

RESEARCH REPORT

Self-harming behaviour: from lay perceptions to clinical practice

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ABSTRACT *Self-harm is a complex phenomena that occurs in many different settings. Multi-factorial explanations predominate in the literature and accounts of treatment reflect this diversity, ranging through psychobiological and psycho-social theories. This study aims to identify, describe and interpret some of the accounts and understandings of self-harm from a cross section of the general population and then relate this to clinical practice. Q Methodology is used to explore various competing viewpoints of lay people in understanding and treating people who self-harm. Eight different accounts were produced from the Explanation Q-sort. All but the Biological account described self-harm as a coping strategy, utilized in response to feelings of helplessness following social interaction and were therefore psycho-social in nature. There were four treatment/policy viewpoints that were all psycho-social in nature. These were influenced by humanistic and cognitive types of therapy and were united by the importance of empathy, positive regard and empowerment. These viewpoints are fully explored in this study. Common themes and factors connecting the explanations and treatment Q-sorts are discussed. These findings are then discussed in terms of their implications to current working practice and further initiatives and research projects.*

Introduction

It can be estimated that one in 600 adults self-harm and require hospital treatment (Kreitman, 1990). We are unable to estimate how many adults self-harm in the population at large and do not require hospital treatment. Self-injury, whilst being a common feature of many societies (Ross and McKay, 1979), largely remains a socially taboo subject within Western cultures. Unsurprisingly, therefore, within many settings, self-injury continues to generate much fear, suspicion and misunderstanding. Both the authors have experience of working within high security mental hospitals. Within forensic

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mental health settings self-harming behaviour is a key issue of therapeutic concern; primarily in relation to female clients, although increasingly in relation to male clients as well (see also, Ballinger, 1971; McKerracher and Watson, 1968; Cullen, 1985; Cookson, 1977). Whilst the most extreme forms of self-injury may be found within forensic settings, self-harm remains a significant issue in all psychiatric services and indeed is a prevalent strategy of survival for people in both (psychiatric) hospital and the community. It is with this in mind that this research was completed as part of an MA in Counselling, focusing on lay perceptions of self-harm.

Self-injury, as a topic of social concern, is treated as being both fascinating and repulsive. These common reactions could be as a psychological defense against difficult emotions. Texts on the subject either locate this behaviour in specific others (e.g., psychiatric patients or criminals) or place self-harm on a continuum that is inclusive of the whole population. 'Self-harm', therefore, can be understood as *any* activity that harms the self, directly or indirectly. The term 'self-injury' is used more specifically to describe the conscious physical injury that people do to themselves. Self-harm is a term that is inclusive of a wide range of socially sanctioned behaviours in different cultures (body piercing, tattooing, sunbathing, head moulding, foot binding) as well as those normally socially condemned (Favazza, 1987). Within Western culture, unacceptable self-harm is pathologized if it occurs in isolation.

Explanations for suicide and self-injury are often conflated within both medical and wider culture are associated by both the medical profession and our society at large and are particularly disturbing to societies that value life at all costs. As a result these behaviours have been made socially taboo subjects and labelled as irrational.

When people are ill, social expectation instructs that they should try to get better. In clinical practice the 'difficult' patients are the ones who do not follow these rules and can result in professionals feeling helpless, as they are unable to offer a prescription or a 'cure'. Self-injury implies a deliberate infliction of sickness on the self.

Intentions of self-harm may range from decoration, lack of provision against harm, injury, through to death. A clear difference recognized by people who self-injure, between suicide and the other types of self-harm is the conscious wish to die (Arnold, 1994). However, self-injury may result in death when the individual has insufficient understanding of the impact or severity of the injuries and is more likely to occur if the self-harming becomes repetitive and addictive in nature (vs. 'Expert' self-injurers).

In summary, although socially unacceptable self-harm is viewed as fascinating and also repulsive by a life-valuing society, many socially acceptable methods of self-harm are also prevalent, but not necessarily recognized. If self-harm becomes too destructive, it is deemed unacceptable and pathologized in the individual in an effort to restore the status quo in society. Although self-injury and suicide are closely linked by method, they clearly differ by motive.

Between 1974 and 1994, rates of self-injury and suicide have increased sharply and women predominate over men by a ratio of around 2:1 (Weissman, 1974; Barnes, 1985). This may be linked to the fact that women in our society have traditionally been dis-empowered and socialized as dependant and helpless. It can be argued therefore that self-harm for women may be a logical response to societal pressures.

Thus it appears that suicide and self-injury are expanding in a society that avoids death at all costs. When an issue is taboo, i.e., Can't be discussed, it cannot be addressed. Hence, the nature of self-harm compels us as people and as a society to challenge our philosophies on death and dying. This can be uncomfortable, but necessary to address the issues surrounding self-harm and suicide.

As the risk factors and epidemiology have now been recognized, models and issues that arise when we attempt to understand why people harm themselves will now be discussed.

Reasons why people self-injure: models and issues

There are a range of models utilised to understand self-harm and many issues that are important. Within the literature, one method of understanding self-harm is to label the behaviour as pathological. The Mental Health Act classification system may be used to pathologise the person and assists diagnoses of Mental Illness (Psychotic), Learning Difficulties or Personality Disorder. Self-injury by people who have learning difficulties is difficult to understand as verbal communication may be limited, therefore self-injury is understood as a destructive communication method, attention seeking or providing sensory stimulation (Ingram, 1989).

Winchel and Stanley (1991) argue that the patients aim in psychotic self-harm seems to be largely about ridding themselves of an offending part of the body in response to delusions or voices. The most diverse reasons for self-injury are reported among people classified as having a personality disorder or not being classified at all under the mental health act. These reasons why people self-harm will now be discussed and are either biological or psycho-social in nature.

Psychobiological theories

There has been an absence of any convincing evidence of hereditary factors linked to self-harm. However, some research demonstrates that a hormonal abnormality predisposes a person to behavioural dyscontrol, which could enable the person to act out their phantasies (Brown *et al.*, 1982; Traskman *et al.*, 1981). Similarly, various studies have suggested that self-injury occurs more commonly at certain times in the female Menstrual cycle (Asch, 1972; Rosenthal *et al.*, 1972). As such, psychobiological theories offer little in comparison to psycho-social theories (to be discussed below) regarding an understanding of self-harm.

Psycho-social theories

Psycho-social theories view self-harm as a response to feelings and thoughts resulting from interpersonal experiences. Self-injury often occurs in response to feelings of rejection and effectively ensures further rejection. The assumption that self-harm is a method of coping with internal reaction to external events underpins all the Psychosocial theories that follow.

Unconscious self destruction. Some Psychodynamic theorists suggest that self-injury is essentially self-destructive in nature and is an externalised representation of an unconscious wish to end life (Tantam and Whittaker, 1992). In contrast, within the authors' practice, many clients view self-injury as a way of coping with life rather than ending it. Hence, self-injury is connected with death and self-destruction, but fails to connect with self-preservation and life.

Thanatos/death wish. Another psycho-dynamic concept is offered by Ferenczi (1956), who suggested that self-injury occurred when murderous wishes have been redirected from external objects towards the self. This has also been supported in the Authors' clinical practice. Therefore self-harm can also be a method of coping with interpersonal difficulties when direct communication of anger may be difficult. A Psychodynamic perspective suggests that self-injury is an internally motivated response to difficult feelings that result from interpersonal problems and offers a partial explanation for self-injury.

Existential angst. Self-injury can be viewed as an existential statement, a means by which the person is able to confirm their existence (Babiker and Arnold, 1997). This has also been supported by a variety of anecdotal evidence. Hence self-injury may occur when a person is feeling depersonalised, to ensure reintegration. For some people, existential angst may go some way in accounting for their reasons for self-harm.

Sacrificial. Fenichel (1945) understood self-mutilation as the person (or animal) sacrificing one part of their body in order for the rest to survive. This would also be similar to people finding themselves in a situation where they feel they have no other way of coping. The person who self-harms feels helpless as they have no other control over the situation. Anecdotally this has been a useful explanation for clients along with some of the other explanations already mentioned.

Visual communication. Self-injury can be a method of emotional communication, either to the self or to other people. As Babiker and Arnold (1997) point out

For most individuals, self-injury seems to be associated with extremely difficult and distressing life experiences, often beginning in childhood.

Child sexual abuse is one such trauma that has been linked to increased self-destructiveness among women and men (Briere and Runtz, 1986; Briere and Zaida, 1989; Sedney and Brooks, 1984; Boudewyn and Liem, 1995).

Self-injury can be understood as a method of attacking the body if the person has negative feelings towards the self. By harming the self, people find a way of taking control of their bodies when they have felt and been unable to do it before. Another method of intra or inter-personal communication is using the body to visually describe feelings. For example, as said by a female client 'my body looks how I feel' (personal communication, 1993). This may then result in other people feeling extreme emotions such as anger, frustration, guilt or feeling manipulated. This may be an accidentail process or occasionally intensional.

Therefore, self-injury can be understood as a method of gaining control externally of the body, other people, or the environment when the person feels out of control within. This would also link in to the behavioural concept that self-mutilation is an operant response, a behaviour which is acquired and maintained by rewarding responses, such as attention. Here, self-injury is more than just an intra-personal coping strategy, it is also a method of stimulating interpersonal change and hence at times can be understood as a 'cry for help', if the aim of the self-harm was to initiate this response in others.

Depression. Depression has long been one of the most common reported reasons why people self-injure (see for example: Offer and Barlow, 1960; Ryback, 1971; Siomopoulos, 1974). It is argued that self-injury gives some short term relief, only for the depressive feelings to return when they view the damage. This can be a method of gaining some control over the physical self or internal feelings. The feelings of helplessness and hopelessness associated with depression have also been frequently reported as reasons for self-harming behaviour (Harrison, 1994; Babiker and Arnold, 1997; Arnold, 1995). If the person feels helpless in a situation, but also feels that they have no future and therefore is hopeless self-harm can become suicide as motivation changes from coping with life to ending it (Beck *et al.*, 1987).

Euphoria. Self-injury has also been described as sensual and enjoyable and may produce euphoric feelings which may serve to avoid difficult feelings. Some people equate it with orgasm in terms of self-harm helping the person to relieve tension and lower anxiety (Harrison, 1994, p. 42). This explanation has been backed up anecdotally in psychiatric settings and is another valuable reason for self-injury. Whilst comparisons with orgasms may overstate the case for some people, nevertheless, self-harm can be effective in releasing endorphines and therefore tension. This is just one method of controlling the external body to produce good or better feelings.

Masking. The physical pain of self-injury may be used to mask emotional pain. Additionally, these feelings may also be avoided by the chaos caused by the self-injury in the external environment. Therefore, self-harm may have an intra-personal meaning, but also have inter-personal and social elements.

Initiation/Ritual. Ross and McKay (1979) noted that some women in their research group self-injured as an act of initiation rite which took place within many other ritualistic behaviours such as chanting and sitting in a circle. Self-harm as a ritual or initiation rite is not uncommon. It can become a learned way of coping with life and a way of maintaining status in a very difficult institution or sub-culture. Many people self-harm for the first time when locked up in institutions (Ross and McKay, 1979).

In conclusion, it seems that self-harming/injurious behaviour is best understood as multifactorial. Self-injury can be both an intra- and inter-personal coping strategy, effecting the self and also others. Whilst biological models fail to embrace the complexity of self-harm, psycho-social models contain diverse explanations.

Thus because it is more meaningful to understand self-harm in terms of psycho-social theories, self-harm can be viewed as a coping strategy for feelings resulting from

inter-personal difficulties and life events. Although self-harm is multifactorial, the combination of feeling helpless, hopeless and trapped or neglected seems to underpin the diverse and complex reasons why people self-harm. As there are many models for understanding self-harm, these have inspired a wide variety of treatment methods.

Treatment for people who self-harm

If self-harm is understood in terms of a biological model, a physical treatment method is required. If self-harm is understood in terms of a psycho-social model, a psycho-social therapy is required.

Physical treatment

Many different psychotropic drugs have been used over the years to treat those psychological states that are associated with self-injurious behaviour. Most commonly, antidepressants have had limited success (Cowdry and Gardner, 1988; Gardner and Gardner, 1975; Gupta *et al.*, 1986; Markovitz *et al.*, 1991) and trials are continuing to present contradictory findings. Anticonvulsants and neuroleptics have also been used with some reduction in self-injury, but sedatives such as the benzodiazepines can result in disinhibition and therefore exacerbate the behaviour (Feldman, 1988).

Other than drug therapies, electroconvulsive treatment (the passage of an electrical current through the frontal lobes of the brain) has been used with people who self-harm. It has been found to have either little effect or merely short term effect in the treatment of people who self-harm (Feldman, 1988).

Overall it seems that the physical treatments have limited impact on self-injurious behaviour. This may be because, whilst psychological factors may have a biological signature, pharmacological treatments do not directly address the many psycho-social reasons why people self-injure. Whilst traditional psychiatry tends to rely heavily on these interventions, because of their limited impact, the search for adequate treatment methods has widened to include psychological and social interventions.

Psycho-social methods

These methods may be used on a one-to-one basis or in group settings.

Feminist psychotherapy. A feminist approach to therapy takes into account women's role in society and aims to empower women to challenge this. This philosophy can accompany any of the other approaches to psychotherapy. This would be relevant if the person's reasons for self-harming related to power issues and sexual inequality. This is often the case when women have been sexually abused (Harrison, 1994).

Humanistic approaches. Humanistic approaches (Rogers, 1951) work on increasing self-esteem and control in the client which would reduce the feelings of helplessness, hopelessness and feeling trapped and therefore the motivation to self-harm. Therefore, these approaches have been reported as the most helpful by many of the people who self-injure. Humanistic approaches are useful because many of the people who self-injure

prefer not to be labelled and diagnosed as this has been unhelpful in the past. It has also been unlikely that they have really been accepted and valued for themselves in the past. Harrison (1994, p. 81) states in her book, *Vicious Circles*:

Therapies which work with a woman at a pace she is comfortable with, such as humanistic or Feminist approaches might be suggested.

Psychodynamic approaches. Psychoanalytic psychotherapy attempts to encourage the client to work on expressing the feelings in words rather than self-injuring and also attempts to make the unconscious impulses, conscious. These approaches which are based in the 'here and now' relationship between client and therapist have also proved to be useful (Kernberg, 1987). By focusing on the relationship with the therapist, the client becomes more open, honest and trusting. This decreases interpersonal difficulties, increasing self-esteem and therefore reduces self-harm.

There are, however, contraindications to psychodynamic treatment. If traumatic childhood events are focused upon in therapy, there is likely to be an increase in self-injury, suicide attempts and general failure in life in the short term (Silver, 1985). Therefore some form of external containment may be required while working through these issues.

In summary, psychodynamic approaches can be useful for some people who self-injure when problems reside in relationship issues.

Behavioural approaches. Behavioural approaches have been used widely in the treatment of people with learning difficulties that self-harm. (Wolf *et al.*, 1967; Lovaas and Simmons, 1969; Jones *et al.*, 1974) This usually involves altering self-injury by stopping social reinforcement of the behaviour or having 'time out' or reinforcement of other behaviours that are more socially acceptable. Punishment was found to be the most effective, but apart from the ethical issues, this method of treatment may link in with the persons need to be punished, especially if they feel responsible for some sort of childhood abuse or need to reenact the abuse with others.

This approach may have some effect when other psychological therapies based on talking cannot be used, for example with people with learning difficulties. If self-harm is motivated by boredom, a more stimulating environment could be effective in reducing the need to self-harm. Many user groups have criticized these treatment methods and suggest that ultimately such approaches exacerbate self-injurious behaviour because they reduce self-esteem and personal control (Arnold, 1995). Talking methods are preferred that are not controlling in nature. Hence, there is some reported success using behavioural methods with people who have learning difficulties who self-injure. In contrast, this approach seems to be less useful with other populations that may have relationship issues.

Cognitive behavioural approaches. Cognitive therapy has been used with some reported success with people who self-injure. Cognitive therapy aims to alter the negative way that people think in order to increase self-esteem and thereby reduce self-injury. It can be very

useful to recognise patterns of self-injury and also negative automatic thoughts prior, during and after self-injury. These techniques can also be combined with relationship skills training. As self-injury is understood as aggression turned inwards, many people who self-injure may need help becoming more assertive with other people. Some women who self-injure reported alternative techniques such as these as useful (e.g., Bristol Crisis Research, Arnold, 1995). Additionally, Salkovkis *et al.* (1990) demonstrated that problem solving therapy helped clients to feel less depressed and hopeless. In summary, the literature was very positive about cognitive behavioural techniques helping people who self-harm and this is also reflected in user perspective publications and anecdotal evidence from psychiatric settings.

Cognitive Behavioural therapy can be perceived as Integrative and/or eclectic (Alford and Beck, 1997). Integrative and Eclectic approaches to psychotherapy and counselling containing psychodynamic and cognitive behavioural elements that are structured by diagrams, letters or contracts have also been demonstrated to work well. (Lansky, 1988; Ryle *et al.*, 1989, Cowmeadow, 1994, Linehan, 1993). Most of the above treatment approaches could be used individually or in groups. Group work undertaken within a range of theoretical approaches has been reported to be useful in the treatment of people who self-harm. Walsh and Rosen (1988) supported the benefit of group work, but noted the need for careful management as members may harm themselves in the group or a counterculture may develop where self-harm equates with status. Family therapy has also been useful with people who self-harm (Tantam and Whittaker, 1992).

Again, these approaches adopt the philosophy that self-harm is due to relational difficulties, feeling helpless, hopeless and trapped and also having a low self-esteem and therefore, would only be useful if these were the primary reasons why the person was self-harming. Therefore, if self-harm is biological in nature, physical treatments may be preferable.

The therapeutic approaches discussed all seem to have some reported success, although one approach alone clearly can not satisfy all individual needs. Treatment for people who self-harm needs to work on developing trusting, empathic relationships that improve communication skills and raise self-esteem in a non-judgemental way, whichever theoretical approach is chosen to use either individually or in a group setting. The chosen method of treatment must take into account the persons' reasons for self-harm and address issues such as, helplessness, hopelessness and feeling trapped within a relationship that empowers the client to make choices.

The literature review has demonstrated that self-harm and self-injury are understood in a multitude of ways. These diverse models of understanding give rise to a wide range of treatment approaches. As such, it was necessary for the authors' to adopt a method of research that engages with contested understandings and conflict, and does not pre-emptively classify one above the other. As a positivistic philosophy and quantitative method would serve to objectify with an external frame of reference and remain neutral and detached, post-structural philosophy was selected to underpin this research. From this perspective, there is no ultimate 'truth', as there is no 'one reason' why people self-harm. Essentially, people are constructed through language and opinion influences everything. This approach adopts the view that discourse does not merely reflect the social world, but actually constructs it. That is: how we talk about something, tells us what the

thing is. Such an approach thus embraces the complexity of social phenomena rather than attempting to reduce it to unpracticable categories and recognizes that there are multiple and competing understandings of the world and social 'facts'. Post-structuralist theories can be used to underpin a range of research methods, but are particularly suited to qualitative research methods.

Q methodology (Stevenson, 1935), a pattern analytic technique, has been chosen for this study as it allows access to layers of individually and collectively shared meaning without sacrificing 'scientific rigour'. It has been used in conjunction with post-structuralist thinking and is an example of an integrated quantitative and qualitative approach to generation and analysis of data. Q Methodology is a dynamic method that allows researcher and participant to interact with the data, a vivid contrast to form filling. Q methodology's primary aim is to identify the way in which language is configured into particular patterns or clusters. These can then be treated as cognitive phenomenon and hence as changing beliefs or attitudes. Therefore, the end result of Q analysis is the definition of a collectively defined account or 'story' that cannot (necessarily) be back tracked to a particular individual. Interpretation is based on analysis of statement positions and participants with reference to the available literature.

Q Methodology involves the construction of a Q-sort which is made up of a series of statements on the issue at hand, in this case, lay perceptions of self-harm. Statements derived from interviews with lay people, were used in this project. Individual remarks such as, 'It seems to me...' or 'I feel that...' demonstrate that the individual is saying something meaningful about personal experience. Q methodology provides a systematic way to examine and reach understandings about such an experience. This approach has been used to empirically investigate individual judgements in a variety of areas including: carers' beliefs about appropriate social and therapeutic rules for psychiatric inpatients (Morrison, 1987); subjective political beliefs (Brown, 1971); and beliefs about infant-mother attachment (Pederson *et al.*, 1990).

Having recognized the complexity of self-harm and selected an appropriate research method, this study aims to;

- (a) Define self-injury from a lay perspective.
- (b) Describe different accounts of self-injury by;
 - (I) Reporting the diversity/range of understandings of self-harm in the lay population.
 - (II) Demonstrate that these accounts are either Biological or Psycho-social in nature.
 - (III) Recognize the intimate relationship between self-harm and suicide.
- (c) Describe different treatment methods for people who self-injure and recognize how the lay perceptions are mirrored in professional theories.
- (d) Make a contribution to our understanding of self-harm and suggest further areas of research.
- (e) Provide a knowledge base that can be used to inform decisions relating to staff training, treatment of people who self-harm and education of the general public.
- (f) Demonstrate the usefulness of Q methodology.

Method

Participants

Three women and two men (total of five people) were interviewed in order to produce a Q-sort. Forty participants from a variety of backgrounds then completed the Q-sorts.

Procedure

The semi-structured interviews took place in the participants' homes and were recorded (with their permission) on audio tape, lasting about 30 mins. Statements were selected, verbatim from the transcripts made of the five interviews. Two Q-sorts were prepared from these statements and a two statements were added from the literature, that were felt to be important, that did not come up in the interviews (a 'hybrid type', McKeown and Thomas, 1988). The first Q-sort, entitled 'Why do people self-harm?' contained 60 statements and the second, 'What can be done to help people that self-harm?' contained 51. These were randomly numbered and typed in boxes that were cut out.

Finally, a pilot of five volunteers were asked to sort the statements into three piles, agree disagree and indifferent/don't know and then complete the Q-sorts and provide feedback to the researcher.

Forty participants were selected to complete the Q-sorts. These people were selected from work colleagues, friends and family. The aim was to include participants from a variety of backgrounds with different careers in order that a range of views were available.

Each participant received a Q-pack, either in person or through the post which included the two Q-sorts (statements and response grids), covering letter, instructions for completion of the Q-sorts, marker numbers for the columns, a consent form and a personal information sheet. Where possible, instructions were given verbally. Participants were asked to sort the statements on a scale of most agree (+6) to most disagree (-6), using a quasi-normal distribution. Participants were then asked to return the completed Q-sorts, consent form and information sheet to me in the envelope provided.

Results

Forty participants completed two Q-sorts each: the explanations Q-sort and the treatment/policy Q-sort. The completed Q-sorts were analysed using factor analysis (principal components), using a PCQ package (Stricklin, 1992). The whole Q-Sorts are factor-analysed for intercorrelations, rather than individual items (as in traditional factor-analysis). Hence persons, not sample items are correlated and therefore this procedure does not require data from a large number of people, unlike other factor analytical methods (McKeown and Thomas 1988). Participants are thus not randomly selected, but selected to be representative of the target population. Respondents loading on each factor indicates the association between respondents and the expressed point of view. Factor arrays are constructed by merging high loading Q-sorts. Finally the factors are interpreted in terms of existing accounts and theories which appear to be reflected in the patterns of responses. The object of analysis is firstly to summarize underlying factors which determine patterns of intercorrelation amongst the data, and also to determine which individual Q-sorts are positively correlated with a particular factor. Factor scores are then displayed in a factor array, from which interpretation proceeds.

The results indicated that for the explanations Q-sort, the 40 sorts of statements reduced to seven independent orderings. Thus, seven accounts explaining self-harm can be differentiated from participants' Q-sort data. The results also indicated that for the treatment/policy Q-sort, the forty sorts of statements reduced to four independent

orderings. Thus, four accounts of treatment/policy approaches can be differentiated. For each factor the separate significantly loading Q-sorts were merged by the computer program, taking account of factor weight (Spearman, 1927). This then gave a single set of factor scores, that is a factor array (one each for explanations and treatment issues) for the statements. The significantly loading Q-sorts for each factor were merged by the computer to give the best exemplars of the 18 factors.

Interpretation of the accounts was based on examination of the relative factor weightings in the factor arrays and was informed by the review of the literature and by reference to the people who defined the factors that were loaded at a significance of more than 0.45.

Discussion

Descriptions and interpretations of account

Explanations of self-harm. The following seven factors were identified by factor analysis, thus lending credibility to the notion that there are a range of explanations of self-harm that are culturally available and which can be drawn on differentially. The first will be described in more detail to outline the process of interpretation, the others will be given in the form of a summary.

Factor 1: The 'visual communication/survival' explanation

Factor one was defined by 20 out of the 40 participants. Because 50% of the participants loaded on this factor, it indicates that this description offers a readily available explanation of self-harm. This account emphasized that self-harm should be understood as a means of taking control of and managing one's life. It is not a failed suicide attempt. This suggests a clear motivational difference between suicide and self-harm:

Statement Number	Factor Score	Statement
13	(+6)	People self-harm to cope with life.
12	(-5)	People self-harm to kill themselves.

Hence, this account suggested that self-harm is a way of coping when life is difficult and feelings of helplessness prevail. Self-harm can help to ease internal distress associated with real life problems:

Statement Number	Factor Score	Statement
6	(+5)	People self-harm to ease their internal distress.
22	(-6)	People self-harm because they feel happy and content with life.

Thus self-harm is an internally motivated coping strategy that serves to resolve emotional distress. This method is used when a life crisis occurs and the person feels helpless. Hence, this account suggests that self-harming helps the person feel in control when life outside is beyond their control. At this time, self-harm serves to reduce feelings

of helplessness that are exceptionally difficult to tolerate. Therefore, self-harm is a means in which internal distress is organized and managed which enables self-control:

Statement Number	Factor Score	Statement
19	(+6)	People self-harm to feel that they are in control.

In this account, self-harm also functions as a communication strategy for internal angst and is a cathartic experience. Thus, the act of self-harm makes internal distress more manageable by expressing difficult feelings and also by enabling others to understand these feelings. This indicates that people who self-harm feel isolated and alone prior to using this method of communication:

Statement Number	Factor Score	Statement
46	(+5)	Self-harm is a way of communicating feelings.
10	(+5)	People self-harm to put outside how they feel inside.

Consequently, self-harm is viewed as not being genetically passed down the family, but is a learnt coping mechanism to cope with difficult feelings:

Statement Number	Factor Score	Statement
41	(-5)	Self-harm is hereditary.

Additionally, this account suggests that self-harm is not associated with mental illness. Therefore, it is not a pathological behaviour, but an understandable human response to a difficult situation:

Statement Number	Factor Score	Statement
26	(-6)	People self-harm because they are mad.

This account also views self-harm as distinct from interpersonal violence, even though helplessness may be a common element. Hence, the person that self-harms would not be judged as being 'mad' or dangerous to others. Therefore, self-harm is not a threat to others but a method of self-preservation. It enables the person to stay alive when few alternative choices are available:

Statement Number	Factor Score	Statement
59	(-5)	People self-harm to prepare to do something violent to someone else.

This account stated that self-harm is a means through which some people cope with real life problems. As such, self-harm was about living or survival, not suicide, and was also a signal that help was needed. Thus, self-harm enabled self-control and was viewed as a method to ease internal distress by non-verbally communicating feelings and cathartic release. Additionally, self-harm was understood as a way to avoid hurting others and

given its adaptive function, was not pathological in nature. This account thus argued that self-harm is an acceptable coping strategy for dealing with feelings of helplessness which is clearly differentiated from ending one's life.

Factor 2: The 'depressed and abused' explanation

This factor was defined by three out of the 40 participants, two of which were men. Self-harm in this factor has a closer association with suicidal intent than in factor 1. Factor 2 described self-harm as a precursor to suicide, as a signal that help is needed. Self-harm was viewed as an act of desperation to avoid suicide however, suicide may occur if the required help was not forthcoming. This account suggested that self-harm was an internally motivated strategy to alert others to suicidal intent and assistance was required to survive. Additionally, this account asserted that self-harm was a method of coping with feelings of helplessness and hopelessness associated with surviving abuse and when life was out of control. Factor 2 suggested that self-harm was influenced by life events that give rise to negative feelings. It was these feelings, rather than the events per se which are implicated in self-harm.

Factor 3: The 'existential angst/helplessness' explanation

One Q-sort was significant here, this was a female perspective. Similar to Factor 2, this account asserted that self-harm was a way of coping with feelings of helplessness, hopelessness and therefore needing to be rescued. Hence, the person that self-harms felt out of control of a situation and required outside assistance to cope. This account also understood self-harm as a way of dealing with difficult feelings associated with abuse, which may result in the person feeling 'dead' after abusive experiences. Hence, self-harm serves as a method of confirming life and as a communication strategy for help from others, rather than a demonstration of achievement.

Factor 4: The depressed and desperate' explanation

Three participants loaded on this account, of which one was male, two were female. This perspective understood self-harm as a conscious internally ineffective way of coping with difficult feelings which could be effective externally in gaining some help. Self-harm was also viewed as a method of expressing anger towards the self. Clearly this account stated that self-harm was a socially motivated coping strategy.

Factor 5

Five out of the 40 Q-sorts were significant here. Four of these were completed by men. One person loaded positively which will be discussed as Factor 5A, who was a 53-year-old Taoist male. The four people that loaded negatively were a female aged 20 and three men in their 30s. This account is Factor 5B (the mirror image of 5A).

5A: The 'biological' explanation

This account emphasized that self-harm is internally influenced by physiological means. Assertion that people were genetically predisposed to self-harm and influenced by visceral/automatic responses rather than meaningful associations or real life issues was a strong component of this factor. Therefore self-harm was not motivated by intra-personal or inter-personal experiences, only biological. This was the only account that did not recognize a relationship between helplessness and self-harm.

5B: The 'psychological/attention seeking' explanation

This factor suggested that self-harm was a method by which some people draw attention to themselves and ask for help. Although this was clearly a theme in other accounts, it was particularly emphasized here. This account described self-harm as a way of coping with difficult feelings and life events, it was not controlled by physiological means. Suicide and self-harm were intertwined and self-harm could be a communication that suicide is the next option if help is not secured.

Factor 6: The 'interpersonal communication' explanation

This account was defined by one 59-year-old man. This factor, like many of the other factors, explained self-harm as a communication strategy. Self-harm was a method of discharging stress and communicating feelings. However in this account, self-harm is about communicating feelings to others, rather than requiring actions from them. Thus implying that just to be understood by others helps to resolve internal distress. Therefore this communication was about feelings rather than a need for action from others or a need to feel special, or recognised. Additionally, self-harm was also a coping strategy for dealing with past abusive memories that may include feeling special and have the result of a calming effect on the person. Therefore self-harm was an effective coping strategy intra and interpersonally and was also a method of communication of post-abuse feelings which increased empathy.

Factor 7: The 'attention seeking/emotional resolution' explanation

Again this account was described by one man from the sample of 40 respondents. This account understood self-harm in terms of an attention seeking cry for help and a method of dealing with feelings and gaining control intra personally. Self-harm was also a method of self-punishment rather than retaliation to others. Self-harm was about attempting to cope with inter-personal difficulties intra-personally and was a learned strategy that is therefore unaffected by biology.

Although the Q-sort factor analysis has extracted seven factors, six were psycho-social in nature and underpinned by feelings of helplessness and/or hopelessness. In these theories, self-harm was a method of coping intra and/or interpersonally. The 'Biological' factor was the only non psycho-social explanation. Four factors of treatment will now be discussed that are all psycho-social in nature.

TABLE I. Summary results table of explanations of self-harm Q-sort

<p>Factor 1: The 'visual communication/survival' explanation. 20/40 participants. Self-harm here, was a coping method to communicate feelings and therefore enable living rather than suicide. It was also a method of avoiding hurting others and was not pathological in nature.</p> <p>Factor 2: The 'depressed and abused' explanation. 1/40 participants. Self-harm was viewed here as a method of coping with feelings of helplessness and hopelessness associated with surviving abuse and also as a precursor to suicide and a signal that help was needed.</p> <p>Factor 3: The 'existential angst/helplessness' explanation. 1/40 participants. Self-harm in this account was a way of coping with feelings of helplessness, hopelessness and therefore needing to be rescued and also a method of dealing with feelings following abuse that may leave the person feeling 'dead'. Therefore a method of confirming life and a communication strategy.</p> <p>Factor 4: The 'depressed and desperate' explanation. 3/40 participants. Self-harm was understood as an internally ineffective way of coping with feelings, but was externally effective in gaining help. A socially motivated expression of anger towards the self.</p>	<p>Factor 5A: The 'biological' explanation. 1/40 participants. The person was understood as being genetically predisposed to self-harm, therefore there was no relationship between life events and self-harm.</p> <p>Factor 5B: The 'psychological/attention seeking' explanation. 1/40 participants. A method by which some people draw attention to themselves to ask for help. Suicide and self-harm were inter-linked.</p> <p>Factor 6: The 'interpersonal communication' explanation. 1/40 participants. Self-harm was a strategy for communicating post-abuse feelings to others and discharging stress, but not about asking others for help.</p> <p>Factor 7: The 'attention seeking/emotional resolution' explanation. 1/40 participants. Self-harm was seen as a 'cry for help' and a method of taking control of feelings within the person. It was a learned method of self-punishment.</p>
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Treatment and policy issues

Factor 1: The 'humanistic/cognitive' approach to treatment

Factor 1 was defined by eight out of the 40 participants. Six participants were men and two women. In summary, this account stressed that people who self-harm should be cared about and understood and have their distress recognized. They should not be punished or rejected for this behaviour. It is essentially a humanistic perspective with an emphasis on understanding.

Factor 2: The 'cognitive behavioural' approach

Factor 2 was defined by seven participants, four were men and three women. This factor argued that therapy and psychiatric services were helpful to the person who self-harms if they were supportive. Therefore, this account also echoed the opinion of the other accounts that punishment and secure settings were not useful. These settings would be attempting to control feelings with external forces and therefore exacerbate feelings of being out of control and therefore self-harm.

Factor 3: 'Psychiatric therapy' approach to treatment

10/40 participants defined this factor. Five were men and five were women. This factor stated that therapy and psychiatric services were useful if supportive in nature. Help should be based on an understanding of why the person self-harmed. Long-term work was emphasised, either individually or in a group.

This factor was defined by six of the participants. This sample contained four men and one woman. This factor stressed acceptance, understanding, empathy, empowerment and taking the people that self-harm seriously. Hence punishment, rejection and secure environments are inappropriate for people who self-harm as they would exacerbate the motivating feelings. Therefore working on an internal locus of control which would enable the person to resume responsibility for themselves would be helpful.

As most of the factors recognized that self-harm is psycho-social in nature and underpinned by feelings of helplessness, it is unsurprising that punishment and rejection were deemed inappropriate. Hence, the treatment factors all emphasized positive regard for the person that self-harms. This is just one theme that was common to the factors.

A summary of the factors identified by Q factor analysis can be found in Tables I and II. The implications of underlying discourses will now be discussed, alongside training and recruitment issues. Additionally, an evaluation of the appropriateness of Q methodology to this project also follows.

Common themes have been produced through some of the factors from the explanations and treatment Q-sorts and a few inter-group differences have been noted. There are also connections between the understanding and treatment Q-sorts that will be discussed in relation to relevant literature. The implications of the stated discourses will then be presented and the research method and project as a whole will then be evaluated in the text that follows.

TABLE II. Summary results table of treatment for people who self-harm Q-sorts

<p>Factor 1: The 'humanistic/cognitive' approach to treatment. 8/40 participants. People who self-harm should be cared about, understood and have their distress recognized.</p>	<p>Factor 3: The 'psychiatric therapy' approach to treatment. 10/40 participants. Therapy and Psychiatric services are useful if supportive in nature. Help is based on an understanding of why the person self-harmed. Long-term individual and group work approaches useful.</p>
<p>Factor 2: The 'cognitive behavioural' approach. 7/40 participants. Therapy that looked at different methods of coping and psychiatric services were seen as useful for people who self-harm.</p>	<p>Factor 4: The 'empathic empowerment' approach. 5/40 participants. Acceptance, understanding, empathy, empowerment and valuing people that self-harm would enable the person to resume taking responsibility for themselves.</p>

Explanations of self-harm

The following two themes were extracted from the seven factors discussed in the last chapter. The strongest themes will be discussed first. Six out of the seven factors agreed that self-harm was motivated by feelings in response to a social situation. One factor stated that motivation for self-harm was biological in nature and therefore was not influenced by feelings or social situations.

Self-harm as a coping strategy. Six out of the seven factors all made reference to self-harm being a method of coping with difficult feelings. Various feelings were discussed in different accounts, such as; fear, anger and sadness. These feelings however, are all underpinned with deeper feelings of being trapped and the resulting feelings of helplessness and having little (if any) control. Hopelessness was also a key feature when self-harm was understood in terms of suicidal intent. These feelings are difficult for anyone to cope with and may relate to current life events or issues from past experiences.

Self-harm is just one method of coping with these very difficult feelings. Other methods include depression, anxiety, psychosis, aggression, substance abuse and many types of behaviour labelled as 'criminal', or 'deviant' in Western society.

Communication

All of the six factors recognized that communication was a central issue in self-harm. Communication can be with the self and/or to other people. When self-harm has a social effect, it may be about enabling other people to really understand about their feelings that cannot be verbalised, or will have little effect if spoken (Babiker and Arnold, 1997, p. 82). In terms of communication, self-harm can also be about influencing other peoples behaviour, which in this study was about achieving a rescuing response from others. If

the significant other responds by rescuing, they take control of the person that self-harms or the situation at hand. This may or may not initially be helpful to the person, but in the long-term it exacerbates the very feelings that motivate self-harm. Therefore if self-harm is understood in terms of a coping response to difficult feelings, it is both effective and ineffective interchangeably.

The 'depressed and abused', 'existential angst/helplessness' and the 'interpersonal communication' factors all emphasized that the difficult feelings originated from past abusive experiences. Self-punishment was also a method of coping in the 'depressed and abused' explanation. Self-punishment can help the person come to terms with previous abuse by re-enactment, which can improve understanding (Babiker and Arnold, 1997, p. 80). During self-harm, the person can develop an empathy with the abuser and/or victim when they feel safer due to self-infliction and also being in the present day, rather than being when the abuse occurred. In effect the person that self-harms is both the abuser and the abused at the same time and these familiar feelings may be preferable to current feelings. Self-harm may also be about punishing oneself for the guilty feelings associated with abuse, or about cleansing the body and excising the badness.

So although communication was a strong theme in most factors, the content differed. Self-harm may communicate a need to be rescued or to cope with life alone and is also a method of expressing feelings or suicidal intent. Communication can also be intra-personal, with the self, or inter-personal, with other people.

Displacement of feelings

Three factors understood self-harm in terms of re-directing angry feelings from other people towards the self (Harrison, 1994, p. 53). These factors were; the 'depressed and desperate', 'attention seeking/emotional resolution' and the 'visual communication/survival' models. Due to low self-esteem, this may be a safer way to cope with angry feelings when they feel inadequate or insecure, or fear the extent and consequences of their anger.

Alternatively, the 'existential angst/helplessness' model argued that although self-harm and aggression are motivated by similar feelings (i.e., helplessness followed by anger) they are very different in nature. Self-harm is often underpinned by a belief that other people are better than the self, whereas aggression is often underpinned by a belief that the self is better than others.

Confirmation of life

The 'existential angst/helplessness' model of understanding self-harm stressed that self-harm is a technique to confirm self-existence. This has also been reflected in the literature and has often been linked to feelings about past abuse that may leave the person feeling depersonalised and 'dead' (e.g., Babiker and Arnold, 1997, p. 78). Therefore self-harm is associated with life-recognition rather than death. This is an important theme even though it did not feature strongly in the other factors.

Communication, displacement of feelings and confirmation of life were all important coping strategies when self-harm was caused by feelings of being trapped. One of the

seven factors, however, did not have feelings of helplessness as a key issue. This factor's theme will now be discussed.

Biologically motivated self-harm. Within the 'biological' model of understanding self-harm, genetic predisposition was the underlying factor. The person is influenced by physiological responses, therefore self-harm is motivated by visceral or automatic responses. Thus, the person that self-harms is not influenced by social experiences or the resulting feelings. These causes were actively apposed in the other factors where self-harm was in response to feelings and social interactions.

Thus the common themes of six out of the seven factors view self-harm as a coping strategy, primarily about intra personal or interpersonal communication. Humanistic and cognitive behavioural theories underpin these models of understanding and are also the predominant theories that were previously discussed and are specifically supported by user-led literature (Harrison, 1994; Arnold, 1995).

Having discussed the common themes from the explanation factors, I will now discuss the themes from the treatment and policy factors.

Treatment and policy issues

The following themes were extracted from all of the four factors of the treatment and policy Q-sort. The person who loaded on the 'biological' explanation was confounded on the treatment Q-sort, therefore all common themes that follow hold the assumption that self-harm is motivated by feelings of hopelessness and/or helplessness.

All four factors agreed that there are three essential qualities that are helpful to people that self-harm. These are;

- (a) Empathy.
- (b) Positive regard for the person.
- (c) Empowerment of the person.

Given that self-harm is a method of communication, empathy and understanding from a person who values the person that self-harms is essential. This is also emphasized by Harrison (1994), Arnold (1995) and Babiker and Arnold (1997). The three setting conditions for help, (listed above) would serve to assist in increasing self-esteem and therefore reduce the internal motivation for self-harm. It is hardly surprising that all factors agreed that rejection, punishment and being locked up were detrimental to the person that self-harms and would only serve to increase feelings of helplessness.

An empowering approach to treatment. Setting conditions for therapy should be empowering in themselves but the 'empathic empowerment' model stated explicitly that the control needs to remain with the person that self-harms and that they need to do what feels right for them, this has also specifically been stressed by Harrison (1994, p. 79). Therefore therapy should be about helping the person regain control and responsibility rather than needing to be rescued by others.

An alternative coping strategy. The 'cognitive behavioural' model of treatment emphasized a need to help the person cope in a different way with these difficult feelings. Alternative methods of coping have also been reported as useful by people who self-harm (Arnold, 1995, p. 21). This suggests that self-harm is presently socially unacceptable. Although this method of treatment was also accompanied with a need to challenge society's narrow views on self-harm and make it more socially acceptable, which will enable people that self-harm to feel more understood and more able to talk about their experiences.

If the setting conditions for therapy suggested earlier occurred, the persons self-esteem would increase and the person would feel on a more equal footing with other people. This would then help them to use alternative methods of coping with the underlying feelings like becoming more assertive with other people.

Long-term work, individual and group-work approaches. The 'cognitive behavioural' model stressed that long-term individual work was useful. The 'psychiatric therapy' model stressed long-term individual and group work approaches in psychiatric settings. Both individual and group work settings have been reported as useful by people who self-harm and also in much of the professional literature (Arnold, 1995; Walsh and Rosen, 1988; Babiker and Arnold, 1997; Cowmeadow, 1994; Favazza, 1989; Harrison, 1994; Linehan, 1993; Tantam and Whittaker, 1992). These issues did not feature strongly in the other factors. The importance seemed to be in the type of help rather than how or where it was received.

Thus the strong themes all factors have in common indicate that a humanistic philosophy and approach is useful, which contains empathy, positive regard and empowerment, alongside a cognitive behavioural approach, using problem solving methods and learning alternative coping strategies. Interestingly these are also the documented chosen approaches by the people that self-harm (Harrison, 1994; Arnold, 1995). If self-harm is understood as being in response to feelings of helplessness and hopelessness, humanistic and cognitive approaches would serve to empower the person to make choices that they felt they did not have before, and therefore reduce the motivating feelings and the resulting need to self-harm.

Commentary

This project makes no claims that all the available accounts relating to self-harm are described. However, a number of discourses have been named. A danger of this process is that the accounts described here will become fixed in nature in the same way that traditional methodologies fix. However, it is emphasized here that the accounts described in this project are fluid and evolving and do not occupy a fixed position.

This study cannot measure whether the explanations and treatment approaches in the literature chapter are right or wrong. It is however, able to demonstrate that humanistic and cognitive behavioural methods and theories are drawn upon by lay people in understanding and helping people who self-harm. By theorising the reasons that the lay people used these accounts, it is suggested that a fuller explanation of the stability of some accounts over others is facilitated.

Within this study, there was however, a clear avoidance of any scapegoating, apart from the one 'biological' factor. People who self-harm were not labelled as 'sick' or pathologized by society. This demonstrated a surprising acceptance of self-harm within our human experiences. This suggests a greater level of psychological development within the participants.

A prevalent theme throughout all of the factors, was that people who self-harm can be helped and should not be punished or rejected by other people. It seems strange that given this acceptability from the lay population about self-harm that some psychiatric services continue to in effect reject and stigmatize people who self-harm by refusing help or labelling them as 'untreatable' (Arnold, 1995, Harrison, 1994; Pembroke, 1994). Behavioural methods that disempower people who self-harm are still commonplace in many psychiatric settings, although cognitive behavioural, psychodynamic and humanistic methods are also recognized and presently being used. People that self-harm are still sent away from some psychiatric services deemed as being 'un-treatable' and may be viewed as not having a 'serious mental-illness'. Many psychiatrists still use a medical/biological model of treatment which uses medication to treat 'mental illness'.

There seems a powerful process of projective identification at work between people within psychiatric services and the people within the 'professional' services (Jureidini, 1990). It certainly seems from this study that some lay people remain outside of this process and can remain empathic, non-judgemental and not reject people who self-harm, thus keeping at a distance and not receiving any transference projections. This study has clearly highlighted the need within professional settings for psycho-dynamic supervision that helps workers discuss feelings of helplessness and focus on the projective identification process that surrounds self-harm. It is not the workers knowledge of self-harm that is at fault, but how they manage the emotional turmoil involved in the process and avoid punishing and rejecting clients. Therefore workers need to develop self-awareness in their emotional processes in Projective Identification, which can be facilitated through supervision. This type of supervision is common-place in counselling and psychotherapy, but a rarity in psychiatric settings. Emotional knowledge of this process is also very important for family members and significant others of people who self-harm.

Implications

Completion of this study has drawn attention to implications in areas of treatment, training, recruitment and future research projects. These are now explored in turn. The use of Q-sorts, in individual or group setting could be useful as a method of exploring understandings and facilitating reflection and feedback. Clients could produce their own Q-sorts by generating their own range of statements and then focus on the things that have particular resonance for that person. This offers the opportunity for the therapist to explore how a patient uses accounts rather than just which accounts the client draws upon.

The treatment approaches contained within the treatment factors of a cognitive behavioural and humanistic nature are widely used within psychiatric and non-statutory settings. These methods of working with people who self-harm are becoming more

supported in publications, especially user-led or focused (Harrison, 1994, Arnold, 1995, Babiker and Arnold, 1997). The authors' have certainly found these approaches useful within both more traditional counselling and psychiatric settings. Hopefully with the emphasis on psycho-social interventions in psychiatry, experiences for people who self-harm will improve.

Indeed, training and supervision are large parts of culture change within institutions. Q-sorts could also be developed as a tool for training and supervision. Similar to the idea for therapy, the person could work on their own Q-sort and use this to explore their understanding of self-injury. These informed groups could then be compared to original groups for effectiveness.

As self-harm is such an issue in psychiatric services and Accident and Emergency departments, a Q-sorts understanding self-harm could be used as a selection process for recruitment. This could focus on how the applicants used the statements available to understand self-harm.

Education about the process of projective identification and supervision are vital when working with people who self-harm. Projective identification and self-harm should be on the curriculum for every health care worker in the psychiatric system. Within some parts of Liverpool, Manchester and Stoke-on-Trent, this has already occurred for nursing students (general and psychiatric) but this needs to be wider spread. Self-harm should be a national agenda for all professions.

Research

This piece of research was clearly limited in what it could achieve. However, it does suggest some possibilities for the future. More biographical information could be utilized to further explore who uses which accounts, how they use them and why. Specific groups could include lay people, care givers and people who self-harm.

Considering the fairly open, empathic non-judgemental accounts that came out of this study. It would be interesting to conduct a similar study with employees and family or friends who care for people that self-harm. There seems to be a big issue regarding how carers feel about people who self-harm when help that is offered does not work. One would also focus on how punishment and rejection occur even though the carer may know that this can make the person who self-harms feel worse. Following this study the author has a contention that closer relationships with people who self-harm are more likely to become punitive in nature.

This research project was at times emotionally very difficult and time consuming to complete. Through the process of supervision the researcher became aware of a parallel process of becoming helpless and hopeless at times when emotionally very stuck. This only goes to highlight the intensity of the process of self-harm in terms of projective identification, not only to the helpers, but also researchers, if the method is qualitative in nature. This study clearly has only served to set some agendas for future research, training and supervision in the area of self-harm, but has also demonstrated positive aspects of lay peoples' perceptions.

Concluding remarks

Given that talking about self-harm is still relatively taboo, it is felt that Q methodology provides a useful method of generating accounts about this subject in a less threatening way, yet provides a rich source of information.

This study served to describe how lay people understand self-harm and suggested some of the functions that these accounts might serve. By explicating the various functions of accounts it becomes possible to challenge those accounts that further compound self-harming behaviour. This is the first stage of that process and this project was more about describing lay peoples' perceptions about self-harm and also as a ground base on which to plan and implement future research in this area. It has certainly highlighted that there seems to be a process of projective identification occurring when people work closely with people who self-harm. As such, in healthy clinical practise, this process needs to be recognized and understood, thereby increasing empathy. In order for this to happen sufficient training and supervision needs to be provided to avoid helpers responding to their own counter transference feelings which may result in rejection and punishment of the person that self-harms.

For this study to realize it's potential, resources need to be made available to develop further research into perceptions of the people who self-harm and also their carers and also the parallel processes that seems to occur. Resources also need to be provided for the training and supervision for helpers, from many diverse areas working with people who self-harm.

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