hoc descriptive analyses), suggested that therapists sometimes increased their adherence to cognitive rationales and techniques to correct problems in the therapeutic alliance. They discovered that such increased focus however, seemed to worsen alliance strains, thereby interfering with therapeutic change. In other words, the therapist treated these strains (e.g., disagreement with the cognitive therapy rationale and its related tasks), as a manifestation of the client’s distorted thoughts, which needed to be challenged. Such interventions led to repeated
cycles characterised by the therapist’s perseverance in the application of cognitive techniques, and the client’s increased unresponsiveness to the treatment (confirming earlier work by Schaap et al., 1993).

In defence of their findings, however, Castonguay et al. (1996) commented that it was conceivable that their therapists failed to use the cognitive model and techniques in a flexible way. Because the therapists were conducting a manualised treatment, they may have used some techniques more frequently or rigidly than they would have in a more naturalistic clinical context. This in turn, may have created or exacerbated alliance problems. Moreover, with regards to client experiencing, their findings point to the therapeutic value of client’s involvement in cognitive therapy, thereby confirming the importance of recent attention given to the affective processes within the cognitive-behavioural movement (Mahoney, 1991; Teasdale, 1993).

The mechanisms of change by which the experiencing leads to improvement, however, remain speculative. Teasdale (1993) has suggested that emotional experiencing in cognitive therapy may facilitate change by helping clients access and modify basic meaning structures. As hypothesised by Greenberg and Safran (1987), it is also possible that the experience of “primary feelings” (e.g., sadness) provides information to clients about their needs (e.g., desire to be close to others) and thereby facilitates behavioural change (e.g., motivating clients to increase social contacts).

The concept of the ‘therapeutic alliance’ was originally developed by psychoanalytic theorists (e.g., Greenson, 1965; Sterba, 1934), who discussed the patient’s ability to form a ‘working alliance’ to work with the therapist’s interpretations. Ignored in early writings of behavioural techniques, cognitive-behavioural therapists nevertheless came to recognise the value of the relationship itself as a means to facilitate the process of therapy (e.g., Goldfried & Davison, 1994; Raue & Goldfried, 1994; Raue et al., 1997). Although differing conceptualisations have also been put forward, Bordin’s (1979) formulation of the therapeutic alliance has become generally accepted over the years. According to Bordin, the therapeutic alliance consists of three related components: goals, tasks, and bond. The quality of the alliance depends on the extent to which client and therapist agree on the goals of treatment, the extent to which client and therapist
agree on the tasks to achieve these goals, and the quality of the bond that develops between them.

Theory suggests that therapeutic orientations may very well evidence different alliance qualities across goals and tasks, and proffer different theoretical assumptions about its nature and function (Gaston et al., 1995). Psychodynamic therapy, for example, has been characterised by more emotionally charged and potentially more uncomfortable sessions, and CBT has been characterised by smoother and, as a result, less strained sessions (Raue & Goldfried, 1994). The therapeutic alliance has nevertheless been identified as the crucial factor to the change process in psychotherapy (see Clarkson, 1990, 1995). A good alliance has been shown to predict client improvement across approaches – including psychodynamic-interpersonal (e.g., Strupp & Binder, 1984) and cognitive-behavioural psychotherapies (e.g., Arnkoff, 1995; Castonguay et al., 1996; Horvath & Symonds, 1991; Raue & Goldfried, 1994). Since the concept has fairly stable associations with treatment results, it is likely that the therapeutic alliance has considerable overlap with the Rogerian therapeutic conditions.

Rogers (1951, 1957) first laid down the variables of empathy, nonposessive warmth, positive regard, and genuineness as being necessary and sufficient conditions for the achievement of client change. Numerous studies have since demonstrated that cognitive-behaviour therapists are highly involved in the development and maintenance of a good relationship with their clients. A strong therapeutic alliance has been shown to consistently affect CBT outcome in depression (Gaston et al., 1991; Marmar et al., 1989), affective disorders (Horvath & Greenberg, 1989; Muran et al., 1995; Raue et al., 1993; Safran & Wallner, 1991), and with addictions (Carroll et al., 1997). Non-significant findings in the treatment of depression however, have been reported by Krupnick et al. (1994, 1996), though this appears to have been the result of different research methodologies.

Furthermore, significant associations with outcome have been shown to be more consistent when the Rogerian therapist conditions are evaluated by the clients themselves rather than by therapists or independent raters. For example, in four retrospective studies, clients were asked what they felt had been the most helpful
aspect of their cognitive-behavioural therapy (Llewelyn & Hume, 1979; Murphy et al., 1984; Ryan & Gizynski, 1971; Sloane et al., 1977). All four studies consistently reported that clients had found the relationship with their therapist more helpful than the cognitive-behavioural techniques that were employed.

Empirically, studies examining aspects of the alliance or non-specific ‘relationship factors’ across orientations, have provided mixed evidence. Sloane et al. (1975) found outside observers rated behaviourally oriented therapists as displaying significantly higher levels of empathy, genuineness, and interpersonal contact than psychoanalytically oriented therapists, but they rated both sets of therapists equally on the display of warmth. Brunink and Schroeder (1979) analysed audiotaped sessions to compare the verbal behaviour of therapists from different orientations. They found that observers rated cognitive-behaviour therapists as using more supportive communications (such as reassurance, praise, and sympathy) than either psychoanalytic or gestalt therapists did, but they rated all the therapists equally on empathy and rapport.

Irrespective of approach, it can be concluded that cognitive-behaviour therapists employ relationship skills as much as do therapists from other orientations. Two clusters of therapist-client interpersonal behaviour have been identified that seem to be more clearly associated with CBT outcome: a) the Rogerian therapist variables – empathy, non-possessive warmth, positive regard and genuineness; and b) the therapeutic alliance (Keijsers et al., 2000). This supports the conclusion that relationship factors in general have a consistent but moderate impact on CBT outcome.

Furthermore, the therapeutic relationship in CBT appears to be characterised by an active, directive stance on the part of the therapist (Wogan & Norcross, 1985), in addition to high levels of support, and high levels of empathy and unconditional positive regard (see Goldfried et al.’s, 1997, excellent comparative analysis of therapeutic foci within therapy sessions). Questions remain however, as to whether an active, directive stance on the part of the therapist promotes favourable treatment results on its own merit, without any positive ‘relationship’ to speak of. Definitive answers to such questions may in the future come from ongoing research in the field of
Information Technology. Innovative trials that make use of palm-top computer programs in the treatment of generalised anxiety and panic disorders have been piloted (Newman et al., 1997; 1999). Results to date indicate successful outcomes, shedding some doubt on the need for the traditional face-to-face contact with a therapist.

Finally, if treatment success in CBT is expressed in terms of symptom reduction, it is likely to result principally from the patients' ability to acquire more adequate coping behaviour to deal with their symptoms. Within the psychotherapy process literature, there are only a few studies on the impact of therapists' use of directive intervention on treatment (see Orlinsky & Howard, 1986). Important concepts such as motivating strategies, persuasion, and social power, which may all serve to understand how therapists influence their clients, still needs further research.

In summary, this essay has reviewed various studies that have looked at the relative contribution of non-specific relationship factors versus the technical factors of cognitive therapy. It would appear there is some evidence to suggest that therapeutic change is dependent upon both the therapists' system and method of delivery, as well as the components that actively challenge client's faulty appraisals. Thus, as psychologists, we need to pay particular attention to the therapeutic relationship and our diction, in making a significant contribution to the outcome of cognitive therapy.
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Ethical issues encountered in qualitative research: Reflections on interviewing adolescent in-patients engaging in self-injurious behaviours

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Introduction
Qualitative research is a fast developing and innovative field of enquiry. The most commonly used method of collecting qualitative data is the research interview. Interviewing participants for psychological research can be difficult at the best of times, let alone with a particularly challenging and vulnerable client group. There are a number of ethical implications that must be considered in this situation. Guided by The British Psychological Society codes of conduct and ethical principles, researchers may not only have to fulfil their University or Institution's expectations for undertaking ethical research, but also negotiate approval with one or more NHS ethical committees. The theoretical requirements however, are not always adequate preparation for the actual practical experience.

This article addresses some of the practical and ethical problems that were encountered in a qualitative research study. It describes and reflects on some of the difficulties faced by a trainee counselling psychologist undertaking interview-based research with a particularly vulnerable client population: young people engaging in self-injurious and/or suicidal behaviours. Self-injurious behaviour is a disturbing and growing phenomenon among this age group, and research that can further our understanding is always needed. In this paper, 'I' refers to the researcher and first author (AB), although the reflections presented here were developed and refined partly...
through discussion with the supervisor of the research and second author (MJ).

The setting for this research was an adolescent unit which managed to combine the traditional concepts of a 'therapeutic community' (originating from the concepts of Main, 1946), and a more didactic hospital ward environment for the treatment and containment of young people. A number of important ethical issues can arise when interviewing young people in a residential setting. Some of the techniques used to satisfy 'standard ethical protocols', and manage situations prior to, during, and after research interviews, in addition to issues arising in the wider context of this setting, are highlighted.

Participants recruited were individual self-injuring or suicidal adolescent in-patients not currently detained under the 1983 Mental Health Act or 1989 Children Act (see Jones, 1999), but undertaking voluntary treatment within the residential unit for a wide range of persistent or enduring mental health difficulties. The aims of the research were to incorporate broader definitions of 'self-injurious behaviour' into the analysis of male and female adolescent in-patients' views, subjective experiences, and social constructions of a wide range of risk-taking behaviours: those which knowingly invite physical injury or harm to the self, and which typically arouse feelings of shock and alarm in those who witness them. The study adopted an Interpretative Phenomenological Analysis (IPA) approach (see Smith, 1996; Smith et al., 1997, 1999), to capture the researcher's concern with exploring individual participants' perspectives, whilst also recognising the research experience as a dynamic process, to some extent shaped by the interests and concerns of the researcher.

**Ethical issues with vulnerable young people**

The potential hazards or risks for an individual associated with participation in any research is a major consideration in the completion of any ethical committee research application form. The precautions to be taken to minimise and deal with such a situation also have to be anticipated and answered to. In the above research, it was evident with such a potentially 'triggering' topic under investigation, that certain issues raised by an in-depth interview might cause distress to some participants. It had to be convincingly argued that this researcher was receiving ongoing clinical training and supervision, and would, therefore, be sensitive to these issues through an awareness of the psychodynamic processes associated with in-depth interviewing.

It verges on the unethical for a researcher to address sensitive issues with participants, re-stimulate painful experiences, record them and then simply depart from the interview situation (Finch, 1984). For these reasons, a comprehensive debriefing and handover was incorporated into the interview schedule. In making a case for interviewing self-injuring or actively suicidal adolescents, a clear understanding and mutual perception of 'risk' – for both the young person and the researcher – had to be made explicit in the preamble and 'checked-out' in the debriefing component of the interview.

The young people were informed at the beginning of the interview that I would keep what they said to me private unless there was a perceived risk to themselves or to others. It was further explained that should they seem distressed upon completion of the interview, this would be conveyed to the charge nurse on duty, indicating the level of distress and perceived level of risk. It was also made explicit that no information would be passed on without talking about it with them first.

It was particularly useful to include as part of the research process, patients' accounts of their experiences of the interview itself. The actual experience of discussing their own or others' self-injurious behaviours seemed to provide considerable relief, and most of the young people reported the subjective experience as useful and rewarding. For those young
people for whom some upsetting or confusing issues were brought up by the interview, the debriefing provided an opportunity to express such views. They were able to request of me that a more detailed handover be given to the member of staff on duty, empowering them to then inform other staff and peers of their perhaps 'charged' state of mind or feelings of vulnerability, and requesting help in not acting on self-destructive impulses.

The therapeutic programme of the unit itself provided many opportunities for the young people prior to and after the interview to discuss with staff any issues which arose. I was fortunate in that I was also invited and able to attend the large 'community meeting' at the end of the day, which acted as an additional 'container' to any distressing material (Bion, 1961). This proved a welcome space for three participants to bring to the attention of the community their experiences, as a further means of keeping themselves safe and refraining from engaging in self-injurious behaviour.

I had taken the prior step of consulting with lead clinicians and individual Management Teams responsible for each young person, as to their suitability in undertaking the research interview. In general discussions with additional multidisciplinary staff members, it was considered unlikely that the young people would experience more distress than would be expected on the unit in which they were resident, or in their therapeutic groups.

Additional precautions nevertheless included becoming acquainted with the unit's detailed procedural Risk Management System, which could also have been implemented in extreme circumstances. A clear statement to this effect was made, in addition to ensuring that the interviews would be (and were) conducted in a safe environment, and that would (and did) not take place when staff levels were reduced (for example, at times of staff change-over or before weekend leave).

Participants in a qualitative interview are subject to further risks. Participation in qualitative interviews can be time consuming, privacy endangering, and intellectually and emotionally demanding in ways that quantitative research rarely is. To make matters worse, it is difficult for participants to anticipate these dangers at the outset of the interview. Researchers must take care to see that the participant is not overly or subtly victimised by the interview process. The 'standard ethics protocol' offered in most good qualitative research handbooks can go some way to suggesting strategies by which participants rights can be protected (see Patton, 1990; Ely et al., 1991).

The manner in which I chose to present my research as an entirely separate activity and enquiry from the main therapeutic 'work' of the community 'programme', was a reflection of this. The hour-long individual face-to-face research interviews were 'framed' as an opportunity for the young people to talk about their views and experiences in depth, with regard to either their own and/or others' self-injurious behaviour.

Reinharz (1992) argues that interviewers may consciously wish to either 'down play' or 'play up' their professional status, according to whom they are interviewing. Such an approach is in contrast to the model of interviewing advocated by Oakley (1981). This requires on the part of the interviewer an openness or personal responsiveness, an engagement for striving for intimacy. I found it particularly useful for my status to remain somewhat ambiguous. As a trainee counselling psychologist I was neither labelled by the institution as a visiting 'staff member', nor 'student nurse', but rather as an 'independent researcher'. This afforded me the freedom not to be aligned with the staff team dynamics, and the opportunity to sit and chat informally with the young people in their free time outside of therapy groups.

Although previously intuitively 'known' to me that trust was a central issue in research interviewing, I quickly rediscovered that it had to be earned, and was most likely to be developed through some 'giving' of oneself. This proved
initially somewhat of a dilemma for me in terms of the concept of ‘therapeutic neutrality’, not to mention being a difficult characteristic to convey to a group of young people for whom considerable abuse, neglect, or deprivation had been present in their early lives.

‘Being myself’ with the young people, having a cup of tea, joining in with a conversation, or simply just quietly sitting, seemed to leave a deep impression upon my participants.

In hindsight, I believe this had a considerable influence upon how successful I proved to be in recruiting both the slightly more reluctant young men and the young women. The level of trust the individual young people placed in me as an interviewer was possibly enhanced by the assurance of confidentiality in the forum of the therapeutic community, and anonymity in the context of potential future publications.

With the first round of interviews underway, I discovered additional ‘group dynamics’ were having an effect on my planned consecutive sampling technique – which I hypothesised seemed particular to the setting of a therapeutic community. Patton (1990) has warned that depending on the setting of the interview, interviewees may later be ostracised by their peers for having talked. The reverse seemed to occur in this instance (which boded well for recruitment). However, this resulted in some competition amongst the young people to be interviewed. It was possible to raise this issue with staff members in a supervision arena, where interviewer effects and group dynamics could be reflected upon.

In the actual interviews themselves, I did not need to assume a greater degree of control than I was comfortable with, with regard to intervening or directing the interview in a particular way. This was perhaps safeguarded against with clear ‘opt out’ statements provided at the outset for participants. This included reassurance to the effect that: there were no right or wrong answers; the questions were designed to allow them to explore the subject area as freely as possible; they could stop the interview at any time without having to give a reason; and if they did not want to answer a question they could say so and I would move on to the next question.

Learning to develop appropriate boundaries was an important part of the investigative process. Participants were encouraged through the medium of the handover meeting to nursing staff, not to blur the ‘researcher boundary’ role I chose to maintain. Nevertheless, I believe I displayed warmth, empathy and genuineness as interpersonal qualities in my interaction in the interview. There has been considerable controversy over this. Hammersley and Atkinson (1983) argue that there has to be some degree of both social and intellectual distance, for it is this ‘space’ that creates the opportunity for analytical work (in the research sense). McCracken (1988) describes it as where the reflexive ‘self-as-instrument’ process takes place, and disapproves of the use of active listening strategies in the research interview.

How much emotion the researcher displays and their degree of involvement will vary from one individual to another, and will also be affected by the sensitivity of the research topic. I drew a distinction between Coyle’s (1998) rationale for using the counselling interview as a research instrument, preferring Oakley’s (1992) concept of ‘socially supportive interviewing,’ yet redirecting these young people to their therapeutic community network and the multidisciplinary staff team who knew them best.

Conclusions
Having completed 16 interviews with adolescents who engage in a spectrum of moderate to severe self-injurious behaviours, I am persuaded that the benefits outweigh the risks in contemplating the ethical issues involved with qualitative research interviews. I was initially concerned with the potential risk of ‘triggering’ further or increased self-injurious behaviour in this vulnerable and impulsive patient group. To my great surprise and from subsequent feedback
from both staff and young people, there were no incidents of self-injurious behaviour attributed to the demands or stressors of a very direct and personal research interview.

This paper has addressed the fact that accessing young people’s lives, experiences, and views needs to be handled with great sensitivity, care and skill. Counselling psychologists are in a very strong position to eschew more traditional methods that can undermine an individual’s ‘voice’ or ‘power’, effectively integrating theoretical knowledge and clinical practice skills into their research investigations. Studying both the obvious and the more obscure ethical issues that arose with a challenging and ‘at risk’ client population, ensured that the research process itself (as well as the quality of responses to questions) was as engaging as it was revealing. The experience of interviewing young people revealed to me once again how we adopt multiple roles in our relations with others, and how becoming deeply involved with our research material particularly during data collection requires extensive examination.

References


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Therapeutic Practice Dossier

This dossier reflects work fulfilled during the three years of my psychotherapeutic training. It contains a description of each of my clinical placements followed by a personal account of my integration of practice, theory, and research.

Further details of client studies, process reports, placement logbooks and supervisors' evaluation forms pertaining to this dossier are available to the examiners in a separate appendix. Due to the confidential nature of the material contained within this appendix, it is not available for public access.
First Year Placement: Community Mental Health Team & Psychology Department

October 1998 – August 1999

My first year training placement was divided between an integrated Community Mental Health Team (CMHT) and a tertiary Adult Mental Health Psychology Department situated within a large NHS General Hospital site.

Both services catered to a variety of clients (with moderate, severe and enduring mental health difficulties), aged between 17 and 75 years old. Clients were generally referred by either their general practitioner or psychiatrist for psychological difficulties. These ranged from post traumatic stress disorder, panic attacks, anxiety, personality disorders, psychoses and schizophrenia, obsessive compulsive disorders, eating disorders, childhood sexual abuse, anger, depression, and bereavement. Both services worked closely together to improve the mental health and social functioning of individuals who were referred within the community, to prevent relapse, readmission, or at least minimise hospital stays.

The CMHT served a population of 43,500, and referrals were discussed and allocated at a weekly multidisciplinary team meeting involving psychiatrists, senior registrars, community psychiatric nurses, occupational therapists, and social workers. Psychologists formed an integral part of the multidisciplinary team. Accordingly, I offered assessments and brief supportive therapy, normally of 10 weeks duration.

The Adult Psychology Department represented a clinical staff team of 16 with a wide diversity of specialist interests. This placement provided me with the opportunity to practice both short and longer-term therapies. The theoretical orientation was broadly humanistic and a person-centred approach pre-dominated. I was nevertheless able to begin to apply psychodynamic and cognitive-behavioural approaches, where appropriate. A Chartered Counselling Psychologist provided individual supervision on a weekly basis. I also attended weekly post-graduate (continuing professional development) lectures and presentations hosted by the hospital.
Second Year Placement: Psychotherapy Department

September 1999 – August 2000

My second year placement was within an Adult Psychotherapy Department situated in its own building on a large NHS General Hospital site.

The psychotherapy unit provided assessment and treatment to individuals in the community either on an outpatient or inpatient basis. The service catered to a variety of clients, between the ages of 18 and 70 years old. Clients were referred by their general practitioner, psychiatrist, or other clinical psychology services, and were assessed for their suitability for psychodynamic therapy. Psychological difficulties ranged from post traumatic stress disorder, personality disorders, obsessive compulsive disorders, eating disorders, childhood sexual/physical/emotional abuse, anger, depression and bereavement.

The department provided individual therapy (minimum of six months) or long term therapy lasting several years, as well as group therapy and couple therapy. I saw individual clients on a weekly basis for the duration of my placement (eleven months). I also undertook joint work as a co-therapist running a closed mixed-sex membership long-term psychotherapy group (originally) for 7 adult outpatients, who attended the psychiatric day hospital on a weekly basis. I joined the group as a co-therapist thirteen months into its life expectancy of 2 years, and completed the course of psychological therapy started with its members. My male co-therapist was an experienced qualified Group Therapist and Art Therapist.

Supervision for individual client work was provided twice weekly in both individual and group forums by a senior psychoanalytic psychotherapist who had also trained as a clinical psychologist. My supervisor worked within a fairly pure psychodynamic approach (based on Kleinian theory), and my main ‘taught supervision’ was shared with two other learners. In this group forum, each of us had approximately half-an-hour to 45 minutes during which written detailed process notes from weekly sessions of one or two of our patients were presented.
Individual supervision was also provided on a weekly basis, where additional client work, theoretical, practical and administrative issues were discussed. Supervision for the small psychodynamic group took place for 45 minutes with my co-therapist on a weekly basis, and in a group setting with an external facilitator (Group Analyst) for one hour, every six sessions.

During this placement, I was given the opportunity to present my second year research project at the Post-Graduate Education Centre. The audience included a wide range of hospital staff including consultants, psychiatrists, psychotherapists, specialist registrars, community psychiatric nurses, specialist mental health workers, occupational and art therapists, and students from most disciplines. I also attended a one-day multidisciplinary conference, organised by the hospital, titled: 'Young People on the Edge: What Happens to Thinking? The Individual, The Network and The Legal Frame'.
My third year placement was divided between a Community Mental Health Team (CMHT), and a Co-ordinated Psychological Treatments Service (CPTS).

The CMHT offered support to people with a wide spectrum of severe and enduring mental health difficulties, aged between 18 and 65 years, and operated within an integrated care programme approach. Clients were referred by their general practitioner or psychiatrist from either primary or secondary care services, and assessed for their suitability for psychological therapy. The large multidisciplinary team was divided across Assessment & Brief Therapy; Continuing Care; and Forensic Services. Together they aimed to improve the mental health and social functioning of individuals who had been referred within the community, to prevent relapse, readmission, or at least minimise hospital stays. During the first part of the placement, I undertook comprehensive assessments including mental state examinations and risk assessments, provided brief psychological interventions, and presented comprehensive written reports for the community Assessment & Brief Therapy team.

Within the CPTS, individual, group, couple, short-term or long-term therapy lasting several years was available. A wide range of theoretical orientations was represented and applied in practice, including cognitive-behavioural, psychodynamic, systemic, and cognitive-analytic therapies. I provided brief and longer-term individual, couple, and group therapies to clients using cognitive-behavioural and integrative (also schema-focused and psychodynamic) approaches. I also co-facilitated an extended anxiety management group (over 12 sessions). My female co-therapist was a Chartered Clinical Psychologist. Individual supervision was provided on a weekly basis by a UKCP registered Principal Clinical Psychologist who specialised in cognitive-behavioural therapy.
Additional professional activities included attending psychology meetings and multidisciplinary team meetings; liaising with psychologists, psychiatrists, community psychiatric nurses, occupational therapists, and social workers; attending day conferences, training workshops, continuing professional development lectures, and research presentation forums across several sites of the large teaching hospital. I also presented my third year research year research project to members of the psychology department.
A PERSONAL ACCOUNT OF INTEGRATING THEORY AND RESEARCH INTO THERAPEUTIC PRACTICE

Overview

Hollanders (2000) argues that the process of integration develops in a combination of three different loci: internally (i.e., primarily within the individual practitioner); externally (i.e., primarily outside the practitioner); and within the relationship (i.e., primarily 'in the between' person and person). He maintains that within each of these spheres, integration is a highly personal phenomenon guided by a multitude of influences. Internal influences include intrinsic personality characteristics of the therapist, personal 'intuition' supported by consistent and coherent rationales, and the process of reflection drawn on in each new situation. External influences are concerned with 'meta-theoretical' integration, the technical application of an integrative framework 'in practice', and the identification of effective elements or 'commonalities' across therapeutic approaches. Within-the-relationship influences are associated with the structure, content, breadth, and duration of communicative interactions between the therapist and client.

This paper presents an account of my personal journey as a 'trainee' integrative counselling psychologist, in an endeavour to make transparent the relative contributions some of these influences have had on my developing therapeutic practice. Firstly, I will outline some of the core tenets of counselling psychology and my epistemological position, explaining how and why I have chosen to work from my current perspective, alongside the relative contributions of supervision and personal therapy. I will then briefly describe the core theoretical models covered in my training, highlighting those aspects that have influenced my personal and professional development to date, and how I have come to integrate the different ideas I have been exposed to. This will provide an overarching perspective of some of the skills and techniques I have drawn from and found useful in my work with a broad range of psychological difficulties. I will illustrate this by means of clinical examples where appropriate, demonstrating the attention I pay to both process and content in my therapeutic encounters. Pseudonyms have been used throughout to protect confidentiality of clients and family members. Lastly, I will describe how my increasing psychological knowledge has both informed and contributed towards my
research interests in the psycho-social (and sometimes political) sphere of working with vulnerable and/or distressed adolescents, further aiding my endeavours to become a 'scientist-practitioner'.

The core tenets of counselling psychology
The core tenets of counselling psychology have their roots in humanistic traditions, eschewing diagnosis as a primary concern, preferring to focus instead on underlying problems and difficulties (British Psychological Society, 1998). Across the breadth of the discipline, integration is reflected in the co-existence of many narratives. Regardless of orientation or practical approach primacy is given to the ‘therapeutic relationship’. There is ample evidence of the crucial role that the quality of the therapeutic relationship plays in both therapy outcome (Horvath & Greenberg, 1994; Horvath & Symonds, 1991; Orlinsky et al., 1994) and human development (see Clarkson, 1990, 1995; and O'Brien & Houston, 2000 for comprehensive reviews).

The importance placed on the therapeutic relationship is influenced by basic assumptions about human nature. A person is born with natural potential which develops through relations with other people (Maslow, 1973; Rogers, 1961; Winnicott, 1965). Research has shown that infants come into the world as active partners in the infant-parent relationship (Brazeldon & Cramer, 1991). With the development of the ‘self’ comes the process of interpreting the meaning and nature of the world including, crucially, interaction with other people (Sullivan, 1953). The person generates internal ‘working models’ (Bowlby, 1988; Fairbairn, 1952; Stern, 1985, 1995) of these relations with others, which form the basis for interpersonal action. In this way, each person co-creates the relationships of which s/he is a participant. Heidegger (1962) has argued that ‘being-in-the-world’ with others is central to and inseparable from the human condition.

Working with the therapeutic relationship involves listening not only to what is being said but also monitoring what is going on in the ‘here-and-now’ of the session, i.e., the transferential or existential aspects of the ‘real relationship’. It has been argued that attention paid to the therapeutic relationship is the therapy itself (O’Brien & Houston, 2000), not withstanding the importance of theoretical knowledge and technical
expertise or skill. The experience of being accepted and heard by the therapist and having the opportunity to explore thoughts, phantasies, feelings and behaviours deeply, can be immensely helpful and healing for the client (though such attitudes and actions by the therapist will always be experienced through the client’s ‘tapestry’ – Paul & Pelham, 2000). These are just a few of the reasons for the importance I place on developing a good ‘working alliance’ in my therapeutic work with clients.

Although differing conceptualisations have been put forward (Gaston et al., 1995), Bordin’s (1979) formulation of the therapeutic or working alliance has become generally accepted over the years. Used as a framework that describes the elements involved in therapy, he argued that the working alliance consists of three related components: goals, tasks, and bonds. Research has shown that a strong working alliance appears to be created and maintained partly by the therapeutic skills and/or competence of the therapist, and partly by the client’s emotional involvement or ‘experiencing’ of affective reactions (Castonguay et al., 1996). Frank (1973) and Lambert (1986) have identified several additional ‘non-specific’ or ‘common therapeutic factors’.

It has been shown that, initially, choices of intervention are likely to be made on the basis of personal preference, training experience and the type of assessment procedures undertaken (Dryden, 1984; Norcross & Prochaska, 1982; Steiner, 1978). The manner in which such choices become evident or influence a session will depend upon a wide range of variables, not least, upon the current life experiences of both the therapist and the client. Following my initial contact with a client, the whole process of my choice of intervention, its application and the resultant outcome will become the object of reflection for me personally and in conjunction with others in supervision.

**Supervision, personal therapy, & peer contribution**

I have been particularly fortunate to receive support and guidance from some extremely experienced senior practitioners during the course of my training. Regular supervision has often provided ‘containment’ (Bion, 1962) and a ‘secure base’ (Bowlby, 1958, 1988) from which I have been encouraged to take tentative (and sometimes falteringly uncomfortable) steps into the quagmire of emotions that exist in
therapeutic relationships. I have been encouraged to explore both the content and process of sessions from different vantage points, making use of 'trial identification' (Fleiss, 1942) and empathy in my understanding of clients. I feel this has honed my abilities into 'becoming' a more responsive and reflective practitioner – a process and position which Bion (1975) hoped no therapist would ever fully complete nor omnipotently imagine they had 'arrived' at. Accordingly, supervision has shaped my capacity to self-monitor, promoting and strengthening my own 'internal supervisor' (Casement, 1985).

In tandem with these supervisory experiences, I have found that self-scrutiny in personal therapy has helped me learn about conflicts and their resolution on an intimate level. One of the reasons counselling psychologists are deemed to need a period of personal therapy is in order to explore personal prejudices (Farrell, 1996). These prejudices can be about other people's personal backgrounds, cultures, belief systems and relationship styles, and may potentially interfere with the counselling process (Syme, 1994). Having thought carefully about these issues at the outset, my decision to remain in personal therapy for the duration of my training was planned and purposeful. Personal (ongoing) therapy has highlighted the 'blind spots' of my own frame of reference (Jacobs, 1988), and facilitated my learning to set aside or effectively 'bracket' these biases in my work with clients (Jennings, 1992). For example, I have been able to explore some of my own intolerant views regarding certain cultures, increasing my awareness and understanding of 'individual differences', in order to abandon my stereotypical prejudices and more readily accept the phenomenology of my clients. The experience of 'being in' therapy has also provided me rich opportunities for learning via direct observation: especially witnessing my own therapist 'at work'.

The support and inspiration of my fellow trainees has also been invaluable in strengthening my self-confidence, particularly with 'difficult to engage clients'. Peer group forums have provided me with the opportunity to listen, consider, discuss, even argue at times, improving my capacity for reflective judgement on a multitude of levels. This has sometimes involved the ability to think dialectically – a philosophical system of working hard towards a resolution of differences (Woolfe, 2000). Through these reflexive endeavours, I feel that I have come to appreciate the intricacies of
human interaction on both the macro and micro levels, paying attention to context, content and process.

**Personal epistemology**

There is evidence for the continued proliferation of integration within most schools of psychotherapy (Arnkoff & Glass, 1992; Garfield & Kurtz, 1977; Hinshelwood, 1990; Norcross & Prochaska, 1988). Due to limitations of space in the present paper, however, interested readers are directed to Hollander’s (2000) comprehensive summary of the current debates within and across the divides of eclectic and integrative therapeutic practice.

In a thorough review of existing approaches, Roth and Fonagy (1996) concluded that: ‘each model has its advantages and disadvantages though in our judgement there may be arguments favoring training of clinicians in more than one modality (i.e. in both an exploratory and a more structured psychotherapy). There is some evidence […] indicating that therapists may have better outcomes if they are able to adapt their technique to match client characteristics (which may mean at times employing a different modality of treatment’ (p.374). A view which is supported in our current government-funded NHS climate of ‘evidence-based practice’ (Department of Health, 2001).

Early on in my training, it became increasingly evident to me that not every client in every situation fitted well into a single theoretical model. It appeared, therefore, that the components of a successful therapy implied a certain philosophical attitude. One of the major reasons I initially chose to train as a counselling psychologist was to become conversant with (and hopefully, eventually fluent), in three or more psychological ‘languages’. The pathway I have chosen is therefore aimed at developing a theoretical integrity, which is flexible instead of dogmatic, and which places greater value on the open-ended exploration of the integration of theory, research and practice. As Woolfe (1996) has warned, strict adherence to a single ‘school’ could restrict the practitioner’s ability to enter into the client’s phenomenological frame.
This is not to say that I believe that integration is the final solution. As noted by Clarkson (1995), there are at least a dozen different integrative theories ‘out there’. One could make about this proliferation the same comment made by Polkinghorne (1992) about the building blocks of these attempts towards integration: ‘the large number of theories claiming to have grasped the essentials of psychological functioning provide prima facie evidence that no one theory is correct’ (p.158). This is just to say that my epistemological position is one of ‘fluid’ integration of different ideas to help my understanding of the specific person/situation I’m faced with.

My starting point in therapy is therefore to consider each individual’s idiosyncratic theory about their own and others’ experiences. This stems for a personal stance and preference for not ‘pigeon-holing’ people into categories or ‘boxes’. Life experience and the pluralistic nature of society today, to quote an old axiom, have repeatedly taught me that ‘one can never judge a book by its cover’. Research evidence also suggests that personal epistemologies influence therapeutic process and outcome in important ways (Neimeyer & Morton, 1997; Vincent & Lebow, 1995). Therapists influenced by post-modern thinking aim to take a ‘not knowing’ stance (Anderson & Goolishian, 1988), replacing a predetermined view of how an individual should change with a collaborative posture where client and therapist can equally examine the belief systems by which the individual views ‘reality’.

Training experience

Having briefly described the internal and within the relationship influences on my process of integration, the external influences can necessarily be attributed to the progression of my training experiences and the core theoretical models covered. This has broadly included humanistic/phenomenological, psychodynamic and cognitive-behavioural teachings. Possibly also because of the resulting need to understand different ideas and approaches, the theorists that have been most useful to me in practice are those who have also allowed themselves to be creatively influenced by other schools.
Humanistic/phenomenological perspectives

My first year training placement was divided between an integrated Community Mental Health Team (CMHT) and a tertiary Psychology Department in a large General Hospital. Working in a setting where brief-therapy models were offered (10 sessions), I came to understand the importance of undertaking a comprehensive assessment for the purposes of aiding psychological formulation, making decisions about how best to help the client, and/or defining appropriate treatment goals. Maslow (1968:iii) has argued that the relationship between the humanistic and phenomenological elements of the ‘third force’ in psychology, is one of outlook and method.

Carl Rogers [1902-1987] believed that people were capable of growing and developing into what he called ‘the fully-functioning person’ (Rogers, 1959, 1961, 1969, 1977). In his work, he placed great emphasis on accurate empathy, nonpossessive warmth (positive regard), and genuineness (congruence), as the necessary and sufficient conditions for client change (Rogers, 1951, 1957). I duly encountered many situations where the establishment of the therapeutic relationship was fundamental to change. For example, working with a 26-year-old father who had been sexually abused by his mother as a child, the main focus of our therapeutic work together became the establishment of trust and forming a secure (non-sexualised) bond and attachment. This acted as a model for future relationships with his child and girlfriend. The relationship, therefore, in this case was considered the key element for his growth.

The use of humanistic techniques, such as reflecting, clarifying and paraphrasing have helped me to check out with clients whether my explanations, tentative hypotheses and/or interpretations are congruent with their phenomenological experience. At the same time, these techniques have also enabled me to convey to clients that they have been heard and understood. By adopting a phenomenological method of comprehending the world, Robinson (1979) argues we are driven to an essentially humanistic position on human psychology. Furthermore, ‘the goal of the phenomenological method is not to expose and explore what is truly real – since that remains an impossibility – but, rather to clarify both the variables and invariants of phenomenological reality’ (Spinelli, 1989: 80).
It was also the emphasis on the power of a 'real relationship' (Alderstein et al., 1983; Gelso et al., 1983) as a therapeutic 'tool' that first impressed me when I started therapy with clients in the early days. There is a risk that this may seem overly simplistic however, and it should be acknowledged that there are limitations to this approach. For instance, there are occasions where a humanistic perspective on the 'here-and-now' of the session seems to pay insufficient attention to past transferential feelings.

**Psychodynamic perspectives**

Previous academic study for a Masters degree had introduced me to the psychoanalytic concepts of the British school of 'object-relations' (Freud, 1915; Fairbairn, 1941; Klein, 1932; Winnicott, 1958). I had previously found in depth study of their writings to be challenging and stimulating, but my hitherto theoretical understanding had not been called into question. Whilst on a theoretical level, I could appreciate the importance given to early trauma in developing personality structure, and the role of the unconscious in determining behaviour, anxiety and defences, when I came to my second year specialist placement, I nevertheless struggled to translate some of these theories into practice.

Feeling somewhat 'deskilled', initially I adhered too rigidly to the guidelines of neutrality, minimal interpretation and the use of silence as my therapeutic 'tools'. Strachey's (1934) tripartite formulation guided my preliminary attempts at 'trial interpretations', bringing together the current difficulty, the transferential situation, and the infantile or childhood constellation of conflict or deficit. I subsequently found the 'middle ground' approach to the process of interpretation and interaction in therapy most usefully represented in Malan's (1979) paper on the 'Two Triangles'. The 'triangle of conflict', consisting of defence, anxiety, and hidden feeling, and the 'triangle of insight or person', comprising of others (current or recent past), transference (here-and-now of the session) and parents (distant past).

Supervision provided me with opportunities to reflect on my experiences, revealing to me occasions where the therapeutic relationship could easily become distorted through powerful and primitive forces arising from early mental mechanisms – including
splitting, projection and projective identification (Klein, 1933, 1935, 1946). Progressively, object relations theory has become invaluable to me clinically, in terms of understanding transference-countertransference interactions between client and therapist (Klein, 1952; Little, 1951; Racker, 1982; Segal, 1986) as well as my experiences within larger group dynamics (see Bion, 1961, 1967; Foulkes, 1948, 1964, 1975).

In reconciling some of the more traditional psychodynamic stances with the tenets of counselling psychology, I began to incorporate a more empathic and humanistic 'way of being' with my clients. I was relieved to first come across the work of Heinz Kohut, then Merton Gill. Kohut (1971, 1977, 1984) has been accredited with combining humanism and psychoanalysis because of the centrality of empathy in his approach (see Kahn, 1997a). Gill (1982) believed that Freud's tenets of remembering in the transference (Freud, 1915) were not sufficient alone to facilitate therapeutic change. To Gill, the value of transference lay in providing the client a chance to re-experience impulses, feelings and expectations, this time around directed towards the therapist (Gill, 1982). To facilitate the therapeutic relationship he encouraged a stance in the therapist of willingness, even determination to discuss the client's feelings and impulses with interest, objectivity, and without defensiveness (see Khan, 1997b, for a review) – which is also a humanistic-existential idea (see Gestalt therapy; Houston, 1995; Perls et al., 1951; Perls, 1969).

To this end, Gill believed that the most power of all was to be found in the client's talk about the relationship with the therapist. The 'Kohutian' and 'Gillian' principles of therapy revealed to me that what clients say (and sometimes do not say) is of great importance to them. A particularly vivid example of this springs to mind, as presented in a psychodynamic process report with Mrs M:

**Client:**  
...Because I've talked to you about things I've never spoken to about anyone in my whole life before... (Tears and sniffles, eventually taking a tissue) And, -and, I suppose it's left me wondering where do I go from here. I mean, I know that's not the way it happens or anything, but it's felt like I've just spilt my story over the past three weeks. I've thought about so many
things that I haven't though about before. (...) And, I suppose I feel a bit embarrassed really.

**Therapist:** So it seems like there is a wish for me to provide you with some rules or guidelines... [I felt very warm towards Mrs M, with a sense that we had established a good working rapport and alliance. In hindsight, these countertransference feelings were most likely a reaction to being flattered, which at the time also masked a sense of helplessness in me, of wanting to help her out and provide an easy solution.]

**Client:** -Well yes, but I know that's not the way it works, or that's what happens, but I just feel so lost in it all I suppose. (...) I mean I think it's really difficult when you haven't been shown how to do things, normally. It reminds me of Christmas when I was at home, and just how awful it was... [Mrs M went on to describe several experiences she had spoken about in our previous session together, leaving me to wonder whether she remembered telling me about these incidents, and either way, what this may have been about. Only at the point of writing up my weekly process notes did I realise that I had also forgotten to record the very same details the week before. In the session, I could only wonder at what I was missing, and responded with:]

**Therapist:** I wonder if you worry that I'll betray you as well, as it feels like others have done in the past...[Said tentatively].

**Client:** Yes, well yes I have worried about that (Tears trickling down her cheeks) because I started thinking 'Oh I wonder what Bella thinks of me, I wonder if Bella thinks that I'm just being oversensitive, or whether she thinks that I'm a waste of time. [In my mind, this seemed to link with material from the previous week, and her possible unconscious fears of overburdening or damaging me. On leaving the session, she had nodded towards the couch beside where she sat, asking me in jovial tone if that was where I took my 'rests'. I now understood her earlier comment to refer to anxieties around lack of containment, and her experience of my momentary 'inattentiveness'.]
I have not presented any background to this example here, as I feel it highlights with
greater clarity Mrs M’s ‘unconscious communication’ in the therapeutic encounter.
Smith (1991) has referred to the merits of this process as useful ‘supervisory
feedback’ from the client. Whilst I strive to remain attentive to such interactions,
actively listening and taking my cues from my clients, my opening remark in the
above vignette is an example of a transference interpretation, where in hindsight, I
appear to have reacted in a manner gratifying to my needs as opposed to Mrs M’s.
Furthermore, my feelings in the countertransference did not appear congruent with my
intervention, and in its harshness, could potentially have damaged or hindered the
therapeutic relationship (Heimann, 1950).

Occasional ‘empathic failures’ (Kohut, 1977) or ‘therapeutic errors’, can nevertheless
provide the points of breakthrough as much as breakdown (Safran, 1993). Fortunately,
my comment prompted a lengthy narrative from Mrs M, but I was still left with a
feeling of ‘missing something’. Feeling rebuked, I was nevertheless reminded of my
lapse via her unconscious communication, and my attention drawn to possible ‘attacks
on linking’ (Bion, 1959). Towards the end of the session, we can see Mrs M’s
reparative instincts seemingly wanting to retain me as her ‘good object’ in the
transference (Klein, 1935, 1946, 1952).

I have found that object relation accounts can be framed in ways which do not
contradict parallel understandings from other sources, such as attachment theory
(Bowlby, 1969) and current cognitive and developmental psychology (see for example
1992). Object relations theory is concerned with the impact of the infant’s earliest
years on personality structure and patterns of relationships. CAT for example,
incorporates ‘cognitive’ elements that are interpreted in a broad sense as referring to
higher mental functioning, including emotions, and that of the organisation of action
or ‘reciprocal role procedures’ (Ryle, 1995). Where CAT leaves earlier versions of
object relations theory behind is in giving emphasis to what is historically accessible
in terms of our relationships with others, rather than suggesting that emotional
difficulties are the result of inner drives and impulses at war with each other (Crossley
& Stowell-Smith, 2000). This model provided me with a useful introductory

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alternative framework for uniting intrapsychic and interpersonal processes understood in terms of cognition, affect, action and communication.

**Cognitive-behavioural perspectives**

When first encountering cognitive-behavioural approaches at the beginning of my third year specialist placement, I was inevitably confronted with the seeming paradox of developing a personal synthesis that could reconcile psychodynamic and cognitive perspectives. I was introduced to the original work of Albert Ellis (1962) and Aaron Beck (1963; Beck et al., 1979, 1985), and the more recent developments in the cognitive paradigm (e.g. Beck, J, 1995; Safran & Segal, 1990; Salkovskis, 1996; Wills & Sanders, 1997). Having been so thoroughly immersed and absorbed in the detailed 'introspective' analysis of therapeutic processes, I initially experienced the concrete and tangible 'tools' of thought records, desensitisation programmes and behavioural experiments etc., as a welcome relief.

Over time, I have learnt to develop a collaborative and/or psychoeducative stance that can facilitate objectivity, without neglecting to pay enough attention to my therapeutic 'rapport'. Weishaar and Beck (1987) consider this a classic pitfall experienced by trainees – a useful lesson to learn from nonetheless: "therapists with less than a full understanding of cognitive therapy may view it as a technique-orientated approach and fail to appreciate the centrality of the relationship between patient and therapist" (p.83). My understanding of this is elaborated in an essay I wrote discussing the suggestion that "In cognitive therapy, therapeutic change is not dependant upon the therapeutic system of delivery but on the active components which directly challenge the client's faulty appraisals" (see academic dossier, this volume, p.27).

Helping clients challenge their 'faulty' appraisals and replace maladaptive behaviours, thoughts and beliefs with new adaptive ones has greatly enriched my understanding of 'case conceptualisation' which is considered a vital first step in the treatment process (Salkovskis, 1996; Wills & Sanders, 1997). This has enabled me to explore the meaning clients ascribe to the events in their lives and the way they experience them. This has also helped me to deal with the tension between the prescriptive nature of traditional cognitive-behavioural therapy and the humanistic and phenomenological value systems which form the basis of counselling psychology practice.
I have found that in paying particular attention to my 'process' (McLeod, 1996), I have come to develop a personal integration between some of the proponents of humanistic, psychodynamic and cognitive paradigms. Drawing on my experiences and increasing psychological knowledge over the past three years, I have found that cognitive-behavioural techniques with a notable emphasis on 'schemas' have further provided a useful framework to assist me in my efforts to work integratively, particularly with severe and enduring mental health difficulties. The following section describes some of the specific techniques I have found useful in my clinical practice.

Theoretical integration in practice
Expanding on Beck's (1967, 1976) original cognitive therapy for depression, schema therapy is "a pioneering integration of cognitive behaviour therapy with gestalt, object relations, and psychoanalytic approaches. It expands on conventional cognitive behaviour therapy by placing more emphasis on the therapeutic relationship, affective experience, and the discussion of early life experiences" (Young, 1999: vii). It should be emphasised however, that many if not all the ideas and techniques that make up this approach have been presented decades before by various authors from different perspectives. Schema-focused therapy, therefore, is an eminently integrative approach (whether or not its proponents say so or prefer to label it 'cognitive' for marketing reasons). The influence of Padesky (1994) and Young's (1999) insights on my practice can be exemplified by my work with Miss A:

Ann, an attractive 20-year-old woman, was referred to the Co-ordinated Psychological Treatments Service with a cluster of presenting problems that appeared vague yet pervasive. Her symptoms included chronic depression since the age of 16, more recent generalised anxiety "worrying about nothing, and panic attacks", social phobia, agoraphobia, frequent tearfulness, low self-esteem and lack of motivation. Her habitual coping strategies involved 'binge-drinking' in order to "blank out" unwanted thoughts, and she appeared highly avoidant of expressing any emotions. She further gave the impression of being a particularly needy young woman, and reported experiences of bullying and a long history of relationship
difficulties, especially with her mother. On previous contact with psychiatric services, she was diagnosed with a borderline personality disorder, following an overdose of sleeping tablets 2-years earlier. An intelligent and insightful young woman, on assessment she demonstrated some keenness and motivation to explore and try to overcome her difficulties in a structured way. Together we explored her desire to reduce the frequency of her 'binge-drinking', and agreed to try to address some of the underlying issues contributing to both her self-destructive behaviours and low self-esteem. A therapy contract of 10-months duration was agreed.

With Ann’s history of interpersonal relationship difficulties in mind, I turned to the research literature as a starting point to support my endeavours. It has been shown that a strong therapeutic relationship consistently affects CBT outcome in depression (Gaston et al., 1991; Marmar et al., 1989), affective disorders (Horvath & Greenberg, 1989; Muran et al., 1995; Raue et al., 1993; Safran & Wallner, 1991), and with addictions (Carroll et al., 1997). For clients who believe that people always let them down, I have found that developing a relationship where the therapist does her best to be reliable and trustworthy, can also begin the process of challenging underlying assumptions and distorted beliefs. This is similar to Winnicott’s (1971) notion of ‘good enough’ mothering or providing a reparative ‘facilitating environment’. My therapeutic relationship with Ann provided her with an arena where she could practice alternative or new behaviours, such as being angry in the ‘here-and-now’ of the session (e.g. with the therapist), and learning gradually to express emotions rather than avoid them.

With its focus on childhood origins and developmental processes of ‘Early Maladaptive Schemas’ (EMS), a schema-focused approach has enabled me to bring together psychodynamic perspectives on attachment theory (Holmes, 1993) with both cognitive-behavioural and experiential techniques. Like insecure attachment patterns (Ainsworth et al., 1978; Main & Solomon, 1986) and ‘bad objects’ (Klein, 1957), EMS (Young, 1999) are considered to be the result of developmentally deficient experiences with parental figures. They refer to extremely stable and enduring themes that develop during childhood or adolescence, which are elaborated throughout an individual’s lifetime.
To summarise briefly, EMS are considered to comprise of memories, bodily sensations, emotions and cognitions, which inevitably serve as templates for the processing of later experience. These unconscious or implicit ‘internal working models’ (Bowlby, 1969) contain representations of both desired and feared interpersonal outcomes that have to be ‘warded off’ (Horowitz, 1991). Hence, despite being dysfunctional to a significant degree, they will strenuously fight for their survival. This is often seen in clients who seem to repeat pervasive self-destructive patterns of behaviours in their daily lives and/or relationships. In the therapeutic encounter, I am careful to stress that it is not the individual who is considered to be ‘pathological’, rather the schema process itself, which has become deeply entrenched through repeated activation so as to become a ‘way of life’. Similarly, I have found it important to emphasise both the adaptive as well as the maladaptive characteristics of the schema.

Some of the specific methods used to trigger schemas in Ann’s sessions included emotive techniques such as imagery, role-play and gestalt ‘empty chair’ techniques (see Arnkoff, 1981). Glickauf-Hughes and colleagues (1996) have shown that “therapeutic gains are most likely to be noted where gestalt techniques are used in tandem with techniques recommended by Object relation theorists (Kohut, 1977; Winnicott, 1965) such as empathy with the client’s feelings and attention to their needs” (p.67). Such interpersonal techniques were used to highlight Ann’s interactions with other people, exposing the role of her schemas.

This necessarily involved making the best use of the ‘here-and-now’ and the ‘transference relationship’, paying attention to the ‘therapeutic frame’ through the maintenance of firm boundaries (Gray, 1994), and ‘observing limits procedures’ (see Green et al., 1988; and Linehan, 1993). The latter usually involves preserving the personal limits of the therapist – the therapist’s sense of self, as it were, according to Marsha Linehan’s (1993) ‘dialectical’ guidelines for working with individuals with borderline personality disorder.

Another of hallmark of schema therapy is its emphasis on psychological case conceptualisation, which is openly shared with the client, and feedback and further
collaborative fine-tuning actively encouraged. I shared my formulation of Ann's difficulties which seemed to originate from the development of insecure/dependant attachments as a child (Bowlby, 1969, 1977), and which appeared to have left her feeling preoccupied and terrified of rejection from others. She agreed she had learnt very early on to overcome her difficulties in social situations with the help of alcohol and/or patterns of emotional and behavioural avoidance. We identified other vulnerability factors which seemed to encapsulate her strong 'need to perform' and fear of exposing her 'real self' (Kernberg, 1975; Kohut, 1971, 1977).

Together we were able to identify and challenge pervasive themes and patterns in her life: primary schemas of 'Self-Sacrifice', 'Approval-Seeking' and 'Subjugation', all seemingly fuelled by fears of 'Abandonment' and 'Failure'. In other words, Ann appeared to focus excessively on the desires, feelings, and responses of others, at the expense of her own needs. She believed this was necessary in order to gain love and approval, maintain her sense of connection, and avoid retaliation. This usually involved suppression and a lack of awareness regarding her own anger and/or natural inclinations. Such 'schema modes' have some overlap with Berne's (1961, 1977) concept of ego states, and can be actively changed through the schema therapy style of empathic confrontation and empathic reality-testing.

Accordingly, I used cognitive techniques to challenge Ann's schema-driven "misconceptions, distorted attitudes, invalid premises, and unrealistic goals and expectations" (Beck, 1967, p.284). Dysfunctional thoughts were identified and the evidence for and against them considered, with the aim of gradually substituting new thoughts and beliefs. I initially anticipated a high level of resistance to change, since schemas represent lifetime patterns of behaviour that inevitably fight for their survival. The construction of flashcards to overcome this difficulty was particularly useful, with Ann encouraged to use these as a reminder and chance to repeatedly verbalise alternative points of view in response to core beliefs like "I am worthless" and "I am unlovable".

With persistent practice at this and other cognitive techniques (challenging of NATS, e.g. "No one will ever talk to me at a party"), Ann's beliefs in her schemas gradually began to weaken over the course of therapy. Concurrently, behavioural experiments
were also employed. Hierarchical lists of social anxiety related situations were drawn up, and over a period of a few months tested out and reported on. In this respect, an empirical approach, insofar as the analysis of evidence for and against her core beliefs, was a critical aspect in facilitating schema change.

In summary, our collaborative and psychoeducative approach facilitated her learning to adopt a ‘third-eye’ objectivity regarding the origins and defensive tactics of her schemas (maintenance, avoidance, and compensation strategies). In turn, this enabled Ann to recognise patterns of behaviour within all her inter-personal relationships, and gradually begin to affect some change. Specifically, this included developing alternative (non-self-destructive) coping strategies, increasing her sense of autonomy and self-esteem, reducing levels of anxiety, all of which in turn, improved her mood.

**Integrating research into clinical practice**

Rowan’s (1990, 1998) criticisms have been influential in developing my own arguments in deconstructing biases, particularly as they relate to DSM-IV’s (APA, 1994) nosological categories. As Irvin Yalom says: ‘The standard diagnostic formulation tells the therapist nothing about the unique person he or she is encountering; and there is substantial evidence that diagnostic labels impede or distort listening’ (Yalom, 1980: 410). Counselling psychologists are in a position to eschew terminology contributing to such conceptual biases. From one perspective, even the most objective diagnoses of clients may be seen as socially constructed discourses that often carry destructive implications (Raskin & Epting, 1993).

Accordingly, my research interests stemmed from previous employment within an adolescent therapeutic community where the majority of young people engaged in self-injurious behaviours (SIB). The research literature on this phenomena, to my mind, seemed particularly biased by gender, cultural and social constructions (see Bowen 1999 – this volume). Many of the psychological ‘treatments’ I reviewed seemed harshly judgemental and prescriptive, and frequently appeared to run the risk of overlooking individuals’ unique feelings and reactions. Furthermore, the ‘medical’ model seemed to apply a knowledge base prescriptively, which by-and-large seemed
only to have revealed *promising* though not definitive positive outcomes (Hawton, *et al.*, 1998).

This highlighted for me the importance of weighing up formal research outcomes, with the idiosyncratic experience of the individual. Adopting a phenomenological approach to research into the experiences and perceptions of adolescent SIB enabled an open-ended inquiry into what constitutes SIB for young self-harmers (see Bowen, 2000 – this volume). In order to understand my participants' intentional world of lived experience, I had to first arrive at it by a suspension, or 'bracketing off', all my presumptive constructs about their behaviour (Aanstoos, 1983).

On a broader scale, practising as a 'scientist-practitioner' implies pushing the boundaries of formal research 'usefully'. My third year investigation was aimed at exploring the attitudes towards adolescent SIB across the broad spectrum of multidisciplinary mental health professionals that come into contact with such young people (see Bowen, 2001 – this volume). This endeavour helped me to better understand what judgements I may import, and equally determine what appears ineffective in my intervention strategies with this vulnerable and/or distressed client group.

**Concluding remarks**

My training has provided me with invaluable clinical experiences, and exposure to a breadth of theoretical and psychological knowledge. In this paper, I have attempted to demonstrate how my approach has matured and become more balanced in my appraisals, i.e., how I have come to integrate theory, research and practice.

To summarise, at this stage in my professional development my approach aims to be integrative, in the sense that it is informed by psychodynamic (Freud, Klein and Winnicott) and person-centred frameworks (after Rogers, 1951), concentrating on past conflicts and current relationships respectively. I also aim to be flexible in my encounters, adapting the degree to which any given session is client versus therapist-led. I monitor this through 'active listening' to the client's narratives as well as my own thoughts and feelings in the countertransference, and tailor my responses
according to the needs of the individual within an ‘interactive model’ (Strawbridge & Woolfe, 1996).

On a final note, I would like to convey my support for Clarkson’s (1994) cyclical model of professional enhancement, where the learning edge or developmental stretch is to pass through the phase of ‘unconscious incompetence’, preceded and followed over and again with a level of ‘conscious competence’ (Robinson, 1974). I hope that I may continue to ‘work through’ the low ebbs of the sequel each time with renewed vigour, striving to achieve competency by repeatedly involving myself in a cycle of continuing education, questioning and research.

Hollander’s (2000) view of the ‘integrationist’ is to: ‘develop connectedness with the different parts of the field, to stand between the various schools, to encourage dialogue and debate, and to find ways of helping each to discover and respect the contributions of the other. In short, [...] to serve as a kind of ‘statesperson’ within the field’ (p.44). To this end, I hope to continue to develop both personally and professionally in my endeavours, aiding the profession to establish some cohesive and/or unifying direction within continuing diversity.
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Research Dossier

Three research reports are included within this dossier, one from each year of the PsychD course. Together they constitute a single research programme which explored the phenomenon of adolescent self-injurious behaviour.

The first paper reviewed the literature in the area and explored some of the gender differences in behavioural presentation and conceptual understanding of self-injurious behaviour. Implications for therapeutic practice with reference to promising therapies with suggested utility for counselling psychologists are also discussed.

The theme of personal discourses and phenomenological experiences of self-injurious behaviour was pursued in the second year research project. Here, the views of adolescent inpatients themselves were explored.

The final research project was concerned with attitudes towards self-injurious behaviour among multidisciplinary mental health professionals and adolescent self-harmers. This project revealed how certain psychosocial variables may affect individual responses towards such acts in therapeutic practice.
GENDER DIFFERENCES IN PRESENTATION AND CONCEPTUALISATION OF ADOLESCENT SELF-INJURIOUS BEHAVIOUR: IMPLICATIONS FOR THERAPEUTIC PRACTICE

Abstract
The UK is reported to have the highest rate of self-injurious behaviour (SIB) in Europe. It is no longer underrepresented in adolescent male populations, and further appears to correlate significantly with the increase in young male completed suicides. Early research suggested mental health professionals view males as being psychologically healthier than females. Gender differences in behavioural presentation and conceptual understanding of SIB may account for such disparity. The fields of counselling psychology and psychotherapy are in the advantageous position of embracing broader perspectives in which to challenge methodological and conceptual biases within existing medical frameworks. Differential gender biases in the nosology of comorbid conditions, psychodiagnosis, and treatment decisions are identified. Mental health workers across disciplines continue to find the management of SIB a challenge despite the wealth of theoretical models available to inform practice. Some techniques and promising therapies (Dialectical Behaviour Therapy and Problem-Solving Therapy) are highlighted as practicable approaches for counselling psychologists. Conclusions reveal future research may benefit from incorporating broader definitions of SIB expressed across the sexes. Further investigation into treatment efficacy with particular emphasis on the impact of gender role socialisation is also indicated.
Introduction

There is an extensive literature on self-injurious behaviour (SIB), scattered widely within the domains of psychiatric and mental health journals. Most clinical writings are grounded in medical-based models, placing emphasis on categorisation and a tendency to view the person as a symptom of their problematic behaviour. This does not accord easily with the more humanistic roots of counselling psychology and its primacy on the psychotherapeutic relationship. Counselling psychologists and psychotherapists working with clients along a continuum from outpatient settings to inpatient care are likely to come across adolescent self-harm in a multitude of forms. In order to plan and provide effective interventions, an ‘integrative conceptual framework’ must draw from a multitude of theories and resources available.

Therapists are in a position to ‘clear a space’ for additional alternative investigations. These may include theories and ‘readings’ of social reality, which collectively offer fresh possibilities for psychological research and practice (Neimeyer, 1998). Emphasis on and concern for clients’ perceptions and their internal events, further highlight the ways in which individual experiences cannot be separated from social, cultural, and historical processes, particularly those of gender biased constructs and contexts.

This article will present a synthesis of the literature, describing and defining the nature of SIB in the context of adolescence and young adulthood. It will examine the legacy of methodological and conceptual bias in modern research today – including differential sex bias in diagnostic classification and, how different sets of assumptions affect the treatment received by young male and female self-harmers. The review will also consider some of the methodological difficulties in establishing incidence and prevalence, with particular emphasis on the seemingly striking differences in presentation across gender. Finally, it will examine some of the therapeutic models psychologists use to inform their practice, and explore the effectiveness of treatments from outcome studies.
Clinical Definitions of SIB

SIB can encompass a broad array of acts. Historically, conceptual and linguistic confusion has often resulted from using various terms to describe similar behaviours. 'Self-mutilation' is a commonly used term, and the most frequently cited definitions appear to be Walsh & Rosen's (1988) "deliberate, non-life threatening, self-effected bodily harm or disfigurement of a socially unacceptable nature" (p.10); and Favazza's (1989) "complex group of behaviours in which there is deliberate, direct destruction or alteration of body tissue without conscious suicidal intent" (p.13). Both these definitions stipulate excluding behaviours such as overdosing or swallowing objects from their category, justified by the fact that they do not result in visible harm.

Seemingly polarised in the literature, the term 'deliberate self-harm' has been used to include intentional self-poisoning or self-injury, irrespective of the apparent purpose of the act (Hawton & Catalan, 1987). In a recent UK study Hawton and colleagues illustrated that self-poisoning – for example an overdose of analgesics – appears to be the most common form followed by cutting (Hawton et al., 1997). Both behaviours were among the top five causes of acute medical admissions across the sexes during the period 1976-1990 (Hawton & Fagg, 1992). However, it could be argued the term 'self-injurious behaviour' (SIB) is preferable because it accommodates the variety of self-destructive acts which knowingly invite physical injury, whether overt or covert, and which typically arouse feelings of shock and alarm in those who witness them.

In more specific nosological terms, Favazza & Rosenthal (1993) classified three types of self-mutilation based on the severity of the act: major, stereotypic, and superficial. Major self-mutilation is the most extreme and uncommon form. It consists of infrequent acts and often results in permanent disfigurement (for example, castration, limb amputation, enucleation of eyes). It is most often associated with psychotic or acute intoxicated states. Stereotypic self-mutilation consists of fixed, often rhythmic patterns of expression, seemingly devoid of symbolism (such as head banging, eyeball pressing, and finger or arm biting). It is most commonly seen in institutionalised persons with learning disabilities but also occurs in autistic and schizophrenic individuals, as well as those with other genetic syndromes (Deb, 1998). Superficial or moderate self-mutilation is the most varied type and, although a significant indicator of distress, results in comparatively little tissue damage. Nevertheless, it can include
cutting, burning, needle-sticking, hair-pulling, bone-breaking, hitting, deliberate overuse injuries, and interference with wound healing as a means of self-inflicted damage.

More recently, superficial self-mutilation has been further broken down into compulsive, episodic, and repetitive types (Favazza, 1996; 1998). Compulsive self-mutilation is more closely associated with obsessive-compulsive disorders. Compulsive acts may be seen in persons trying to relieve tension or prevent something bad happening to them. Both episodic and repetitive self-harm are impulsive acts, and the difference between them seems to be a matter of degree (Herpertz et al., 1995; 1997). What begins as episodic (engaged in every so often by people who do not think about it otherwise and do not identify as ‘self-injurers’) may escalate into repetitive self-mutilation.

It is further argued that SIB may be conceptualised as a disease in its own right and not merely a symptom of a comorbid condition. To define a disease however, we should be able to ascertain the aetiology of symptoms and predict the outcome, and SIB does not appear to fit into this category. There is currently a proposed diagnostic category called the ‘Repetitive Self-Harm Syndrome.’ Many practitioners (Alderman, 1997; Favazza & Rosenthal, 1993; Kahan & Pattison, 1983, 1984) believe certain behaviours should be classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; APA, 1994) as a separate Axis I impulse-control disorder, not as an Axis II personality disorder. Given that SIB often occurs without any apparent disease and sometimes persists after other symptoms of a particular psychological disorder have subsided, there are grounds to review the current nosologic classification system. This view has some evidential support. Favaro & Santonastaso (1998) used factor analysis to distinguish between the nature of compulsive and impulsive acts in a study of bulimics who self-harm. They reported that suicide attempts, substance abuse, laxative abuse, skin cutting, and burning loaded on the impulsive factor.

In light of this common clinical picture presented by repetitive self-harmers, the acute versus chronic nature of the behaviour itself may be characterised by different cognitive, interpersonal and intrapsychic processes (Clark & Fawcett, 1992; Maris,
Rudd *et al.* (1996) have suggested the need to consider repetitive self-harmers as a group characterised by elevated suicide risk, both with respect to the breadth and duration (i.e. chronicity) of comorbid Axis I diagnoses, and severity of symptoms. This has important theoretical implications in terms of understanding the motivation and intent of the behaviour itself, as well as the more precise prediction of subsequent attempts, and even eventual suicide.

**Differentiating SIB & Suicide Attempts**

There are differences in conceptualisation between self-harming and suicidal behaviours. Major reviews have upheld the notion that they are distinct (Favazza 1998; Feldman, 1988; Tantam & Whitaker, 1992; Winchel & Stanley, 1991). Suicide attempts are reported to provide little relief, to be repeated less frequently, and to have less communicative value (Van der Kolk *et al.*, 1991). An underlying cognitive assumption holds that a person who truly attempts suicide seeks to end all feelings whereas a person who self-harms seeks to ‘feel better’. Considerable research points to the highly communicative quality of certain types of SIB (cutting and overdosing), particularly in younger and female populations (Collins, 1996; Coombs *et al.*, 1992; Handwerk *et al.*, 1998; Leenaars, 1992). These generalisations have been applied to both sexes with little equivalent study being undertaken into distress communicated through other forms of SIB by young male populations.

Teenage incidences occurring within interpersonal contexts are frequently cited as examples of attempts to influence another person’s affection (Hawton *et al.*, 1982; Topol & Reznikoff, 1984). The further understanding is that in instances where SIB is used to elicit desirable behaviours from others in the environment, or used to communicate anger or distress, the reactions of others may also reinforce the behaviour.

Goldney (1981) reviewed the research evidence and concluded that those who carry out deliberate self-harming acts of high potential lethality are at greater risk of subsequent suicide. Repetitive self-cutters in particular have been shown to suffer social ostracism, and in desperation may attempt suicide (Favazza & Conterio, 1988). Thus, although SIB may not be originally suicidal in intent, therapists need to remain aware of the potentially confounding vulnerability and protective factors.
Prevalence

There are numerous methodological problems in establishing the incidence and prevalence of SIB. It is difficult to gain an accurate picture of the epidemiology, since Oxford (Hawton, 1992; Hawton et al., 1994, 1996, 1997) and Edinburgh (McLoone & Crombie, 1996) are the only two UK centres with a continuous monitoring system. Even with a national cohort, statistical estimates are crude since most incidences of SIB never come to service attention. This is because acts are frequently carried out in secret, and wounds may be superficial and easily treated by the individual (Gardner & Chowdry, 1985).

Another aspect is that sample studies are not always representative of the larger population. Presentations may not be in recognised or agreed forms within and across the spectrum of professions traditionally encountering SIB. Most of all, studies do not take into account differences in expression across gender. Data come largely from hospital attenders, not inclusive of community samples, and most research has been conducted on deliberate self-poisoning rather than inclusive of other forms of SIB such as cutting.

Cross-national comparison studies by the WHO/EURO multicentre study on parasuicide from 15 European countries continue to gather estimates for parasuicide (defined as an act of deliberate self-harm) for all ages (Platt et al., 1992). Figures of admissions come from a wide range of health facilities where SIB is likely to be treated. Mean annual incidences across sites in the year 1989 were 222 per 100,000 for females and 167 per 100,000 for males. Schmidtke et al. (1996) reported that the UK has the highest rate of SIB among 15–24-year-olds in Europe. They found the mean suicide attempt rate for the years 1989 to 1992 in these centres was 193 per 100,000 for young women and 140 per 100,000 for young men, for a female to male ratio of 1.4:1. As with other estimates based on treated samples, these figures are likely to be underestimates due to non-treated attempts.

According to Hawton et al. (1997), the most reasonable current total UK estimates are around 400 per 100,000 population per annum. In reviewing trends in deliberate self-harm between 1985-1995 (n = 7437 following 10,631 episodes of SIB) they found a substantial increase in rates and repetition in both genders during the 11-year study
period. This amounted to a 62.1% increase in males and a 42.2% increase in females; the largest rise was in 15-24-year-old males (+194.1%). Changes in SIB rates correlated with changes in national suicide rates in both males and females in this age group (Spearman's rho = 0.60, \( P = 0.053 \) for males, and rho = 0.58, \( P = 0.06 \) for females).

Weissman et al. (1999) attended to some of the sampling criticisms, and presented a direct comparison between rates of suicide ideation and attempts from community household surveys conducted in 9 countries around the world in the 1980s. They summarised that the well-documented increased risk of completed suicide in men, as compared to women, and the closer sex ratios for suicidal ideation than attempts, suggest that the risk reflected in ideation is similar between the sexes but that the outcome differs. These studies highlight that the variability of rates across sites and countries is most likely due to cultural features (whether in the translation of research questions being misunderstood, and/or a difference in conceptualisation of the behaviours).

There remain widely opposing views as to whether the gender paradox in SIB (with differential definitions between suicide ideation, attempts, and completion) is a real phenomenon, or merely the artefact of bias in data collection (Canetto, 1997). Some of the differential rates obtained between the sexes regardless of intent may in part be due to the different methods employed (e.g. hanging for men, pills for women). Adolescent males use more lethal methods in their suicide attempts than the same aged females (Black, 1986; Hoberman & Garfinkel, 1988) and, although males make fewer attempts (Lester, 1990), they are more often successful (Borst & Noam, 1989; Hawton & Fagg, 1988). Explanations for this are reviewed later, and may arise from gender ideologies and socialisation practices that vary greatly by culture and historical periods (Krushner, 1995; Unger & Crawford, 1996; Zinn et al., 1997).

**Difficulties with Diagnostic Classification**

The diagnostic classification of mental disorders is currently being debated in preparation for the next edition of the *DSM-IV* (APA, 1994). In relation to SIB it disregards etiology, and therefore is subject to change over time as our knowledge
increases, especially with ongoing research into biological mechanisms and markers. More generally, a critique of the manual is that classification is simplistic, as are all phenomenological classes. It is also argued that bias in sampling procedures and in the diagnostic criteria themselves were prevalent in the original methodology of establishing conditions and categories (Hartung & Widiger, 1998). Specifically, accurate estimates of differential sex prevalence are difficult to obtain and are subject to substantial dispute and controversy (Eagly, 1995; Widiger & Spitzer, 1991).

The focus on diagnostic classification and mental illness definitions could be seen as inimical with a counselling psychology approach. Nevertheless, therapists need to attend to such issues as it has a bearing on how an understanding of SIB has been constructed and reconstructed with reference to scientific and medical knowledge to date. Systematic sex biases may be the result of failures born out of the evolution of such medical-based practice despite well-intentioned efforts (Hartung & Widiger, 1998). Notwithstanding numerous other limitations, the DSM-IV's clinical usefulness is evident in its descriptive categories. It provides a comparative reference point for health professionals and a mutual language of meaning. Within this context, deconstructing conceptual gender biases, and the impact of value judgements on actual experiences and intrapsychic cognitions of adolescent self-harmers, can be useful in the therapeutic encounter.

*Research Methodology Bias*

Differential sex prevalence rates of SIB are likely to be dependent on too many variables to determine with any complete sense of satisfaction. Methodological research biases include, but are not limited to: sex difference in willingness to seek treatment; ability or willingness to acknowledge the disorder's presence (i.e. need for help); reactions of others to the syndromes (societal and cultural taboo); and presence of co-morbid disorders or conditions that affect the likelihood of seeking or receiving treatment.

Contrary to some authors' views, the differences that do occur may not simply be a reflection of sexism in society (Kaplan, 1983) or researchers themselves (Caplan, 1995; from biased sampling in clinical settings), but rather reflect differences that are independent of sex-related differences in the etiology of a disorder. Reports of SIB in
the form of tricho-tillomania (hair pulling) for example, are exaggerated in women. This finding is noted to reflect potential “differential treatment seeking based on cultural or gender-biased attitudes regarding appearance (e.g.) acceptance of normative hair loss among males” (APA, 1994, p.620) rather than a true sex ratio for the disorder.

Attending to further sampling criticisms, whilst SIB (particularly self-mutilation) has predominantly been seen in women in psychiatric clinics, Back-Y-Rita (1974) commented that when one turns from hospital admissions to police records the situation reverses. A study of 432 adolescents in a long-term stay facility in Georgia, USA, investigated the impression that male self-harming incidents were more indicative of imprisoned adolescents’ pervasive maladjustment than of a discrete psychiatric episode (Chowanec et al., 1991). SIB in this instance was best understood as a poor problem solving strategy for handling psychological distress.

Comorbidity and SIB
Differential diagnosis associated with SIB is most common among the personality disorders of Axis II in DSM-IV. Within the “dramatic-emotional” cluster B dimension, definitions inclusive of a broader conceptualisation of SIB can be identified. These include a tendency to be aggressive with a reckless disregard for personal safety – in antisocial personality disorder (Virkkunen, 1976); inappropriate anger and impulsive self-harming behaviour – in borderline personality disorder (BPD; Schaffer et al., 1982); and a pervasive pattern of excessive emotionality and attention-seeking behaviour often through physical appearances – in histrionic personality disorder (Pfohl, 1991). The only direct reference to self-mutilation or suicidal threats in the current DSM-IV is located as a sub-section entry of BPD.

Problems arise with those clients who do not meet at least five other diagnostic criteria for BPD besides displaying impulsivity in at least two areas that are potentially damaging. Individuals with this disorder may “binge eat, abuse substances, engage in unsafe sex, or drive recklessly...display recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour” (APA, 1994, p. 651). This diagnosis is generally inappropriate for the ‘sub-clinical’ self-harming clients who are encountered in psychotherapy or counselling psychology practice (Turp, 1999).
Additional Axis I (clinical) and Axis IV (psychological or situational) comorbid conditions are also frequently indicated. SIB has been recognised as an associated symptom of a variety of disorders: Post-traumatic Stress Disorder (PTSD) after rape (Greenspan & Samuel, 1989) and war (Pitman, 1990); Multiple Personality Disorder (Dissociative Identity Disorder – Coons & Milstein, 1990); eating disorders (Favazza et al., 1989; Parkin & Eagles, 1993); Addison's Disease (Rajathurai et al., 1983); depersonalization (Simeon et al., 1992); substance abuse (Wylie et al., 1996); alcohol dependence (Merill et al., 1992; Suokas & Lonnqvist, 1995); and depressive disorders (Newson-Smith & Hirsch, 1979). The most frequently encountered statistical overlaps are between self-harm, eating disorders, substance/alcohol abuse, and violent outbursts (Arnold, 1995; Fonagy & Target, 1995). Women tend to be over-represented in the first two categories and men in the latter two.

Gender Bias in Psychodiagnosis

Certain personality disorders (e.g. antisocial personality disorder) are diagnosed more frequently in men. Others (e.g. borderline and histrionic personality disorder) are diagnosed more frequently in women (APA, 1994). Although the differences in prevalence probably reflect real gender differences in the presence of such patterns, research has indicated over- and under-diagnosis in groups of clinicians given identical symptomatology case histories, except for the designation of gender (Adler et al., 1990; Ford & Widiger, 1989). This is most likely because of social stereotypes about typical gender roles and behaviours.

The percentage of females with diagnoses of histrionic personality disorder has been found to be higher when diagnoses are made on the basis of unstructured clinical interviews or self-report measures (81%) than when diagnoses are made by using semi-structured interviews (69%; see Corbitt & Widiger, 1995, for a review). Unfortunately, empirical evidence indicates that clinicians frequently do not attend to diagnostic criteria (Harper, 1994; Widiger & Trull, 1991). Instead, this representative heuristic seems to reflect how many clinicians make a diagnoses (Garb, 1996). Thus, it would appear that oftentimes a constructed gender-biased ‘hunch’ may carry more salience than any clinical evidence of symptomatology.
The effect of gender bias has been particularly salient for the diagnosis of BPD (Adler et al., 1990; Ford & Widiger, 1989; Garb, 1995; Henry & Cohen, 1983; but see Becker & Lamb, 1994). DSM-IV recognises that BDP is diagnosed predominantly (about 75%) in females. Similarly, antisocial personality disorder diagnosed from the age of 18 (and its equivalent childhood- and adolescent-onset conduct disorder) is said to be “much more common in males” (APA, 1994, p.647 and p.88 respectively). The prevalent pathological components of recklessness or risk-taking behaviour (also stated as impulsive in nature) may simply reflect SIB expressed differently across boys and girls. Even the expression of conduct disorder in girls is said to take different forms (Eme & Kavanaugh, 1995; Goodman & Kohlsdorf, 1994; Robins, 1986; Zoccolillo, 1993). Antisocial personality disorder may be underrepresented in females, particularly because of the emphasis on aggressive items in the definition of conduct disorder.

**Treatment Decisions Related to Gender**

Garb (1997) undertook a comprehensive review of potential biases in clinical judgement and treatment decisions. Little evidence of gender bias occurred when clinicians read case histories and rated the appropriateness of hospitalisation for adolescents who had attempted suicide (Morrissey et al., 1995). In contrast, the effect of client gender has been found to be significant when clinicians make decisions about hospitalisation for adults, at least under some conditions – in particular diagnostic categories. When individuals were diagnosed as having comorbid psychotic depression or neurosis, 66% of the males and 43% of the females were hospitalised. When individuals were diagnosed as having comorbid personality disorder and/or a substance abuse disorder, 50% of the females and only 18% of the males were hospitalised (Rosenfield, 1982).

The effect of gender also varied by diagnostic category in another study (Baskin et al., 1989). Female prison inmates, but not male prison inmates, were more likely to be placed in a mental health facility when they expressed violence towards themselves or others. Male inmates were more likely than female inmates to be placed in a mental health facility when the presenting complaint was depression. It would appear that when individuals deviate from perceived stereotyped gender role behaviour (i.e. 97
aggressive females and depressed men), they are seen as being at greater risk or in need of additional mental health supervision.

Within psychiatric services negative attitudes towards people who self-harm in particular have been highlighted (Brogan et al., 1998). Clients with a diagnosis of BPD are frequently treated as outcasts by clinicians, or 'flagged' under this term to indicate to future care-givers that someone is difficult to treat or a troublemaker (Herman, 1992; Hogg & Burke, 1998). Whilst BPD is not construed as a self-inflicted disorder, these individuals often suffer the stigma of their 'behaviour' being seen as undeserving and detracting from the clinical care of others whose illnesses are not perceived as self-inflicted (Creed & Pfeffer, 1980). This highlights the negative consequences of labelling from diagnoses which are hypothetical constructs inferred partly from client/patient/inmate self-reports, which often ignore socio-political dimensions, and tell us little about the individual person or their social context.

Research on behavioural prediction tasks has revealed that where the effect of gender is significant, prognostic ratings are more favourable for female clients than male clients. Again, this is the case when clients are described by the same case histories except for the designation of gender (Fernbach et al., 1989; Hansen & Reekie, 1990; Teri, 1982). It would appear that gender role expectations do play a significant role in how self-injurious adolescents are treated, with the added implication that men who self-injure are taken more “seriously” by mental health clinicians (Barnes, 1985). Thus, how a client’s experiences are understood and conceptualised inevitably affects the style of treatment philosophy a psychologist may adopt.

Issues of care must go beyond the immediate treatment of physical conditions. This raises the question whether SIB can be treated homogeneously when in effect regardless of gender, they represent a heterogeneous population (Khan, 1987; Spirito et al., 1987). On hospital admission, more boys than girls are sent to psychiatric wards, and boys are proposed follow-up care more frequently than girls. On the other hand, boys and girls are not treated differently with respect to psychiatric consultations during hospitalisation or co-ordination with external care (Gasquet & Choquet, 1993).
Perhaps a more controversial approach to increasing male use of services would be to modify psychotherapy and counselling services to be more congruent with masculine socialisation (Good & Wood, 1995). One such change would be to focus less on emotional expressiveness and more on instrumental changes and control (e.g. Ipsaro, 1986). Such a change would be consistent with Robertson & Fitzgerald's (1992) finding that men with greater 'male gender role conflict' are more interested in services such as workshops, seminars, and videotape libraries than they are in traditional one-to-one therapy activities.

Though the effects of client gender may generally be absent when clinicians make decisions regarding the type of psychotherapy (e.g. based on individual, group, or family therapy; length, approach, and theoretical model – Hansen & Reekie, 1990; Murray & Abramson, 1983; Oyster-Nelson & Cohen, 1981; Rabinowitz & Lukoff, 1995; Stearns et al., 1980; Wrobel, 1993), one can speculate about when gendered treatment bias is most likely to occur. One study revealed that female clients were more likely to be seen in individual therapy, whereas male clients were more likely to be seen in group therapy for the more typically male orientated diagnosis of antisocial personality disorder (Fembach et al., 1989).

It has also been shown when assigning clients to therapists, clients are likely to be assigned to therapists of the same sex (Schover, 1981; Shullman & Betz, 1979). Such matching is arguably useful for promoting 'empathetic understanding' within the therapeutic alliance (Rogers, 1975). It may further permit the therapist to identify more readily with the clients' gender role socialisation, implicit concepts of self, and vocabulary. Other instances of gender and treatment bias will undoubtedly be found in the future, but they are not apparent now.

**Conceptual Bias Across Gender**

Historically, society has viewed and rewarded men for individualism and independence, essentially minimising relationship factors in their lives. Early research suggested that mental health professionals viewed males as being psychologically healthier than females (Broverman et al., 1970). To date, such popular representations are maintained in the wider context of women generally seeking more psychological help (Deane & Chamberlain, 1994; Deane & Todd, 1996). Women's problems are
conceived of as personal ones, and are dealt with via the mental health system whereas men’s problems are seen as social ones (as an indication of cultural, economic, or social malaise) and are dealt with via social services and the legal system (Canetto, 1991, 1997). Thus, how a person has been socialised, rather than biological sex, can have a powerful effect on how that person expresses distress through SIB, and from where they receive treatment (Jack, 1992).

Although not solely a feminist issue, feminist critiques have postulated that the study of gender and suicidal behaviour has been based on the theory that men and women’s inherent natures are different. The implicit assumption is that a woman’s nature is viewed as ‘weak’, whereas a man’s nature is viewed as ‘strong’, and therefore superior (Range & Leach, 1998). In a series of papers, Canetto (1991; 1992; 1992-1993; Canetto & Lester, 1995) discusses traditional thinking in the major English-speaking countries (UK, Australia, USA, Canada). She concludes that women ‘attempt’ suicide out of love, whereas men ‘commit’ suicide out of pride. Thus, constructing a view of SIB that does not result in death (often called attempted suicide or parasuicide implying that the act was a failure) is labelled negatively and seen as a female phenomenon. In contrast, suicidal acts that result in death (often called completed suicide implying that the act was a success) are labelled positively within a male phenomenon, even though the person dies.

Counselling psychologists and psychotherapists are in a position to eschew terminology contributing to such conceptual bias. From one perspective, even the most objective diagnoses of clients may be seen as socially constructed discourses that often carry destructive implications (Raskin & Epting, 1993). Adopting a broad social constructionist position can lead to epistemological difficulties (see Burr, 1995; and Neimeyer, 1998, for reviews). For the client in therapy however, the recognition of multiple versions or constructions of “truth” – particularly with reference to the situational context of gender – can be a liberating and empowering experience (Bordo, 1990; Sexton, 1997; Worell & Etaugh, 1994).

Discursive analytic approaches have successfully been adopted within constructionist therapeutic contexts (Kaye, 1996; McNamee & Gergen, 1992). Such approaches deconstruct clients’ language use, its functions, and notions of “objectivity”. A
primary goal for constructionist ‘counselling’ is for therapists to help clients see their problems as separate entities from themselves, externalising the problem, rather than viewing SIB as a central part of their identity – as Epston & White (1995) discovered.

Within the recurrent motifs and construction of increased “crisis” in male mental health, men appear to enact stereotypes of masculinity, commonly perceived as being strong, not seeking support, and not confiding in others (Coyle & Pugh, 1998). Such traditional cultural influences are believed to have dictated trends that men do not express their feelings (Coyle & Morgan-Sykes, 1998). These and other gendered notions may shed light on the interpretation that men do not readily use their emotions as a resource in either the public or private sphere (Hothchild, 1983).

It may be that men’s embodied fear is that they will be seen as feminine or attention seeking like girls. Equally confounding the situation, their expression of SIB may be labelled delinquent or aggressive within negative masculine constructs. This might explain why fewer men as opposed to women actively seek/are referred for psychological support. Only when men have reached a stage of desperation and not given in to the impulsive nature of their distress by completing suicide, may they then turn to psychotherapeutic options.

Precipitating and Risk Factors

From an empirical perspective, causes of SIB are likely to be multiple, combining social, developmental, psychological, and biological factors. Adolescent SIB, more often than not, has identifiable precipitating events that have a direct and discernible impact on the adolescent’s identity, sense of autonomy, and independence (e.g. conflict with family or peer group, peer group status change, social isolation or rejection: Berman & Jobes, 1993).

Walsh & Rosen (1988) examined the relationship between background experiences and risk factors. These included loss of a parent, childhood illness, physical and/or sexual abuse, marital violence, and familial SIB. All variables significantly correlated, yet the strongest links were noted with a history of abuse and witnessing marital violence. Significant conditions ‘triggering’ self-injury during adolescence were recent loss, peer conflict, intimacy problems, body alienation, and impulse disorder. In
light of these symptoms, we are again reminded BPD is the most commonly assigned diagnosis with individuals who have been subject to abuse – not always sexual – in childhood (Kernberg et al., 1989; Linehan, 1987; Schaffer et al., 1982; Simeon et al., 1992).

Theoretical Models of SIB
SIB can be understood in many different ways emphasising the co-existence of a multiplicity and variety of situation-dependent ways of life. Some accounts seek to locate self-mutilation in terms of psychiatric diagnoses, some focus on antecedent causes, whilst others concentrate on the function and meaning of self-harm. A full review of psychological models is beyond the scope of this article – and has been well documented elsewhere (see Favazza, 1989, 1998 and Suyemoto & MacDonald, 1995). The social factors relate to the immediate world of the adolescent today. SIB in the community is thought to be on the rise along with an increase in depression among this age group (Diekstra & Garnefski, 1995). Youth culture reflects much of this in its music and other forms of social identity representations. There are increasing examples of the more socially acceptable forms of self-mutilation in schools, and on the streets – tattoos, pierced noses, tongues, and multiple ear piercing (Favazza, 1996). This is not to minimise the seriousness of SIB, but to raise the question of what cultural influences are also present. It has been argued that the increase in self-injury may reflect a larger increase in societal distress (Eckersley, 1993; Lester, 1998).

Another perspective is to see it cognitively. The psychological determinants of negative affect (depression, anger, and anxiety), and cognitive biases (hopelessness, low self-esteem), have long been recognised in relation to SIB (Pinto & Whisman, 1996). The experiences of deprivation, rejection, or loss of love, are presupposed to develop into feelings of anger or resentment towards the person responsible and subsequently to be internalised and directed additionally at oneself. These angry and aggressive feelings are said to lead to guilt and a sense of worthlessness. It is precisely this sort of process material that is potentially of greatest use in constructing formulations and designing interventions within therapeutic settings.
A marked difference in the conceptualisation of SIB is the nature of aggression and towards whom it is expressed. Women are over-represented in the so-called internalising disorders, in which the pain and hostility are turned inwards. Men, on the other hand, are over-represented in the so-called externalising disorders, for example involving some degree of external destructive behaviour (Miller, 1994). For this split to be made so rigidly seems contradictory. In some ways, all SIB is a kind of 'internalisation' in the form of self-punishment (hence, the original term “anger turned inwards” – Cain, 1961). In other ways, SIB presents like an ‘externalising’ disorder because it involves a degree of aggression and the defiance of social, religious, and sometimes legal prohibitions (as viewed by behaviourists in the need to expel or relieve tensions – Gemma, 1989).

The medical model in the past has tended to pathologise and focus on the problems or weaknesses of adolescent self-harmers. A recent alternative has been to consider the individual engaged in SIB as capable or resilient. There is increasing evidence that superficial self-mutilation can be understood as a maladaptive attempt at self-help (Favazza, 1989; Favazza & Rosenthal, 1993), or morbid form of coping (Favazza, 1998). It provides rapid (although temporary) relief from overwhelming psychological distress. Release of tension, acquiring control, reconfirming the presence of one’s body, dulling feelings, and converting unbearable emotional pain into manageable physical pain, are commonly cited reasons for SIB (Callahan, 1996).

The theory-practice link indicates that a substantial proportion of self-harming adolescents feel unable to generate solutions to their problems, or show inaccuracies in the appraisal aspects of problem solving in the face of high life stress (Wilson et al., 1995). Haines & Williams (1997) found that self-mutilators reported greater use of ‘problem avoidance’ as a coping strategy and perceived themselves to have less control over problem-solving options, particularly when presenting with low self-esteem and low optimism about life. These feelings of disempowerment may reflect the chronic invalidation many self-injurers have experienced.

How SIB manifests itself depends on different coping and personal management styles. Inconsistent gender differences in coping styles have been found (Folkman & Lazarus, 1980, 1982; Lazarus & Folkman, 1984). Frydenberg & Lewis (1991) report
that girls are more fatalistic and resigned to difficult circumstances, whereas boys are more aggressive and private in their activities. This supports the notion that girls and boys are socialised differently into expectations of what constitutes acceptable and unacceptable ways of coping with problems, and the potential style of SIB engaged in across the sexes (Canetto, 1997).

To ground this in the light of adolescent development is to examine the underlying assumptions behind differences in maturing boys and girls. Girls are reported to mature faster than boys during puberty (Petersen & Taylor, 1980), and this may affect their views about the harm they may be doing to their bodies. Girls may be more realistic in their appraisal of the consequences when considering increasingly dangerous methods, albeit effective ones, of tension release. At face value, this would account for the reported differential gender rates of SIB, suicide attempts, and completed suicides (Rudd et al., 1996).

Taken in conjunction with the perceived ‘femininity’ of non-fatal SIB and the association between masculinity and killing oneself, some coping strategies should perhaps be challenged. Following explicit assessment of the adolescents’ beliefs about gender and suicidal behaviour, it may be beneficial to confront the notion that cutting, for example, is a relatively acceptable way to deal with difficulties in females, and to reduce the stigma of surviving a suicide attempt in males.

**Implications for Therapeutic Practice**

There are questions around whether differences in treatment strategies should apply across genders, despite evidence that those exhibiting SIB are traditionally reluctant, difficult, and resistant to treatment programmes (Aronson et al., 1989). The impact of male socialisation on the therapeutic encounter has shed light on men’s lesser willingness to participate in therapy (Betz & Fitzgerald, 1993). Accordingly, clients’ difficulties need to be addressed in an understanding environment, exploring constructions of gender identity within realistic societal and cultural demands.

There are several treatment options available to the counselling psychologist working with the self-harming adolescent. Psycho-educative, psychosocial, and problem-
solving approaches have proven utility – particularly in terms of reducing direct outcome measures of suicidal ideation and repeat attempts; but also for indirect measures such as depression, anxiety, hopelessness, or the continued need for emergency services (Blackburn et al., 1981; Lerner & Clum, 1990; Linehan, 1993; Rudd et al., 1996). An in-depth exploration of the literature revealed that (despite differential treatments received and reported as gender bias) there are no gender specific therapeutic approaches advocated across the sexes that have been measured on outcome.

Consistent with existing standards of care however, the assessment and therapeutic aims essential in working with SIB can be organised into four broad categories: (a) diagnosis, (b) assessment, (c) treatment, and (d) safeguarding/protection of the client (Berman & Jobes, 1992; Bongar, 1992; Jobes & Berman, 1993). From the limited research available to date, Rudd & Joiner (1998) developed an integrative conceptual framework organising and emphasising these important treatment targets regardless of therapeutic orientation. They include crisis intervention in the form of symptom relief and crisis resolution during the beginning phase of therapy; a short-term agenda of skill development during the middle phase of therapy; and a long-term agenda of working on self-image and interpersonal functioning during the end phase of therapy.

This has important implications for psychologists and therapists, where although the mechanism of action may vary from clinician to clinician (i.e. the psychotherapeutic model), the content of therapy (i.e. assessment and treatment agendas) should essentially be identical given both the nature of the problem being targeted and the consistency of applicable research. This fundamental assumption is consistent with emerging empirical support for relatively broad-based integrative approaches to treating SIB (e.g. Linehan, 1992; McLeavy et al., 1994; Salkovskis et al., 1990; Van der Sande et al., 1997).

**Outcome Studies**

In a 1998 review of controlled studies, Hawton et al. evaluated the effectiveness of ten different approaches to treating SIB: intensive education and outreach, provision of a special crisis card enabling faster treatment in Accident and Emergency (A&E), problem-solving therapy, and dialectical behaviour therapy (DBT) were compared to
standard aftercare; inpatient behaviour therapy was compared to inpatient insight-oriented therapy; admission to hospital was compared to discharge after A&E visit; flupenthixol (fluanxol, an anti-psychotic drug with severe potential side-effects) and antidepressants were each compared to a placebo; follow-up by the initial treating therapist was contrasted with follow-up by a different therapist; and long-term therapy was compared with short-term therapy.

No intervention produced a statistically significant reduction in repetition, although for some there was a trend in that direction. The heterogeneity of the varied trial aims meant that little pooling of the data was possible. Trials tended to recruit highly selected client groups in small numbers, limiting the representativeness of self-harming populations. Particularly marked was the very low number of males included in the cross section of studies. Despite a host of other methodological and conceptual criticisms, reductions in SIB were nevertheless reported in several studies.

The flupenthixol study showed a reduction in repeat self-harm, but it was a very small study and there is some concern that the possible side effects of fluanxol outweighed any benefit. Providing individuals with an emergency support crisis card – which carries advice about seeking help in the event of future self-harming or suicidal feelings – proved encouraging for reducing repetition rates (Cotgrove et al., 1995; Morgan et al., 1993). For the applicability of psychotherapeutic treatment in the latter instance, agreed goals or strategies may be negotiated together in assessment consultation. The two most promising interventions highlighted by Hawton et al. (1998) are summarised below:

**Dialectical Behaviour Therapy**

The first of these is dialectical behaviour therapy, so termed because it combines the need for change in behaviour with acceptance of negative feelings. This method was introduced mainly for young women who engage in chronic repetitive self-harm, particularly with associated BPD characteristics (Linehan, 1987, 1993; Linehan et al., 1991; Simpson et al. 1998). It is intensive, involving in its full form a year of individual therapy, group sessions, social skills training and access to crisis contact. Its goals are to teach new coping mechanisms, better impulse control, emotional
moderation and regulation, self-awareness and knowledge, and cognitive restructuring. There are limitations to its applicability and cost-effectiveness, particularly for those individuals' for whom services at times appear to have little else to offer. Further research is required; nevertheless, it provides an interesting model for psychotherapists to refer to.

Problem-Solving Therapy
The second intervention is problem-solving therapy. This is a brief treatment aimed at helping the client to acquire basic problem-solving skills through a series of steps, i.e., identification of personal problems; constructing a problem list which clarifies and prioritises them; reviewing possible solutions for a target problem; implementing the chosen solution; reappraising the problem; reiterating the process; and training in problem-solving skills for the future (D'Zurilla, 1986). This usually involves about six one-hour sessions, with some reading material and homework tasks.

Improved standardisation has come from the newly emerging Manual-Assisted Cognitive Therapy (MACT; Evans et al., 1999). This manual-based treatment combines bibliotherapy (six self-help booklets containing elements of DBT) with six sessions of cognitive therapy – more practicable in busy clinical settings. Whilst still in its infancy, pilot results to date suggest it is effective in reducing the number and frequency of self-harm episodes, with simultaneous reduction in depressive symptoms. In the climate of evidence-based practice, problem-solving therapy has been shown to be an effective treatment for depression in other settings (Roth & Fonagy, 1996). In further SIB studies, it has led to improvements in additional relevant outcomes such as mood and social adjustment (House et al., 1992).

Conclusion
Suffice it to say there is no shortage of questions remaining about this behaviour. We simply do not know which adolescents (e.g. diagnostic subgroups, comorbid problems, severity of risk, familial conditions, let alone which sex) are best suited for specific treatment approaches (i.e. hospitalisation versus a range of outpatient alternatives). Additionally, we do not know whether specific therapeutic approaches
will prove effective both within specific and across the diverse range of diagnostic entities presented by self-injurious or suicidal adolescents. Nor do we understand the nature of change (i.e. type and degree in terms of targeted variables and associated symptomatology), the mechanism of change (i.e. psychotherapeutic orientation or method – individual, group, or family), or its stability over time (i.e. duration of change).

It is evident that individuals hurt themselves because it serves some function for them, and possibly several functions. Whichever constellation of motivational assumptions or theoretical models counselling psychologists and psychotherapists choose to inform their practice, increasing young people’s ability to express their feelings verbally and learning to use constructive behavioural alternatives are still general components associated with improved management of SIB in therapy (Nelson & Grunebaum, 1971). The most encouraging therapies to date seem to improve on inter-personal and problem-solving skills, though developing a discursive explanation that makes sense to the individual also appears promising.

The main conclusion drawn from the literature is the overall increase in SIB especially among young men. This has important implications for both medical and psychotherapeutic services. It may indicate a reversal of progress towards achievement of national suicide targets as outlined in the Health of the Nation (NHS Management Executive, 1993) and the recent Green Paper Our Healthier Nation (DOH, 1998). As a barometer of adolescent distress, it is clear that mental health professionals need to examine the effects of treatment and support that young men may or may not be receiving. It could be surmised that services have largely only been helpful to females. As suggested by Overholser et al. (1990) “males may require suicide prevention programs that differ from the kind generally provided” (p.391) at present.

Gender differences in presentation and conceptualisation of adolescent SIB are not well served by the current medical diagnostic classification system. Biases in research methodology, psychodiagnosis, and conceptualisation appear to maintain the status quo. Future research may benefit from investigating broader definitions of SIB. This may encompass a greater variety of acts expressed across the sexes because of gender
role socialisation, and in particular, highlight forms not traditionally recognised as SIB in young men. Further prospective studies may improve our understanding of the relationship between patterns of injury, diagnosis, and long-term risk of future self-harm potentially leading to suicidal behaviour.
References


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APPENDIX

Instructions for Authors: *Counselling Psychology Quarterly*
Appendix

Counselling Psychology Quarterly
Instructions for Authors:

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UNDERSTANDING ADOLESCENT SELF-INJURIOUS BEHAVIOUR: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF PATIENTS’ VIEWS AND EXPERIENCES.

Abstract
The present study employed an interpretative phenomenological approach to analysing adolescent inpatient views, subjective experiences, and conceptualisations of self-injurious behaviour. Specifically, it explored the context, explanations (intra- and inter-personal processes), perceptions of gender difference/similarity in behavioural acts, societal responses, emotional and ethical issues, in addition to young people’s views and experiences of current therapeutic interventions for self-injurious behaviour.

The qualitative approach captured the researcher’s concern with exploring individual participants’ perspectives, whilst also recognising the research experience as a dynamic process, to some extent shaped by the interests and concerns of the researcher. As part of a commitment to transparency, the analytic procedure is outlined systematically. Interpretations are illustrated with quotations from the data set, enabling readers to assess the persuasiveness of the analysis for themselves.

The analysis of 16 interviews revealed a number of important constructs. Four higher order themes are reported concerning: the influences of ‘gender role socialisation’; ambivalence around ‘being seen’; SIB as a means of ‘coping’; and expressions of ‘need’, as proposed by the young people themselves. The narratives revealed that a move towards a broader conceptualisation of self-destructive acts under the umbrella term ‘self-injurious behaviour’, may also challenge some of the existing gender biased constructs and contexts.
UNDERSTANDING ADOLESCENT SELF-INJURIOUS BEHAVIOUR: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF PATIENTS’ VIEWS AND EXPERIENCES.

Introduction

Self-injurious behaviour (SIB) is frequently perceived as a pathological behaviour that is particularly prevalent in adolescents. The incidence of self-mutilation for example, in adolescents and young adults (aged 15-35) has been estimated at 1,800 per 100,000 (Favazza & Conterio, 1988), compared to estimates of 14 to 750 per 100,000 in the general population. In adolescent inpatients, the incidence reaches 40% (Darche, 1990). As with other estimates based on treated samples, these figures are likely to be underestimates due to non-treated incidents. According to Hawton et al. (1997), the most reasonable current total United Kingdom estimates are around 400 per 100,000 population per annum.

SIB has been called many things; traditionally ‘self-mutilation’ has been defined as a direct, socially unacceptable behaviour that causes physical injury where the individual is not ‘attempting suicide’ but is in a psychologically disturbed state (Favazza, 1989, 1998; Kahan & Pattison, 1983; Walsh & Rosen, 1988). Seemingly polarised in the literature, the term ‘deliberate self-harm’ has been used to include intentional self-poisoning or self-injury, irrespective of the apparent purpose of the act (Hawton & Catalan, 1987).

The operational definition of SIB in the present study incorporated a very broad range of risk-taking behaviours: those which knowingly invite physical injury or harm to the self, and which typically arouse feelings of shock and alarm in those who witness them. With therapeutic implications in mind, this enabled the research to explore a wider range of conceptualisations and discursive explanations that ‘made sense’ to the young people.

There remain widely opposing views as to whether the gender paradox in SIB (with differential definitions between suicide ideation, attempts, and completion) is a real phenomenon, or merely the artefact of bias in data collection (Canetto, 1997). Some of the differential rates obtained between the sexes regardless of intent may in part be
due to the different methods employed (e.g., hanging for men, pills for women). For example, adolescent males are reported to use more lethal methods in their suicide attempts than the same aged females (Black, 1986; Hoberman & Garfinkel, 1988) and, although males make fewer attempts (Lester, 1990), they are more often successful (Borst & Noam, 1989; Hawton & Fagg, 1988).

Accordingly, SIB is no longer underrepresented in adolescent male populations, and further appears to correlate significantly with the increase in young male completed suicides both across Europe (Hawton et al., 1998) and in the UK (Hawton et al., 1993; Kreitman et al., 1991; Rudd et al., 1996). Some authors suggest that explanations for this may arise from gender ideologies and socialisation practices that vary greatly by culture and historical periods (Krushner, 1995; Unger & Crawford, 1996; Zinn et al., 1997).

Further study of gender and SIB has been based on the theory that men’s and women’s inherent natures are different. The implicit assumption is that a woman’s nature is viewed as ‘weak’, whereas a man’s nature is viewed as ‘strong’, and therefore superior (Range & Leach, 1998). However, there are increasing motifs and constructions of “crisis” in male mental health (Coyle & Morgan-Sykes, 1998; Coyle & Pugh, 1998), where men appear to enact stereotypes of masculinity, commonly associated with ‘not seeking support, and not confiding in others’ (Bruckenwell et al., 1995). Such traditional cultural influences are believed to have dictated trends that men do not express their feelings. These and other gendered notions may shed light on the interpretation that young men do not readily use their emotions as a resource in either the public or private sphere (Hothchild, 1983).

Historically, society has rewarded men for individualism and independence, essentially minimising relationship factors in their lives. Early research suggested that mental health professionals viewed males as being psychologically healthier than females (Broverman et al., 1970). To date, such popular representations are maintained in the wider context of women generally seeking more psychological help (Deane & Chamberlain, 1994; Deane & Todd, 1996). Women’s problems are conceived of as personal ones, and are dealt with via the mental health system, whereas men’s problems are seen as social ones (as an indication of cultural,
economic, or social malaise), and are dealt with via the social services and the legal
system (Canetto, 1991; 1992-3). Accordingly, it could be argued that how a person
has been socialised, rather than biological sex, can have a powerful effect on how that
person expresses distress through SIB, and from where they receive treatment (Jack,

The fields of counselling psychology and psychotherapy should also be careful to
eschew terminologies contributing to such conceptual bias. Differential gender biases
in the nosology of comorbid conditions, psychodiagnosis, and treatment decisions
have been identified in relation to adolescent SIB (Bowen, 1999). From this
perspective, even the most objective diagnoses of clients may be seen as socially
constructed discourses that often carry destructive implications (Raskin & Epting,
1993).

The majority of studies of self-harm in psychiatric settings do not include direct
interviews with the young people concerned, and have largely been in the
epidemiological, theoretical or quantitative arenas. Within the fresh possibilities for
psychological research and practice, a space has been left open for alternative
investigations. This research places emphasis and concern on patients' perceptions
and their internal events highlighting the ways in which individual experiences cannot
be separated from social, cultural, and historical processes (Bordo, 1990; Worell &
Etaugh, 1994), such as those of gender biased constructs and contexts.

The present study was designed to explore some of these issues within a specialist
adolescent psychiatric inpatient unit: a) to explore perceptions of similarities and
differences in the presentation of SIB across gender; b) to investigate a range of
experiences and conceptualisations surrounding male and female behaviours; c) to
explore subjective views on the treatment received by young men and young women;
and most importantly d) to gain a perspective from the young people themselves.

It was hoped that an examination of the ways that young people make sense of their
experiences would add to the current theoretical understanding of SIB and its impact
on those working with it. It was hoped that consistent patterns, themes and
descriptions of processes for both young men and women would emerge from the
accounts allowing some tentative generalisations and integration of the phenomenon of SIB to be developed.

The following propositions guided the research. It was expected that SIB would evoke powerful and contradictory feelings in the young people, and that differing perceptions across gender would reflect these subjective experiences. It was further predicted that the accounts from young women would focus more on internalising precipitating factors, whereas those recounted by young men would involve a greater number of externalising events. It was also expected that their accounts would relate to each other with some areas of overlap and difference. It was hoped that a qualitative approach would enable participants to articulate previously unstated, unattended, or subjugated understandings, explanations and beliefs.

Method

Participants

The study was granted ethical approval from the [Name of] NHS Research Ethics Committee and the University of Surrey Advisory Committee on Ethics [see Appendix I], and attempts were made to recruit a sample of young people who engaged in SIB. Under the current premise there was particular concern that young males who may not identify themselves as ‘self-harmers’ or ‘cutters’, may equally be engaging in self-destructive acts that are traditionally not included under the umbrella term ‘self-injurious behaviour’. These represent some of the ‘other voices’ which are traditionally lost in empirical research. A strategic decision therefore was made to include adolescent males who denied SIB symptomatology. It was anticipated that these individuals’ views and experiences would still contribute to the study, in addition to being the precise group of young individuals who are traditionally excluded from representations.

The final inclusion criteria incorporated behaviours defined by the more traditional acts of self-injury: forms of ‘deliberate self-harm’, ‘self-mutilation’ or ‘intentional self-poisoning’, as well as other forms of impulsive and self-destructive behaviours. Further examples included broader concepts of risk-taking behaviours, such as:
substance abuse, reckless driving, over-use injuries, unprotected sex, as well as those perhaps more commonly associated with deviant behaviour and/or masculine activities, as alternative forms of SIB. No attempt was made to make any distinction between ‘genuine suicide attempts’ and ‘parasuicide’. It was hoped that the young people themselves would explore such distinctions in the research.

A specialist psychiatric adolescent unit was approached in order to obtain permission to approach potential participants [see Appendix II]. The unit combined the traditional concepts of a ‘therapeutic community’ – originating from the concepts of Main (1946) – and a more didactic hospital ward environment for the treatment and containment of young people. An information sheet with details about the research was passed to all inpatients in the first instance [see Appendix III]. In describing the study to potential participants, care was taken not to convey the hypothesis about gender differences in the presentation of SIB. This reduced the risk of ‘labelling’ either sex, and increased the potential of attracting male participants engaging in self-harming acts. The study was simply described as being interested in “understanding patients’ views and experiences of adolescent self-injurious behaviour.” The voluntary nature of participation was also emphasised.

A total of 16 participants were recruited following an informal presentation to ‘the community’ (all members of the multidisciplinary staff team and 17 resident inpatients). One patient chose not to participate for personal reasons. Recruited participants were self-injuring or suicidal adolescent inpatients, aged between 16-19, not currently detained under the 1983 Mental Health Act or 1989 Children Act (see Jones, 1999), but undertaking inpatient treatment within the psychiatric unit for a wide range of persistent or enduring mental health difficulties.

Procedure
Participants were interviewed face-to-face at the residential unit. Interviews lasted between half-an-hour and an hour-and-a-quarter and were recorded on audiotape. Participants under the age of eighteen years required additional parent/legal guardian signed consent, obtained by return of post following telephone communication [Appendix IV & V]. All participants signed a consent form [Appendix VI], which provided details of confidentiality. The sensitive nature of the interview was made
clear to participants in advance of the interview [Appendix VII]. All participants completed a brief background information questionnaire [Appendix VIII], and a Self-Injurious Behaviour Inventory – a self-report checklist (adapted from Sansone, Wiederman & Sansone, 1998, [Appendix IX]). The inventory enabled the research to broaden the range of self-injurious acts beyond traditional conceptualisations, and participants were also requested to evaluate checklist items.

A semi-structured interview schedule was then administered [Appendix X], consisting of open-ended questions supplemented by reflections on the emotions or content of responses, requests for clarification, and probes (e.g., “can you tell me more about that?”). Development of the interview schedule was assisted by themes identified from an in-depth review of the current literature (Bowen, 1999). Two pilot interviews were conducted via the Internet to allow refinement of the interview questions. Adjustments were made according to the feedback received from two self-injuring young people based in the United States of America.

The final interview schedule explored five main themes: 1) the context of SIB: how the young person defined it, where, when, and how it happened; 2) the explanations offered by the young person for the behaviour: both attributable to the processes within the individual and interpersonal issues; 3) the perception of gender differences in SIB presentation: differences in role socialisation, conceptualisation, and behavioural acts; 4) the ethical issues involved for the young person, the adults responsible for their care, and the emotional impact it had on others; and finally, 5) the responses of others towards SIB: how these were experienced by the young person, and their views on current therapeutic interventions.

There was considerable scope for the participant to influence the direction of the interview. A comprehensive debriefing was offered [Appendix XI], providing participants with an opportunity to discuss any difficulties that had arisen as a result of talking about their experiences (Finch, 1984). A technique of ‘socially supportive interviewing’ was employed, requiring on the part of the interviewer an openness or personal responsiveness, and engagement for striving for intimacy (Oakley, 1992).
Additional ethical considerations were safeguarded through regular consultation with lead clinicians and Management Teams responsible for the young people. Each participant was involved in a brief handover given to a staff member upon completion of the interview. Participants were also redirected to their therapeutic community network and the multidisciplinary staff team who knew them best, which acted as an additional 'container' for any distressing material (Bion, 1961).

**Analytic Strategy**

Interviews were transcribed verbatim [see Appendix XII for an example of a full interview transcript] and subjected to Interpretative Phenomenological Analysis (IPA). This procedure has been used to analyse qualitative data on a range of health and well-being issues (for examples, see Flowers *et al*., 1997, 1998; Golsworthy & Coyle, 1999; Jarman *et al*., 1997; Holmes *et al*., 1997; Macran *et al*., 1999; Osborn & Smith, 1998; Smith, 1999). IPA essentially captures the researcher's concern with exploring individual participants' perspectives, whilst also recognising the research experience as a dynamic process, to some extent shaped by the interests and concerns of the researcher (see Smith, 1996a, 1996b; Smith *et al*., 1997, 1999).

IPA is strongly influenced by symbolic interactionism (Denzin, 1995), which argues that the meaning individuals ascribe to events are of central concern to the researcher and can only be arrived at through a process of interpretation. Thus IPA, while seeking to elucidate individual perceptions of meaning, recognises that this process is influenced by and dependent on the interpretative framework of the researcher who must try to make sense of such perceptions. The idea that verbal reports are reflective of underlying cognitions is by no means universally accepted (Coyle, 1995). While IPA does not claim that the thoughts of an individual are transparent within verbal reports, analysis is undertaken with the assumption that meaningful interpretations can be made about that thinking (Smith *et al*., 1997).

Good qualitative research should be open about its process of analysis (Smith, 1996b). It is therefore useful to outline the analytic procedure systematically (Elliott *et al*., 1999). The first step involved repeated readings of what seemed to be the most conceptually rich interview transcript. During this process, aspects of the data that were considered to be of potential significance to the research questions were noted,
as well as key phrases and processes. The notes included attempts at summarising, making connections with other aspects of the transcript or initial interpretations. Within each transcript, such notes were then condensed as similarities (and differences) and the meaning of various aspects of the transcript were identified. The resulting key words or phrases represented the initial themes for that transcript. Particular attention was paid to examining each transcript as an individual and separate case.

For this study, as well as looking for overall shared themes, elucidation of the complexity of the phenomenon under investigation meant that individual variation was an important element. The initial list of emergent themes for each transcript was then analysed alongside themes from other transcripts, producing a consolidated list of themes, with extracts from the transcripts grouped under the theme headings. However, individual experiences were not jettisoned, as these often extended understanding of the complexity of the common themes and the processes that underpinned them. Indeed, attempts to account for variability within the data often led to the creation of new themes [see Appendix XIII, for an example of categorised data from a transcript]. Concern with this discerning process led to a particular sensitivity to the connections that participants made between different aspects of their experiences. This enabled links between themes to be made, although occasionally ambiguous lines of perceived causation were discerned.

**Evaluating the Analysis**

Due to the acknowledgement of the role of the researcher’s interpretative framework in IPA, traditional evaluative criteria (i.e., validity and reliability) are inappropriate in IPA work (and in many other forms of qualitative research) as they assume a disengagement between the researcher and the topic under investigation (Henwood & Pidgeon, 1992). Therefore, more appropriate criteria needed to be considered, such as transparency, persuasiveness and internal coherence (Elliott *et al.*, 1999; Potter & Wetherell, 1987; Smith, 1996b). The author kept a Research Diary, recording the research process and the development of ideas over the course of the study. The narratives provided details of the intimate levels of engagement required in qualitative research, in addition to contributing cultural and contextual richness. [Extracts from
the Research Diary are available to the examiners in a separate appendix. Due to the confidential nature of this material, it is not available for public access].

Different researchers may foreground different aspects of the data set. Thus as part of a commitment to transparency, it is important to acknowledge the interpretative frameworks which the researcher brought to bear upon the analysis. At the time of the study, the researcher was a counselling psychology trainee who had prior first hand experience of working with young people engaging in SIB and was (and still is) a proponent of multidisciplinary treatment in therapeutic communities. Therefore, a tendency might have arisen in the analysis to focus on particular issues in the data set which resonated with her previous working experiences in this setting and with her outlook on the subject. However, the development of themes was closely monitored at each stage with the aid of a research supervisor. This enabled verification that emergent themes and interpretations were grounded in and supported by the data. This process was designed to reduce the risk of the final analysis arising from a purely idiosyncratic interpretative framework.

Furthermore, as most interpretations in this paper are illustrated with quotations from the data set, readers can assess the persuasiveness of these interpretations for themselves. This will also help in assessing the internal coherence of the research by allowing readers to judge whether the researcher has achieved a coherent and integrated analysis while attending also to the nuances of the data (Banister et al., 1994; Elliott et al., 1999; Smith, 1996b). In the quotations that appear in the analysis, information within square brackets has been added for the purpose of clarification. Empty square brackets indicate the omission of material; ellipsis points (…) indicate a pause in the participants’ speech; and the use of upper case lettering indicates emphasis. Participants’ names have been replaced by pseudonyms which aim to reflect their ethnicity at the same time as protecting confidentiality. The source of each quotation is indicated in order to demonstrate that the analysis has not been over-reliant upon particular participants.
Preliminary Analysis

Background Information

There were eleven female and five male participants, with a mean age of 17.6 years (range 16–19 years; SD = 0.96). Nine had attained a pass in at least one GCSE (56.25%), two held a GNVQ (12.50%) and five had no educational qualifications (31.25%). Twelve participants described their ethnicity as White and the remaining four as Chinese, Indian, Black-African and Indian-Caribbean.

The young people represented a particularly vulnerable client population, characteristic of participants recruited from specialist tertiary psychiatric services. Six participants had a history of prior psychiatric inpatient hospitalisation. The most commonly reported Axis I (clinical) diagnosis was depression, with a variety of Axis IV (psychological or situational) comorbid conditions (DSM-IV; APA, 1994). Most respondents indicated that symptoms other than SIB were the major determinants of their current inpatient admission. Most frequently this included suicidal ideation and/or interpersonal or familial relationship difficulties. Four participants reported a history of childhood physical or sexual abuse, and ten of the participants’ parents were divorced or deceased.

Each participant reported engaging in at least 3 out of the 24 defined methods of intentional self-harm measured on the adapted Self-Injurious Behaviour Inventory. The estimated number of self-injurious acts was variable, ranging from 3 to 3263 incidents per individual. The latter participant’s data was excluded from the analysis as an outlier (because the total number of incidents was estimated as the average number of cuts per single episode of repetitive ‘cutting’). The mean estimated number of self-injurious acts in the remaining sample was 189.6 incidents per individual (n = 15, range = 3–807, median = 66, SD = 272.99). The mean length of time participants had engaged in SIB was 4.3 years from first incidence (time span range 1–9 years; SD = 2.78). The median and modal reported age of onset was 15 years (age range 8–17 years; SD = 2.70).

A further 20 different types of self-destructive behaviours were described by ten participants, and were suggested for inclusion on the SIB Inventory. These included:
pinching, overeating, vomiting or purging, sniffing aerosols or solvents, sharing
needles, self-strangulation, hanging, suffocation, cutting off circulation to limbs,
punching walls, breaking things, being sexually provocative, provoking aggression in
others, blood letting, self-stabbing, or sticking with sharp objects, climbing high
buildings, jumping from roofs, running away, and smoking cigarettes. From examples
of methods measured on the SIB Inventory, six participants considered ‘distancing-
self from God as punishment’ to be self-injurious, whereas three participants did not,
and would have removed this item from the inventory altogether.

Results

The analysis of the interview data set revealed a number of important participant-
derived issues (see Appendix XII for an example of a full copy of a transcript),
however, due to limitations of space this paper is only able to present a detailed
analysis of four higher-order themes that emerged. Of particular interest to the
researcher (and perhaps the wider fields of counselling psychology and
psychotherapy, these themes included: the influences of ‘gender role socialisation’;
ambivalence around ‘being seen’; SIB as a means of ‘coping’; and as expressions of
‘need’, as proposed by the young people themselves.

The Influences of ‘Gender Role Socialisation’

The subjective views of the young people varied according to their own
experiences or descriptions of friends who engaged in SIB, with regards to whether
they perceived any gender differences or parallels in self-harming acts.
Specifically, contradictory beliefs were expressed about whether young men or
young women harmed themselves more often, more severely, or received similar
attention/treatment for their behaviours.

One of the striking constructs highlighted by both young women and young men was
the perception that young men use more violent or dramatic methods of SIB. In
response to the question “What in YOUR experience are any similarities or
differences between young men and young women who harm themselves?”, Gail responded:

I think that men go for more violent ways out. My cousin about five years ago committed suicide. He tied a rope around his neck and jumped off a bridge. [ ] Basically guys go for more violent ways and they end up succeeding basically. Girls just tend to go for the overdoses.

This general view was held by nearly all of the young people interviewed, even with limited experience or contact with others engaging in SIB. A young man, Ivanchu, described:

I haven’t actually met that many males who harm themselves, but it seems, from what I have seen, that males who harm themselves generally hide them [injuries], and they don’t show them, whereas females generally show the cuts to people. That’s one thing I guess. Males can often do it quite violently and once they decide to do it they do it REALLY violently.

A number of other factors were identified as gendered influences on SIB including stereotypical beliefs, sexist perspectives, unequal or different societal expectations and gender role socialisation, as well as different trends in conceptualisation. Leyah summarised this well:

I think that young men are frowned upon more, you know, you should be this big macho guy who can handle everything and now you are being this weak little thing. They’re not even allowed to cry most of the time. They have to keep their emotions inside. [ ] When they cut themselves it’s really awful as well, but I think that it’s more common for women, they’re just seen as – “oh, you POOR thing”, but with men it’s different. It’s really sexist. [ ] A lot of the time for men, they’re brought up to be like their fathers and they fail and they feel really bad and they commit suicide because they’re brought up to have these great expectations which they can’t keep because maybe they just want to be themselves.

A marked difference in the conceptualisation of SIB was the nature of aggression and towards whom it was expressed. Participants perceived women as being over-
represented in the so-called internalising disorders, in which pain and hostility are turned inwards (frequently symbolised by the swallowing of tablets). Men, on the other hand, were seen as over-represented in the so-called externalising disorders, for example involving some degree of external destructive behaviour or incitement of aggression. For this split to be made so rigidly seems contradictory. In some ways, all SIB is a kind of ‘internalisation’ in the form of self-punishment (hence, the original term “anger turned inwards” – Cain, 1961). In other ways, SIB presents like an ‘externalising’ disorder because it involves a degree of aggression and the defiance of social, religious, and sometimes legal prohibitions.

Angry feelings were most frequently reported to be a precursor and accompaniment to SIB (often with circular causality). The implications are that men seem unwilling to express their emotions ‘appropriately’ except through an explosive discharge of anger – which is largely turned against the self:

It’s really terrible because they’re [young men] going to explode obviously and then they go and hang themselves, or shoot themselves or overdose or anything, it’s just really, really terrible. (Leyah).

Ivanchu elaborated further:

I think that a large part of it is probably what society expects, the roles that males and females have to fulfil. I mean, in terms of males, then I would say generally, even though it’s starting to change now, the generally accepted male is still supposed to keep the emotions and pain or hurt or whatever to themselves and not show it. Even though on the outside this seems to be encouraged, but ultimately if you do it outside you don’t get the same respect that males seem to need in this society. So if you hurt you are supposed to keep it to yourself, whereas females are allowed to cry and allowed to attract attention.

Many young people described feeling pressured by what society considers ‘normative’ behaviour, alongside rigid gender role expectations placed on them. As a result, male SIB was kept secret (which would appear to contradict the externalising theory), whereas female SIB was seen as a permissible expression or externalisation of inner pain. Abigail described some of the accompanying differences in attitude:
I think it's a lot more popular in girls, and I think that boys that do self-harm, in the sense of cutting, keep it to themself a lot more; they don't show people and don't get the help, where girls can actually go up to people and say “look, I'm doing this and I need the help”. I think it's a lot more the people's– the male's pride; it's like “I'm macho so I can't say that I'm self-harming.” Whereas women realise that it's a problem and go and get some help.

*Ambivalence around 'Being Seen'*

Additional views held that women in general were ‘allowed’ to express their emotions, though this was often negatively construed and equated with ‘attention-seeking’ behaviour. Reframed as a positive construction also using less pejorative terminology, was the theme of ‘reaction-seeking behaviour’, as Leyah explained:

> I think that with a lot of people – I can tell from experience, I think a lot of it's for attention. I'm not trying to say that they're attention seekers, but it's really a cry for help to be noticed. [ ] Even to have people worried about you, which is what people like. I mean I don’t really like it that much, but sometimes I really want people to worry about me and to understand how much pain I'm going through. On the other hand I see how much pain they go through because of me and I'm just wasting my own life and wasting everyone else's time.

Within this notion was the unconscious desire to be ‘seen/noticed/found’ and for the young person's pain to be recognised, despite considerable ambivalence also expressed around such needs:

> Every time I did try to talk to my parents about my problems, they were too busy wrapped up in their own problems to listen. I got so sick and tired of trying to talk to them that I gave up in the end. (Gail).

Another explanation for the secrecy that accompanies SIB may perhaps be understood in terms of feelings of ‘shame and guilt’ that often perpetuate or maintain it:
I actually feel very embarrassed. I know that my step-mother told a lot of friends when I took my last overdose and it was very difficult for me because I just see myself as being a freak, the black sheep of my family. It’s just been increasingly hard and difficult. (Leyah).

Gail goes on to describe her ambivalence around detection and discovery of her SIB:

The problem is that if you try to hide them [cuts] people will see them, but if you make it obvious they never saw them. I always made it obvious so that no-one ever noticed. I would sit in class and while the teacher was talking I would have this little blade in my hand, so you couldn’t see it, and I would be messing around with my hand. It was so obvious no-one ever saw it. I didn’t act any different so it wouldn’t give any signs away [ ] unless they force it out of me [ ] with the scratches on my hand I used to say that my cat had scratched me and for a while they believed me because I’m so good at covering things up – it’s UNBELIEVABLE. It’s like I’ve always been able to cover up my tracks.

In lying about her scars, implying a desire to keep her actions secret, Gail’s sense of shame is highlighted. However, this appears painfully contradictory in her ambivalent attempts to be noticed in the classroom (by her teacher or perhaps her peers), especially when she describes a further sense of ‘pride’ or even ‘achievement’ in being able to hide her actions.

A recurring theme for both young men and young women was an awareness of the impact or influence their SIB had on others, particularly that of emotional blunting or distancing:

It’s made a lot of difference to my family who’ve become very distant. [ ] It just has a great emotional impact on people. Some people get very sad, some people want to help and others are so distant that I feel they don’t care any more. They feel that they DO care, but they can’t get too close, because they can’t worry about me any more, they have to worry about themselves. (Leyah).

Other areas of overlap in SIB were conceived across the sexes. Parallels were drawn between young men and young women in the fact that they both harm all areas of their
body, but that young men were perceived as less indiscriminate and young women as more vain, and therefore selective with regards to location of injury:

It seems that girls quite often do it [cut] on their legs, quite a lot of them do it on their arms as well, but quite a lot of them do it on their legs. The few males that I have seen seem to do them all over really. Actually, I don’t really notice that much difference in the way that both do arms. It’s mainly on limbs, seldom on the face. I guess in the end they still care about their looks which is probably more so in girls than boys. I don’t think I have seen anyone self-harm on their face. (Ivanchu).

**SIB as a Means of ‘Coping’**

How SIB manifested itself appeared to depend on different coping and personal management styles (Haines & Williams, 1997). Inconsistent gender differences in coping styles have been found (Folkman & Lazarus, 1980, 1982; Lazarus & Folkman, 1984). Frydenberg and Lewis (1991) also reported that girls are more fatalistic and resigned to difficult circumstances, whereas boys are more aggressive and private in their activities. Participants’ narratives supported the notion that girls and boys are socialised differently into expectations of what constitutes acceptable and unacceptable ways of coping with problems, and the different methods of SIB engaged in across the sexes (Canetto, 1997).

The analysis revealed SIB could be understood in many different ways emphasising the co-existence of a multiplicity and variety of situation-dependent ways of life. Some accounts sought to place SIB in relation to psychiatric diagnoses, some focused on antecedent causes, whilst others concentrated on the function and meaning of self-harm. Four subthemes describing different functional coping styles were highlighted in the narratives. SIB was conceptualised as a method of ‘preventing suicide’, as a form of ‘release’, as a ‘means of expression’ and/or a ‘need to control’ intolerable feelings for the young person.

In the following anecdote, Anthony had previously been talking about a suicide attempt that was successfully managed with a resultant act of self-harm (cutting of wrists):
I didn’t really want to kill myself because my parents would have been very upset; well you KNOW how parents react to that kind of stuff. [ ] I threaten’d myself with a knife. [ ] But I didn’t do it because I knew at the end of the day that if I did it, it would end my life. Because at the time, I wanted to do it badly. What I’m saying is it’s not a very nice way.

For most young people, SIB was differentiated from suicidal intent based on severity of the act:

I think that the first thing that remotely approaches self-harm is probably cutting my wrists and I suppose that’s one of the most common ways you hear, say in the media, about killing yourself, so in a way that’s just a suicide attempt really. In a sense it wasn’t serious enough to classify as a suicide attempt. I suppose that would come under self-harm. (Ivanchu).

A few participants however, reported occasions when the intensity of their feelings increased to such an extent that the conceptualisation between an act of self-harm and a suicide attempt became blurred. It was particularly at this stage where the theme of ‘poor impulse control’ would be spoken about:

It makes me feel really depressed, but then that’s how I should be I think... because that’s how I really feel. [ ] Usually it’s just in my mind all the time; it’s not anything that I can get out of; I have no choice and when I’ve decided that I am going to, then I have no choice. It doesn’t matter whether someone stops me, because I will DO it [attempt suicide] a different way. [ ] Before it’s just like a massive impulse kind-of-thing and I can’t really stop it. Because it does release something; I don’t know what it is... It makes me feel a bit better, especially afterwards when you can feel it and the blood and everything; it makes me feel a bit better; a bit more normal. (Alice).

The conceptualisation of SIB as a (physical or emotional) ‘release’ was a particularly common theme. It appeared to provide rapid (although temporary) relief from overwhelming psychological distress. Release of tension, acquiring control, reconfirming the presence of one’s body, dulling feelings, and converting unbearable emotional pain into manageable physical pain, were also commonly
cited reasons for SIB. For some, this resulted in the immediate resurgence of negative emotions and anger, once again directed at the self (confirming earlier themes of circular causality):

It's a release when I do it, but afterwards it's horrible because I hate seeing the marks on my arm. That's when the anger kicks in with myself and I'll get even more angry because I've done that, and now I've got another scar on my leg or my arm and it's another time of having to wear long sleeves. Every time the scars begin to heal, I'll go over 'em again. So they'll get worse and it's like the summer comes and I can't wear my short sleeves because I've got scars on my arms and people give you these snide comments... it's difficult. (Abigail).

Acts of self-harm also appeared to serve as a basic way to 'express' overwhelming and internally intolerable affect, and redirect anger from the other onto the self (Darche, 1990; Raine, 1982). Some cutters needed to have physical evidence of their injury in order to feel that their emotions were real, justified, or able to be tolerated, as Steve recounted:

One of the reasons is, as I said, mainly is for the purpose, along with my acts of self-harm [ ] to a certain extent to show myself how I feel. I guess, because I have a serious problem with crying [expressing feelings] so I suppose at times, although it's very rare, I actually do it to SHOW myself.

Steve described the conversion of his feelings into a concrete and visible behaviour through the act of self-injury, as a way of recognising and identifying emotions. In this instance anger, anxiety or pain is not directed outward to the perceived abandoning object (or 'meaningful' other), but is turned inward against the self, in a dynamic akin to psychoanalytic explanations of depression (Darche, 1990; Woods, 1988). Participants often described that it was not the object (or individual) that was hated for leaving, but rather the self, for both the anger and the need to self-harm (Simpson & Porter, 1981). SIB has further been conceptualised by Rosen and colleagues (1990) as the need both to externalise the emotion, as well as to express the affect to others.

An alternative perspective emphasised by some participants, was the need to 'control' emotion rather than express it. Feelings of extreme helplessness often prevailed when
faced with perceived difficult events or impossible tasks, along with a need for control over the anger, the need, and the environment:

If one thing went wrong – it's like I always had this thing about perfectionism [ ] I would get really upset about it and really take it to heart and take it out on myself [overdose], like I should have planned it better, and not let others know [my feelings]. (Sharon).

SIB was sometimes described as an attempt to regain control by channelling the anger at the abandoning object actively against the self, or by enacting the anger that was perceived to be coming from the object (or important person) and resulting in abandonment (Freidman et ah, 1972; Raine, 1982). In these instances SIB reflected a need to enact what is passive, obtaining a sense of control over one's emotions and therefore the events that elicited them. Control is gained by self-harming as the action externalises the emotions turning them into something concrete and specific, enabling the person to distance from them. Alice explained:

I think mostly it's to do with anger, yes; overdosing and stuff like that is probably just to do with anger and not being able to take what's going on and make a distraction. Because you have something else to focus on, rather than your own emotions.

Many participants spoke about the psychological determinants of negative affect (depression, anger, and anxiety), and cognitive biases (hopelessness and low self-esteem), as triggers for SIB:

I don't really like myself much. I never really liked myself... I kind of blame myself for a lot of things, like my parents splitting up, my brother going weird [hyperactive with behaviour problems] and my mother being depressed. Because I was bullied at school, for ages, since I was eleven or something. That kind of pushed down my self-esteem and my self-confidence and how I felt about myself. I never really thought that I was worth anything and I thought that everything was my fault so therefore I had to be punished and the only way I could punish myself was by hitting and scratching and stuff. (Natalie).
Cognitive and affective influences have long been recognised in relation to SIB (Pinto & Whisman, 1996). The experiences of deprivation, rejection, or loss of love, are presupposed to develop into feelings of anger or resentment towards the person responsible and subsequently internally. These angry and aggressive feelings seemed to lead to guilt and a sense of worthlessness in many of the young people’s experiences. It is precisely this sort of process material that is potentially of greatest use in constructing formulations and designing interventions within therapeutic settings.

**Expressions of ‘Need’**

Researchers and therapists agree that one of the most therapeutically relevant dynamics of the self-harmer is their difficulty verbalising emotions and needs (i.e. expressing emotion; Bennum & Phil, 1983; Simpson, 1980). Most participants confirmed that the expression and control of emotions were primary tasks for them. Ellen described how she would have liked staff to respond ideally following an act of SIB:

> Insist that I TALK, rather than bottle it up. [ ] Keep questioning me on how I was feeling at the time, what made me do it and things. [ ] Because I feel that I don’t get enough push. I mean, it’s probably a bit of an expectation, but I do expect the staff here to help me to talk about it, to push me at times and question me, but sometimes that just doesn’t happen which leads me to feel really bad.

The desire to have staff sit down and ‘talk’ with them about their difficulties and underlying feelings was expressed by nearly all the participants. Strong emphasis was also placed on not wanting to bear the negative judgements of others (perceived as indifferent/passive/critical or otherwise):

> The day after I came back and told them – I’d told them that I’d taken an overdose, it would have been nice to have someone to actually sit down and talk to me, instead of saying, “go and wait around there; go and wait outside, I’ll call you when the taxi’s ready...”. It would have been nice for someone to actually have sit down and asked me why I’d done it, instead of being shouted at. (Simon).
Further criticisms of treatment methods described the unhelpful emphasis sometimes placed on the young person’s behaviour rather than their feelings:

I wouldn't totally focus on the cutting because that's all THEY [staff] do. They will make a whole conversation about cutting and that's not what it is though – they don’t look deep enough at what the person is feeling. (Tracy).

Some of the helpful strategies identified nevertheless complimented many of the current integrative practice methods used to manage adolescent SIB. These included practical management of wound cleaning, removal of objects that could be used for harm, sharing of experiences, clarifying misunderstandings, dissemination of greater information, caring and understanding attitudes, and talking (therapies). Natal described the kind of support he would provide to someone who was self-harming:

By taking the razor off them, like the staff would. The staff would take whatever they're using off them. [ ] I would try an’ calm them down and talk to them; that this’s not good for you, you’re damaging your skin and it won’t look good – your scars will stay like that forever.

Other accounts emphasised the need to make the adolescent ‘in therapy’ aware of some of the many discrepancies between their own beliefs and actions when in comparison to those of their peers, helping them become aware of their own impact on others (for example, emotionally within the transference-countertransference relationship; Gabbard et al., 1994), and learning more effective means of communication – be that of their distress or within interpersonal relationships. Leyah described the impact her SIB had on others and her wish for more effective communication:

They get really shocked. My family get very shocked, frightened, scared, terrified – my family and my friends. The first hospital I was in the doctors would immediately put me on antidepressants [ ] I was put on Prozac and it stopped working and I know that it was a major factor in my suicide attempt… [ ] It still makes me very angry and frustrated that I can’t get through to anyone. (Leyah).
Many young people in the study viewed the treatment and management of SIB as important to their overall mental and psychological well-being. Several participants spontaneously commented that they thought the subject was important, and the vast majority appeared to welcome the chance to talk about their views and experiences. Of those who were approached, only one young person refused to take part in the study – declining for personal reasons. Several also expressed the hope that such research might lead to changes in treatment practice.

From the perspective of these young people, it would seem that effective therapies need to focus on developing the young person’s ability to articulate emotions and needs, and to use alternative forms of communication to channel feelings and create an environmental response. It would further appear that deconstructing conceptual gender biases, and the impact of value judgements on actual experiences and intrapsychic cognitions of adolescent self-harmers, could be extremely useful in the therapeutic encounter.

**Overview**

The data set consisted of the retrospective accounts of 16 young people admitted to a residential psychiatric unit, presenting with severe and enduring mental health difficulties at the more extreme end of the spectrum. Accordingly, the severity of SIB may not be representative of a sample in the community. Numbers were also limited to adolescent patients receiving treatment in the unit at the time of the study, perhaps resulting in more female ‘voices’ being heard. Participants nevertheless represented a very heterogeneous group of young people in terms of background, living circumstances and presenting difficulties. The present sample also confirmed other research trends indicating that self-mutilators in particular, often have a history of physical or sexual abuse as children (Carroll *et al.*, 1980), and are more likely to come from families characterised by divorce, neglect or parental deprivation (Carroll *et al.*, 1980; Rosen *et al.*, 1990).

It is acknowledged that the relationship between the actuality of events and the accounts provided by participants may have been subject to memory distortions, and recall biases, in addition to particular influences of the setting. There is evidence to
suggest however, that retrospective reports and autobiographical memory are not necessarily and inevitably inaccurate and unstable (e.g. Blane, 1996; Brewin et al., 1993; Neisser, 1994). Within the context of the therapeutic community, specific therapy groups or incidents during the course of the residential week may have held special meaning or heralded an emotional impact prior to interview for some participants. Whilst care was taken to minimise these possibilities through close monitoring and feedback from the nursing team, any such influences however were not formally assessed. It was therefore assumed in this study, that the accounts offered by the participants bore some relation to the actuality of the events they described but no claims were advanced concerning the nature of that relationship.

The study pointed to some of the difficulties that may be experienced by young people receiving psychological treatment for SIB in specialist psychiatric inpatient services in Britain. While there was some overlap in views and experiences, participants reported that differences in behavioural acts and conceptualisations of SIB were frequently influenced by stereotypical gender role socialisation processes. This lends support to the view that some of the gender differences reported in SIB rates may be an artefact of bias in sampling procedure according to the definition of the methods employed (see Bowen, 1999 for a review), as opposed to any real difference in numbers of self-destructive acts across the sexes.

Hawton et al., (2000) recently reported that ‘self-injury’ (defined as any injury recognised as having been deliberately self-inflicted) was more common in episodes of deliberate self-harm by young males, whereas ‘self-poisoning’ (defined as the intentional self-administration of more than the prescribed dose of any drug – including overdoses of “drugs for kicks”) was more common in females. The present study revealed a prolific number of different types and methods of SIB conceived of and engaged in by the young people (as rated on the Self-Injurious Behaviour Inventory Questionnaire), suggesting that a move towards a broader conceptualisation of SIB may address some of the confusion and challenge existing gender bias conceptualisations.

The present study also highlighted some of the functional aspects of SIB. Models viewing SIB as a resilient coping mechanism used to avoid suicide (Favazza, 1998) or
a maladaptive attempt at self-help (Favazza, 1989; Favazza & Rosenthal, 1993) were well supported. The majority of participants confirmed that for them, acts of self-harm were distinct from suicide in intent, lethality, phenomenology and associated features. Such views appear to lend support to the classical psychoanalytic proponents of SIB which have described it as an active way to avoid suicide, providing a sense of mastery over death (Firestone & Seiden, 1990) or a compromise between the life and death drives (Menninger, 1938).

Participants’ accounts further highlighted some of the emotional ‘release’, ‘expressive’ and/or ‘controlling’ functions of SIB. These constructs have been evidenced in a number of studies, confirming many therapists’ views that SIB fulfils a function of control and regulation of affect, especially concerning the feeling of anger (Suyemoto & MacDonald, 1995). Differentiated internalising/externalising disorders (Miller, 1996), releasing overwhelming emotions (Gemma, 1989), and/or transforming emotional pain into physical pain (Callahan, 1996) were other commonly cited reasons for SIB. Many of the young people were able to make constructive use of these psychological explanations, and suggested reframing SIB into alternative practical and/or verbal solutions in the management of their own treatment.

Any conclusions drawn from this data set must be tentative because of the questions about how representative these views and experiences are. Nevertheless, the role of counselling psychologists may be considered vital when working with young people presenting with SIB. The centrality of the therapeutic relationship and the humanistic underpinnings of counselling psychology may provide a facilitating environment for distressed individuals to explore their emotions regarding stressors or triggers to SIB.

Therapeutic intervention needs to consider the initial contact and/or early stages of therapy as an important opportunity for developing some understanding about the young person’s own conceptualisation of their SIB. Constructions may be widely different to some of the traditional concepts of ‘deliberate self-harm’, with the young persons’ potential hope for change and their future, heavily influenced by the (negative or otherwise) attitudes of the mental health workers involved in their care.
There is a significant gap in the literature around adolescent experiences of SIB, with the most notable exclusion being of young men's views. This is possibly a result of the fewer number of young men receiving psychological support for SIB. The current study nevertheless set out to redress this omission. The findings suggest future research may benefit from broadening the conceptualisation of self-destructive acts under the umbrella term “self-injurious behaviour”, perhaps with greater emphasis on the impact of gender role socialisation across the sexes.

Further research into treatment process and outcome with these young people is also warranted. Most of the information on treatment has been from small, inpatient populations, yet Favazza and Conterios's (1988) study suggests that outpatient therapy may have a higher success rate, at least from the patient's point of view. How patients view their SIB changing over time may also be beneficially compared with information from therapists on treatment efficacy.
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This paper was submitted for publication in *Counselling Psychology Quarterly*, in March 2001.

**LIST OF APPENDICES**

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14 February 2000

Ms A Bowen  
Department of Psychology  
University of Surrey

Dear Ms Bowen

Understanding adolescent self-injurious behaviour: A qualitative study of patient’s view and experiences (ACE/99/67/Psych)

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol and the subsequent information supplied and has approved it on the understanding that the Ethics Guidelines are observed.

The letter of approval relates only to the study specified in your research protocol (ACE/99/67/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions and if the study is terminated earlier than expected (with reasons). I enclose a copy of the Ethics Guidelines for your information.

Date of approval by the Advisory Committee on Ethics: 14 February 2000
Date of expiry of Advisory Committee on Ethics approval: 13 February 2005

Please inform me when the research has been completed.

Yours sincerely

Helen Schuylenman (Mrs)
Secretary, University Advisory Committee on Ethics
Registry

cc: Professor L J King, Chairman, ACE  
Ms M John, Principal Investigator, Dept of Psychology

Enc

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Ms. Arabella Bowen  
Counselling Psychologist in Training  
Department of Psychology  
School of Human Sciences  
University of Surrey  
Guildford  
Surrey GU2 5XH

Dear Ms. Bowen,

Ref: Study 99/69

Title: Understanding Adolescent Self-Injurious Behaviour:  
A Qualitative Study of Patient's Views and Experiences

I am pleased to inform that your study has been approved by the Barnet Local Research Ethics Committee following receipt of the revisions to your study.

If for any reason you wish to change any details in your study this must have the approval of the Committee prior to introducing these changes. We would also like a brief annual report of your study and notification of when it is completed.

We wish you all success with your study.

Yours sincerely,

Michael Beaman  
Chairman
Appendix II

PERMISSION AND CONSENT TO CONDUCT RESEARCH

Title: Understanding Adolescent Self-Injurious Behaviour: A Qualitative study of Patient’s Views and Experiences.

Researcher: Arabella Bowen, BSc. Hons., PsychD trainee

Outline Explanation:
Self-Injurious behaviour is a confusing area and people have different opinions about why someone might harm themselves and what can be done to help. When young people harm themselves in a residential setting, the adults/staff have to decide how best to respond. This research is trying to increase the understanding about how young people feel about their self-injurious behaviour to get a clearer idea about how adults might help.

What would be expected of the young people who participate?
All information for this research will be obtained from face-to-face interviews with the researcher which will last not longer than an hour and a half. For the young person, participation will initially be discussed with the Keyworker. If the young person expresses an interest in participating, consent will then be sought from the appropriate parent/legal guardian. For any young person aged 16 years or under, this will be written consent. On the day of the interview written consent will be sought from the young person.

The focus of the interview is about the young person’s experience of self-harm or being around people who self-harm; why they think people injure themselves, and what they think a helpful response would be. There will be a debriefing following the interview. I would like to interview some young people who self-harm and some that do not self-harm, but have friends that do.

All personal information given in the interview will be kept confidential, unless it is considered to be harmful to the individual or others. Any information passed on will be discussed initially with the participant. Information that could lead to identification of participants will not be included in the write-up of this research. Anyone who agrees to participate can withdraw from the study at any stage without necessarily giving a reason. The well-being of the person will be of central concern throughout.

I (Medical Director) ___________________________ Date 1/2/00

hereby give my permission for this piece of research to take place at

[Name of Clinic]

I give overall consent for the young people to participate on the understanding that the above requirements are met.
INFORMATION FOR PATIENTS

I am writing to inform you about, and invite you to participate in a research study that I am conducting. I am a Counselling Psychologist in Training in my second year of a Practitioner Doctorate course at the University of Surrey, and I am currently working with young people and adults at another psychotherapy department in Surrey. This research has been granted ethical approval by [Name of] NHS Research Ethics Committee.

The title of this study is: “Understanding Adolescent Self-Injurious Behaviour: A Qualitative Study of Patient’s Views and Experiences.”

Aim of the Study
In general this study is looking at patient’s views and experiences of self-injurious behaviour during adolescence. Symptoms of self-harm or self-injury can be distressing to both the individuals and their carers, and further insights into these experiences may help us to understand more about self-injurious behaviour and have implications for the practice of therapy. In particular the study aims to look closely at two areas: 1) young people’s views and experiences of self-injurious behaviour, and 2) the responses of others towards self-injurious behaviour.

Participation
I am looking to involve adolescent inpatients in this study. You indicated an interest to your lead clinician at the [Name of] Clinic, who gave me permission to speak with you.

The study involves interviewing participants individually. I would like to interview you using a semi-structured research interview. The questions are designed so that you can answer the subject area as freely as possible, the format of which is a well recognised method of interviewing. The interviews last between 45 minutes and one hour, and may generally be experienced as interesting and potentially helpful. The interview would be audiotaped so that I do not forget anything you have said, and will enable me to find common themes from your views and others. I can assure you that confidentiality will be maintained and any records will be destroyed at the end of the study, if that were your wish. If I thought there were issues from the interview that needed to be discussed with staff at the clinic, I would discuss this with you first.

Your decision to participate in this research is yours to make, and refusal to participate will not affect in any way your treatment at the clinic. You have the right to withdraw at any time without giving a reason.

I will come to the clinic to answer any queries you might have. Having decided you would like to participate, a letter to your parent/legal guardian explaining the study will be written, also asking their consent for your participation.

I look forward to meeting you.
Yours sincerely,

Arabella Bowen
Psychologist, B.Sc. Hons., M.A.
I am writing to inform you about, and invite your child to participate in a research study that I am conducting. I am a Counselling Psychologist in Training in my second year of a Practitioner Doctorate course at the University of Surrey, and I am currently working with young people and adults at another psychotherapy department in Surrey. This research has been granted ethical approval by [Name of] NHS Research Ethics Committee.

The title of this study is: "Understanding Adolescent Self-Injurious Behaviour: A Qualitative Study of Patient’s Views and Experiences."

Aim of the Study
In general this study is looking at patient’s views and experiences of self-injurious behaviour during adolescence. Symptoms of self-harm or self-injury can be distressing to both the individuals and their carers, and further insights into these experiences may help us to understand more about self-injurious behaviour and have implications for the practice of therapy. In particular the study aims to look closely at two areas: 1) young people’s views and experiences of self-injurious behaviour; and 2) the responses of others towards self-injurious behaviour.

Participation
I am looking to involve adolescent inpatients in this study. Your child indicated to their lead clinician that they would like to participate in this study, and the [Name of] Clinic gave me permission to contact you.

The study involves interviewing participants individually. I would like to interview your child using a semi-structured research interview. The questions are designed so that the subject area can be answered as freely as possible, the format of which is a well recognised method of interviewing. The interviews last between 45 minutes and one hour, and may generally be experienced as interesting and potentially helpful. The interview would be audiotaped so that I do not forget anything that has been said, and will enable me to find common themes from their views and others. I can assure you that confidentiality will be maintained and any records will be destroyed at the end of the study, if that were your wish.

The decision to permit your child to participate in this research is yours to make and will have no bearing upon their treatment or your involvement at the [Name of] Clinic. You or your child has the right to withdraw from the study at any time without giving a reason.

I will telephone you in a few days to answer any questions you might have.
I look forward to speaking with you,

Yours sincerely,

Arabella Bowen
Psychologist, B.Sc. Hons., M.A.
Appendix V

[NAME OF] HEALTH AUTHORITY

Ref: ..............


PARENT/LEGAL GUARDIAN CONSENT FORM

Please ask the parent/legal guardian to complete the following:

Please circle as appropriate

Have you read the Parent/Legal Guardian information sheet? YES/NO

Have you had an opportunity to ask questions and discuss the study? YES/NO

Have all your questions been answered satisfactorily? YES/NO

Have you received enough information about the study? YES/NO

Who have you spoken to about the study? Dr/Mr/Ms ..................

Do you understand that you are free to withdraw your child from the study
- at any time
- without having to give a reason
- without affecting your child’s future care? YES/NO

Do you agree for your child to take part in this study? YES/NO

Signed: .................................................. Date..............
(Parent/Legal Guardian)

Name in capitals: ..................................................

Witnessed: .................................................. Date..............

Signed: .................................................. Date..............
(Researcher)

Note: On completion of the trial the signed consent forms must be sent to the Chief Executive of the [Name of] Health Authority for storage. This is the responsibility of the researcher.
[NAME OF] HEALTH AUTHORITY


PATIENT CONSENT FORM

Please ask the patient to complete the following:

Please circle as appropriate

Have you read the patient information sheet? YES/NO

Have you had an opportunity to ask questions and discuss the study? YES/NO

Have all your questions been answered satisfactorily? YES/NO

Have you received enough information about the study? YES/NO

Who have you spoken to about the study? Dr/Mr/Ms ..............................

Do you understand that you are free to withdraw from the study - at any time - without having to give a reason - without affecting your future medical care? YES/NO

Do you agree to take part in this study? YES/NO

Signed: .................................................. Date ..................
(Patient)

Name in capitals: ..............................................................

Witnessed: .................................................. Date ..................

Signed: .............................................................. Date ..................
(Researcher)

Note: On completion of the trial the signed consent forms must be sent to the Chief Executive of the [Name of] Health Authority for storage. This is the responsibility of the researcher.
SEMI-STRUCTURED INTERVIEW SCHEDULE

Participant No.:

AREAS TO BE COVERED WITH EACH PARTICIPANT BEFORE THE INTERVIEW BEGINS:

• Thank you for volunteering to take part in this research. I hope that you will benefit from the chance to talk about your personal experience of self-injurious behaviour.

• I hope that this research will influence the training of staff working with young people.

• I would like you to read the consent form that you were given before we met and for you to ask me any questions you may have about this research before I ask you formally to give your consent to the interview.

• I would like you to know that you can stop the interview if you want to and you do not have to give a reason. If you do not want to answer a question just say so and we will move on to the next one.

• I will keep what you say to me private unless there is a risk to yourself or others. We will have a brief meeting with a member of staff when we finish the interview, to handover how it went. I will not pass any information on without talking to you first. No names will appear in the write-up.

• I will provide a summary of the results which you will be able to request.

(ALLOW TIME FOR PARTICIPANT TO READ THE CONSENT FORM)

• Do you have any questions? (record)

(SIGN/WITNESS CONSENT FORM)

Record interview date:_____________________

Record time interview began:_______________

• This interview is concerned with gathering accounts of the ways in which adolescent self-injurious behaviour affects you, your attitude and views towards self-injurious behaviour, and what you feel about the way that it is managed: the help that is offered, and the information available. There are no right or wrong answers, and the questions are designed so that you can answer the subject area as freely as possible. The interview is divided into six parts, and the first section starts with some background information.
BACKGROUND INFORMATION

- To begin, I’d like to get some basic information about you (such as your age, and education). The reason that I’d like this information is so that I can show those who read the research report that I managed to obtain the views of a cross-section of people. The information that you give will never be used to identify you in any way because this study is entirely confidential. However, if you don’t want to answer some of these questions, please don’t feel that you have to.

1. Are you: male __ female __

2. How old are you? [ ] age [19] year born

3. Which of the following ethnic groups would you say you belong to? (tick the appropriate answer)
   - Black-African __
   - Black-Caribbean __
   - Black-Other __
   - Chinese __
   - Bangladeshi __
   - Indian __
   - Pakistani __
   - White __
   - Other (please specify): ________________

4. What is your highest educational qualification? (tick the appropriate answer)
   - None __
   - GCSE(s)/O-level(s)/CSE(s) __
   - AS level(s) __
   - A-level(s) __
   - S level(s) __
   - Diploma (HND, SRN, etc.) __
   - Degree __

5. Who do you live with at weekends outside of the clinic?

   Is this different to your family/home situation?
## SELF-INJURIOUS BEHAVIOUR INVENTORY

**Instructions:** Please answer the following questions by ticking either, “Yes,” or “No.” Tick “yes” only to those items that you have done intentionally, or on purpose, to hurt yourself.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Have you ever intentionally, or on purpose,...</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1. Overdosed? (If yes, number of times ; last time )</td>
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<tr>
<td></td>
<td></td>
<td>2. Cut yourself on purpose? (If yes, number of times ; last time )</td>
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<td></td>
<td>3. Burned yourself on purpose? (If yes, number of times ; last time )</td>
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<td></td>
<td></td>
<td>4. Hit yourself? (If yes, number of times )</td>
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<td></td>
<td></td>
<td>5. Banged your head on purpose? (If yes, number of times )</td>
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<td></td>
<td></td>
<td>6. Scratched yourself on purpose? (If yes, number of times )</td>
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<td></td>
<td></td>
<td>7. Attempted suicide? (If yes, number of times ; last time )</td>
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<td></td>
<td></td>
<td>8. Prevented wounds from healing?</td>
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<tr>
<td></td>
<td></td>
<td>9. Made medical situations worse, on purpose (e.g., skipped medication)?</td>
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<tr>
<td></td>
<td></td>
<td>10. Abused prescription medication?</td>
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<td></td>
<td></td>
<td>11. Exercised an injury on purpose?</td>
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<tr>
<td></td>
<td></td>
<td>12. Starved yourself to hurt yourself? (If yes, number of abuse episodes )</td>
</tr>
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<td></td>
<td></td>
<td>13. Abused laxatives to hurt yourself?</td>
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<td></td>
<td></td>
<td>14. Abused alcohol to hurt yourself? (If yes, number of times passing out , near death )</td>
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<td>15. Abused drugs to hurt yourself? (If yes, number of times passing out , near death )</td>
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<tr>
<td></td>
<td></td>
<td>16. Driven recklessly on purpose? (If yes, number of times )</td>
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<td></td>
<td></td>
<td>17. Been promiscuous (i.e., had many sexual partners)? (If yes, how many )</td>
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<td></td>
<td></td>
<td>18. Had unprotected sex to put yourself at risk? (If yes, number of times )</td>
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<td>19. Lost a job on purpose? (If yes, number of times )</td>
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<td>20. Set yourself up in a relationship to be rejected? (If yes, number of relationships )</td>
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<td>21. Distanced yourself from God as punishment?</td>
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<td>22. Engaged in emotionally abusive relationships? (If yes, number of relationships )</td>
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<td>23. Engaged in sexually abusive relationships? (If yes, number of relationships )</td>
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<td>24. Tortured yourself with self-defeating thoughts?</td>
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Have you engaged in any other self-destructive behaviours that were not asked about in this inventory? If so, please describe these.

*Adapted from Sansone, Wiederman & Sansone (1998)*
YOUNG PERSON INTERVIEW

Section 1: BACKGROUND DETAILS

Could you tell me who you regard to be in your immediate family? (E.g. parents, siblings...)

Do you feel any part of your family history has contributed to how you came to be staying at this clinic? And if so, what part(s) of your family history?

Can you tell me about your condition, and the treatment you have received to date?

How does this link to your self-injurious behaviour?

EXPERIENCE & CONTEXT OF SIB

What was your definition of self-injurious behaviour before coming to this clinic? And, how is this different to now?

How do you harm yourself?

What other ways have you seen other people harm themselves?

If you do not ‘self-harm’ in the traditional sense, what other activities do you occasionally get into which you would consider to be self-injurious behaviour? (Go straight to SIB inventory)

How long have you been SIB yourself? (SIB = their ‘word(s)’)

Can you describe what usually happens (e.g., how often, when, where it happens)?

What else do you do and use, and where else on your body? (Prompts)

What is the experience of SIB like? (Await response: elaborate on their points. Prompt for associated cognitions, feelings at the time and subsequently)

• To broaden the range of self-injurious acts we are discussing, I’d like to show you a list of behaviours which some people consider to be self-injurious. Could you tick and tell me which ones you have ever done yourself?

(ALLOW TIME TO READ SIB INVENTORY)

What would you add or remove from this inventory?
Section 2:  EXPLANATIONS OF SIB

Why do you think you self-harm?

How do you explain it to other people? (e.g., explain scars)

When did you first start and why?

Are there common situations or feelings that lead up to it?

What seems to be the trigger for you to SIB again?

Do these triggers change? (e.g., over time, situations)

Does the SIB change anything? (emotionally/physically/spiritually)

Why do you think other people SIB? (self-harm, cut)

How do you feel about them?

Section 3:  PERCEPTIONS OF GENDER DIFFERENCES

What contact do you have with people of the same and opposite sex who self-injure?

Do you talk about your experiences with them? (other young men and/or women)

What is your experience of any similarities and differences between young men and young women who harm themselves?

Do you think your experiences reflect how things are generally?

In thinking about young men and young women who harm themselves, specifically in relation to the wide range of self-injurious behaviours:
- In what ways are they similar and different in how they view themselves?
- How are they similar and different in their attitude towards others who self-injure?
- Which self-injurious behavioural acts do they do that is similar or different from each other?

Where do you think people’s assumptions behind SIB similarities and differences come from?

What are your responses based on? (observation, speculation, discussion, other sources)

How do you explain [real or imagined] SIB gender differences and similarities? (What would be your pet theory..., understanding based on..., different motivations...)

Do you think young men and young women are treated the same or differently in relation to their SIB? In what way?
From another perspective, do you think society sees young men and young women's SIB differently? If so, how?

What are some of the expectations placed on them by society in relation to their SIB? (in attitude/behaviour)

Section 4: ETHICAL ISSUES

What do you think the ethical issues surrounding (your) SIB are? (social, religious or moral values, concern over what is considered right and wrong behaviour, worry about legal issues)

What do you think the adults involved in your care should most be concerned about in relation to your SIB? (staff, friends, family)

What are you most worried about for yourself?

What emotional impact does your self-injurious behaviour have on others? (family, friends, staff or other young people)

How do you think your SIB makes them feel?

How do you feel about other people knowing about your SIB?

What are your attitudes and feelings towards other people who self-harm?

How does others' SIB make you feel?

Section 5: TREATMENT OF SIB [RESPONSE OF OTHERS]

When you SIB what do people normally do?

What do you think and feel about that?

Remembering back to your last incident of SIB, how would you have liked staff to respond ideally?

How would you have liked other young people to respond ideally?

Looking back, say a week later, would you still feel the same way?

What kind of support would you provide to someone who was self-harming? (help, advice, therapy intervention)

Have your views on SIB changed over time? If so, how did this come about? (books, TV, Internet, friends, self-initiated)
Section 6: CLOSURE OF INTERVIEW

Is there anything else you would like to tell me about your experiences or views which I have not asked you about?

Is there anything about this interview that you have found distressing, and that you feel it would help to return to and get more support with?

(RETURN TO ANY ISSUES THAT MAY NEED PASSING ON AND DISCUSS WITH THE YOUNG PERSON)

Prompts for the investigator to encourage more detailed responses:

_How helpful do you find that_
_Could you give an example of what you mean_
_What makes you say that_
_Could you say more about that_
_I wonder if you could talk a bit more about that_
DEBRIEFING

AREAS TO BE COVERED:

- Thank you for taking part in this interview. I hope that this research will help people to understand self-injurious behaviour in young people better. Before we finish, I have a few questions about the interview.

How do you feel having finished the interview?

Was there anything that was particularly upsetting or confusing in it?

What did you find helpful or unhelpful about the questions asked? [In what way was it helpful/unhelpful?]

Do you think there were important things missing in the interview?

Do you have any questions now about the interview or what I will do with the information?

If you think of any other questions about this research please tell your Keyworker and they will contact me. I will get back to you as soon as possible.

What motivated you to take part? Why do you think you chose to participate?

Would you be interested in being interviewed again next year if this becomes a two-part study?

I would like to present a summary of this research when I have finished it. Would you like to receive a copy if you are no longer at the clinic? I would be very grateful for any comments you may have about the summary.

Lastly, we will now be meeting with a member of staff to discuss how the interview went. Is there anything you would like me to convey to them? Do you have any questions about this before we go?

- Thank you for your help. I would like to reassure you again that all you have said today will remain anonymous in the write-up.

Record time interview ends __________________________
Appendix XII

YOUNG PERSON INTERVIEW: LEYAH

- This interview is concerned with gathering accounts of the ways in which adolescent self-injurious behaviour affects you, your attitude and views towards self-injurious behaviour, and what you feel about the way that it is managed: the help that is offered, and the information available. There are no right or wrong answers, and the questions are designed so that you can answer the subject area as freely as possible. The interview is divided into six parts, and the first section starts with some background information.

Section I: BACKGROUND DETAILS

How old are you? 18  What year were you born in? 1981

Could you tell me who you regard to be in your immediate family?

My mum, my dad, most likely my step-mum, my half-brothers, my half-sister, my full sister, my grandparents, my cousins, my aunts, my uncles.

So you have actually got quite a big family. Who do you live with?

I live with my mum and my step-dad and my sister, my half-sister, but I count her as my sister.

I'm with you. Do you feel any part of your family history has contributed to how you came to be staying at this clinic? And if so, what part(s) of your family history?

I think that when I was a very little girl, my whole family, practically all of the females were really obsessed with dieting and it became quite a structure of my life. Like my mum would have this sheet on the fridge that would have a smiley face saying "yes" on it and a sad face saying "no" on it and it would list all of the bad foods and all of the good foods, so from a very early age I learnt that you can't have these foods and you can have these foods. That led to a very bad eating disorder.

Bulimic, anorexic, both?

Bulimia. Even though, after I had my liver transplant, I lost a lot of weight and I went down to seven stone and I couldn't eat at all and they did think that I was anorexic for a while, but I wasn't. There've been a lot of times when I've tried to be anorexic, but it was too hard.

It doesn't work for you. You mentioned you had a liver transplant. What happened there?

I took a huge overdose. I took 63 Paracetamol. I didn't tell anyone for about a day and half, two days and then my mum just guessed and she immediately made me ring the hospital and they immediately got me an ambulance and my liver had already deteriorated. I was dying and everything.
So I suppose to get a liver transplant that must have happened quite quickly as well. Where you on dialysis?

Yes, everything.

I don't know too much about it. I was going to say how do parts of your family history link with your self-injurious behaviour, obviously an overdose, that does. Is there anything else do you think?

Of my family?

Yes.

Well, I know that my sister, when she was I think 15, 16 or 17 she was quite badly bulimic and her teeth went rotten and stuff and she was also anorexic for a while and her periods stopped and everything. My dad’s cousin, committed suicide and my mum’s cousin committed suicide as well.

There's quite a lot of sadness and suffering.

**EXPERIENCE & CONTEXT OF SIB**

What was your definition of self-injurious behaviour before coming to this clinic? And how is this different to now. How would you have defined it before coming here?

Before I came here I had been in various psychiatric hospitals as well and whenever anyone said the word self-harm, I just thought it meant that they cut themselves, but now I think of it as eating disorders and overdoses and things like that.

So those would have been your words as well even before, “self-harm”; or do you think you thought of it like that even before the other psychiatric clinics?

What do you mean, people cutting themselves?

Yes.

Yes.

Did you come across much of it beforehand, I mean in school, friends or–?

I didn’t experience any cutting, but I did experience some of my friends having eating disorders, taking overdoses, feeling very suicidal.

Which is quite common. How do you harm yourself?

Well it’s been three weeks since I stuck my fingers down my throat, but that went on for five years. There was a year and a half when it stopped completely.
There might have been just three times in that year and a half that I did it, because I was put on Prozac and that would really really help me to control it and I wasn’t obsessed with myself at all. I even think that having so much negativity and saying and believing that you are suicidal; I think that’s self-harm as well. Obviously the overdoses I’ve taken as well.

Are there any other ways?

I think that when I was very little, I think that I was 9, 10 or 13 and I used to get deodorant glass bottles and I used to hit myself on the arms and get these big bruises, but it was only on occasions that I would do it. When I was in [Name of] Psychiatric Hospital, I actually received these flowers from this horrible man and I actually threw the vase across the room. I don’t know whether that’s self-harm; I think it’s because you are so angry.

What other ways have you seen other people harm themselves? You mentioned that you had seen other people feeling suicidal and stuff, what else have you seen other people do?

I know that in my last hospital there was a woman I had to share a dormitory with, she was in the bed next to me, and we were watching the television and we couldn’t go back to our room and I wanted to know why. I found out that she had jumped out of the window and she actually died. They said that it was because they gave her an injection and it went wrong, but I knew that she was suicidal already, because I did kind of know her. I also had some friends in the other hospital and one of them he had awful cuts; I mean here it looks like scratches what they do to themselves, these terrible cuts and he was picking at it and my dad had come to see me and all this blood literally gushed everywhere. I actually fell down on the floor; I was hysterical because it looked so bad. I still think people here are self-harming, but compared to what I’ve seen, it’s really nothing.

That does sound very awful.

I used to have these other friends who used to get pieces of glass and cut up themselves. A friend of mine who cuts all over her face and all over her body, you couldn’t see any skin at all, it’s just really bad. Of course eating disorders can be really bad as well because there was an Eating Disorder Clinic at the other hospital and I mean some of them were literally dying and it was really sad – so eating disorders, suicide attempts, cutting, all the things like that.

How long have you been self-harming, or cutting or overdosing, what word do you use for it. Do you use SIB or self-harm?

I use self-injurious, because it is very self-centered really.

So how long have you been?

I think that when I was 9, I started hitting myself with bottles, but that was really just on occasions really. I started being very badly bulimic when I was 13; it was
just kept a secret for so long. I was bullied very badly at school and I remember this boy just kept telling me that I was fat all the time, and that was horrid. But it just devastated me and I took my first overdose when I was 13. Then I literally forgot about it – I mean this has little relevance, but at the first psychiatric hospital I went to, I was diagnosed as having manic depression, which I don’t have, which I was told in the last psychiatric hospital. I went to a group for manic-depressives and this guy was saying how he had overdosed and stuff like that and I had completely forgotten about overdosing. Shortly before that, the true love of my life had broken up with me and I still can’t cope with it and I definitely couldn’t cope with it then, knowing that I had this terrible mental illness at such a young age. I was watching this music concert that I knew he would be going to and I just went and took some pills, because I had heard it from this man and I just thought; overdose. Then again I did it last June. So it started a little bit when I was 9, but really from 13 to 18, but hopefully when I turn 19 it will all stop, even though I have just been saying in the group that I want to die, so I still feel really bad.

"You said a little bit about how the experience happens; what does actually happen, like how often, when does it happen?"

How does it happen?

Yes.

I think that the throwing up is a lot at home when I just excuse myself to powder my nose or something; everyone is talking merrily and –

"That’s when you just go upstairs?"

Yes. It’s also been done HERE a great deal; it’s been done in all the psychiatric hospitals, restaurants.

"So what do you actually do; do you drink a lot of water to help you throw up, is that how it happens?"

No, I just immediately go to the toilet afterwards; I just run to the toilet or I eat very quickly so that it’s not digested properly and it will just come up so easily. It’s just sticking your fingers down your throat.

"What’s the experience like?"

It’s awful; it’s really awful. It’s been just over three weeks now and it’s been unbearable for me to cope with the fact that I’m not harming myself any more, but in saying that I did drink washing up liquid a couple of weeks ago, but it’s so hard not to throw up, because it’s control. Even though it doesn’t really help you to lose weight, it’s really really hard. I think that it should stop because I don’t like all the attention I get from it. Also it really is PURE vanity, because it makes my face really bloated. I’ve looked at pictures when I was little and my neck was quite thin and now it’s very swollen. It’s a lot to do with vanity.

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• To broaden the range of self-injurious acts we're discussing, I'd like to show you a list of behaviours which some people consider to be self-injurious. Could you tick and tell me which ones you have ever done yourself?

You see I see overdosing as taking pills, because HERE they say because I've had bubble bath and washing up liquid, they say that's overdosing, but I see it as taking pills.

-Is that burned yourself?

I used to do that thing with the bottle, but quite a lot of the time when I hear myself talking; I just slap my face.

They're quite in your face aren't they; they just list them as they are [referring to the checklist].

A lot of times I can't even think. I put bags on my head; more than twenty; I can't remember. What's abusing prescription medication?

I suppose that's if you are given drugs and you overtake or undertake the dose or just mess around-

I was actually put on Section for doing things like that.

It's a difficult one that; setting yourself up in a relationship when you know that you are going to be hurt or rejected.

Yes.

It's a bit like what you were saying before; the torturous thoughts, thinking badly about yourself.

Is there anything that you would add to that list, that you might not have done, but you think is self-injurious, or anything that you would take off as well, that you wouldn't consider?

I think that maybe, erm, if someone was being over-provocative or something-

Provocative aggressive; provocative sexually?

Sexually. And aggressive, but more sexually, because I think that's self-injurious.

So setting yourself up to get abused almost, to get used.

I'm sure there are more, but I can't think.

Section 2: EXPLANATIONS OF SIB

Why do you think you self-harm? I think because I hate myself so much and I don't know how to deal with myself. I'm quite scared of myself really, because I am very
temperamental and unpredictable and I get really guilty about things, like my parents' divorce and I always blame things on myself, but then when I’m very rude to people and very distant and when I get in a state and won’t let people touch me, I get very ‘Oh I must go and do something to myself.’ I feel I must go and do something to myself because it discourages some people. And really a lot to do with my overdose, when I had my transplant, so I feel really guilty about that, but most of the time I just wish it could’ve been someone else that got the liver instead of me.

How DO you explain it to other people?

I get quite touchy about explaining it to other people.

So do you explain it to other people? What do you say?

I mostly get very upset and start crying or I just – since my transplant my thoughts are often very confused so I just try to explain it as best I can or I just choose to ignore them.

I think you mentioned when you first started; I think the first thing was hitting and then the overdose thing; why do you think that was?

I think that the hitting was the fact that I didn’t have my daddy around and it was really hard for me and my mother just went to work all the time and I had all these au-pairs looking after me and it was really hard. I used to cry all the time “I want my mummy” and I would get really upset.

It was really hard. When did you first start and why?

It was probably when I was 9 because I started dieting then as well, and 10.

The bullying you said as well?

It was the bullying and it was a lot to do with my parents’ divorce and I was always very shy; I mean I’m not that shy anymore, but I’ve always had low self-esteem and not been very confident.

Are there common situations or feelings that lead up to it?

I think that if there’s a family gathering it’s very hard for me. It’s not so much that I’m asked lots of questions, it's people saying, “oh you look so much better” and actually inside I just feel like complete SHIT. It’s awful, it’s like you can’t see, because I have got all this makeup on and dolled myself up; it’s really hard and a lot of the time with the bulimia I would eat and immediately go and throw up and I already felt nauseous anyway from being there, so it was really hard. I know that when I first came here, [Patient name] took an overdose and, it sounds really horrible, but I really wanted the attention to be on me. I pretty much always wanted to die, but my heart wasn’t so much set on it, but at that time I kinda wanted the attention to be on me as well, or me even more, so I just went and took some bubble bath, because I wanted it to be me. I think that with a lot of people, I can tell from experience, I think a lot of it is for attention. I’m-
not trying to say that they are attention seekers, but it's really a cry for help to be noticed.

To be noticed, to be seen?

Even to have people worried about you, which is what people like. I mean I don't really like it that much, but sometimes I really want people to worry about me and to understand how much pain I'm going through. On the other hand I see how much pain they go through because of me and I'm just wasting my own life and wasting everyone else's time.

What seems to be the trigger for you to self-injure again? I know that you mentioned that it's coming up to three weeks, but what do you think are the triggers that would be around?

I think with the throwing up bit, it has a lot to do with: like I wake up in the morning and say, 'right, I'm not going to have any biscuits, I'm not going to have any chocolates', I rule out all these foods and then I go and eat them and then I think, 'what have I done?' and then I just go and throw up.

So it's having all the food around which is the trigger?

Yeah. Especially in a Jewish family there's a lot of food around, so it's very hard.

Do these triggers change over time? Situations?

I think that sometimes if I talk to people. I know that at times I was put on one-to-one observations in various hospitals and that would control me more, but that would still make me feel really bad and I would still try and attempt suicide, but a lot of the time I couldn't throw up because people would be watching me, so it would be really hard.

Does the SIB change anything, emotionally/physically/spiritually?

Well I know that when I was in [Place name] to have my operation I was asked if I heard voices and I said "no" and ran out of the room because I thought that they would think that I was schizophrenic, but I actually do, because my mother went to see a psychic and she told my mother that my guardian angel is my great grandmother and it was even before I took my overdose that I was hearing some kind of voices and I even told the lady; she asked me why I took the overdose, and I said because there was a voice in my head which said that it would work this time. I have just been hearing all these voices saying - don't throw up - and really badly saying, sometimes I don't know who it is and whether it actually is my great grandmother speaking to me or whether it is myself and sometimes I think it is the devil or God or [Name] - my grandfather's best friend who died very recently or if it is this guy who gave me his liver; I don't know who it is and it drives me mad. They tell me all sorts of terrible things and a lot of the time I will go and harm myself because I can't get these voices out of my head. I do pray to God a lot to help me and guide me, but emotionally hurting yourself just makes everything so much worse.
With bulimia your emotions are all over the place, your hormones are mucked up, your appearance is terrible; it’s really awful. Lots of people are wary of you because you hurt yourself so much. You just get very upset that they distance themselves from you, like my cousin and my mother for instance are very distant to me now.

So it has changed the contact that you have with them now?

Yes

I think you said a bit about why you think other people self-injure, you said sometimes it is for attention, to have people worry about them. Are there any other reasons?

I think it’s because they’re going through a great deal of pain and it’s like a release. I know that if I did it and I had this scar, I looked at it and I thought ‘I cut myself because I was feeling bad’, but now look I’ve got this for God knows how long now. It’s like I have this huge scar from my transplant and I look at it and think ‘what were you thinking?’, even though I do still feel that way, it has such a dramatic impact on your life; it’s horrible. If anyone sees it, I will have to explain it to them; it’s hard.

How do you feel about other people who self-injure?

A lot of the time I feel a lot of anger and frustration towards them because I know that I don’t cut myself; I do other things. I know that stereotypically when people say self-harm, people immediately think of cutting which is what I immediately do think of as self-harm, even though my opinion HERE has changed. It’s just to do with pain. I don’t feel very nice about it. I would like to help them in a way, but I do think it’s for a lot of attention. For instance one of the girls here said, “do you want to see my self-harm?” and I said, “no, that’s pathetic”. There are a few of the girls here who don’t show at all and keep their long sleeves on. When I first saw them I had no idea. Some of them will walk around with their shorts on and crop tops and it’s almost like a fashion statement – ‘look at ME, I hurt myself’ And that’s awful really, it disgusts me in a way.

There’s quite a lot of feeling there.

Section 3: PERCEPTIONS OF GENDER DIFFERENCES

The next bit is about gender differences, whether there are any or not, because it’s not something that people normally look at. What do you think are the similarities and differences in attitude between young men and young women who harm themselves?

I think that young men do harm themselves, but they’re very scared of women doing it. They’re very wary ‘why aren’t we eating, why do you make yourself throw up?’. For instance, my friend says that to me and he won’t have anything to do with me any more because he doesn’t understand the suicide attempt.
I just said to him ‘If you don’t understand, I don’t think you want to understand, that’s fine’, but inside I was dying because he was one of my best friends. I think that a lot of men do it, but they see women differently; they see women as weaker, you know, ‘Of course women do it, you know she’ll do it because she has her period.’ A lot of the time if you’re upset they’ll say, “do you have your period?” It’s really awful. It’s like I can’t have a feeling without having my PERIOD. It’s terrible. It’s just not very nice. I know a lot of men who do it, they do it more dramatically than women do, like they will shoot themselves, they will put the gun in their mouth and a woman will take pills; it’s very different.

That was my next question: What are the similarities in behaviour between young men and young women; what do they do that’s different or the same? You mentioned shooting, pills; what else do you think?

I keep adding to the list-

That’s fine, it shows that it flows.

I basically think that it’s so dramatic the way that men do it. I think that a huge percentage of them hang themselves, although I know a lot of women do that as well.

That’s something which is not actually on the list. I hadn’t thought of that either – so that’s something that could be added: hanging or strangulation.

That’s really awful. I suppose in a way some of them – I think in young women and young men a lot of the suicide attempts are seen as glamorous almost, it’s like, “I took an overdose”, it’s almost fashionable – it’s not something to be proud of. I know when I was younger I thought that I was quite cool, I had seen so much pain, it’s terrible.

Cool, as in – can you say a bit more about that?

Like WOW really fashionable. I didn’t really understand what an overdose meant.

Do you think young men and young women are treated the same or differently for their self-injurious behaviour and in what way?

I think that young men are frowned upon more, you know, you should be this big macho guy who can handle everything and now you are being this weak little thing. They’re not even allowed to cry most of the time. They have to keep their emotions inside. It’s really terrible because they’re going to explode obviously and then they go and hang themselves, or shoot themselves or overdose or anything, it’s just really, really terrible. When they cut themselves it’s really awful as well, but I think that it’s more common for women, they’re just seen as – “oh you POOR thing”, but with men it’s different. It’s really sexist.

How do you understand and explain gender differences and similarities in relation to self-injury. How would you explain that?
I don’t think that anyone should self-injure themselves at all, but I think that men and women have every right to do the same things, but I don’t think that they should self-injure themselves. I think it should just be the same.

*Do you think that they have the same motivations to harm themselves?*

No, I think that a vast majority of women are concerned with their looks and breakups with their husbands or their boyfriends and things like that and they get very distressed, but I know that there’re a lot of men who get very distressed at breakups of relationships as well.

*Maybe in a different way?*

A lot of the time for men, they’re brought up to be like their fathers and they fail and they feel really bad and they commit suicide because they’re brought up to have these great expectations which they can’t keep because maybe they just want to be themselves. I think that’s got a lot to do with it as well.

*From another perspective, do you think society sees young men and young women’s self-injurious behaviour differently and, if so, how?*

I think that society sees them different – like, erm, I think for instance, I don’t know if this is true, but I think that quite a lot of black people think, ‘you can’t do that to yourself’, more than white people.

*That it’s not culturally acceptable?*

No, I don’t think it is and very much so with the Catholics as well, especially in places like Italy it’s not accepted at all – because you’re given life. I think that society sees it very badly, but I think that they favour women more – that they self-injure because, you know, they are weak and maybe they have got post-natal depression, maybe they have got PMS; men, they can’t do that. So society takes a very sexist view.

*What do you think are some of the expectations placed on them; different attitudes or behaviours; to self-injure, not to self-injure?*

I think that a lot of people in society are brought up NOT to know about it, but then if you are dumped in a psychiatric hospital you WILL know about it, so it’s quite hard.

*Do you think that there is a big difference between inside and outside, you know, what goes on, the attitudes?*

Yes. I have forgotten the question now.

*What are some of the expectations placed on them by society; the young men and young women, so the reasons why they-*

Transcript p.10
I think that the young men are expected to go to the army and become doctors, have these high professions; women are expected to bear children, be housewives. I think that there’re too high expectations of the males definitely.

To achieve?

To achieve the greatest – and a lot of them can’t. Again, they’ve got to be themselves. I think that their expectations are way too high, it’s terrible.

Does that go the same for women; do you think that the expectations on them are too high?

I don’t think that they are too high.

I suppose difficult in a different way.

Section 4: Ethical Issues

What do you think are the ethical issues surrounding your SIB?

I’ve completely forgotten what that means.

Ethical – I suppose, concern or worry for other people, or legally – there may not be any.

Surrounding my self-harm?

Yes.

I know that a lot of people are very anxious about me. For instance at Christmas time my big sister came over and she just said, “I don’t want you to die” and was just crying. It was really sad and it was really hard, but at the same time I feel like that, so I can’t keep holding it in, but obviously I wouldn’t say that to my little brother or sister, but it’s very hard for them because they just don’t know what to do most of the time. A lot of them are very cold and distant; I’ve lost lots of friends from it. On the other hand I have a lot of support.

What do you think the adults involved in your care should most be concerned about in relation to your self-harm?

They should just be concerned about how very suicidal I am, and how much I hate myself. How I have no idea what to do and how these voices, who I don’t know who they are, whether they’re spirits or me, that they’re absolutely bombarding me. They’re killing me because I don’t know what they are and they should really be aware of that.

What are you most worried about for yourself?
I’m just worried that I won’t ever be happy and I won’t ever live a life. Because I know that there’s a lot of potential in me to get better, but there’s this great big brick almost holding me back, saying, ‘don’t just carry on being this negative, miserable person’. Then there’s something else saying, ‘just get out and achieve my dreams because what if I did die tomorrow and I hadn’t done anything – it would be terrible’, but then on the other hand I think, ‘what’s the point, I shouldn’t even be here’. I get so irritable all the time; it’s not very nice.

*What emotional impact does your self-injurious behaviour have on others?*

I know that my mother gets very depressed. She was very depressed recently and in the past four months she’s had therapy and it’s made her very strong. Her voice is not full of emotion any more. It’s made a lot of difference to my family who’ve become very distant-

Wary?

Yes and with friends, I have very few, I don’t have many. I used to have a lot; I used to be quite a popular girl. It just has a great emotional impact on people. Some people get very sad, some people want to help and others are so distant that I feel they don’t care any more. They feel that they DO care, but they can’t get too close, because they can’t worry about me any more, they have to worry about themselves.

*How do you feel about other people knowing about your self-injury?*

I actually feel very embarrassed. I know that my step-mother told a lot of friends when I took my last overdose and it was very difficult for me because I just see myself as being a freak, the black sheep of my family. It’s just been increasingly hard and difficult. I know that she told one of her friends and she was praying for me; she came and said, “how are you – don’t do anything silly again”. I thought this is a rather strange context to say that in really. I know that my brother’s cousin, who is my step-mothers nephew said, “oh [Leyah’s] been taking drugs” and he said, “no, she just took an overdose”. I thought, “just took an overdose, just dying, just having this deteriorated liver ripped out of her body, cut in the middle of my body – “JUST”, you KNOW?

*Extreme, in a way?*

Yeah.

*What are your attitudes and feelings towards other people who self-harm. How does it affect you?*

A lot of the time I get angry with them, but I also get very sad for them, particularly in the abuse of alcohol as I see that as an escapism. I know a member of our family who’s an alcoholic and it’s very hard because I’ve seen people in other hospitals who are alcoholics and it was very difficult for them. It’s another form of escapism. I think, ‘what are you trying to escape from?’ I get angry and I think why can’t they just talk about it instead of abusing themselves all the time. Because when you’re in places like this and you’re trying to get out
yourself, you’re thinking this person did that and this person did this and then you get in a state and think, should I copy them? It’s really hard.

Yes, not knowing what to do?

Section 5: Treatment of SIB [Response of Others]

When you self-injure what do people normally do?

The doctors?

Anyone

They get really shocked. My family get very shocked, frightened, scared, terrified – my family and my friends. The first hospital I was in the doctors would immediately put me on antidepressants, which I do still want to be on because I do feel they help but, in saying that, I was put on Prozac and it stopped working and I know that it was a major factor in my suicide attempt, because it does motivate you to try to kill yourself. That was said in the papers, by the doctors, everywhere.

So a mixed sort of review about it.

Yeah

Remembering back to your last incident of SIB, how would you have liked staff to respond ideally? What would you have liked them to do, in the perfect sense?

I would have liked them to say, “look, Leyah, you are obviously in a lot of pain and we are going to give you this antidepressant which doesn’t make you—” because in the past I’ve got very high from antidepressants, so maybe they’ve got some kind of research. They spoke to my doctors about what would be safe for my liver and said – “obviously you can’t cope with anything, so you can just go on this antidepressant and see how it is, instead of—”

That would be ideal?

Yes. I mean I had to stay over the weekend; I mean I requested to stay over the weekend and they agreed, but then they said to me that there was a possibility that I would be institutionalised. “If we had been there we would have sectioned you on the spot” and I thought – who’re you to tell me that?

How would you have liked other young people to respond ideally?

I was actually glad that they were angry because I know that I would have felt the same.

So that was a good response?

I mean with my last one, that was with washing up liquid, but with the overdose,
the last overdose in June 1999, they were very sympathetic. I know one of my best friends was quite angry. I was so out of it I didn’t realise the anger until I read the card she wrote. She just wrote – "you KNOW that you are going to hear my mouth about this my dumpling" – so it wasn’t even, gosh she’s going to have a go at me, it was almost in jest. Sometimes I think, it’s a horrible way to put it, but sometimes I think that the novelty will wear off, because in a way it is almost a novelty. ‘Hey everyone pay attention to ME’ and they do for a while – it’s over now.

*It’s also about them having an opportunity to say how they feel about what has happened – what effect it had on them.*

*Looking back, say a week later, after the incident, would you still feel the same way?*

Yes I do.

*That’s a common feeling?*

I really do. It’s hard to say it, but in all honesty, I really do.

*What kind of support would you provide to someone who was self-harming: help, advice, therapy intervention?*

At the moment I wouldn’t be a great help, but if I was more balanced I would tell them of my own experiences, which I’ve been doing a lot here, apart from when I get really down and depressed and stuff. I just basically show them my scar and tell them the stories of what I’ve been through and how it’s not really worth it because actually – I can’t say this for myself right now – but there’re times when I have thought there is a tomorrow and it won’t be so bad tomorrow. When you talk about it – it’s a cliché, but ‘a problem shared, is a problem halved’.

*Have your views on SIB changed over time and if so, how did this come about? From books, TV, Internet, friends, yourself?*

I think I’ve got more angry about it because I do it to myself, so I think.... And then I see it on TV and people telling people and stuff. But there’s a lot of misunderstanding. Again it’s very hard. My views change as my mood change, a lot and quite regularly, but I don’t think that anyone else should do it to themselves. I don’t think that I should throw up any more, but I must find a way of controlling my weight, but I don’t think that people should do it to themselves. It still makes me very angry and frustrated that I can’t get through to anyone.

**Section 6: CLOSURE OF INTERVIEW**

*Is there anything else you would like to tell me about your experiences or views which I’ve not asked you about?*
I think that hurting people is self-injurious behaviour. I think that all the rapists, they are really disgusting and it's abominable what they do and they should be hanged. I do know people who've been raped, here and in other places and they all self-injure themselves because they think that it's their fault they were raped and abused and things. I think that's really terrible.

Is there anything about this interview that you have found distressing, and that you feel it would help to return to and get more support with?

I think just the fact that I feel so suicidal. These thoughts are really bombarding me, these voices, that I don't really know what they are and that my relationship with my mother has completely deteriorated.

So it's really thinking about those sorts of things that makes it difficult.

And the fact that when I'm trying to get better, I've everyone else's negativity around me and then I want to leave here.

DEBRIEFING

• Thank you for taking part in this interview; was it that bad?

It was a bit exhausting; emotionally draining.

I think it is, yes. How do you feel having finished the interview?

Satisfied. I feel like I was in a therapy session…

Transcript p.15
Example of Categorised Data from Transcript (Levah)

Key:
- `text-` paraphrased
- `'text'` direct quote
- `...` more to direct quote before/after
- `text` interviewer questions/comments
- `()` suggestions
- `[ ]` my interpretation

Themes | Pages Numbers | Extract
---|---|---
**1. Societal (Greater External Environment) / Western Influences**
Concern with external body image / appearance | (1,5,8, 10) | • ‘...my whole family, practically all of the females were really obsessed with dieting...’
• ‘Also it really is PURE vanity, because it makes my face really bloated. I’ve looked at pictures when I was little and my neck was quite thin and now it’s very swollen. It’s a lot to do with vanity.’ [result of purging]
• ‘With bulimia your emotions are all over the place, your hormones are mucked up, your appearance is terrible; it’s really awful.’
• ‘Do you think that they have the same motivations to harm themselves?’ ‘No, I think that a vast majority of women are concerned with their looks...’

Societal disapproval of SIB / received negative judgements | (9/10, 10,10, 12,15) | • [against men] = ‘I think that young men are frowned upon more...They’re not even allowed to cry most of the time. They have to keep their emotions inside...When they cut themselves it’s really awful as well, but I think that it’s more common for women, they are just seen as – “oh you POOR thing”, but with men it’s different. It’s really sexist.’
• [cultural differences] = “Do you think society sees young men and young women’s self-injurious behaviour differently and, if so, how?” ‘I think that society sees them different – like, erm, I think for instance, I don’t know if this is true, but I think that quite a lot of black people think, ‘you can’t do that to yourself’, more than white people.’ “That it’s not culturally acceptable?”
• [religious pressures] = ‘No, I don’t think it is, and very much so with the Catholics as well, especially in places like Italy it’s not accepted at all – because you’re given life. I think that society sees it very badly, but I think that they favour women more – that they self-injure because, you know, they’re weak and maybe they’ve got post-natal depression, maybe they’ve got PMS; men, they can’t do that. So society takes a very sexist view.’[moral differences to what is considered acceptable]
• ‘I know that my brother’s cousin, who’s my stepmothers nephew said, “oh Leyah’s been taking drugs” and he said, “no, she just took an overdose”. I thought, ‘just took an overdose, just dying, just having this deteriorated liver ripped out of her body, cut in the middle of my body’ – “JUST” you KNOW’ [received judgement from family members-minimising (?)]
• ‘...the fact that when I’m trying to get better, I’ve everyone else’s negativity around me and then I want to leave here.’ [wanting support, and implied reduction of judgements]

2. Concern with Others / Social Comparisons
Concern with attitudes of others | (1,12, 14) | • ‘can and can’t have foods-
• ‘I know that my brother’s cousin, who’s my stepmothers...
nephew said, “oh Leyah’s been taking drugs” and he said, “no, she just took an overdose”. I thought, ‘just took an overdose, just dying, just having this deteriorated liver ripped out of her body, cut in the middle of my body’ – “JUST” you KNOW [angry at received negative judgement from others]

- “How would you have liked other young people to respond ideally?” I was actually glad that they were angry because I know that I would have felt the same…I know one of my best friends was quite angry. I was so out of it I didn’t realise the anger until I read the card she wrote. She just wrote – “you KNOW that you are going to hear my mouth about this my dumpling” – so it wasn’t even, ‘gosh she’s going to have a go at me,’ it was almost in jest.’

Reactions toward peers’ SIB [*Split in thinking between own SIB and that of others, as if the two do not equate (!)]

(8) “How do you feel about other people who self-injure?” ‘A lot of the time I feel a lot of anger and frustration towards them because I know that I don’t cut myself; I do other things... I would like to help them in a way, but I do think a lot of it is for attention.’

Impact on others - emotional

(1,3,6, 8,9,11, 12,13, 14) • ‘...my mum just guessed and she immediately made me ring the hospital’...[fear]

- ‘I also had some friends in the other hospital and one of them he had awful cuts...and he was picking at it and my dad had come to see me and all this blood literally gushed everywhere. I actually fell down on the floor, I was hysterical because it looked so bad’ [hysteria]

- ‘I feel I must go and do something to myself because it discourages some people.’ [intimacy vs. distancing of others]

- ‘Lots of people are wary of you because you hurt yourself so much. You just get upset that they distance themselves from you, like my cousin and my mother for instance are very distant to me now.’ [wariness, distrust, distancing, rejection]

- ‘I think that young men do harm themselves, but they’re very scared of women doing it. They’re very wary ‘why aren’t we eating, why do you make yourself throw up?’ For instance, my friend says that to me and he won’t have anything to do with me any more because he doesn’t understand the suicide attempt. I just said to him ‘if you don’t understand- I don’t think you want to understand, that’s fine’, but inside I was dying because he was one of my best friends.’ [distancing, rejection]

- ‘I know that a lot of people are very anxious about me. For instance, at Christmas time my big sister came over and she just said, “I don’t want you to die” and was just crying. ...but it’s very hard for them (siblings) because they just don’t know what to do most of the time. A lot of them are very cold and distant; I’ve lost lots of friends from it.’

- “What emotional impact does your self-injurious behaviour have on others?” I know that my mother gets very depressed...It’s made a lot of difference to my family who’ve become very distant...It just has a great emotional impact on people. Some people get very sad, some people want to help and others are so distant that I feel they don’t care any more. They feel that they DO care, but they can’t get too close, because they can’t worry about me any more, they have to worry about themselves.’ [significant others give responsibility back to young person; results in emotional distance / blunting]
- 'They get really shocked. My family get very shocked, frightened, scared, terrified - my family and my friends.'
- ‘...the last overdose in June 1999, they were very sympathetic. I know one of my best friends was quite angry. I was so out of it I didn’t realise the anger until I read the card she wrote. She just wrote – “you KNOW that you are going to hear my mouth about this my dumpling” – so it wasn’t even, ‘gosh she’s going to have a go at me’, it was almost in jest...’ [awareness of making others angry]

### Competitiveness (comparisons with others)

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<thead>
<tr>
<th>(2,3,7,8,9)</th>
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<tr>
<td>- ‘my sister...my dad’s cousin...my mum’s cousin...’ [sibling rivalry]</td>
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<td>- ‘I still think people here are self-harming, but compared to what I’ve seen, it’s really nothing.’</td>
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<td>- ‘[Patient name] took an overdose and, it sounds really horrible, but I really wanted the attention to be on me.’</td>
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<td>- ‘I would like to help them in a way, but I do think a lot of it is for attention... There’re a few of the girls here who don’t show at all and keep their long sleeves on. When I first saw them I had no idea. Some of them will walk around with their shorts on and crop tops and it’s almost like a fashion statement – look at ME, I hurt myself’</td>
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<td>- ‘...I suppose in a way some of them – I think in young women and young men a lot of the suicide attempts are seen as glamorous almost, it’s like, “I took an overdose”, it’s almost fashionable – it’s not something to be proud of. I know when I was younger I thought that I was quite cool, I had seen so much pain, it’s terrible.’</td>
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### Copy-cat behaviours

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<th>(7,13)</th>
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<td>- ‘I pretty much always wanted to die, but my heart wasn’t so much set on it, but at that time I kinda wanted the attention to be on me as well, on me even more, so I just went and took some bubble bath, because I wanted it to be me.’ [rivalry, jealousy]</td>
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<td>- ‘...when you’re in places like this and you’re trying to get out yourself, you’re thinking this person did that and this person did this and then you get in a state and think, should I copy them? It’s really hard.’ [needs self-restraint – different to being competitive (?)]</td>
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### 3. Self (focused) / social comparison – relationship between self and others

#### (Self)-responsibility vs. attribution of blame

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<th>(3,7,12)</th>
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<td>- ‘[Patient in previous psychiatric hospital] I found out that she had jumped out of the window and she actually died. They [staff] said that it was because they gave her an injection and it went wrong, but I knew that she was suicidal already, because I did kind of know her.’</td>
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<td>- ‘Especially in a Jewish family there’s a lot of food around, so it’s very hard.’ [displacement of responsibility]</td>
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<td>- ‘What do you think the adults involved in your care should most be concerned about in relation to your self-harm?’ “They should just be concerned about how very suicidal I am, and how much I hate myself... They (internal voices) are killing me because I don’t know what they are and the should really be aware of that.”</td>
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#### Disavowal / abdication of responsibility for actions / SIB

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<td>- ‘...but hopefully when I turn 19 it will all stop, even thought I have just been saying in the group that I want to die, so I just feel really bad.’</td>
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<tr>
<td>- ‘The first hospital I was in the doctors would immediately put me on antidepressants, which I do still want to be on because I...’</td>
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do feel they help but, in saying that, I was put on Prozac and it stopped working and I know that it was a major factor in my suicide attempt, because it does motivate you to try to kill yourself. That was said in the papers, by the doctors, everywhere.’ [abdication of responsibility, attribution of blame on doctors and medication? – *contradictory link with earlier statement of medication helping poor impulse control (p.3)]

- ‘...I had to stay over the weekend; I mean I requested to stay over the weekend and they agreed, but then they said to me that there was a possibility that I would be institutionalised. “If we had been there we would have sectioned you on the spot”...’

[desire for containment, abdication of responsibility?, giving control over to someone else / authorities]

| Violence / damage to others equivalent to SIB | (15) | ‘I think that hurting people is self-injurious behaviour. I think that all the rapists, they’re really disgusting and it’s abominable what they do and they should be hanged. I do know people who have been raped, here and in other places and they all self-injure themselves because they think that it’s their fault they were raped and abused and things. I think that’s really terrible [desire for revenge (?) wanting to hurt others] |

4. Internalised / Externalised feelings within the young person (process material)

| External presentation vs. internal feelings, beliefs, thoughts | (6,9) | • ...it's people saying, “oh you look so much better” and actually inside I just feel like complete SHIT. It’s awful, it’s like you can’t see, because I have got all this makeup on and dolled myself up; it’s really hard and a lot of the time with the bulimia I would eat and immediately go and throw up and I already felt nauseous anyway from being there, so it was really hard.’

[anxious masking]

- ‘They’re (young men) not even allowed to cry most of the time. They have to keep their emotions inside. It’s really terrible because they’re going to explode obviously and then they go and hang themselves, or shoot themselves or overdose or anything, it’s just really, really terrible.’ |

| Self-image / concept of self (as a self-harmer? other?) | (9,11) | • ‘...a lot of the suicide attempts are seen as glamorous almost, it’s like, “I took an overdose”, it’s almost fashionable – it’s not something to be proud of. I know when I was younger I thought that I was quite cool...’

- “What are some of the expectations placed on them by society; the young men and young women, so the reasons why– I think that the young men are expected to go to the army and become doctors, have these high professions; women are expected to bear children, be housewives. I think that there’re too high expectations of the males definitely.’

| Internalised feelings - negative thoughts, low self esteem, lack of belief in self, poor self-image [or pervasive pattern / personality makeup or characteristic?] | (1,3,6,8) | • ‘...list all of all the bad foods and all of the good foods’

- ‘I even think that having so much negativity and saying and believing that you are suicidal; I think that’s self-harm as well.’

- ‘...I hate myself so much...’ [low self-esteem]

- ‘...I was always very shy; I mean I’m not that shy anymore, but I’ve always had low self-esteem and not been very confident.’

- ‘...but emotionally hurting yourself just makes everything so much worse. With bulimia your emotions are all over the place...’ |

| Externalised feelings – angry emotions / expressions of: | (3,3,8,9,12,13,14) | • ‘...when I was very little...9,10 or 13 and I used to get these deodorant glass bottles and I used to hit myself on the arms and get these big bruises...’ [expression of anger]

- ‘...I actually received these flowers from this horrible man and
I actually threw the vase across the room. I don’t know whether that’s self-harm; I think it is because you are so angry.’

- “How do you feel about other people who self-injure?” ‘A lot of the time I feel a lot of anger and frustration towards them because I know that I don’t cut myself; I do other things… I would like to help them in a way, but I do think a lot of it’s for attention. [jealousy spurs anger towards peers? Felt as an emotion but not acted upon]
- ‘I think that young men are frowned upon more, you know, you should be this big macho guy who can handle everything and now you are being this weak little thing. They’re not even allowed to cry most of the time. They have to keep their emotions inside. It’s really terrible because they’re going to explode obviously and then they go and hang themselves, or shoot themselves or overdose or anything, it’s just really, really terrible.’ [implies men unable to discharge emotions appropriately except through explosive discharge of anger – turned in onto the self; implies men aren’t allowed to feel anger, but are able to express it through behaviour]
- ‘I know that my brother’s cousin, who’s my stepmother’s nephew said, “oh [Leyah’s] been taking drugs” and he said, “no, she just took an overdose”. I thought, ‘just took an overdose, just dying, just having this deteriorated liver ripped out of her body, cut in the middle of my body’ – “JUST” you KNOW.” [angry at her actions / behaviour (and feelings?) / or expression of anger being minimised (even though inappropriate) – treatment implications; more focus on the actions at the expense of the feelings]
- “What are your attitudes and feelings towards other people who self-harm. How does it affect you?” ‘A lot of the time I get angry with them, but I also get very sad for them, particularly in the abuse of alcohol as I see that as an escapism… I get angry and I think why can’t they just talk about it instead of abusing themselves all the time.’ [angry at the frustration with others / feels hopeless? Hypocritical?]
- “How would you have liked other young people to respond ideally?” ‘I was actually glad that they were angry because I know that I would have felt the same…’

### 5. Secret shame and Guilt

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<th>Secretive behaviour</th>
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<td>‘I didn’t tell anyone for 1½-2 days.’</td>
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<td>‘…I just try to explain it as best I can or I just choose to ignore them.’</td>
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<td>‘…my big sister came over and she just said, “I don’t want you to die” and was just crying. It was really sad and it was really hard, but at the same time I feel like that. So I can’t keep holding it in, but obviously I wouldn’t say that to my little brother or sister, but it’s very hard for them because they just don’t know what to do most of the time.’ [keeping a secret because of shame?]</td>
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<tr>
<th>[Shame (&amp; guilt?)] – maintaining secretive self-injurious behaviour</th>
<th>(1,4,6, 6,7,12)</th>
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<tr>
<td>‘I didn’t tell anyone for 1½-2 days.’ (implied)</td>
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<tr>
<td>‘I started being very badly bulimic when I was 13; it was just kept a secret for so long.’</td>
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<td>‘…I get really guilty about things, like my parents’ divorce and I always blame things on myself, but then when I’m very rude to people and very distant and when I get in a state and won’t</td>
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let people touch me, I get very 'Oh I must go and do something to myself.' I feel I must go and do something to myself because it discourages some people. And really a lot to do with my overdose, when I had my transplant, so I feel really guilty about that, but most of the time I just wish it could have been someone else that got the liver instead of me.'

- 'I get quite touchy about explaining it to other people.' “So do you explain it to other people? What do you say?” 'I mostly get very upset and start crying or I just- since my transplant my thoughts are often very confused, so I just try to explain it as best I can or I just choose to ignore them.'

- ‘...when I was in [Place name] to have my operation, I was asked if I heard voices and I said “no” and ran out of the room because I thought that they would think that I was schizophrenic, but I actually do...’ [hears own internal voice / conscience - no evidence of psychosis]

- “How do you feel about other people knowing about your self-injury?” ‘I actually feel very embarrassed. I know that my stepmother told a lot of friends when I took my last overdose and it was very difficult for me because I just see myself as being a freak, the black sheep of my family. It’s just been increasingly hard and difficult.’ [Shame, wanting to keep it secret?]

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<th>Self-expression vs. constraint [repression]</th>
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<td>Interpersonal relationship difficulties (4,6, 10,12)</td>
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<td>‘...I had completely forgotten about overdosing. Shortly before that, the true love of my life had broken up with me and I still can’t cope with it...’</td>
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<tr>
<td>‘I think you mentioned when you first started... why do you think that was?’ ‘I think that the hitting was the fact that I didn’t have my daddy around and it was really hard for me and my mother just went to work all the time and I had all these au-pairs looking after me and it was really hard. I used to cry all the time “I want my mummy” and I would get really upset. [insecure / poor attachments]</td>
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<td>‘I think that a vast majority of women are concerned with...breakups with their husbands or their boyfriends and things like that and they get very distressed, but I know that there’re a lot of men who get very distressed at breakups of relationships as well.’ [SIB = expression of distress]</td>
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<td>‘...friends, I have very few, I don’t have many. I used to have a lot; I used to be quite a popular girl. It just has such a great emotional impact on people. Some people get very sad, some people want to help and others are so distant that I feel they don’t care anymore.’ [her actions have pushed others away]</td>
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<thead>
<tr>
<th>Familial difficulties (2)</th>
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<tr>
<td>[divorced parents] ‘my sister was quite badly bulimic...also anorexic...my dad’s cousin committed suicide and my mum’s cousin...as well’</td>
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<tr>
<th>Previous psychiatric history (2)</th>
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<tr>
<td>‘...before I came here I had been in various psychiatric hospitals as well...’</td>
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<tr>
<td>Stigma / consequence of psychiatric diagnosis / label on the young person</td>
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<td>----------------------------------------------------------------------</td>
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<td>• ‘...this has little relevance, but at the first psychiatric hospital I went to, I was diagnosed as having manic depression, which I don’t have, which I was told... and I definitely couldn’t cope with it then, knowing that I had this terrible mental illness at such a young age [13].’</td>
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<td>• ‘...when I was in [Place name] to have my operation, I was asked if I heard voices and I said “no” and ran out of the room because I thought that they would think that I was schizophrenic, but I actually do...’ [hears own internal voice / conscience – no evidence of psychosis]</td>
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<td>• “How do you feel about other people knowing about your self-injury? ‘I actually feel very embarrassed. I know that my stepmother told a lot of friends when I took my last overdose and it was very difficult for me because I just see myself as being a freak, the black sheep of my family. It’s just been increasingly hard and difficult.’ [labelling by family or internalised negative self-image, feels like an outcast / ostracised]</td>
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<tr>
<th>Attributable cause(s) [(triggers), external / situational stressors]</th>
<th>(4,6,6,13)</th>
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<tr>
<td>• ‘I was bullied very badly at school and I remember this boy just kept telling me that I was fat all the time, and that was horrid. But it just devastated me, and I took my first overdose when I was 13.’</td>
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<tr>
<td>• “I think you mentioned when you first started... why do you think that was?” ‘I think that the hitting was the fact that I didn’t have my daddy around and it was really hard for me and my mother just went to work all the time and I had all these au-pairs looking after me and it was really hard. I used to cry all the time “I want my mummy” and I would get really upset.’</td>
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<tr>
<td>• ‘It was the bullying and it was a lot to do with my parents’ divorce and I was always very shy; I mean I’m not that shy anymore, but I’ve always had low self-esteem and not been very confident.</td>
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<tr>
<td>• ‘I think that if there’s a family gathering it’s very hard for me.’ It’s not so much that I’m asked lots of questions, it’s people saying, “oh you look so much better” and actually inside I just feel like complete SHIT. It’s awful, it’s like you can’t see, because I have got all this makeup on and dolled myself up; it’s really hard...’</td>
<td></td>
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<tr>
<td>• ‘They get really shocked. My family get very shocked, frightened, scared, terrified – my family and my friends. The first hospital I was in the doctors would immediately put me on antidepressants, which I do still want to be on because I do feel they help but, in saying that, I was put on Prozac and it stopped working and I know that it was a major factor in my suicide attempt, because it does motivate you to try to kill yourself. That was said in the papers, by the doctors, everywhere.’</td>
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<tr>
<th>Poor impulse control</th>
<th>(1,3,6,7,14)</th>
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<tr>
<td>• ‘...led to very bad eating disorder’ (bulimia) ‘I’ve tried to be anorexic, but it was too hard.’</td>
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<tr>
<td>• ‘I was put on Prozac and that would really help me control it [purging]...’</td>
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<tr>
<td>• ‘I’m quite scared of myself really, because I’m very temperamental and unpredictable...’</td>
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<tr>
<td>• ‘...I wake up in the morning and say, right, ‘I’m not going to have any biscuits, I’m not going to have any chocolates’, I rule out all these foods and then I go and eat them and then I think, ‘what have I done?’ and then I just go and throw up.’</td>
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| • ‘I don’t think that I should throw up any more, but I must find a
7. Descriptions / Conceptualisations of SIB

| Terminology used for SIB | (2,3) | • ‘...whenever anyone said the word self-harm, I just thought it meant they cut themselves.’
  • ‘Do you use SIB or self-harm?’ ‘I use self-injurious, because it’s very self-centered really.’ [self-centered orientation / concern]

| Move to broader conceptualisation of SIB (influenced by the unit vs. previous contact with SIB) | (2,8) | • ‘...but now I think of it [SIB] as eating disorders and overdoses and things like that.’
  • ‘I know that stereotypically when people say self-harm, people immediately think of cutting which is what I immediately do think of as self-harm, even though my opinion HERE has changed. It’s just to do with pain. I don’t feel very nice about it. I would like to help them others who self-injure in a way, but I do think it’s for a lot of attention.’

| Method(s) of self-harm (differentiated) | (3,5,5) | • (Cutting) = ‘I used to have these other friends who used to get pieces of glass and cut-up themselves. A friend of mine who cuts all over her face and all over her body, you couldn’t see any skin at all, it’s just really bad.’
  • (Overdosing) = ‘You see I see overdosing as taking pills, because HERE [the hospital] they say because I’ve had [swallowed] bubble bath and washing-up liquid, they say that is overdosing, but I see it as taking pills.’ [symbolism of cleansing her insides / internalisation]
  • (Sexual provocation) = ‘Is there anything that you would add to that list?...’ ‘I think that maybe, erm, if someone was being over-provocative or something? ‘Provocative aggressive; provocative sexually?’ ‘Sexually. And aggressive, but more sexually, because I think that’s self-injurious.’ So setting yourself up to get abused almost, to get used.’

| Experience of / contact with others engaging in SIB | (2,3) | ‘I didn’t experience any cutting, but I did...eating disorders, taking overdoses, feeling very suicidal.’

| (7A) Coping strategy (conceptualised to manage suicidal feelings / survive / remain alive) | (4,4,8,13) | • ‘So it started a little bit when I was 9, but really from 13 to 18, but hopefully when I turn 19 it will all stop, even thought I’ve just been saying in the group that I want to die, so I just feel really bad.’
  • What is the experience of SIB like? ‘It’s awful, it’s really awful. It’s been just over three weeks now and it has been unbearable for me to cope with that I am not harming myself any more. But in saying that, I did drink washing-up liquid a couple of weeks ago, but it’s so hard not to throw up, because it’s control.’
  • ‘They [the internal voices (conscience)] tell me all sorts of terrible things and a lot of the time I will go and harm myself because I can’t get these voices out of my head.’ [SIB = method of distraction from internal feelings]
  • ‘...particularly in the abuse of alcohol as I see that as an escapism. I know a member of our family who’s an alcoholic and it’s very hard because I’ve seen people in other hospitals who’re alcoholics and it was very difficult for them. It’s another form of escapism. I think, ‘what are you trying to escape from?’

| (7B) SIB = a release (physical & emotional) | (8) | ‘...you said a bit about why you think other people self-injure, you said sometimes it is for attention, to have people worry about them. Are there any other reasons?’ ‘I think it’s because they’re going through a great deal of pain and it’s like a release.’

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• 'Even though it [purging] doesn't really help you to lose weight, it is really, really hard. I think that it should stop because I don't like all the attention I get from it.'
• 'I know that when I first came here, [patient name] took an overdose and, it sounds really horrible, but I really wanted the attention to be on me. I pretty much always wanted to die, but my heart wasn't so much set on it, but at that time I kinda wanted the attention to be on me as well, on me even more, so I just went and took some bubble bath, because I wanted it to be me. I think that with a lot of people; I can tell from experience, I think a lot of it's for attention. I'm not trying to say that they're attention seekers, but it's really a cry for help to be noticed.' “To be noticed, to be seen?”
• ‘Even to have people worried about you, which is what people like. I mean I don’t really like it that much, but sometimes I really want people to worry about me and to understand how much pain I’m going through. On the other hand I see how much pain they go through because of me and I’m just wasting my own life and wasting everyone else’s time.’
• ‘I would like to help them [others who self-injure] in a way, but I do think a lot of it’s for attention. For instance one of the girls here said, “do you want to see my self-harm?” and I said, “no, that’s pathetic”. There’re a few of the girls here who don’t show at all and keep their long sleeves on. When I first saw them I had no idea. Some of them will walk around with their shorts on and crop tops and it’s almost like a fashion statement – look at ME, I hurt myself. And that’s awful really, it disgusts me in a way.’
• ‘... I suppose in a way some of them – I think in young women and young men a lot of the suicide attempts are seen as glamorous almost, it’s like, “I took an overdose”, it’s almost fashionable – it’s not something to be proud of. I know when I was younger I thought that I was quite cool, I had seen so much pain, it’s terrible.’
• ‘When they cut themselves... they’re just seen as “oh you POOR thing.”’ [eliciting a reaction from others: need for sympathy (?)]
• ‘Sometimes I think, it’s a horrible way to put it, but sometimes I think that the novelty will wear off, because in a way it is almost a novelty. “Hey everyone pay attention to ME”, and they do for a while – it’s over now.’ [Classic example of ‘crying-wolf’]

8. Pressures of gender socialisation (Gender Differences / Similarities) in SIB

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<thead>
<tr>
<th>Stereotypical gender roles / influences on SIB</th>
<th>(9,9/10,10,11)</th>
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<tr>
<td>[gender stereotyping of role socialisation]</td>
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<tr>
<td>[sexist perspectives]</td>
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• ‘I think that a lot of men do do it (self-injure), but they see women differently; they see women as weaker, you know, ‘Of course women do it, you know she’ll do it because she has her period.’ A lot of the time if you’re upset they’ll say “do you have your period?” It’s really awful. It’s like I can’t have a feeling without having my period, it’s terrible. It’s just not very nice.’ [Link with literature (Canetto, 1991, 1997) that women’s SIB tends to be medicalised, whereas men’s tends to be conceptualised in terms of social problems.]
• ‘I think that young men are frowned upon more, you know, you should be this big macho guy who can handle everything and now you are being this weak little thing. They’re not even allowed to cry most of the time. They have to keep their
<table>
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<tr>
<th>Solar System</th>
<th>Planet 1</th>
<th>Planet 2</th>
<th>Planet 3</th>
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<tr>
<td>Mercury</td>
<td>1.5 km</td>
<td>1.2 km</td>
<td>1.8 km</td>
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<tr>
<td>Venus</td>
<td>3.2 km</td>
<td>2.9 km</td>
<td>3.5 km</td>
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<tr>
<td>Earth</td>
<td>6.4 km</td>
<td>6.1 km</td>
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<td>Mars</td>
<td>6.7 km</td>
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<td>Jupiter</td>
<td>11.2 km</td>
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<td>Saturn</td>
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<td>Uranus</td>
<td>19.2 km</td>
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<td>Neptune</td>
<td>23.4 km</td>
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<td>Pluto</td>
<td>28.6 km</td>
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<td>28.9 km</td>
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it is, instead of…’ [focus on medication management; desire for understanding? / through talking therapies?]

- ‘…there is a lot of misunderstanding. Again it’s very hard. My views change as my mood change, a lot and quite regularly, but I don’t think that anyone else should do it to themselves. I don’t think that I should throw up any more, but I must find a way of controlling my weight, but I don’t think that people should do it to themselves. It still makes me very angry and frustrated that I can’t get through to anyone.’ [treatment strategy = help with communication skills / identification of feelings].

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<tr>
<th>Severity of SIB acts vs. suicidal intent</th>
<th>(2,12)</th>
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<tr>
<td>• ‘…I was dying and everything.’ ‘-on dialysis-‘</td>
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<tr>
<td>• “What do you think the adults involved in your care should most be concerned about in relation to your self-harm?” ‘They should just be concerned about how very suicidal I am, and how much I hate myself…They (internal voices) are killing me because I don’t know what they are and the should really be aware of that.’</td>
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<tr>
<th>Action taken by others following knowledge of SIB</th>
<th>(2,13)</th>
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<tr>
<td>• ‘…she immediately made me ring the hospital, and they immediately got me an ambulance…’</td>
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<tr>
<td>• ‘They get really shocked. My family get very shocked, frightened, scared, terrified – my family and my friends. The first hospital I was in the doctors would immediately put me on antidepressants, which I do still want to be on because I do feel they help but, in saying that, I was put on Prozac and it stopped working and I know that it was a major factor in my suicide attempt…’ [family and friends react with shock and fear; doctors react with antidepressant medication; treatment implications: desire for counselling psychologists to react with talking and understanding – link to that section].</td>
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<tr>
<th>Consequences of SIB (realisation, acknowledgement)</th>
<th>(2,8,11,12)</th>
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<tr>
<td>• ‘…my liver had already deteriorated’</td>
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<td>• ‘It’s like I have this huge scar from my transplant and I look at it and think: what were you thinking, even though I do still feel that way, it has such a dramatic impact on your life; it’s horrible. If anyone sees it, I’ll have to explain it to them; hard.’</td>
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<td>• ‘…it’s very hard for them because they just don’t know what to do most of the time. A lot of them (family members) are very cold and distant; I’ve lost a lot of friends from it. On the other hand I’ve a lot of support.’ [Contradiction / ambivalence around others distancing reactions].</td>
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<tr>
<td>• ‘…friends, I have very few, I don’t have many. I used to have a lot; I used to be quite a popular girl.’</td>
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<tr>
<th>Anxious about (own) future</th>
<th>(12)</th>
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<tr>
<td>“What are you most worried about for yourself?” ‘I’m just worried that I won’t ever be happy and I won’t ever live a life. Because I know that there’s a lot of potential in me to get better, but there’s this great big brick almost holding me back, saying, “don’t just carry on being this negative, miserable person.” Then there is something else saying, “just get out and achieve my dreams” because what if I did die tomorrow and I hadn’t done anything – it would be terrible, but then on the other hand I think, what’s the point, I shouldn’t even be here. I get so irritable all the time; it’s not very nice.’ [motivation for improvement / SIB reduction + associated symptoms (?), e.g. depression is low; negative circular thinking].</td>
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<tr>
<td>Helpful strategies</td>
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<td>[supportive techniques, according to young people, and what they would offer]</td>
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<td>(14,14, 14)</td>
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<td>• &quot;What kind of support would you provide to someone who was self-harming: help, advice, therapy intervention?&quot; 'At the moment I wouldn't be a great help, but if I was more balanced I would tell them of my own experiences, which I've been doing a lot here, apart from when I get really down and depressed and stuff. I just basically show them my scar and tell them the stories of what I've been through and how it's not really worth it because actually - I can't say this for myself right now - but there are times when I have thought there is a tomorrow and it won't be so bad tomorrow. When you talk about it - it's a cliché, &quot;but a problem shared, is a problem halved&quot;.' [Sharing of experiences; talking (therapy) - treatment implications! + knowledgeable person(s); time (?)]</td>
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<tr>
<td>• '...I see it on TV and people telling people and stuff. But there's a lot of misunderstanding. Again it's very hard.' [treatment strategies = clarify misunderstandings; dissemination of information]</td>
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<tr>
<td>• '...I don't think that I should throw up any more, but I must find a way of controlling my weight, but I don't think that people should do it to themselves. It still makes me very angry and frustrated that I can't get through to anyone.' [Help with poor impulse control; identification of feelings; and communication skills.]</td>
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<tr>
<td>• '...the fact that when I'm trying to get better, I've everyone else's negativity around me and then I want to leave here.' [wanting support]</td>
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Appendix XIV

Counselling Psychology Quarterly
Instructions for Authors:

Click here to check your article status

Manuscripts should be sent either to the Editor, W. J. Alladin, East Yorkshire Community Healthcare Department of Psychology, Westwood Hospital, Beverley HU17 8BU, UK. E-mail: wialadin@aol.com, or to Professor E. Thomas Dowd, Department of Psychology, 118 Kent Hall, Kent State University, Kent, Ohio 44242, USA. E-mail: edowd@kent.edu. Original papers whose substance has not been published elsewhere can be considered only if three complete copies of each manuscript are submitted, and all submissions will be sent anonymously to referees. Manuscripts should be typed on one side of the paper, double spaced, with ample margins of at least one inch. The first sheet should include the title of the paper, name(s) of author(s), and for each author academic and/or professional qualifications as commonly used by the author, main appointment and address. The second page should repeat the title, and contain an Abstract of not more than 200 words. The third page should repeat the title as the heading to the start of the main text of the paper. All pages should be numbered. Proofs for checking will normally be sent to the first author, to whom any correspondence and offprints will also be addressed. Footnotes to the text should be avoided wherever this is reasonably possible.

Short communications and case reports normally limited to four journal pages (approximately 2400 words including tables and references) will be published in the next possible issue of the journal. They can cover matters of topical interest or work in progress.

References should follow the style of the American Psychological Association (Publication Manual, 4th edn, 1994) i.e. they should be indicated in the typescript by giving the author’s names, with the year of publication in parentheses, e.g. Smith (1984); or if there are more than two authors, Smith et al. (1984). If several papers from the same author(s) and from the same year are cited, (a), (b), (c), etc. should be put after the year of publication. The references should be listed in full alphabetically at the end of the paper on a separate sheet in the following standard form with regard to the existing style of punctuation and capitalization:


Titles of journals should not be abbreviated.

Illustrations should not be inserted in the text but each provided separately and numbered on the back with Figure numbers, title of paper and name of author. Three copies of all Figures must be submitted. All photographs, graphs and diagrams should be referred to as Figures and should be numbered consecutively in the text in Arabic numerals (e.g. Fig. 3). A list of captions for the Figures should be submitted on a separate sheet and should make interpretation possible without reference to the text. Captions should include keys to symbols.
Tables should be typed on separate sheets and should be given Roman numbers (e.g. Table III). Their approximate position in the text should be indicated. Units should appear in parenthesis in the column heading but not in the body of the table. Words or numerals should be repeated on successive lines; 'ditto' or 'do' should not be used.

Proofs will be sent to the author if there is sufficient time to do so. Proofs, including proofs of illustrations, are supplied for checking and making essential corrections, not for general revision or alteration. Proofs must be corrected and returned to the Editor within 3 days of receipt.

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ATTITUDES TOWARDS SELF-INJURIOUS BEHAVIOUR AMONG MENTAL HEALTH PROFESSIONALS AND ADOLESCENT SELF-HARMERS

Abstract
This study explored attitudes among mental health professionals and adolescent self-harmers towards one of two case vignettes (identical apart for gender) describing a representative young person engaged in self-injurious behaviour (SIB). 174 respondents rated a 35-item questionnaire derived from previous research and the available literature. Factor analysis yielded five stable factors. These were termed: F1 ‘negative and judgemental attitudes’; F2 ‘perception of negativity in societal attitudes’; F3 ‘anxiety around safety and management’; F4 (mostly disagreement with) ‘strong feelings of anger, rejection and frustration’; and F5 ‘positive attitudes and empathetic understanding’. Analyses of variances revealed significant effects on several background variables (including age, gender, sex of individual engaged in SIB, ethnic origin, type of post-graduate training, professional status, number of years in clinical practice, and experience/contact with SIB). Although more needs to be learned about the meanings ascribed to SIB, the spread of responses suggest that attitudes towards SIB are frequently divided and contradictory. Implications of these results for theory, practice, and future research are discussed.
ATTITUDES TOWARDS SELF-INJURIOUS BEHAVIOUR AMONG MENTAL HEALTH PROFESSIONALS AND ADOLESCENT SELF-HARMERS

Self-injurious behaviour (SIB) has been called many things. Specifically under the term ‘self-mutilation’ it has been defined as a direct, socially unacceptable behaviour that causes physical injury where the individual is not ‘attempting suicide’ but is in a psychologically disturbed state (Favazza, 1989, 1998; Kahan & Pattison, 1983; Walsh & Rosen, 1988). More broadly, under the term ‘deliberate self-harm’ it has been used to include intentional self-poisoning or self-injury, irrespective of the apparent purpose of the act (Hawton & Catalan, 1987). Numerous studies have shown that deliberate self-harm or ‘parasuicide’ is one of the most, if not the most powerful predictor of suicide (van Egmond & Diekstra, 1989; Favazza & Conterio, 1988). There is also a well-documented increased risk for completed suicide among young men (less so for young women), both across continental Europe (Platt et al., 1992; Schmidtke et al., 1996) and in the UK (Hawton et al., 1997).

Most definitions have come from professionals themselves and, for historical reasons, are grounded in ‘medical-based models’. Such definitions place emphasis on categorisation and a tendency to view the problematic behaviour as a pathological symptom of some kind. There are numerous inherent difficulties with ‘categorical’ definitions and ‘pathologising’ (see Hartung & Widiger (1998) for a comprehensive review of the current debates regarding classifications within DSM-IV). In particular, they do not accord easily with the humanistic roots of counselling psychology, where the primary concern is for the client as ‘an individual’. Such categorical and/or negative definitions may also affect clinical judgement(s) which, in turn, have been shown to adversely affect the therapeutic relationship and possible treatment outcomes (Allen, 1995).

For the sake of brevity, the term ‘professional’ is used to represent a diversity of mental health practitioners from all levels and grades that come into contact with individuals who engage in self-injurious behaviour(s). The list is not meant to be exhaustive, and includes clinical and counselling psychologists, psychotherapists, psychiatrists, specialist registrars and nurses, social workers and occupational therapists amongst others.
Indeed, mental health workers across disciplines continue to find the management of SIB a challenge, despite the wealth of theoretical models available to inform practice. East (1995) has suggested that the differing values, beliefs and attitudes towards health care between those who work within a biomedical model and those who work within a therapeutic model, may lie at the root of some of the difficulties faced in providing a ‘seamless’ integration of care across the divides of primary, secondary and tertiary NHS services.

The explanations and beliefs of adolescent self-harmers themselves can reveal yet another phenomenology, with different emphases revealing previously unstated, unattended, or subjugated understandings. Previous research has highlighted the presence of social and gender biased conceptualisations which appear to affect young people’s experiences and subjective views of SIB (Bowen, 2000). Specific acts, including both traditional and non-traditional categorically defined forms of impulsive, risk-taking, and/or self-destructive behaviours were conceived of differently across the sexes according to stereotypical gender role socialisation processes. Furthermore, and most interestingly, young people themselves explained their SIB more in terms of coping strategies or personal agency ‘choices’ rather than symptoms of pathological behaviour. This was especially the case when considering their own SIB, though they were much more critical of the self-harming acts carried out by their peers.

Where medically oriented authors in the past have tended to pathologise and focus on the problems or weaknesses of adolescent self-harmers, a recent alternative has been to consider the individual engaged in SIB as capable or resilient (Frydenberg & Lewis, 1991; Lazarus & Folkman, 1984). There is increasing evidence that superficial self-mutilation can be understood as a maladaptive attempt at self-help (Favazza, 1989; Favazza & Rosenthal, 1993), or morbid form of coping (Callahan, 1996; Favazza, 1998; Wilson et al., 1995). How SIB manifests itself appears to depend on different coping and personal management styles (Haines & Williams, 1997).

It therefore seems more appropriate to assess multidisciplinary professionals’ pre-existing knowledge and assumptions about SIB, as well as their feelings, thoughts, and actions in response to a young person engaging in deliberate self-harm. By
looking at how professionals integrate and 'apply' their knowledge towards the seemingly frustrating, apparently poorly understood, and sometimes shocking behaviour of self-injury, this may help pinpoint any 'blindspots' that stem from socialisation processes and contribute towards differing perspectives across discipline, theoretical orientation, and gender. Such information may also assist greater mutual understanding between therapists and clients. Instead of investigating outcomes of therapeutic intervention for deliberate self-harm, an alternative starting point might be to look at how professionals make sense of SIB through an investigation of their 'attitudes'.

To capture what is meant by an attitude the 'three-component model' goes some way towards providing a suitable definition (e.g., Eagly & Chaiken, 1993; Zanna & Rempel, 1988). A person's attitude toward some significant part of their world is a composite expression of what that individual thinks, feels, and does with respect to that aspect of their world. Note that 'what the individual thinks' must be based on their knowledge, but, more importantly, it reflects what they believe and how they select and organise knowledge into belief systems. In turn, what the person feels will be based on these selected and organised beliefs, rather than their total 'knowledge' about the topic. The relation between beliefs and feelings and what the individual does, i.e. their behaviour, is more complex, but refers to past behaviours or behavioural intentions with respect to an attitude object. These three classes of evaluative responses reflect the cognitive, affective, and behavioural components of an attitude. The 'three-component model' further assumes that these responses are moderately correlated with each other (Rosenberg & Hovland, 1960).

The 'unidimensional' concept of attitude (Fishbein, 1967; Petty & Cacioppo, 1981) on the other hand, suggests that most standard methods for measuring attitudes measure affect, that is, a person's overall feelings (favourable or unfavourable) towards the attitude object. For the purposes of this study, the three-component model of attitudes was endorsed. The rationale for this decision is that this model was deemed to offer a more comprehensive and all-encompassing theory of attitudes that could facilitate the exploration of possible sources of difference, similarity and/or misunderstanding among individuals. Ultimately it is hoped that such insight will help identify common
values, beliefs and attitudes towards health care, as a step towards greater collaboration and more effective therapeutic interventions for SIB across the sexes.

This study explores attitudes within a large group of multidisciplinary mental health staff and adolescent self-harmers towards one of two case vignettes, describing a representative young person engaged in self-injurious behaviour. Presented in the form of a referral letter from a GP, questions around themes derived from previous research (Bowen, 2000) and the available literature (Bowen, 1999) were explored by means of a structured questionnaire administered to participants on one occasion. Answers to several questions were sought: firstly, what factors govern professional attitudes towards this client group, and secondly how these factors are affected by staff characteristics such as clinical experience, training, allied discipline and theoretically informed orientation or mode of practice.

Several general exploratory propositions guided the research. It was expected that questions related to SIB would evoke powerful and contradictory feelings among professionals and adolescent self-harmers that would result in different views. These differing perceptions would reflect some of their subjective experiences. Specifically, it was anticipated that groups of multidisciplinary mental health professionals would allude to different thinking around SIB, according to their training backgrounds and/or clinical experiences. It was also anticipated that young people's responses would focus more on personal agency or 'choice actions', reflecting more permissive attitudes, whereas those recounted by professionals would involve a greater degree of 'anxiety and/or hopelessness' related to treatment issues, perhaps reflecting a propensity towards conceptualising SIB as a 'pathological syndrome'.

Where previous research found that young people tend to consider doctors and psychiatrists in particular, to be negative in their attitude towards SIB (Bowen, 2000; see also Platt & Salter, 1987, and Ramon 1980), in-depth interviews with this group of adolescent inpatients nevertheless revealed equally judgemental attitudes and strong feelings of anger expressed towards their self-harming peers. The present study aimed to clarify these suggestions, in addition to those in the literature that refer to negative or 'biased' attitudes towards SIB amongst mental health professionals (Brogan et al., 1998; Creed & Pfeffer, 1980) and society in general (Barnes, 1985; Hogg & Burke,
1998), particularly along the lines of gender-biased judgements (Fernbach et al., 1989; Hansen & Reekie, 1990; Teri, 1982). This involved a move from the search for differences in the sample to the search for commonalities. In other words, instead of just looking for differences between respondents (for example, between the prejudiced and the non-prejudiced), the study also aimed to discover whether the sample as a whole tended to have shared cognitive, affective, and behavioural responses towards SIB.

Method

Ethical approval to conduct this research was granted by The University of Surrey Ethical Committee (see Appendix I). The decision to use a postal questionnaire based approach was made despite the loss of opportunity to obtain richer and more detailed information. However, it increased the potential to survey a greater number of participants’ perspectives, attitudes and experiences, who might perhaps otherwise have been unwilling to give-up substantial amounts of time. It was hoped that the self-completed questionnaire would be a useful tool in the task of elucidating a wide range of participants’ attitudes, which could then be subject to Factor Analysis. Summarising patterns of correlations among observed variables would enable factorial validation of specific items, and assess the extent to which various subscales appear to measure the same concepts. It would also reduce a large number of variables to a smaller set, in an attempt to make sense of the bewildering complexity of attitudes towards SIB. The quantitative approach chosen was not intended to find objective ‘truths’, but to allow for the development of measurements of some of the themes identified in previous research (see Bowen, 2000). Specifically, this would allow statistical comparison between different groups of mental health professionals’ and young self-harmers’ attitudes towards SIB.

Participants

A broad range of multidisciplinary professionals was approached for inclusion in this study. The aim was to represent the diversity of mental health workers that encounter
individuals who engage in SIB in their everyday practice, whether as a primary presenting complaint or secondary to other difficulties.

Accordingly, 414 clinical staff, providing NHS mental health support working within the Directorate of Psychological and General Psychiatric Services across numerous Greater London and Southern Home County sites were approached. Final participants were recruited from a broad range of services, including: specialist Adolescent Inpatient Units, Child & Adolescent Mental Health Teams, Family Consultation services, Community Mental Health Teams, Psychology & Psychotherapy Departments, Co-ordinated Psychological Treatments Services, specialist clinics, community services, day hospital wards, and psychiatric outpatients services, in addition to a sample of independent practitioners registered as Chartered UKCP, BAC, and BABCP practitioners across the UK.

20 male and female adolescent participants (aged 16-21 years) with a history or ongoing presentation of self-injurious behaviour, were also approached from a specialist adolescent psychiatric inpatient unit. These young people were ex-inpatient participants known to the researcher from an earlier phase of the research project (Bowen, 2000), who had agreed to be contacted again for the present study.

Questionnaire
The questionnaire required respondents to consider one of two case vignettes presented as “a typical referral letter received from a GP”. The first vignette (see Appendix II) was a composite, based on two frequently cited descriptions of a ‘typical’ female self-wounding patient (see Favazza & Conterio, 1989; Simpson, 1976). Following the methodology of Lewis & Appleby (1988) and Huband & Tantam (1999), the amount of information included in the composite vignette was deliberately restricted in order to encourage responders to draw on their pre-existing attitudes. The vignettes were also designed to exclude judgements on gender differences, for this was one area of concern that responses to the statements aimed to elicit. It provided limited information about an 18-year-old woman who had cut herself on several occasions following the separation of her parents, but who exhibited no symptoms of psychosis nor major depression, and for whom there was no current
evidence of suicidal intent. No diagnosis was provided. To look at the effects of
gender, a second case vignette was also developed containing identical information
except for gender (describing a young man), and randomly allocated across
participants.

The preliminary sample of questionnaire items was developed from phenomenological
themes identified by a group of self-injuring young people (resident in a specialist
adolescent inpatient unit) from an earlier study conducted by the present author
(Bowen, 2000). Many of the direct views and experiences of these young people were
converted into simple statements, and guided specific items for inclusion in the
research questionnaire. For example, constructions of self-harm as a ‘secretive
behaviour’, ‘exhibitory behaviour’, or a ‘violent act’ were extracted and categorised,
in addition to typical issues of interest to professionals. A pool of 147 statements
reflecting a broad range of attitudes was checked by a second researcher for internal
consistency of groupings. Categorised statements were then further cross-referenced,
and retained or discarded on this basis, with themes identified from a comprehensive
review of the existing literature (Bowen, 1999). Attitudes towards either the young
woman or the young man described in the vignette were assessed by response to 35
statements retained for final inclusion (see Appendix III for a copy of the
questionnaire, including a list of the items).

Statements were carefully designed to explore different levels of participants’
understanding, beliefs and conceptualisations of adolescent SIB. As they were derived
from both the qualitative study and the literature, the questionnaire was considered to
have both content validity and face validity. A pilot study tested accessibility and
relevance of the structured questionnaire with participants recruited via Internet user
groups on the World Wide Web, and a sample of mental health professionals.
Through this process, wording of the research questionnaire was refined and
determined.

For each statement, respondents were asked to tick boxes indicating where their
opinion lay. For clarity, the scale was labelled from Strongly disagree through to
Strongly agree, with the centre point labelled as Neither agree nor disagree.
Responses were subsequently scored on a seven-point Likert attitude scale ranging
from 1 to 7, with a response of *Neither agree nor disagree* scored as 4. Six ‘reverse-meaning’ items where agreeing with the statement suggested a negative or ‘opposite’ attitude towards SIB when compared with other statements, were reversed-scored in all subsequent analyses of the scale. Participants were also given the opportunity to express any feelings or thoughts they had not been asked about, or to comment on any of the statements they had felt particularly strongly about. They were also asked to describe a particular experience they might have had with a young person whom self-injured. Some demographic information was also collected.

**Survey Response**

A total of 174 questionnaires were returned (a response rate of 40.1%). Prior to analysis, attitudes toward SIB were examined for accuracy of data entry, missing values, and fit between their distributions and the assumptions of multivariate analysis. Ten questionnaires were deemed insufficiently complete (with missing values on more than 5% of items) and excluded from the analysis. Twelve questionnaires with single missing values (less than 0.6% of items) – replaced with the means for all items, were retained for analysis. A breakdown of professional disciplines and the proportion of Psychological, Medical, and Social allied groupings is presented in Table 1. A summary of participant characteristics, including gender, age, ethnicity, education, qualifications, training, experience, employment setting, status, and preferred theoretical orientation or mode of practice is presented in Table 2. Each of these characteristics was used as independent variables in subsequent analysis.

[Insert Table 1: Distribution of professional disciplines]

[Insert Table 2: Characteristics of respondents]

**Data analysis**

The statistical procedure used to reduce the original data set was a principal components factor analysis. The data were screened for presence of outliers, absence
of multicollinearity, and factorability of the correlation matrices. Within the principal components analysis (PCA), following inspection of the correlation matrix, an oblique strategy (Direct Oblimin) was selected for rotating the factor structure. This provided a 'non-orthogonal' solution for inter-correlated factors, reflecting a 'real' world situation where factors loading on the attitude towards SIB measure were unlikely to be truly independent (Tabachnick & Fidell, 1989). Adequacy of rotation was ascertained through visual inspection of pairwise plots of these structural coefficients. Additional criteria were used to determine how many factors should be extracted (see Bryman & Cramer, 1999). These included: the absolute magnitude of the eigenvalues of factors (Kaiser’s greater-than-one criterion; 1974), the relative magnitude of the eigenvalues or 'scree test' – a graphical method described by Cattell (1966) – and the interpretability of the factor solution. Several parallel factor analyses were attempted with varying methods of extraction (maximum likelihood, principal axis, alpha factoring) and rotation (orthogonal, e.g. Varimax; and oblique, e.g. Promax), revealing similar satisfactory solutions. Stability and assessment of interpretability guided the final choice of solution presented here.

Following the PCA for the group as a whole, component scores were calculated by averaging the weighted responses across each set of salient variables loading on a factor. The component-score coefficient matrix facilitated the estimation of mean regression scores for each factor, from scores on observed variables for each individual (see Appendix IV for a copy of the component-score coefficient matrix). Although the sample group was large, several variables were examined and it was not possible to match subgroups each time, therefore non-parametric tests were used. All data were coded and analysed using SPSS v10.1 software. Separate one/two-way analyses of variance (Kruskal-Wallis ANOVA by ranks – for groups of different size) were performed for each of the components, according to the host of psychosocial parameters collected. For example, participants were subdivided into 4 groups on the basis of professional allied discipline, which served as independent variables in one-way ANOVAs, with component scores as dependent variables. Between group differences were subsequently assessed using Mann-Whitney U tests (for non-parametric data), revealing the relative strength and direction for each psychosocial parameter. A probability level of $p < 0.05$ (two-tailed) was taken to indicate statistical significance.
Reliability Measures

Bartlett's Test of Sphericity ($\chi^2 = 1293.41, \text{df} = 300, p<0.001$) confirmed accuracy of extraction and appropriate number of factors in the PCA. Visual inspection of the residual matrix revealed small correlations, indicating a close fit between observed and reproduced matrices – confirming reliability and internal consistency of the principal components (Tabachnick & Fidell, 1989). Further indexes of scale cohesiveness were calculated using item-total correlations and Cronbach’s Alpha (1951).

Results

Descriptive statistics and preliminary analyses

In the present sample, 73.5% of practitioners reported having undertaken some form of post-graduate training in psychological counselling or psychotherapy, representing a broad range of theoretical orientations and modes of practice. Overall, 67.7% of professionals had more than 6 years experience in a mental health setting, with 25 respondents (16.1%) in Principal, Senior Management or Consultant positions. The vast majority (92.0%) reported contact or clinical responsibility for at least one individual who self-harmed, with 61.0% of respondents claiming experience with more than 10 self-harming clients/patients. Only 21.9% of professionals, however, had received any specific training in the management of self-injurious behaviours. These trends support the view that contact with individuals who self-harm is common amongst multidisciplinary mental health professionals, further implying that explorations of pre-conceived attitudes and the need for appropriate staff training may be particularly relevant to this group.

Overall sample means, standard deviations, and 95% confidence intervals of the questionnaire items are presented in Table 3. Strikingly, few participants reported that the self-harming individual in the vignette made them feel angry (4.3%), rejecting (3.7%), or frustrated (6.1%), although 68.9% felt that the young person’s behaviour would have an emotional impact on them. The majority of participants (63.4%) made
additional comments in response to the 'referral letter', clarifying their position on individual responses. Many expressed uncertainty about some of the statements (receiving a score of 4 for a response of 'neither agree/nor disagree'), commenting on their inability or desire not to make judgements based on the limited information provided in the vignette. Just over a quarter (26.8%) went on to relate a personal experience of managing SIB. Due to limitations of space, however, qualitative analysis of these valuable contributions will be reported elsewhere.

[Insert Table 3: Mean scores, standard deviations, 95% confidence intervals, and reproduced communalities of questionnaire items]

Factor analysis
Factor analysis was used to explore principal components of attitudes towards the young person in the vignettes using scores from all 35 items. Reproduced communality values (estimates of the variance in each variable accounted for by the principal components in the factor solution) tended to be high, ranging from 0.51 to 0.79. These are also presented in Table 3. The pattern matrix of unique relationships between factors and variables after oblique rotation is presented in Table 4. With a conservative level of .40 (16% of unique variance) accepted for inclusion in the interpretation of a factor, ten variables failed to load on any component.

Closer inspection of the items that failed to load on any factor (subsequently excluded from the analysis), revealed respondents' neutrality towards items suggesting SIB construed as a 'serious social problem', or as a 'violent' or 'impulsive' act. Interestingly, two items reflecting disagreement with a 'focus on the young person's behaviour rather than their feelings', and, stronger agreement with the notion of 'encouraging the sharing of feelings', also failed to load on any factor, limiting the interpretability of the behavioural component of respondents attitudes.

The rotated solution achieved a simple structure (Thurstone, 1947) and yielded five principal components. Interpretation of single factors based on these loadings appeared relatively straightforward. The first (F1) is termed negative and judgmental
attitudes towards SIB, and appears to relate to a disapproving stance that would be conveyed to the individual engaged in SIB. F2 is termed perception of negativity in societal attitudes towards SIB, and relates to the potential consequences of intolerant and negative responses from other people and society at large. F3 is termed anxiety around safety and management of individuals engaging in SIB, and includes items reflecting the seriousness of the mental health problem and worry around the possibility of attempted suicide. F4 is termed strong feelings elicited in response to SIB, and relates to negative countertransferential emotions of anger, rejection and frustration. Finally, F5 is termed positive attitudes and empathic understanding of SIB, reflecting an acceptance of the behaviour as a meaningful expression of internal (psychological) pain.

The salient variables and their structural coefficients ranged from 0.42 to 0.84, accounting for 52.9% of the total variance. It should be noted that the proportion of variance accounted for before rotation is provided merely as an estimated guide to the relative importance of each component. Because factors are correlated, they share overlapping variability, and assignment of variance to individual factors is ambiguous. After oblique rotation, the size of the structural coefficient associated with a factor is a rough approximation of its importance – but proportions of variance and covariance cannot be specified. Comfrey (1973) suggests that loadings in excess of .71 (50% of overlapping variance) are considered excellent, .63 (40% of overlapping variance) very good, .55 (30% overlapping variance) good, and .45 (20% overlapping variance) fair. Alpha reliability coefficients for each of the various subscales are also presented in Table 4. Ranging from .69 to .83, they indicated ‘good’ to ‘very good’ internal reliability and overall scale cohesiveness. Following guidelines of good reporting practice (Thompson & Daniel, 1996), Table 5 presents the principal components item-total correlation matrix, where low correlations provided further evidence for the appropriateness of the oblique rotation.
Since it was suspected that there might be gender differences in attitude towards SIB, a second series of factor analyses was conducted separately for male and female respondents. Similar principal components emerged for both groups (data not shown), with 4 factors extracted for women and 6 for men. For women, one extra item: ‘would convey disapproval of SIB’ (.50) loaded on the first factor, representing 17.94% of the variance accounted for on the perception of negativity in societal attitudes scale. Two additional items: ‘SIB is manipulative’ (.69) and ‘SIB is irresponsible’ (.62) loaded on the second factor, representing 14.06% of the variance accounted for on the strong feelings elicited in response to SIB scale. Three items that made up the original negative and judgemental attitude scale failed to load on any factor: SIB as an ‘attention-seeking behaviour’, ‘copy-cat behaviour’, and ‘used competitively’.

A more complex structure emerged for men, with the item relating to ‘anxiety at the prospect of seeing the young person’ (.42), also loading on the fourth factor. This represented 9.10% of the variance accounted for on the strong feelings elicited in response to SIB scale. A sixth complex factor emerged with three double loading items: ‘would convey disapproval’ (-.42) was negatively associated with ‘imagining the young person feels hopeless’ (.69), and ‘SIB would have an emotional impact’ (.41). This scale was more difficult to interpret, and accounted for only 5.51% of the variance. These findings suggest that SIB is viewed differently among male and female participants. Women appear to rate personal ‘disapproval’ alongside the perception of societal negativity, and seem to be further influenced by the view of SIB as manipulative and irresponsible when associated with feelings of anger, rejection and frustration. Men on the other hand, appear to recognise the emotional impact of SIB, empathise with the young person’s hopelessness and retain any personal disapproval on an opposite pole.

Analysis of Variance
Groups of individuals differed significantly on mean component scores according to various participant characteristics (see Appendix V for a complete listing of the mean...
ranked component regression scores across the range of psychosocial parameters). Relevant findings are summarised under each of the scale item headings below. All scores are corrected for ties, with mean scores presented in parentheses.

**Negative and judgemental attitudes towards SIB**

On the *negative and judgemental attitude* scale, no significant differences were found between mean regression component scores across the entire range of psychosocial parameters considered here, except for that of ethnic origin (Kruskal-Wallis $\chi^2(7)=22.16, p<0.01$). Between group comparisons revealed significant differences lay between mixed-origin participants (146.86), Indian participants (131.00), and white participants (77.50). This trend revealed that both the mixed-origin participants (Mann-Whitney $U=83.00, Z=-3.73, p=0.000$) and the Indian participants ($U=72.00, Z=-1.97, p=0.049$), expressed stronger *negative and judgemental attitudes towards SIB* than their white counterparts.

**Perceived negativity in societal attitudes towards SIB**

Among professionals, type of post-graduate training programme appeared to have an impact on perception and belief about (the potentially rejecting consequences of) *negativity in societal attitudes towards SIB* (Kruskal-Wallis $\chi^2(7)=13.05, p<0.05$). Between group comparisons revealed the greatest differences lay between those who had received no training (85.78), training in counselling skills (103.00), psychodynamic psychotherapy (85.64), cognitive-analytic therapy (CAT; 52.80), and cognitive-behavioural therapy (CBT; 47.00). Professionals with no training (Mann-Whitney $U=122.00, Z=-2.64, p=0.008$), training in counselling skills ($U=13.00, Z=-2.45, p=0.014$) and/or psychodynamic psychotherapy ($U=129.00, Z=-2.56, p=0.01$) – the least cognitive-orientated formalised training programmes – agreed more with the notion that the general public subscribe to stereotypical perceptions of self-harmers as ‘bad’ or ‘mad’, for example, than professionals trained in CBT. These results suggest that practitioners from different training backgrounds interpret and respond to SIB differently across therapeutic orientation. For example, psychodynamic psychotherapists would regard self-harm as a manifestation of unresolved murderous
or sadistic impulses turned against the self rather than against the original object of their rape (Cain, 1961). SIB could also be seen as an attack on the therapy or therapist.

Similarly, those trained in counselling skills rated stronger agreement on the perception of negativity in societal attitude scale than those with a qualification in CAT ($U=5.00$, $Z=-2.03$, $p=0.042$). This suggests that cognitive-orientated practitioners view others and society in general, as more lenient or 'less extreme' in their attitudes towards SIB. This is perhaps accounted for by the more pragmatic views of these cognitive models (Gemma, 1989). Interestingly, however, professionals who had received specialised training in the management of SIB (96.23) were more likely to agree with the perception of negativity in societal attitudes towards SIB compared to those without such training (72.60; Kruskal-Wallis $\chi^2(3)=7.47$, $p<0.05$).

Anxiety regarding safety and management of individual self-harmer

Factor 3 yielded the most interesting significant differences, with respect to age (Kruskal-Wallis $\chi^2(5)=14.68$, $p<0.01$), type of post-qualification training ($\chi^2(8)=19.83$, $p<0.01$), professional status ($\chi^2(3)=14.89$, $p<0.01$), number of years in clinical practice ($\chi^2(7)=15.55$, $p<0.05$), and experience or contact with individuals who self-harm ($\chi^2(5)=9.064$, $p<0.01$). A summary of the significant between subject comparisons is presented in Table 6. In short, young people (114.22) scored higher on the anxiety regarding safety and management scale than professionals aged 46-55 years (82.56) and 56-65 years (54.40) respectively - which was perhaps only to have been expected. Similarly, professionals in the 26-35 years age bracket (93.30) scored higher on this scale than both the older groups.

Concerning professional status, students/trainees (99.14) were more concerned by the issues raised by SIB than more senior practitioners (37.33), as were basic graded practitioners (84.85) compared to consultants/heads of service (71.62). Practitioners with less than 20 years clinical practice (means ranging from 76.90-110.00), expressed significantly more anxiety than those whom had been practicing for 21-25 years (44.92). Significance was not achieved for professionals who had been working for 11-15 years. It was not surprising therefore, to find that participants who had only worked with 1-5 self-harming clients (98.86) also expressed greater anxiety compared
to those who had contact/experience of working with 21+ individuals who self-harmed (71.85).

Once again, type of post-graduate training/qualification appeared to influence scores on this scale. Psychodynamic psychotherapists (62.98) expressed the least degree of anxiety compared to colleagues without training (80.61), qualifications in clinical/counselling psychology (91.88), and/or CBT (105.42). Interestingly, CBT trained professionals (105.42) expressed more anxiety than those without training (80.61), colleagues trained in CAT (50.20), and/or other forms of psychotherapy (65.85).

[Insert Table 6: Between group comparisons indicating strength and direction of psychosocial parameters associated with F3: Anxiety around safety and management of SIB].

Anger, rejection, and frustration in response to SIB

Items relating to feelings of anger, rejection and frustration were negatively associated with the scale. Significant differences were found only for type of post-graduate therapy training (Kruskal-Wallis $\chi^2(8)=19.83$, $p<0.01$), and professional status ($\chi^2(3)=14.89$, $p<0.01$). Professionals trained in CBT (109.17) achieved significantly higher mean scores compared to professionals trained in clinical/counselling psychology (82.46; Mann-Whitney $U=78.00$, $Z=-2.22$, $p=0.03$); no post-graduate training (75.98; $U=153.00$, $Z=-1.98$, $p=0.05$); and psychodynamic psychotherapy training (69.05; $U=122.00$, $Z=2.71$, $p=0.01$). Consultants/heads of service (100.85) achieved significantly higher mean scores than students/trainees (66.86; $U=94.00$, $Z=-2.11$, $p=0.04$).

Positive attitudes and empathetic understanding of SIB

One way ANOVAs revealed that significant differences on mean regression scores on the positive attitude and empathetic understanding of SIB scale were associated with participants’ gender (Kruskal-Wallis $\chi^2(1)=4.34$, $p<0.05$), and with sex of the young
person in the vignette ($\chi^2(1)=6.67$, $p<0.01$). Original statements on this scale were reversed scored. Accordingly, female participants (74.64) when compared to male participants (94.17), were found to have more favourable and/or understanding attitudes towards young people engaging in self-harm ($U=2464.00$, $Z=-2.58$, $p=0.01$). Interestingly, the young man in the vignette (74.77) was viewed more positively than the young woman (90.23; $\chi^2(1)=4.34$, $p<0.05$).

Individual specified professional discipline; clustered professional groupings (e.g. psychological, medical, or social-allied discipline); educational achievement, and preferred theoretical orientation/mode of practice failed to reach significance at the $\alpha = 0.05$ level on any of the psychosocial parameters measured.

**Discussion**

It is frequently acknowledged that surveys of the type presented here are open to bias or are incomplete due to non-returns. In this survey, however, such criticism may be mitigated by several factors – the achievement of a 40.1% response rate from a broad cross-section of multidisciplinary mental health professionals, the rich diversity of opinion expressed in response to open-ended questions, and the fact that only 8% of participants reported no direct clinical experience or contact with SIB. Although there may have been other considerations, such as lack of time (a realistic if not overused excuse within the present day NHS), non-respondents may also have perceived the questionnaire solely to be evaluating negative attitudes towards SIB. They may have expressly chosen *not* to comment on feelings of ambivalence and/or anxiety commonly associated with SIB. Lydeard (1996) has suggested that one of the most important factors that determine response rates is the perceived applicability of the research project to responders. Taken together, this would appear to lend support to participants’ suggestions that they are the ones particularly interested in ‘process issues’ relating to the management of SIB.

Two further limitations warrant attention. First, it was not possible to differentiate between those respondents who ‘neither agreed/nor disagreed’ with particular statements, due to the limited information provided in the vignette, for example, from
those who felt uncertain about a particular judgement. Secondly, the decision to use two vignettes identical in content (apart from gender) as the basis for the survey, must necessitate caution in generalising the data to a broader client group. However, ambiguity about the meaning of ‘unclear’ responses in this study has limited clinical relevance. In practice, limited information may be available for a variety of reasons, and clinical decisions may have to be taken with less than a thorough knowledge of ‘all the facts’. Thus while the protestations were registered, it is suggested that the ‘real’ picture ‘out there’ is even worse, often complicated by uncertainty, ambivalence and conflict.

This study explored attitudes towards self-injurious behaviour among multidisciplinary mental health professionals’ and young people who engage in SIB. Five stable factors were obtained. A cluster of items associated with negative and judgemental attitudes was differentiated from the perception of negativity in societal attitudes, indicating different levels of ‘individual’ and ‘shared’ societal prejudice conceived of across the sample of participants. Mediating the opposite pole of positive attitudes and empathetic understanding of SIB, a further two factors were identified. These were associated with anxiety around safety and management and, (mostly disagreement with) strong feelings of anger, rejection and frustration elicited in response to SIB. Although more needs to be learned about the meaning ascribed to SIB, the spread of responses suggest that, the attitudes measured were frequently divided and contradictory.

One of the important findings from this study is that attitude towards SIB is related to distinct social factors. It is perhaps difficult to believe that so many respondents strongly disagreed with feelings of anger, rejection and frustration in response to a young person ‘cutting’ themselves. This is especially so, given the high proportion of respondents who acknowledged that SIB would have an ‘emotional’ impact on them. Possibly, the relatively young age of the person in the vignette (compared to the age of some of the participants) may have made respondents more likely to feel concerned or anxious rather than frustrated or rejecting when first encountering a young person who self-harms. In clinical practice, feelings of frustration and rejection may come later, especially if they had been unable to help the young person. Alternatively, it may have been that the vignette seemed too improbable, limited in the information it provided,
or removed from participants' sphere of personal experience. Finally, the study was designed by a counselling psychologist 'in training'. Additional response biases may perhaps have stemmed from participants' awareness of the researcher's position and/or a pedagogical tendency to present attitudes towards SIB in a positive light.

Another interesting result was the lack of significant differences in response to attitudes towards SIB among different professional disciplines (for example, between counselling psychologists and psychiatrists), or broader allied groupings (say, between psychological and medical practitioners). The greatest differences instead, were associated with type of post-graduate training and/or qualification undertaken (for instance, between cognitive-behavioural and psychodynamic psychotherapy). This implies that the ‘school’ or theoretical model one trains in differs in terms of what professionals do differently ‘in practice’, yet is not translated across shared professional identities. Such value-laden categories are perhaps more accurately labelled ‘social identities’ (Tajfel, 1978), as they appeared to be customised to suit personal goals – even within this relatively homogeneous sample (Breakwell, 1986, 1993). Thus, it seemed training background was more strongly associated with attitude towards SIB than the personal label ascribed to a mental health professional to describe their role and/or discipline. It was somewhat surprising therefore, that no significant differences were found for preferred theoretical orientation across groups.

Moliner and Tafani (1997) have proposed a theoretical link between the concepts of ‘attitude’ and ‘social representation’, based on a structural approach to representations which accounts for their evaluative nature. Social representations Theory (SRT) offers a theoretical framework which demonstrates changes in social relativity and social influence on psychological processes, such as knowledge. It also takes into account the relevance of the communicative and interactive processes in which knowledge is produced and used (Flick, 1994; Moscovici, 1984, 1994). Accordingly, social representations refer to the collective ideas, thoughts, images and knowledge structures which members of a group share and which are socially constructed (Augoustinos & Walker, 1995).

Moscovici and Hewstone (1983) have argued that social representation contributes to group-identity formation in the sense that merely by sharing a social representation (in
this case, strong disagreement with seemingly negative countertransference feelings, group members come to feel a common identity since they have a common 'world view'. Perhaps this was indicative of a desire to project some of the more empathetic and understanding assumptions underlying the work carried out by mental health professionals. An alternative suggested by only a few respondents was to consider the 'emotional impact' as a useful tool in the therapeutic encounter (Clarkson, 1990, 1995). These observations suggest that although the evaluative responses of participants may result from an individual process, they are nevertheless based on components that are common to all individuals. In other words, when the object of an attitude is the object of a social representation, the manifestation of the attitude can be regarded as an individual process, but its underlying structure must be viewed as a collective phenomenon (Billig, 1993; Moliner & Tafani, 1997).

Some authors have attempted to overcome the epistemological incompatibilities between 'attitude' and the modern concept of 'social representation' by introducing the notion of 'social attitude' (Fraser, 1994; Jaspar & Fraser, 1984). Here, the understanding of attitude is not an individualised one, but related to attitudes shared by members of a given group. Whilst some participants appeared happy to make distinctions between say, objectionable and non-objectionable attitudes, for many, this was a difficult task. In such cases, initial categorisation of opinion seemed insufficient and they were forced to particularise, often drawing on categories more closely related to diagnostic explanations. At the same time, for some participants' their prejudicial beliefs about SIB began to surface. This seemed to involve placing SIB on the whole and young men especially in a more negative category of conceptualisation.

The results did not confirm the hypothesis that doctors and psychiatrists held more negative and judgemental attitudes than the adolescent self-harmers themselves, as speculated by young people in previous qualitative research (Bowen, 2000). Significant differences were found however, between individuals from different ethnic groups. These results should perhaps be interpreted with caution due to the small samples involved. The influence of ethnicity may nevertheless be an interesting avenue for further research, according to different levels of acceptability of self-mutilation in different cultures.
The results did confirm that attitudes should not be studied in isolation (Billig, 1993). Several other psychosocial parameters played a part in influencing the communication of shared knowledge, views and beliefs – particularly, experience or exposure to SIB in the form of specific training and different ideas about its management. Arguably, it is perhaps those interested few who sought to further their understanding of SIB through specialised training, and through this newly communicated knowledge, have come to perceive others (those without additional training in SIB and/or society in general), as holding on to some of the stereotypical constructs of young people who engage in deliberate self-harm.

Huband and Tantam (2000) have surmised that SIB frequently raises anxiety in professionals, arising from fears for the young person’s safety, from concerns about repercussions should they do ‘one cut too many’, and from complex counter-transference reactions (Feldman, 1988). This type of behaviour can also challenge professionals’ views of their autonomy, competence and role (Breeze & Repper, 1998). One defence against such anxiety may be to attribute responsibility and blame away from themselves onto the client. A further interpretation however, is for this anxiety to become manifest via the processes of projection and identification (Klein, 1946; Winnicott, 1968), from ‘individual’ negative and judgemental attitudes to ‘shared’ perceptions of negativity in societal attitudes described in the present scales. Anxiety nevertheless appeared to reduce with age, experience and training – specifically within the more analytically influenced orientations (e.g. psychodynamic/psychoanalytic and cognitive-analytic therapies).

Few gender biases were found among the sample as a whole. Significant differences were only associated with the positive attitude and empathetic understanding of SIB scale. Female professionals, in general, appeared to be more sympathetic towards SIB than their male colleagues. With regards to self-harming clients however, the young woman in the vignette was viewed in less empathetic or understanding terms than the young man. Previous research has suggested that young women who engage in SIB (often given a diagnosis of borderline personality disorder – due to the only direct reference to self-mutilation or suicidal threats in the current DSM-IV), are frequently treated as outcasts by clinicians, or ‘flagged’ under this term to indicate to future caregivers that the individual is difficult to treat or a troublemaker (Herman, 1992; Hogg
& Burke, 1998). The analyses would therefore suggest, as per its historical roots, that the canons of the biomedical model are still being used, not only to judge, but also to make sense of adolescent SIB.

Although it would be presumptuous to attempt to generalise this study to a wider population in the absence of further research and corroboration, the findings suggest considerable variability in cognitive, affective, and (to a lesser extent) behavioural responses to SIB. It is important to point out it is most likely there are other attitudes that have not been discussed here. Furthermore whilst negative and judgemental attitudes towards SIB do exist, these should not discredit the more facilitating positive attitudes, depth of understanding, and empathy for the 'individual' in distress – the hallmarks of client-led psychotherapies (Rogers, 1951, 1957).

Drawing on these ideas, future research needs to examine attitudes towards adolescent SIB in light of the social context (e.g. family, peer group, school, etc.) in which they develop and are encountered outside of mental health settings. A contextual understanding of SIB may be needed to understand the social reality for the adolescent – to the extent that as mental health professionals, we may unwittingly be defending against negative and/or judgemental attitudes ourselves; also to the extent necessary for the advancement of effective prevention and intervention strategies.

The implications from the aforementioned discussion suggest that if the provision of therapeutic treatment within the NHS is to develop, certain changes need to occur concerning both the medical and the therapy communities. It is proposed that there needs to be a reformulation in conceptualisation of adolescent SIB – through which the very nature of social attitudes can begin to challenge 'the public sphere' of negativity towards SIB. It was surprising how few professionals had received specific training in the management of SIB, given the overwhelming proportion of mental health practitioners that encountered such acts in their everyday practice. Not only does vocational training across disciplines need to focus on enhancing practitioners' awareness of the range therapeutic models available for clients who engage in deliberate self-harm (see Hawton et al., 1998 for a comprehensive review), but also the emotional, psychological and social factors impacting on the young person's life. By becoming a more prominent part of NHS workers' curriculum, this may also
improve inter-disciplinary collaboration, which is arguably often more effective than a multi-disciplinary approach (Davy, 1999).
REFERENCES


Table 1: Distribution of professional disciplines

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Returned Forms</th>
<th>Proportion of sample</th>
<th>Professional Grouping Alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Psychologist</td>
<td>28</td>
<td>17.1%</td>
<td>Psychological Allied Disciplines</td>
</tr>
<tr>
<td>Counselling Psychologist</td>
<td>27</td>
<td>16.5%</td>
<td></td>
</tr>
<tr>
<td>Psychotherapist</td>
<td>24</td>
<td>14.6%</td>
<td></td>
</tr>
<tr>
<td>Other Therapist (e.g. Applied Behaviour Analyst/Cognitive-Analytic/CBT)</td>
<td>8</td>
<td>4.9%</td>
<td></td>
</tr>
<tr>
<td>Nurse Specialist (e.g. CPN/RMN)</td>
<td>27</td>
<td>16.5%</td>
<td>Medical Allied Disciplines</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>18</td>
<td>11.0%</td>
<td></td>
</tr>
<tr>
<td>Doctor (e.g. SHO/SpR/Registrar)</td>
<td>6</td>
<td>3.7%</td>
<td>$N = 53$</td>
</tr>
<tr>
<td>Mental Health Practitioner</td>
<td>2</td>
<td>1.2%</td>
<td>(32.3%)</td>
</tr>
<tr>
<td>Social Worker</td>
<td>5</td>
<td>3.0%</td>
<td>Social Allied Disciplines</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>4</td>
<td>2.4%</td>
<td></td>
</tr>
<tr>
<td>Other Allied Discipline (e.g. Art/Dance Therapist)</td>
<td>4</td>
<td>2.4%</td>
<td>$N = 15$</td>
</tr>
<tr>
<td>Teacher</td>
<td>2</td>
<td>1.2%</td>
<td>(9.2%)</td>
</tr>
<tr>
<td>Young self-harmer (Ex-Inpatient)</td>
<td>9</td>
<td>5.5%</td>
<td>Not Applicable $N = 9$ (5.5%)</td>
</tr>
</tbody>
</table>

Note: $N = 164$. 

TABLES OF RESULTS
Table 2: Characteristics of respondents

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>98</td>
<td>59.8</td>
</tr>
<tr>
<td>Male</td>
<td>66</td>
<td>40.2</td>
</tr>
<tr>
<td>Age (years):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17-21 years (Adolescent respondents)</td>
<td>9</td>
<td>5.5</td>
</tr>
<tr>
<td>18-25</td>
<td>9</td>
<td>5.5</td>
</tr>
<tr>
<td>26-35</td>
<td>54</td>
<td>32.9</td>
</tr>
<tr>
<td>36-45</td>
<td>45</td>
<td>27.4</td>
</tr>
<tr>
<td>46-55</td>
<td>36</td>
<td>22.0</td>
</tr>
<tr>
<td>56-65</td>
<td>11</td>
<td>6.7</td>
</tr>
<tr>
<td>Ethnic origin:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>144</td>
<td>87.8</td>
</tr>
<tr>
<td>Other mixed origin</td>
<td>7</td>
<td>4.3</td>
</tr>
<tr>
<td>Black (African/Caribbean/Other)</td>
<td>6</td>
<td>3.7</td>
</tr>
<tr>
<td>Indian</td>
<td>3</td>
<td>1.8</td>
</tr>
<tr>
<td>Pakistani</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>Chinese</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>Education and qualifications:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>GCSE/O-Level</td>
<td>7</td>
<td>4.3</td>
</tr>
<tr>
<td>A-Level</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>Diploma (HND, SNR etc.)</td>
<td>10</td>
<td>6.1</td>
</tr>
<tr>
<td>1st degree (BSc, BA etc.)</td>
<td>42</td>
<td>25.6</td>
</tr>
<tr>
<td>Higher Degree (MSc, MA etc.)</td>
<td>58</td>
<td>35.4</td>
</tr>
<tr>
<td>PhD/PsychD</td>
<td>36</td>
<td>21.9</td>
</tr>
<tr>
<td>Other Qualification</td>
<td>8</td>
<td>4.9</td>
</tr>
<tr>
<td>Status:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student/Trainee</td>
<td>25</td>
<td>15.2</td>
</tr>
<tr>
<td>Graded Practitioner</td>
<td>114</td>
<td>69.5</td>
</tr>
<tr>
<td>Principal/Senior Practitioner</td>
<td>12</td>
<td>7.3</td>
</tr>
<tr>
<td>Consultant/Head of Service</td>
<td>13</td>
<td>7.9</td>
</tr>
<tr>
<td>Post-graduate training:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No post-graduate therapeutic training</td>
<td>41</td>
<td>26.5</td>
</tr>
<tr>
<td>Psychodynamic Psychotherapy training</td>
<td>42</td>
<td>27.1</td>
</tr>
<tr>
<td>Clinical/Counselling Psychology training</td>
<td>24</td>
<td>15.5</td>
</tr>
<tr>
<td>Other post-graduate therapeutic training</td>
<td>13</td>
<td>8.4</td>
</tr>
<tr>
<td>Specific training in Cognitive and/or Behavioural Therapy</td>
<td>12</td>
<td>7.7</td>
</tr>
<tr>
<td>Specific training in Systemic Family Therapy</td>
<td>11</td>
<td>7.1</td>
</tr>
<tr>
<td>Specific training in Counselling Skills</td>
<td>7</td>
<td>4.5</td>
</tr>
<tr>
<td>Specific training in Cognitive-Analytical Therapy</td>
<td>5</td>
<td>3.2</td>
</tr>
<tr>
<td>Specific training with self-injurious behaviours:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No specific training with self-injurious behaviours</td>
<td>121</td>
<td>78.0</td>
</tr>
<tr>
<td>Specific training with self-injurious behaviours</td>
<td>26</td>
<td>16.8</td>
</tr>
<tr>
<td>In-house training</td>
<td>6</td>
<td>3.9</td>
</tr>
<tr>
<td>Dialectical Behaviour Therapy training</td>
<td>2</td>
<td>1.3</td>
</tr>
</tbody>
</table>
Table 2 (Cont.): Characteristics of respondents

<table>
<thead>
<tr>
<th>Clinical experience including training years:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than one year experience in a health setting</td>
<td>5</td>
<td>3.2</td>
</tr>
<tr>
<td>1-2 years experience in a health setting</td>
<td>5</td>
<td>3.2</td>
</tr>
<tr>
<td>3-5 years experience in a health setting</td>
<td>38</td>
<td>24.5</td>
</tr>
<tr>
<td>6-10 years experience in a health setting</td>
<td>30</td>
<td>19.4</td>
</tr>
<tr>
<td>11-15 years experience in a health setting</td>
<td>32</td>
<td>20.6</td>
</tr>
<tr>
<td>16-20 years experience in a health setting</td>
<td>13</td>
<td>8.4</td>
</tr>
<tr>
<td>21-25 years experience in a health setting</td>
<td>13</td>
<td>8.4</td>
</tr>
<tr>
<td>26+ years experience in a health setting</td>
<td>17</td>
<td>11.0</td>
</tr>
<tr>
<td>Did not answer (missing data)</td>
<td>2</td>
<td>1.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific experience with self-injurious behaviours:</th>
</tr>
</thead>
<tbody>
<tr>
<td>No experience of working with self-harming clients/patients</td>
</tr>
<tr>
<td>Contact/worked with 1-5 self-harming clients/patients</td>
</tr>
<tr>
<td>Contact/worked with 6-10 self-harming clients/patients</td>
</tr>
<tr>
<td>Contact/worked with 11-15 self-harming clients/patients</td>
</tr>
<tr>
<td>Contact/worked with 16-20 self-harming clients/patients</td>
</tr>
<tr>
<td>Contact/worked with 21+ self-harming clients/patients</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current employment setting:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient setting/Psychiatric hospital</td>
<td>38</td>
</tr>
<tr>
<td>Psychology department/Co-ordinated Treatments Service</td>
<td>21</td>
</tr>
<tr>
<td>Psychotherapy department</td>
<td>18</td>
</tr>
<tr>
<td>Community Mental Health Team (CMHT)</td>
<td>17</td>
</tr>
<tr>
<td>Other Community Services (e.g. Home treatment/Learning Disability Teams)</td>
<td>16</td>
</tr>
<tr>
<td>Community Adolescent Mental Health Service (CAMHS)</td>
<td>13</td>
</tr>
<tr>
<td>Psychiatric Outpatient department</td>
<td>12</td>
</tr>
<tr>
<td>Private practice</td>
<td>8</td>
</tr>
<tr>
<td>Other settings (e.g. A&amp;E, GP practice, Academic department, Social Services)</td>
<td>7</td>
</tr>
<tr>
<td>Specialist Clinics (e.g. HIV/AIDS services)</td>
<td>5</td>
</tr>
</tbody>
</table>

| Preferred theoretical orientation/mode of practice: | |
|---------------------------------------------------|
| Integrative | 47 | 30.3 |
| Psychoanalytic/psychodynamic | 39 | 25.2 |
| Cognitive-behavioural | 23 | 14.8 |
| Systemic | 11 | 7.1 |
| Cognitive-analytical | 8 | 5.2 |
| Humanistic | 7 | 4.5 |
| Interpersonal | 4 | 2.6 |
| Cognitive | 3 | 1.9 |
| Other (e.g. brief solution-focused) | 2 | 1.3 |
| Existential-phenomenological | 1 | 0.6 |
| Did not answer (missing data) | 10 | 6.5 |

Note: N = 164, unless specified.

a Adolescent participants excluded from the analysis, N = 9.
b 32 respondents reported working in more than one clinical setting.
c 45 respondents indicated more than one preferred theoretical orientation/mode of practice
Table 3: Mean scores, standard deviations, 95% confidence intervals, and reproduced communalities of questionnaire items

<table>
<thead>
<tr>
<th>Summary of Items</th>
<th>Mean Score</th>
<th>SD</th>
<th>95% confidence interval</th>
<th>RC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frustrated with young person</td>
<td>2.07</td>
<td>1.23</td>
<td>1.88 to 2.26</td>
<td>.74</td>
</tr>
<tr>
<td>Angry with young person</td>
<td>1.84</td>
<td>1.10</td>
<td>1.67 to 2.00</td>
<td>.73</td>
</tr>
<tr>
<td>Rejecting of young person</td>
<td>1.76</td>
<td>0.99</td>
<td>1.60 to 1.91</td>
<td>.76</td>
</tr>
<tr>
<td>SIB is unacceptable</td>
<td>2.37</td>
<td>1.60</td>
<td>2.12 to 2.61</td>
<td>.65</td>
</tr>
<tr>
<td>SIB is understandable a</td>
<td>2.74</td>
<td>1.33</td>
<td>2.54 to 2.95</td>
<td>.69</td>
</tr>
<tr>
<td>SIB is manipulative b</td>
<td>2.76</td>
<td>1.42</td>
<td>2.54 to 2.98</td>
<td>.71</td>
</tr>
<tr>
<td>SIB is irresponsible</td>
<td>2.60</td>
<td>1.52</td>
<td>2.37 to 2.84</td>
<td>.63</td>
</tr>
<tr>
<td>Anxious at prospect of seeing young person</td>
<td>2.93</td>
<td>1.70</td>
<td>2.66 to 3.19</td>
<td>.57</td>
</tr>
<tr>
<td>Concerned about level of SIB escalating further</td>
<td>5.49</td>
<td>1.29</td>
<td>5.29 to 5.69</td>
<td>.70</td>
</tr>
<tr>
<td>Worried that young person might attempt suicide</td>
<td>4.81</td>
<td>1.43</td>
<td>4.59 to 5.03</td>
<td>.79</td>
</tr>
<tr>
<td>Would feel responsible for young person’s safety</td>
<td>3.76</td>
<td>1.59</td>
<td>3.51 to 4.00</td>
<td>.63</td>
</tr>
<tr>
<td>SIB would have an emotional impact</td>
<td>4.82</td>
<td>1.41</td>
<td>4.60 to 5.03</td>
<td>.74</td>
</tr>
<tr>
<td>SIB is a violent act</td>
<td>4.80</td>
<td>1.46</td>
<td>4.58 to 5.03</td>
<td>.76</td>
</tr>
<tr>
<td>SIB is an impulsive act b</td>
<td>4.44</td>
<td>1.38</td>
<td>4.23 to 4.66</td>
<td>.72</td>
</tr>
<tr>
<td>SIB equivalent to a suicide attempt</td>
<td>2.26</td>
<td>1.23</td>
<td>2.07 to 2.45</td>
<td>.60</td>
</tr>
<tr>
<td>SIB is a serious social problem b</td>
<td>4.09</td>
<td>1.57</td>
<td>3.85 to 4.33</td>
<td>.62</td>
</tr>
<tr>
<td>SIB is ‘attention-seeking’ behaviour</td>
<td>3.63</td>
<td>1.61</td>
<td>3.38 to 3.88</td>
<td>.73</td>
</tr>
<tr>
<td>SIB is morally wrong</td>
<td>2.07</td>
<td>1.33</td>
<td>1.87 to 2.28</td>
<td>.51</td>
</tr>
<tr>
<td>Imagines young person feels quite hopeless a</td>
<td>2.23</td>
<td>1.00</td>
<td>2.07 to 2.38</td>
<td>.62</td>
</tr>
<tr>
<td>‘Cutting’ is a way of managing feelings a</td>
<td>1.92</td>
<td>0.94</td>
<td>1.78 to 2.07</td>
<td>.70</td>
</tr>
<tr>
<td>‘Cutting’ is overdramatic given the circumstance</td>
<td>2.77</td>
<td>1.38</td>
<td>2.56 to 2.99</td>
<td>.70</td>
</tr>
<tr>
<td>‘Cutting’ is a means of release a</td>
<td>2.35</td>
<td>0.97</td>
<td>2.20 to 2.50</td>
<td>.69</td>
</tr>
<tr>
<td>‘Cutting’ is kept secret because of feeling ashamed a</td>
<td>2.76</td>
<td>1.20</td>
<td>2.58 to 2.95</td>
<td>.76</td>
</tr>
<tr>
<td>Method of SIB is often a ‘copy-cat’ behaviour</td>
<td>3.46</td>
<td>1.41</td>
<td>3.24 to 3.67</td>
<td>.76</td>
</tr>
<tr>
<td>Method of SIB used competitively amongst peers</td>
<td>3.35</td>
<td>1.40</td>
<td>3.13 to 3.56</td>
<td>.78</td>
</tr>
<tr>
<td>Would focus more on behaviour than feelings b</td>
<td>2.36</td>
<td>1.17</td>
<td>2.17 to 2.54</td>
<td>.70</td>
</tr>
<tr>
<td>Would encourage young person to share feelings a</td>
<td>1.93</td>
<td>0.97</td>
<td>1.78 to 2.08</td>
<td>.63</td>
</tr>
<tr>
<td>Would convey disapproval of SIB b</td>
<td>2.34</td>
<td>1.55</td>
<td>2.10 to 2.18</td>
<td>.64</td>
</tr>
<tr>
<td>SIB would be shocking to most people</td>
<td>5.40</td>
<td>1.10</td>
<td>5.23 to 5.57</td>
<td>.58</td>
</tr>
<tr>
<td>SIB would eventually push most people away</td>
<td>4.65</td>
<td>1.21</td>
<td>4.46 to 4.83</td>
<td>.73</td>
</tr>
<tr>
<td>SIB is a serious mental health problem</td>
<td>4.62</td>
<td>1.53</td>
<td>4.38 to 4.85</td>
<td>.72</td>
</tr>
<tr>
<td>Other professionals would generally frown upon SIB</td>
<td>3.57</td>
<td>1.54</td>
<td>3.33 to 3.80</td>
<td>.66</td>
</tr>
<tr>
<td>General Public would consider individual to be ‘bad’</td>
<td>4.20</td>
<td>1.35</td>
<td>3.99 to 4.41</td>
<td>.63</td>
</tr>
<tr>
<td>General Public would consider individual to be ‘mad’</td>
<td>4.80</td>
<td>1.15</td>
<td>4.63 to 4.98</td>
<td>.77</td>
</tr>
<tr>
<td>Society would disapprove of young person’s SIB b</td>
<td>5.20</td>
<td>1.15</td>
<td>5.02 to 5.37</td>
<td>.57</td>
</tr>
</tbody>
</table>

Notes: N=164.
Scale used: 1 = Disagreement, 7 = Agreement.
SD = Standard Deviation.
RC = Reproduced Communalities are in bold type.
Variables failing to load on any factor are in italics.
a Variable with reverse-scored calculated mean.
b Variable with single missing value replaced with the variable mean.
<table>
<thead>
<tr>
<th>Questionnaire items</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
<th>Interpretation</th>
<th>Reliability Coefficient α</th>
</tr>
</thead>
<tbody>
<tr>
<td>Method of SIB is used competitively amongst peers</td>
<td>.76</td>
<td>-.01</td>
<td>-.09</td>
<td>-.03</td>
<td>-.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Method of SIB is often a ‘copy-cat’ behaviour</td>
<td>.68</td>
<td>.04</td>
<td>-.14</td>
<td>-.08</td>
<td>-.07</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young person’s SIB is ‘attention-seeking’ behaviour</td>
<td>.66</td>
<td>-.08</td>
<td>.09</td>
<td>.01</td>
<td>-.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young person’s SIB is manipulative</td>
<td>.57</td>
<td>.05</td>
<td>.04</td>
<td>-.34</td>
<td>.17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would convey disapproval of young person’s SIB</td>
<td>.57</td>
<td>.28</td>
<td>.07</td>
<td>.06</td>
<td>.21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young person’s SIB is irresponsible</td>
<td>.55</td>
<td>.18</td>
<td>.10</td>
<td>-.23</td>
<td>.17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SIB would eventually push most people away</td>
<td>.03</td>
<td>.68</td>
<td>-.00</td>
<td>-.07</td>
<td>-.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Society at large would disapprove of SIB</td>
<td>.17</td>
<td>.67</td>
<td>-.05</td>
<td>.08</td>
<td>-.08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SIB would be shocking to most people</td>
<td>-.01</td>
<td>.66</td>
<td>.13</td>
<td>.04</td>
<td>.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other professionals would generally frown upon SIB</td>
<td>-.09</td>
<td>.66</td>
<td>-.01</td>
<td>-.05</td>
<td>.19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Public would consider young person to be ‘bad’</td>
<td>.08</td>
<td>.65</td>
<td>-.16</td>
<td>.09</td>
<td>-.11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Public would consider young person to be ‘mad’</td>
<td>-.01</td>
<td>.58</td>
<td>.07</td>
<td>-.06</td>
<td>-.19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Worried that young person might attempt suicide</td>
<td>.08</td>
<td>-.08</td>
<td>.80</td>
<td>.15</td>
<td>-.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would feel responsible for young person’s safety</td>
<td>.09</td>
<td>-.05</td>
<td>.73</td>
<td>-.12</td>
<td>.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concerned about the level of SIB escalating further</td>
<td>.25</td>
<td>-.06</td>
<td>.65</td>
<td>.35</td>
<td>-.08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would feel anxious at prospect of seeing young person</td>
<td>-.14</td>
<td>-.04</td>
<td>.58</td>
<td>-.37</td>
<td>.10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young person’s SIB would have an emotional impact</td>
<td>-.22</td>
<td>.13</td>
<td>.49</td>
<td>-.09</td>
<td>.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SIB is a serious mental health problem</td>
<td>-.05</td>
<td>.31</td>
<td>.42</td>
<td>.127</td>
<td>-.12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angry with young person injuring him/herself</td>
<td>.10</td>
<td>-.07</td>
<td>.02</td>
<td>-.84</td>
<td>-.04</td>
<td></td>
<td></td>
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<tr>
<td>Rejecting of young person injuring him/herself</td>
<td>.02</td>
<td>.05</td>
<td>-.04</td>
<td>-.84</td>
<td>-.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frustrated with young person injuring him/herself</td>
<td>.21</td>
<td>-.02</td>
<td>.02</td>
<td>-.79</td>
<td>-.07</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young person’s ‘cutting’ is a means of release</td>
<td>.12</td>
<td>-.05</td>
<td>.08</td>
<td>.06</td>
<td>.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Young person’s ‘cutting’ is a way of managing feelings</td>
<td>.18</td>
<td>-.15</td>
<td>.16</td>
<td>.09</td>
<td>.77</td>
<td></td>
<td></td>
</tr>
<tr>
<td>‘Cutting’ is kept secret because of feeling ashamed</td>
<td>-.05</td>
<td>.03</td>
<td>-.08</td>
<td>.01</td>
<td>.70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imagines young person feels quite hopeless</td>
<td>-.13</td>
<td>.02</td>
<td>-.21</td>
<td>-.01</td>
<td>.59</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eigenvalues</td>
<td>3.97</td>
<td>3.15</td>
<td>2.39</td>
<td>2.09</td>
<td>1.62</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of variance accounted for before rotation</td>
<td>15.9%</td>
<td>12.6%</td>
<td>9.6%</td>
<td>8.4%</td>
<td>6.5%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: Oblimin Rotation with Kaiser Normalization converged in 11 iterations. Variables with loadings >0.40 are in bold type.
Table 5: Principal component correlation matrix

<table>
<thead>
<tr>
<th>Component</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F2</td>
<td>.12</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F3</td>
<td>.05</td>
<td>.09</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F4</td>
<td>-.14</td>
<td>-.02</td>
<td>-.03</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>F5</td>
<td>.08</td>
<td>-.09</td>
<td>-.08</td>
<td>-.12</td>
<td>1.00</td>
</tr>
</tbody>
</table>
Table 6: Between group comparisons indicating strength and direction of psychosocial parameters associated with F3: Anxiety around safety and management of SIB

<table>
<thead>
<tr>
<th>Psychosocial Parameter</th>
<th>Significant between group comparisons</th>
<th>Mann-Whitney U</th>
<th>Z score</th>
<th>P value&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>17-21yrs (Adolescent) vs. 46-55yrs</td>
<td>67.00</td>
<td>-2.70</td>
<td>0.007**</td>
</tr>
<tr>
<td></td>
<td>17-21yrs (Adolescent) vs. 56-65yrs</td>
<td>18.00</td>
<td>-2.21</td>
<td>0.027*</td>
</tr>
<tr>
<td></td>
<td>26-35yrs vs. 46-55yrs</td>
<td>654.00</td>
<td>-2.62</td>
<td>0.009**</td>
</tr>
<tr>
<td></td>
<td>26-35yrs vs. 56-65yrs</td>
<td>140.00</td>
<td>-2.40</td>
<td>0.016*</td>
</tr>
<tr>
<td>Type of post-graduate therapy training</td>
<td>No training vs. Psychodynamic Psychotherapy</td>
<td>79.00</td>
<td>-2.72</td>
<td>0.005**</td>
</tr>
<tr>
<td></td>
<td>Clinical/Counselling Psychology vs. Psychotherapy</td>
<td>324.00</td>
<td>-2.39</td>
<td>0.016*</td>
</tr>
<tr>
<td></td>
<td>CBT vs. Psychotherapy</td>
<td>105.00</td>
<td>-3.06</td>
<td>0.002**</td>
</tr>
<tr>
<td></td>
<td>CBT vs. Other Psychotherapy</td>
<td>39.00</td>
<td>-2.12</td>
<td>0.035*</td>
</tr>
<tr>
<td></td>
<td>CBT vs. CAT</td>
<td>8.00</td>
<td>-2.32</td>
<td>0.019*</td>
</tr>
<tr>
<td></td>
<td>CBT vs. No training</td>
<td>22.00</td>
<td>-2.27</td>
<td>0.023*</td>
</tr>
<tr>
<td>Professional status</td>
<td>Student/Trainee vs. Senior/Principal grade practitioner</td>
<td>35.00</td>
<td>-3.73</td>
<td>0.000***</td>
</tr>
<tr>
<td></td>
<td>Graded practitioner vs. Consultant/ Head of Service</td>
<td>292.00</td>
<td>-3.26</td>
<td>0.001***</td>
</tr>
<tr>
<td>Number of years</td>
<td>Less than one-yr vs. 21-25 yrs practicing</td>
<td>11.00</td>
<td>-2.12</td>
<td>0.035*</td>
</tr>
<tr>
<td></td>
<td>1-2 yrs vs. 21-25 yrs practicing</td>
<td>8.00</td>
<td>-2.42</td>
<td>0.014*</td>
</tr>
<tr>
<td></td>
<td>3-5 yrs vs. 21-25 yrs practicing</td>
<td>111.00</td>
<td>-2.94</td>
<td>0.003***</td>
</tr>
<tr>
<td></td>
<td>6-10 yrs vs. 21-25 yrs practicing</td>
<td>108.00</td>
<td>-2.30</td>
<td>0.021*</td>
</tr>
<tr>
<td></td>
<td>11-15 yrs vs. 21-25 yrs practicing</td>
<td>142.00</td>
<td>-1.65</td>
<td>0.098 n.s.</td>
</tr>
<tr>
<td></td>
<td>16-20 yrs vs. 21-25 yrs practicing</td>
<td>33.00</td>
<td>-2.64</td>
<td>0.007**</td>
</tr>
<tr>
<td>No. of self-harming clients</td>
<td>Worked/contact with 1-5 vs. 21+ self-harmers</td>
<td>644.00</td>
<td>-2.61</td>
<td>0.009**</td>
</tr>
</tbody>
</table>

Notes: *All scores are corrected for ties.

Differences in means significant at *p<0.05; **p<0.01; ***P<0.001.

n.s. = not significant
This paper will be submitted for publication in the peer review *Journal of Mental Health*, in August 2001.

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix I</td>
<td>- Ethical Approval Correspondence</td>
</tr>
<tr>
<td>Appendix II</td>
<td>- Case Vignette: Referral Letter</td>
</tr>
<tr>
<td>Appendix III</td>
<td>- Full copy of Self-Completed Questionnaire</td>
</tr>
<tr>
<td>Appendix IV</td>
<td>- Component Score Coefficient Matrix</td>
</tr>
<tr>
<td>Appendix V</td>
<td>- Mean Ranked Component Regression Scores across the Range of Psychosocial Parameters</td>
</tr>
<tr>
<td>Appendix VI</td>
<td>- Notes for Contributors: <em>Journal of Mental Health</em></td>
</tr>
</tbody>
</table>
Dear Miss Bowen

Coping strategy or pathological behaviour? Young people's versus multidisciplinary mental health professionals' understanding of adolescent self-injurious behaviour (ACE/2000/91/Psych)

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol and the subsequent information supplied and has approved it on the understanding that the Ethics Guidelines are observed.

The letter of approval relates only to the study specified in your research protocol (ACE/2000/91/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions and if the study is terminated earlier than expected (with reasons). I enclose a copy of the Ethics Guidelines for your information.

Date of approval by the Advisory Committee on Ethics: 22 February 2001
Date of expiry of the Advisory Committee on Ethics approval: 21 February 2006

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Advisory Committee on Ethics

cc: Professor L J King, Chairman, ACE
    Mr R Draghi-Lorenz, Principal Investigator, Dept of Psychology
Appendix II

Referral Letter

Instructions: Below is an example of a referral letter sent to you by a GP. Please read the letter slowly, taking time to imagine this young person as your client. As you read it, listen to how you feel and what you think about the individual.

You will then be asked to tick appropriate boxes in answer to the questions that follow.

Dear [Your Name]

I am referring this young woman to you for further specialised care and support. Ann is 18-years-old. She has always been close to her family and previously felt that it was a happy family. Over the past year, however, her mother and father have been fighting more often than not and, apparently every night when she comes home from college they are arguing. Finally, they told her that they have decided to get a divorce and have demanded to know which parent she wants to live with. As she has tried to make up her mind over the past few months, she has found it increasingly hard to express any feelings or talk about her needs with those around her. She has reported drinking excessively on a number of occasions, and has become involved with a group of peers who are frequently in trouble for being disruptive at college. She told me that at first, she had started scratching her arms with her nails. More recently, however, she has begun secretly cutting both her arms with bits of broken glass and razor blades. She has done so on several occasions, as suggested by the number of scars. I am concerned by her behaviour, and would be grateful if you could see her for an assessment, with a view to eventually seeing her for therapy.

Yours sincerely
Dr James
Questionnaire

Instructions: There are 35 statements on the two following pages relating to the referral letter you have just read. Please tick the box beside each statement that reflects or is most like your own opinion on the subject. There are no right or wrong answers. You do not need to think too hard about each statement, the first answer which comes to mind is usually the best. Please answer every question.
<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Slightly Disagree</th>
<th>Neither agree nor disagree</th>
<th>Slightly Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>It frustrated with Ann when I read out her injuring herself</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>It angry with Ann when I read about her injuring herself</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>It rejecting of Ann when I read about her injuring herself</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Ann's self-injurious behaviour is acceptable</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Ann's self-injurious behaviour is understandable</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Ann's self-injurious behaviour is manipulative</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Ann's self-injurious behaviour is responsible</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Would feel anxious at the prospect of being Ann</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Would feel concerned about the level of Ann's self-injury escalating further</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Would feel worried that Ann might attempt suicide</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Would feel responsible for Ann's safety</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Ann's self-harm would have an emotional impact on me</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Ann's self-harm is a violent act</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Ann's self-harm is an impulsive act</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Ann's self-harm is equivalent to a suicide attempt</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Ann's self-harm is a serious social problem</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Ann's self-harm is 'attention-seeking' behaviour</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Ann's self-harm is morally wrong</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Question</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Slightly Disagree</td>
<td>Neither agree nor disagree</td>
<td>Slightly Agree</td>
<td>Agree</td>
<td>Strongly Agree</td>
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<td>------------------</td>
<td>---------------------------</td>
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<td>Imagine Ann feels quite hopeless</td>
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<td>Ann's 'cutting' is a way of managing her feelings</td>
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<td>Ann's 'cutting' is overdramatic given her experiences</td>
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<td>Ann's 'cutting' is a means of release</td>
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<td>Ann's 'cutting' is kept secret because she feels ashamed</td>
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<td>His method of deliberate self-harm is often a 'copy-cat' behaviour</td>
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<td>His method of deliberate self-harm is used competitively amongst peers</td>
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<tr>
<td>When seeing Ann, I would focus more on her behaviour than her feelings</td>
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<tr>
<td>When seeing Ann, I would encourage her to share her experiences</td>
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<tr>
<td>When seeing Ann, I would convey my disapproval of her self-harm behaviour</td>
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<td>Ann's self-harm would be shocking to most people</td>
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<td>Ann's self-harm would eventually push most people away</td>
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<tr>
<td>Ann's self-harm is a serious mental health problem</td>
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<td>Other mental health professionals would generally frown upon Ann's self-harm</td>
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<tr>
<td>The general public would consider Ann to be 'bad'</td>
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<td></td>
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<td></td>
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<td>0</td>
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<tr>
<td>The general public would consider Ann to be 'mad'</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Society at large would disapprove of Ann's self-injurious behaviour</td>
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</tbody>
</table>
Having completed the questionnaire, are there any feelings or thoughts that you have not been asked about that you would like to comment on? If not, please could you comment at least one or more of the above statements that YOU felt strongly about:

Finally, please could you provide some information about yourself. This information will not be used to identify you, and any personal details will remain strictly confidential.

Are you? male □ female □

To which age group do you belong?

18-25 years □ 46-55 years □
26-35 years □ 56-65 years □
36-45 years □ 66+ □

Which of the following ethnic groups would you say you belong to?

Black-African □ Bangladesh □
Black-Caribbean □ Indian □
Black-Other □ Pakistani □
Chinese □ White □

Other □ (Please specify): ........................................................................................................

What is your highest educational qualification?

GCSE/O-level □ Degree (BSc, BA etc.) □
A-level □ Higher Degree (MSc, MA, etc.) □
Diploma (HND, SRN, etc.) □ PhD/PsychD (Doctorate, etc.) □

Other Qualification □ (Please specify): ...................................................................................

What, if any, post-qualification training have you undertaken?

(Please specify): .........................................................................................................................

Have you undertaken any specific training with self-injurious behaviours?

No □ Yes □ (Please specify): ........................................................................................................
What is your profession (E.g., counselling/clinical psychologist, psychotherapist, nurse specialist, social worker, registrar, psychiatrist, etc.), and status? (E.g., student/trainee, consultant, etc.)

(Please specify): ..............................................................................................................................................

How would you describe your current employment setting? (E.g., inpatient/specialist services, day-hospital, out-patient/community setting, psychology department, CMHT, private practice, etc.).

(Please specify): ..............................................................................................................................................

How many years have you been practising (including training years)?

- Less than a year □ 11 - 15 years □
- 1 - 2 years □ 16 - 20 years □
- 3 - 5 years □ 20 - 25 years □
- 6 - 10 years □ 25 years + □

How many self-harming patients/clients have you worked with?

- None □ 1 - 5 □ 6 - 10 □ 11 - 15 □ 16 - 20 □ 21+ □

If so, is there a particular experience that YOU have had with young person who self-injured that you would like to comment on?

What is your preferred theoretical orientation/mode of practice?

- Psychoanalytic/psychodynamic □ Humanistic □
- Existential-phenomenological □ Interpersonal □
- Cognitive-behavioural □ Integrative □
- Cognitive □ Systemic □
- Other □ (Please specify): ..................................................................................................................................

Please could you return the questionnaire in the envelope provided by: 21st April 2001, at the latest.

Thank you for taking part in this survey.
## Appendix IV: Component-score coefficient matrix

### Summary of questionnaire items

<table>
<thead>
<tr>
<th>Questionnaire Items</th>
<th>Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>F2</td>
</tr>
<tr>
<td>---------</td>
<td>--------</td>
</tr>
<tr>
<td>Frustrated with YP</td>
<td>.033</td>
</tr>
<tr>
<td>Angry with YP</td>
<td>-.014</td>
</tr>
<tr>
<td>Rejecting of YP</td>
<td>-.046</td>
</tr>
<tr>
<td>SIB manipulative</td>
<td>.188</td>
</tr>
<tr>
<td>SIB irresponsible</td>
<td>.178</td>
</tr>
<tr>
<td>Anxious re seeing YP</td>
<td>-.096</td>
</tr>
<tr>
<td>Concern re SIB escalating</td>
<td>.109</td>
</tr>
<tr>
<td>YP might attempt suicide</td>
<td>.028</td>
</tr>
<tr>
<td>Responsible for YP Safety</td>
<td>.011</td>
</tr>
<tr>
<td>Emotional Impact</td>
<td>-.107</td>
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<tr>
<td>Attention-Seeking Behaviour</td>
<td>.258</td>
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<tr>
<td>Imagines YP feels Hopeless (Reversed)</td>
<td>-.074</td>
</tr>
<tr>
<td>Way of Managing Feelings (Reversed)</td>
<td>.043</td>
</tr>
<tr>
<td>Cutting = Release (Reversed)</td>
<td>.015</td>
</tr>
<tr>
<td>Cutting Kept Secret Shame (Reversed)</td>
<td>-.047</td>
</tr>
<tr>
<td>Method is Copy-Cat Behaviour</td>
<td>.264</td>
</tr>
<tr>
<td>SIB used competitively</td>
<td>.293</td>
</tr>
<tr>
<td>Would Convey Disapproval</td>
<td>.202</td>
</tr>
<tr>
<td>Shocking to most people</td>
<td>-.031</td>
</tr>
<tr>
<td>Push most people away</td>
<td>-.017</td>
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<tr>
<td>Serious Mental Health Problem</td>
<td>-.026</td>
</tr>
<tr>
<td>Other pros. would generally frown on</td>
<td>-.071</td>
</tr>
<tr>
<td>General Public = ‘Bad’</td>
<td>.023</td>
</tr>
<tr>
<td>General Public = ‘Mad’</td>
<td>-.022</td>
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<tr>
<td>Society = would disapprove</td>
<td>.051</td>
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</table>

**Notes:** YP = Young Person; SIB = Self-Injurious Behaviour

Extraction Method: Principal Component Analysis.

Rotation Method: Oblimin with Kaiser Normalization.

Relevant component scores are in bold type
### Appendix V: Mean ranked component regression scores across the range of psychosocial parameters

<table>
<thead>
<tr>
<th>Psychosocial Parameter</th>
<th>Grouping range</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
<th>F5</th>
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<tbody>
<tr>
<td><strong>Participant gender</strong></td>
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<td></td>
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<tr>
<td>98</td>
<td>Female participant</td>
<td>80.08</td>
<td>82.64</td>
<td>85.69</td>
<td>82.66</td>
<td>74.64</td>
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<tr>
<td>66</td>
<td>Male participant</td>
<td>86.09</td>
<td>82.29</td>
<td>77.76</td>
<td>82.26</td>
<td>94.17</td>
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<td><strong>Sex of vignette</strong></td>
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<td>82</td>
<td>Female vignette</td>
<td>87.37</td>
<td>78.77</td>
<td>82.18</td>
<td>75.92</td>
<td>90.23</td>
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<tr>
<td>82</td>
<td>Male vignette</td>
<td>77.63</td>
<td>86.23</td>
<td>82.82</td>
<td>89.08</td>
<td>74.77</td>
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<tr>
<td><strong>Age</strong></td>
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<tr>
<td>9</td>
<td>17-21 years old (Adolescents)</td>
<td>76.33</td>
<td>97.00</td>
<td>114.22</td>
<td>68.11</td>
<td>59.44</td>
</tr>
<tr>
<td>9</td>
<td>18-25 years old</td>
<td>81.44</td>
<td>81.22</td>
<td>82.56</td>
<td>100.56</td>
<td>82.78</td>
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<tr>
<td>54</td>
<td>26-35 years old</td>
<td>81.87</td>
<td>76.50</td>
<td>93.30</td>
<td>75.67</td>
<td>84.46</td>
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<tr>
<td>45</td>
<td>36-45 years old</td>
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<td>80.49</td>
<td>89.07</td>
<td>85.80</td>
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<tr>
<td>36</td>
<td>46-55 years old</td>
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<td>84.58</td>
<td>66.42</td>
<td>85.47</td>
<td>74.22</td>
</tr>
<tr>
<td>10</td>
<td>56-65 years old</td>
<td>68.20</td>
<td>90.90</td>
<td>54.40</td>
<td>67.70</td>
<td>99.20</td>
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<td>144</td>
<td>White</td>
<td>77.50</td>
<td>81.41</td>
<td>81.44</td>
<td>83.12</td>
<td>79.51</td>
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<td>75.00</td>
<td>71.33</td>
<td>91.67</td>
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<td>125.50</td>
<td>153.00</td>
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<td>86.50</td>
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<td>Other mixed origin</td>
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<td>Student/Trainee</td>
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<td>69.92</td>
<td>37.33</td>
<td>84.58</td>
<td>72.67</td>
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<td>13</td>
<td>Consultant/Head of service</td>
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<td>71.62</td>
<td>100.85</td>
<td>96.08</td>
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<td>65.29</td>
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<td>62.98</td>
<td>69.05</td>
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<td>72.08</td>
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Appendix V (Cont.): Mean ranked component regression scores across the range of psychosocial parameters

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<th>69.86</th>
<th>72.21</th>
<th>59.79</th>
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<td>66.70</td>
<td>63.81</td>
<td>56.52</td>
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<tr>
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<td>51.38</td>
<td>50.25</td>
<td>64.50</td>
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<tr>
<td>18 Psychiatrist</td>
<td>68.28</td>
<td>64.61</td>
<td>50.11</td>
<td>63.28</td>
<td>79.50</td>
<td></td>
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<tr>
<td>27 Nurse Specialist</td>
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<td>81.81</td>
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<td>66.87</td>
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<td>9 Adolescent participants (self-harmers)</td>
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<td>97.56</td>
<td>114.89</td>
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<td>Preferred theoretical orientation or mode of practice</td>
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<td>60.26</td>
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<td>52.00</td>
<td>137.00</td>
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<td>74.39</td>
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<td>80.96</td>
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<td>3 Cognitive</td>
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<td>56.33</td>
<td>64.00</td>
<td>93.00</td>
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<td>80.71</td>
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<td>69.51</td>
<td>63.04</td>
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</tr>
<tr>
<td>11 Systemic</td>
<td>44.45</td>
<td>74.55</td>
<td>52.91</td>
<td>83.45</td>
<td>64.36</td>
<td></td>
</tr>
<tr>
<td>2 Other brief therapy (e.g. solution-focused)</td>
<td>58.00</td>
<td>61.00</td>
<td>65.00</td>
<td>29.50</td>
<td>107.50</td>
<td></td>
</tr>
<tr>
<td>Number of years in clinical practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Less than one-year practicing</td>
<td>73.20</td>
<td>48.20</td>
<td>94.00</td>
<td>56.60</td>
<td>90.00</td>
<td></td>
</tr>
<tr>
<td>5 1-2 years practicing</td>
<td>95.80</td>
<td>80.00</td>
<td><strong>110.00</strong></td>
<td>85.20</td>
<td>103.00</td>
<td></td>
</tr>
<tr>
<td>38 3-5 years practicing</td>
<td>84.97</td>
<td>80.87</td>
<td><strong>87.32</strong></td>
<td>69.50</td>
<td>73.42</td>
<td></td>
</tr>
<tr>
<td>30 6-10 years practicing</td>
<td>76.40</td>
<td>81.13</td>
<td><strong>76.90</strong></td>
<td>79.97</td>
<td>69.93</td>
<td></td>
</tr>
<tr>
<td>32 11-15 years practicing</td>
<td>70.84</td>
<td>73.91</td>
<td>69.81</td>
<td>80.47</td>
<td>70.94</td>
<td></td>
</tr>
<tr>
<td>13 16-20 years practicing</td>
<td>78.85</td>
<td>80.23</td>
<td><strong>87.77</strong></td>
<td>63.31</td>
<td>75.00</td>
<td></td>
</tr>
<tr>
<td>13 21-25 years practicing</td>
<td>76.92</td>
<td>68.31</td>
<td><strong>44.92</strong></td>
<td>92.69</td>
<td>92.15</td>
<td></td>
</tr>
<tr>
<td>16 26 years +</td>
<td>60.63</td>
<td>74.00</td>
<td>64.00</td>
<td>79.75</td>
<td>83.25</td>
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</tr>
<tr>
<td>Specific training in the management of SIB</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>121 No SIB training</td>
<td>77.89</td>
<td>72.60</td>
<td>78.62</td>
<td>77.84</td>
<td>79.02</td>
<td></td>
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<tr>
<td>26 Specific training with SIB</td>
<td>80.65</td>
<td><strong>96.23</strong></td>
<td>74.73</td>
<td>65.19</td>
<td>76.27</td>
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</tr>
<tr>
<td>2 Dialectical Behaviour Therapy training</td>
<td>74.00</td>
<td>72.00</td>
<td>94.50</td>
<td>95.00</td>
<td>105.00</td>
<td></td>
</tr>
<tr>
<td>5 In-house training</td>
<td>53.00</td>
<td>101.00</td>
<td>58.00</td>
<td>126.20</td>
<td>36.00</td>
<td></td>
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</table>
### Appendix V (Cont.): Mean ranked component regression scores across the range of psychosocial parameters

<table>
<thead>
<tr>
<th>Experience</th>
<th>Description</th>
<th>13</th>
<th>29</th>
<th>22</th>
<th>13</th>
<th>20</th>
<th>67</th>
</tr>
</thead>
<tbody>
<tr>
<td>No experience</td>
<td>Contact/ worked with 1-5 clients</td>
<td>73.69</td>
<td>69.38</td>
<td>98.38</td>
<td>80.46</td>
<td>100.31</td>
<td></td>
</tr>
<tr>
<td>Contact/ worked with 6-10 clients</td>
<td>84.86</td>
<td>80.66</td>
<td>98.86</td>
<td>78.10</td>
<td>81.38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact/ worked with 11-15 clients</td>
<td>82.95</td>
<td>79.27</td>
<td>89.14</td>
<td>70.00</td>
<td>82.41</td>
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<td></td>
</tr>
<tr>
<td>Contact/ worked with 16-20 clients</td>
<td>74.85</td>
<td>91.54</td>
<td>74.54</td>
<td>90.38</td>
<td>84.15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact/ worked with 21+ clients</td>
<td>78.10</td>
<td>75.40</td>
<td>82.00</td>
<td>78.65</td>
<td>82.35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact/ worked with 1-5 clients</td>
<td>85.84</td>
<td>87.27</td>
<td>71.85</td>
<td>88.52</td>
<td>79.28</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:** F1 = Negative and judgemental attitude towards SIB; F2 = Perception of negativity in societal attitudes towards SIB; F3 = Anxiety around safety and clinical management of young person engaging in SIB, F4 = Strong feelings elicited in response to SIB; F5 = Positive attitude and empathetic understanding towards SIB. Means reaching significance between pairs of comparisons are in bold type.
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c) For chapters within multi-authored books:

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