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Repeated self-wounding: Women's recollection of pathways to cutting and of the value of different interventions

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Background. More information is needed on the processes that result in self-wounding and how these are modulated by the selection and delivery of interventions available to those working in non-specialist settings.

Methods. Ten women participated in a semi-structured interview where they recalled their experiences of cutting and the helpfulness of specific interventions. Transcripts of these self-reports were analysed using grounded theory methods.

Results. Having a long-term relationship with a key worker and being encouraged to express feelings were viewed as the most helpful strategies, whereas relaxation was often reported as making self-injury worse. The helpfulness of a given intervention was reduced when delivered by someone perceived as underconcerned, overprotective or incompetent. Two pathways to self-wounding were identified: cutting may result when there is a steady increase of tension until a threshold is reached (the 'spring' path), or as a result of the 'switching on' of the impulse (the 'switch' path). Dissociation during cutting and a craving for cutting were more often associated with switching to the impulse. Different management strategies are called for when the switch path has developed, which appears particularly the case for individuals who have been repeatedly self-wounding over a substantial period of time.

Repeated or episodic self-wounding is a subset of self-harm that is commonly, though not exclusively, associated with so-called 'borderline functioning'. It is prevalent among women receiving care from mental health services and can raise anxieties for staff who

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are charged with their management. The behaviour is difficult to treat and hard to understand, partly because it often appears overdetermined in that it can serve more than one function simultaneously (Suyemoto, 1998). It is particularly problematic for those who endeavour to provide effective help without the benefit of clear guidelines for appropriate clinical practice (Allen, 1995).

Self-wounding has been the subject of considerable investigation in recent decades (Favazza, 1998). Studies of what women who self-wound find helpful have indicated the value of face-to-face support, non-punitive responses from others and being able to express feelings and explore underlying issues (e.g. Arnold, 1995). A number of causal and maintenance factors have been identified (Connors, 1996; Figueroa, 1988). Various theories have been advanced to explain the function it serves, and Suyemoto (1998) provides a comprehensive review of the key functional models and specific treatments that match to them.

Several novel or modified therapeutic approaches have been developed that appear effective in managing self-destructive behaviour (Linehan, 1993; Raj, Kumaraiah, & Bhide, 2001; Sheard *et al.*, 2000; Townsend *et al.*, 2001). Unfortunately, and perhaps inevitably, most of these require specialist training and few are currently available to clients receiving treatment within a general psychiatric setting. Psychiatrists, ward staff, occupational therapists and community nurses who work within non-specialist services are unlikely to be trained in such therapies and tend instead to rely on a limited number of pragmatic management strategies gleaned from their own training and experience or from the literature.

Outcome studies for such generic strategies are hard to find. Although some information is available on how professionals view their effectiveness (Huband & Tantam, 1999), further investigation is needed to define the factors that modulate how such interventions are perceived by those who self-wound. An individual's pathway to self-wounding (i.e. her established pattern of cognitions and feelings) is one possible factor, since it is likely to affect the dynamic between the selection of an intervention and its perceived helpfulness. For example, in the tension-reduction model described by Brain, Haines, and Williams (1998), self-injury results from attempt to reduce internal tension and regain control, perhaps of dysphoria or unpleasant dissociative experience (Kemperman, Russ, & Shearin, 1997). A pathway is established in which cutting regulates intolerable affect and is reinforced by its reliability in achieving this (Machoian, 2001). An individual experiencing this path might be expected to welcome an intervention that conveys the sense that she is regaining control. Other pathways may exist, however, perhaps causing the individual to perceive the same intervention in a very different light.

Another possibility is that the perceived helpfulness of any intervention depends more on the context of its delivery and the emotion that it engenders, and less on its ability to address underlying issues. This is important clinically since clients are unlikely to engage with any intervention that generates strong negative reaction, and emotions such as anger, powerlessness and self-hate have all been found to be closely associated with repeated self-harm (Brittlebank *et al.*, 1990; Sakinofsky & Roberts, 1990).

We therefore suggest there is value in exploring the relationship between perceived management style (a combination of the strategy selected and the subtle balance of interpersonal factors involved in its delivery) and the consequent emotional response in a patient predisposed to cutting or burning herself.

We report here a phenomenological study of the personal experience of a small sample of women in relation to past episodes of self-wounding. Three research questions were addressed:

(a) what pathways to self-wounding had these women experienced and what characteristics differentiated those experiencing one pathway from those experiencing another;
(b) what were their experiences of the strategies deployed by staff in their attempt to limit self-injury; and
(c) what had modulated their perception of the helpfulness of such strategies.

An analysis based on grounded theory was selected as particularly suitable for capturing both common themes and individual differences in participants' experiences.

Method

Sample recruitment

We sought a sample of women who had experience of injuring themselves and who were comfortable being interviewed. A further requirement was that they had sufficient contact with professional services to be able to comment on a range of clinical interventions. Inclusion criteria were therefore a history of at least two episodes of self injury recorded as without suicidal intent, and of receiving treatment from acute mental health services. For geographical convenience, we chose to focus on patients located within a department of general psychiatry providing the NHS service to a county in central England. Information about the study was summarized in a leaflet approved by the relevant medical ethics committee and made available to potential participants at a local day hospital and via six consultant psychiatrists responsible for a mix of urban and rural catchment areas. The women who subsequently volunteered were only accepted into the study if they had read the leaflet, had been given the opportunity to ask questions, and gave their written consent.

The final sample comprised 10 women who were interviewed about recollections of their self-wounding and its management. The size of the sample was not predetermined, however, since data were collected following the principle of saturation. After the eighth interview it became difficult to elicit new themes from the transcripts, and it was decided after the tenth interview that a saturation point had been reached and the request for volunteers discontinued.

Characteristics of the sample

Basic demographic and descriptive data about self-harm were collected from the participants. Ages ranged from 21 to 48 years ($M = 35.1$ yrs). All had self-injured by

cutting and seven had also burnt themselves on occasion. The number of lifetime episodes ranged from 4 to 42 with the pattern of repetition determined by self-report as frequent (greater than once per month; $n = 4$; mean number of episodes = 30.5) or infrequent (less than once per month; $n = 6$; mean number of episodes = 8.7).

Prior to interview, each participant completed the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986), which is shown to have good internal and test–retest reliability (Carlson & Putnam, 1993), high construct validity and good internal consistency (Dubester & Braun, 1995). Scores here ranged from 26 to 66 ($M = 45.9$, $SD = 13.9$). For comparison, normal scores for adults in the general population have been found to lie between 4 and 15 (Carlson & Putnam, 1993). Using a score of 30 as a threshold to differentiate high from low levels of dissociation (Carlson *et al.*, 1993), eight of those interviewed fell within the higher category, implying that significant dissociative experience was common in the sample. Mean DES scores were greater for the frequent self-injurers (50.0) than for the infrequent group (43.2).

Each participant also completed the Parental Bonding Index (PBI; Parker, 1979), which measures perceptions of parental figures in the first 16 years of life with good construct and predictive validity, and high reliability (Parker, 1983). PBI scores indicated low perceptions of parental care (maternal care: $M = 8.3$, $SD = 6.8$; paternal care: $M = 10.1$, $SD = 6.4$; normal adult scores are respectively 27.0 and 24.0). Overprotection scores were considerably higher than the mean for normal subjects (mean maternal score: 23.1, $SD = 8.6$; mean paternal score: 29.7, $SD = 5.4$; normal adult scores respectively 13.5 and 12.5).

Interviews

Each participant was guaranteed anonymity and took part in a semi-structured interview designed to elicit recollections of

(a) how she perceived her self-wounding had been managed by professional staff, and
(b) her subjective experience prior to self-wounding.

For (a), 18 strategies for managing the behaviour were identified from the literature (Huband & Tantam, 1999) and presented in turn in an interview conducted by the main author. For (b), participants were encouraged to clarify any reference they made to cognitions and feelings that had preceded each incident of self-wounding they reported, or which they felt had precipitated it.

The interviewer described each strategy by a single phrase or sentence, keeping descriptions as short and as simple as possible to aid comprehension. If a participant reported no experience of a particular strategy, the interviewer moved directly to the next statement. When a participant reported experience of a strategy, she was asked to recall a time when that strategy had been particularly helpful to her, and then to recall another time when it had been particularly unhelpful. She was also given the option to make no comment and to 'pass' to the next question if she wished. Those who wished to make comment were encouraged to voice their most significant memories of both

helpful and unhelpful interactions in relation to that specific strategy, and to recall the feelings engendered by their perceptions of the behaviour of others who attempted to provide professional help. The interview was structured in this way to avoid any participant feeling pressured to recall distressing material; it allowed clients to volunteer descriptions of episodes they felt comfortable recounting, and to stay silent about those on which they did not wish to dwell.

Whenever an individual claimed experience of a strategy she was asked to indicate her overall opinion of it in relation to her self-wounding using a visual analogue scale. The scale consisted of a line, 56 mm in length and anchored at its ends by the phrases 'very unhelpful' and 'very helpful'. In analysis, a response score in the range −4 through 0 to +4 was obtained by subdividing the line into nine equal segments using an overlay.

Each participant was encouraged to focus on past incidents of self-wounding but not of self-poisoning. All interviews followed the same format, were transcribed verbatim, and lasted no longer than an hour. The interviewer frequently reflected back to the participant what had been said in an attempt to enhance the validity of the data collected, and any anomalies were discussed and resolved. A record was also made of the interviewer's impressions after each session. Several precautions were taken to ensure the emotional well-being of those interviewed. First, each was made aware that she could withdraw at any time without penalty. Secondly, it was agreed that the interviewer would contact an appropriate mental health professional if concerned about deterioration in her mental state as result of the interview. Thirdly, arrangements were made to check whether the interview process had been distressing or had triggered memories that might be difficult to control. None of the interviewees said that it had, and none withdrew their participation.

Analysis

While the interviews were semi-structured and encouraged participants to focus on their experiences of a specific set of interventions, the format was sufficiently open-ended to allow them to talk freely of their experiences both prior to and following self-wounding incidents. A grounded theory approach was selected for exploring this material since it requires ongoing analysis the products of which are then used to guide further interviews. Thus new participants were asked to reflect on material relevant to themes derived from interviews that had gone before. This process encouraged repeated comparison of the various themes that emerged and forced us to question carefully our assumptions and interpretations.

Each interview was transcribed and its content analysed with the help of a computer program (Code-A-Text; Scolari Software). Transcripts were analysed following the main steps in grounded theory and using the constant comparative method (Strauss & Corbin, 1990). Initially, phrases and sentences in the text were inspected in an attempt to identify key descriptive categories, referred to here as 'themes'. Notes were made during the analysis of any apparent patterns and these were compared with the interviewer's impressions written at the time of the interview. Wherever possible,

substantial themes were named and a code assigned to the relevant block of text, making extensive use of *in vivo* codes drawn directly from participants' own words (Strauss, 1987, p. 33).

This process allowed substantive codes to be assigned to key themes. Codes were compared for similarity and difference at each subsequent stage of analysis which, on occasion, resulted in new themes being defined. The set of themes was then delimited by inspecting the interrelationships between codes and subsuming categories to form a smaller set of higher level concepts. Finally, the raw data was again reviewed and re-coded on the basis of the emergent set of key themes.

To obtain information about factors modulating opinion of the various strategies, themes were formally extracted following the procedure described above. Interaction variables and emotional-state variables were distinguished, which allowed us to identify patterns that emerged in experiences of the care that had been received and also to explore associations between interaction and emotional response. To obtain information about pathways to self-wounding, all words or phrases describing personal experience preceding self-injury were extracted, coded into themes and subsequently delimited following a similar iterative process. Since many of the women reported one experience leading to another prior to self-injury, the transcripts were revisited and additional coding added to denote the temporal order of such experiences whenever this was reported.

Validation

It is particularly important for a qualitative study to be able to demonstrate the trustworthiness of the results (Henwood & Pidgeon, 1993) and this issue was addressed in several ways. First, we include here a number of quotations transcribed verbatim from participants' own accounts, allowing readers to form their own opinions about the validity of the themes extracted. Secondly, the accuracy of the data collected was enhanced through the process of reflecting information back to participants in interviews. Thirdly, the validity of the coding was checked by asking an independent researcher to code random samples of transcribed data whilst blind to the results of any previous coding.

Results

Pathways to self-wounding

The analysis yielded 10 key experiential themes in relation to participants' reports of their subjective experience before cutting themselves. These are summarized in Table 1, together with illustrative quotes extracted directly from the transcripts. Since several episodes were being recalled by the women interviewed, participants often recalled experiences that were grouped as one experiential theme in one episode but other experiences, grouped into other experiential themes, during other episodes.

Table 1. Experiential themes derived from experiences recalled prior to self-wounding

Theme	*N* of participants reporting	Examples
Winding up	9	'feeling wound up'; 'it's tension that builds up'; 'pressure building up'; 'ready to fizz over'
Effort to resist	8	'I've struggled for days, trying to fight it'; 'trying not to'
Cueing tension	7	'that can set me off'; 'got me going'; 'started it off again'
Premeditation	7	'once I've decided I'm going to do it, I'll cut whatever or whoever'
Recollection	6	'reliving the past'; 'just remembering things I've done to myself'
Switching on	6	'it switches on and off'; 'it happens in an instant'
Triggering	6	'the final straw'; 'that made me cut'
Craving	5	'I just wanted to cut'; 'need to'; 'just want to do it'
Involuntary action	4	'like it's someone else doing it'; 'like I'm on automatic pilot'
Rumination	3	'can't get the thoughts—memories—out of my head'; 'going over thoughts of doing it'

Note: One participant may report different experiences, grouped in different experiential themes, during different self-wounding episodes.

The most common experiential theme, applying to the recall of nine of the 10 participants, was 'winding up'. The second most common was 'effort to resist' (eight participants). Six reported the theme of 'switching on'. Since most participants recalled more than one theme and provided information on their temporal order, we were able to construct a flow diagram summarizing how one led on to another in those to whom the theme applied (see Fig. 1).

Following the approach outlined by Strauss and Corbin (1990), we then attempted to conceptualize the central phenomena by searching for the smallest number of core categories that encompassed participants' accounts of their experiences prior to cutting. Transcripts were re-examined to test whether any particular set or sets of themes emerged, and whether any one set was commonly reported in a way that distinguished it from any other. We located just two contrasting sets and surmized that these represented two distinct pathways to self-wounding. One, which we call the 'spring', is associated with a feeling of becoming increasingly 'wound up'. The other, which we call the 'switch', is associated with a sudden and often overwhelming desire to cut, as if a switch has been thrown. Returning to the transcripts, we then coded for either the spring or the switch process in each recalled incident, and drew together similarly coded incidents to derive the following summaries.

The spring

Nine women recalled self-wounding as a result of an unpleasant and ill-defined emotional state that intensified over time before it became intolerable. They were aware that self-wounding provided them relief, albeit short-lived. For some, the feeling of relief

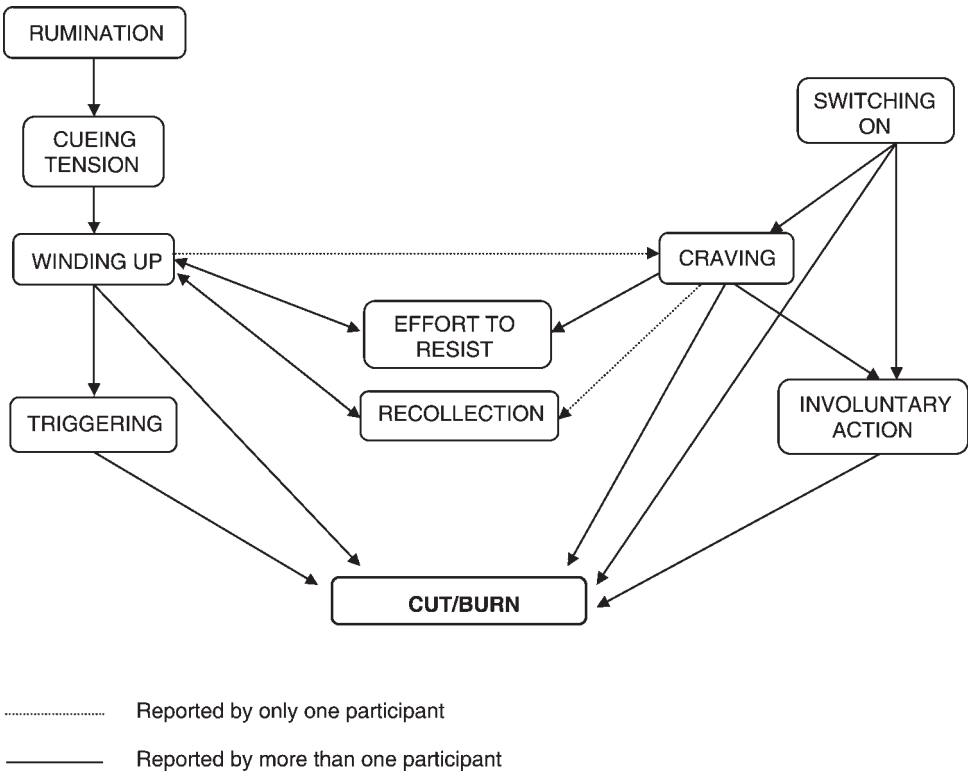

Figure 1. Progression from one theme to another contained in participants' recall of prodrome of self-wounding.

was rapidly replaced by an unwelcome emotional state often described as guilt. Sleep—or overdose of medication to induce sleep—was cited as an effective alternative release. Most referred to interpersonal factors that increased the tension, and these were frequently and critically attributed to the interactive style of professional staff or to the nature of a particular management strategy. Eight participants described periods during which they struggled between cutting and not cutting. In this context, reference was made to staff members not appreciating or not recognizing the effort to resist that the women often (but not always) made to ward off hurting themselves. Such periods could be lengthy (as long as five days), with the act of self-harm occurring only when they felt they could resist no longer and finally gave up the battle. In some episodes there was a triggering factor that substantially increased the tension, making it much harder for them to resist. Attempting to practice relaxation techniques during such internal conflict was reported as particularly unhelpful; one woman commented, 'when it's like that, I'm always like too scared to let myself go,' while another explained, 'I can only do it [relaxation] when I feel OK, and not when I'm wound up.'

The switch

Winding up could lead to self-wounding directly with an individual eventually giving up the struggle and cutting herself deliberately to ease tension. However, some participants

reported episodes when there was no premeditation but where cutting followed directly on from the sudden appearance of the desire to cut. One woman said: 'when it's like that like it just . . . like it switches on and off . . . and I want to cut myself so badly, but maybe I'm not sure why at the time'. Those recalling this pathway were often at a loss to explain their behaviour, saying things like 'it just seems to happen' or 'it happens in an instant', and described an impulse to cut as switching on of its own accord. Once the switch had been thrown, some of the women described a craving to cut, while others just went ahead and did it. In total, six of the 10 participants recalled experiences that suggested the switch had occurred. One woman, who did not recall ever experiencing the mounting tension of the spring and only recalled the switch pathway, said that her cutting was unpredictable and involuntary, but after the impulse came, was inevitable and uncontrollable. For another, both voluntary and involuntary action appeared to operate within a single episode of self-injury: 'I was trying to do a few small cuts . . . sort of to calm me down, and then I'd done a nasty big one . . . which I didn't intend to do.' We observed that those who reported the switch pathway tended to have a greater number of lifetime episodes ($M = 23.7$) than those who did not ($M = 8.0$).

Reports of dissociation

Several women made comments suggesting that they were dissociated at the time of their self-wounding, for example describing amnesia for cutting themselves, numbness at the time of the wound, and of feeling like the cut was to 'another person's arm . . . not really mine'. Dissociation was reported more frequently if individuals were following the switch pathway and had experienced craving, a sudden impulse to cut, or had cut themselves without thinking. We also observed that those who reported the switch pathway tended to have higher scores on the DES ($M = 55.0$, range $= 43$–66) compared to those who did not ($M = 32.3$, range $= 26$–39).

Emotional themes

We wished to explore whether there was any association between the pathway to self-wounding and the emotions that preceded it. We therefore located any reference to feelings that preceded self-injury or were recalled as having the potential to precipitate it. Each was then classified into one of eight emotional themes (see Table 2) of which feeling powerless, uncared for, shame and anger were the most commonly reported.

There was evidence that particular individuals were attuned to particular emotional themes and were more likely to recall these. For example, all women recalled feelings that were grouped in the theme 'uncared for'. Most women experienced different uncared for feelings in different episodes, but two only ever experienced feelings of abandonment whereas two others never expressed abandonment but often felt judged or criticized.

There were 48 recalled episodes that could definitely be assigned to either the switch ($n = 39$) or the spring ($n = 9$) pathway. We examined whether there was

Table 2. Feelings recalled by participants as leading to self-wounding

Emotional theme	Frequency (all references)	Specific to spring path (39 instances)		Specific to switch path (9 instances)	
		Participants reporting	Reports	Participants reporting	Reports
Powerless[a]	59	7	29	3	5
Uncared for[b]	56	5	12	2	3
Shame	13	3	4	1	1
Anger	11	4	4	1	1
Ignored	9	2	2	1	1
Reticent	8	2	4	0	0
Mistrust	7	2	2	1	1
Guilt	6	1	2	1	1

Notes: [a]feeling controlled, impotent, vulnerable, invaded; [b]feeling abandoned, criticized/judged, neglected, rejected, not encouraged, misunderstood.

a difference in the frequency of emotional themes between the two pathways (see Table 2, cols 3–6), but there was none.

Ratings of management strategies

There were 14 management strategies that all of the participants remembered staff using. The women rated how helpful these were, and the mean scores are presented in rank order of helpfulness in Table 3. 'Having a long-term relationship with one key worker' and 'expressing feelings about the past' were rated overall as the most helpful methods of managing their self-wounding. 'Being taught relaxation techniques' was experienced as the least helpful. Indeed, many reported that relaxation actually had the potential to make their self-injury worse, but that they had been unable to convince staff that this was so. Psychotherapy or counselling was generally experienced as helpful. However, several participants reported 'drifting off' and 'losing the plot' in their therapy sessions, or complained about their therapist enduring silences during which they found it hard to remain focused; re-examination of the transcript coding revealed that the members of this subgroup reported dissociative experiences more often than did the rest of the sample.

We compared the rankings of women who sometimes switched into self-wounding with those who never did. Those who switched, in comparison to those who did not, ranked having their contact restricted to certain staff higher in helpfulness; they gave lower rankings of helpfulness to receiving counselling or psychotherapy, being questioned about sexual trauma, and being matched with staff who were emotionally neutral to self-wounding.

Table 3 also includes data from a previous study of the views of clinical staff towards managing self-injury (Huband & Tantam, 1999). The women in the current study and the clinical staff previously surveyed had a similar positive opinion about expressing

Table 3. Opinions of the helpfulness of strategies for managing self-wounding

	Participants' views		Clinicians' views[a]	
Strategy	Rank	*M*	Rank	*M*[b]
Having available a long-term relationship with one key worker	1	3.9	8	1.2
Being encouraged to talk about and express feelings from your past	2	3.4	2	2.4
Being given a 24-hour emergency contact telephone number	3	2.2	11	0.2
Getting counselling or psychotherapy	4	2.1	5	1.6
Taking prescribed medication	5	2.0	13	−1.2
Having contact with staff who don't show a lot of emotion about self-injury	6	1.6	6	1.6
Being asked about any sexual problems in your past	7	1.5	7	1.4
Regular discussions taking place between all staff involved in your care	8	1.1	1	3.9
Being admitted to hospital	9	1.0	14	−1.8
Having staff pay minimum attention to your wounds	10	1.0	9	2.0
Having others take charge of sharp objects	11	0.5	12	−1.2
Being encouraged to care for your own wounds yourself	12	0.1	4	1.8
Being encouraged to have contact with only certain staff	13	0.0	10	0.8
Being taught relaxation techniques	14	−1.7	3	2.0

Notes: [a]data from Huband and Tantam (1999); [b]mean scores scaled to range −4 to +4.

feelings about the past. The two groups appeared, however, to have very different views on the helpfulness of certain strategies. Hospital admission, medication and a long-term relationship with a key worker appeared more popular with the women interviewed here than with the staff group, while the converse was true for relaxation training.

Emotional appraisal of management style

It can be argued that the nature of an intervention is less important than the way it is experienced. All women recalled specific strategies that had been helpful in some situations and unhelpful in others. For 51% of such cases, individuals recalled one feeling when a strategy had been helpful and the opposite feeling when it had been unhelpful. In an attempt to find out what had altered an individual's reaction to a strategy, we re-analysed the interview transcripts looking for comments about the staff

member who had delivered it. In such cases, we found that a strategy was more often recalled as helpful when implemented by staff recalled as being caring, promoting autonomy or acting competently. The same strategy was more often recalled as unhelpful when delivered by staff recalled as showing a lack of concern, overprotection or incompetence.

Discussion

A study of this type is subject to certain limitations. First, the investigation focused on participants' recollections of past events but did not seek any evidence of what actually occurred. Though some discrepancy is inevitable, this will not be particularly relevant when, as is often the case, it is an individual's *perception* of the way her self-wounding is managed that governs her response. Secondly, as with much qualitative research, the sample may be considered naturalistic and non-random since it necessarily comprised individuals who had volunteered to contribute. This may raise uncertainty about the degree to which it is representative of the wider population of women who self-wound. We note, however, that several characteristics of our sample were similar to those found in other studies of self-wounding women, including significant dissociative experience (Brodsky, Cloitre, & Dulit, 1995; van der Kolk, Perry, & Herman, 1991) and greater dissociation scores among those who cut more frequently (Low, Jones, MacLeod, Power, & Duggan, 2000). In addition, women in the sample recalled low care and high overprotection from parental figures. This combination, often described as 'affectionless control', has been found to be associated with suicidality (McGarvey, Kryzhanovskaya, Koopman, Waite, & Canterbury, 1999; Oquendo & Mann, 2000) and is in keeping with findings that borderline patients perceive their parents as less caring and more overprotective than other groups (Goldberg, Mann, Wise, & Segall, 1985).

More research is needed to substantiate a two-path explanation of self-wounding. However, the concept of a spring pathway accords with clinical experience, is grounded in the language used by those who self-wound, and aligns with the tension-reduction model summarized by Brain *et al.* (1998). The key issue for those experiencing this path appears to be one of control.

The concept of a 'switch' pathway is also grounded in the language used by those who self-wound, and reports of craving are in keeping with the addictive features often observed in serial cutting (Faye, 1995). The key issue for those experiencing this path appears to be desire rather than control. In the current study, those who experienced switching and craving tended to have cut themselves more often, raising the possibility that the switch path establishes itself with repetition of the behaviour. While further work is needed to substantiate this, there is a general recognition that repetition leads to a change in presentation; for example, Favazza (1998) commented that self-injury that is at first intermittent often becomes an habitual, overwhelming preoccupation somewhere between the fifth and twentieth episode.

Clinical experience suggests that the idea of cutting as a means of tension reduction is widely accepted, whereas the concept of switching into a craving for cutting is less familiar to many clinical staff within a general psychiatric setting. Where this second pathway exists, there will be advantages to all parties in acknowledging it and providing treatment and management more appropriate to addictive behaviour such as those suggested by Prochaska and Velicer (1997).

Women in the sample tended to favour strategies that involved interpersonal contact with staff even though such interactions were reported as very unhelpful at times. Being encouraged to express feelings about the past was also valued, suggesting that the processing and discharging of emotion can be important in limiting the behaviour. While receiving counselling or psychotherapy was generally seen as helpful, some women struggled with this intervention; those who had difficulty appeared particularly prone to dissociative experiences and complained that their therapists were either too silent or insufficiently directive. This adds weight to the view that conventional interpretative or psychodynamic therapeutic approaches can be unsuitable for highly dissociated clients for whom specialized cognitive techniques have been developed and may be more appropriate (Kennerley, 1996). We were struck by the fact that many of the women in the sample had such a strong dislike to being taught relaxation techniques. Their experiences suggested that relaxation weakened the self-control perceived necessary to prevent giving in to the urge to self-harm. This has clinical significance for clients with this vulnerability since it is clearly unethical to advocate an intervention that has potential to precipitate self-injury.

Some caution is needed when interpreting the apparent differences between staff and patients about the value of certain strategies for managing self-wounding. It can be argued that the two studies are not directly comparable as the response scores reported here were of clients' personal experience of interventions, whereas the clinician's views reported by Huband and Tantam (1999) were given in relation to a representative case vignette. We also acknowledge difficulty in justifying comparison between the opinions of a large group of staff and those of a very small group of patients. Nonetheless, these results do indicate those management strategies that are most likely to generate discord between women who self-wound and the staff involved in their care. This also has clinical significance, since such friction is unlikely to lead to a positive outcome.

The findings reported here also demonstrate that the choice of intervention can be less important than the way it is delivered. In some cases, the clinician who can deliver a strategy, however selected, in a style that is perceived as caring, competent and which promotes autonomy is more likely to have success than one who cannot.

Conclusions

Some common themes leading to self-wounding emerge from this study. Staff can inadvertently wind up their clients—or even trigger self-wounding—by not being aware of these and by increasing the tension. We found evidence for two contrasting pathways

to cutting, one of which may develop as a function of repetition of self-harm. The same emotions lead to self-harm by either the switch or the spring pathway, but the experience is different. Different management strategies are called for when the switch path has developed, which appears particularly the case for individuals who have become chronic.

If these results are generalizable, clinicians would be advised to:

(a) consider dissociation in women who cut themselves regularly;
(b) acknowledge that conventional psychotherapy can be unhelpful for women with significant dissociative experiences or with a long history of self-injury; and
(c) be aware that relaxation therapy may be contra-indicated for some members of this client group.

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