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Locating Culture in Accounting for Self-Harm amongst Asian Young Women

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ABSTRACT

Epidemiological studies have suggested that the incidence of self-harm is on the increase in the UK especially amongst Asian young women. Explanations of 'culture clash' and Asian culture as pathogenic are prevalent in clinical psychological research. This paper reports findings from interviews with seven Asian young women with a history of self-harm and eight interviews with service providers. A discursive analysis of the accounts indicates diverse construals of self-harm, which include 'release from distress', 'ending it all', 'effecting change' and '(taking) control', which are located within narratives of distressful circumstances. These accounts implicate 'Asian' culture in diverse ways including in relation to the creation and maintenance of distress and to the access of pathways to support and care. These accounts are used to explore some implications for service provision that include: sites and sources of support and forms of care. It is argued that clinical psychological research and practice should make central patients'/clients' meanings and needs (as located within broad socio-cultural circumstances) rather than privileging 'culture' to the neglect of other concerns. Copyright © 1999 John Wiley & Sons, Ltd.

Key words: self-harm; 'Asian' culture; accounts and narratives; service provision

INTRODUCTION

Recent years have seen a growing interest in the issue of self-harm both within the mainstream mass media and in clinical/psychological research. The release of findings from epidemiological studies has been accompanied by reports of 'soaring' rates of suicide and an 'epidemic' of self-harm in the UK, especially amongst south Asian young women (D'Alessio and Ghazi, 1993; Hodes, 1990). However, a range of issues come into play regarding both the definition and conceptualization of self-harm for which there is no clinical consensus, as well as that of 'Asian' culture.

The term 'self-harm' is commonly used interchangeably with parasuicide to cover a broad range of behaviours. It has been calculated that there have been 17 attempts to sub-divide different forms of self-harm (Walsh and Rosen, 1988). For example, it has

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been suggested that self-harm is inclusive of, but dividable into two broad categories, 'self-poisoning' such as overdosing, and 'external self-injury' to the body such as cutting or burning the skin (Favazza, 1987). Alternatively, Babiker and Arnold (1997) categorize overdosing, suicide and parasuicide as 'self-harm', cutting and burning, as 'self-injury/mutilation', adding a further category, 'self-destructive behaviours' which includes eating disorders and substance abuse. Others argue that self-harm is a distinct category from attempted suicide, with the former having a different set of meanings in which the primary aim is not self-annihilation.

The 'professionalization' of the understanding of self-harm through a reliance on definitions, sub-divisions and categories as above, has received criticism on various grounds (Arnold, 1995; L. Johnstone, 1997; S. Johnstone, 1997; Pembroke, 1994). L. Johnstone (1997) points out that the 'professionalization' of self-harm has, in the main, taken place within clinical/psychiatric sites, within which a focus is placed on the individual and their self-harming behaviours, divorced from a concern with their relationships with significant others, including family and intimate partners. Treatment offered through psychiatric services often concentrates on lessening the self-harming behaviours rather than exploring reasons for self-harming (Tantam and Whittaker, 1992). Such treatment has been evaluated by individuals who self-harm, as unhelpful, in failing to engage with distressful circumstances leading to self-harm, and sometimes as damaging in contributing to the individual's distress (Arnold, 1995). This has led for calls for research which attends to the meanings, experiences and needs of individuals who self-harm (Arnold, 1995; Spandler, 1996).

This was a starting point for this research study where a decision was taken to work with a broad definition of self-harm to include overdosing and self-cutting, as well as eating 'disorders' such as anorexia and bulimia, as these have been taken as self-damaging behaviours, which can be argued to be 'chosen' body management strategies for dealing with emotional distress. The decision to work with a broad definition was made also on the basis of accounts of women who self-harm who report their engagement in various forms of self-harming behaviours which cut across the categories suggested above (Tantam and Whittaker, 1992).

Despite the difficulties in defining and explaining self-harm, in the UK, women are reported as having the highest levels of self-harm, in contrast with men who are at greater risk for completed suicide (Babiker and Arnold, 1997; Health of the Nation, 1994). Recent attention has been directed at the incidence of self-harm in south Asian young women in the UK. In an UK context the use of the ethnic category 'south Asian' refers broadly to those peoples whose familial or cultural backgrounds originate from the subcontinent of India, Pakistan and Bangladesh. The term 'Asian' is broad and heterogeneous; diversified along the lines of religion, class, migration patterns, language, traditions and identifications with regional areas 'back home'—places that may be urban or rural (Woollett *et al.*, 1994). Research conducted in the UK, based on analyses of local hospital admissions data and surveys carried out in school settings have suggested that Asian young women are at higher risk for attempted suicide and eating 'disorders' such as anorexia and bulimia as compared with White Caucasian and African–Caribbean young women (Merrill and Owens, 1986, 1988; Mumford and Whitehouse, 1988; Pendall *et al.*, 1991; Soni-Raleigh, 1996).

Various reasons have been advanced to account for the incidence of self-harm amongst Asian young women. These include that self-harm represents a replication of

white Caucasian women's expressions of distress as communicated through the body, through the process of acculturation to Western cultures (Burke, 1976; Hodes, 1990; Merril and Owens, 1988). The increasing rates of suicide attempts and diagnoses of eating disorders in Asian communities in the UK were initially explained as being a result of difficulties experienced by migrants in making the cultural transition to living in Britain [see Littlewood's (1995) critique of this explanation]. However, different formulations of 'culture clash' have remained prevalent explanations as to why Asian young women may experience distress resulting in their self-harm (see, for example, Bhadrinath, 1990; Merrill and Owens, 1988).

This explanation of 'culture clash' is rooted in the socio-historical context of the post-war migration experience in the UK. It is utilized in situations where Asian communities in Britain have attempted to retain to a high degree their cultural traditions and values. From an assimilationist position this is taken as causative of stress and hence problematic (Brah, 1996; Littlewood, 1995). However, 'culture clash' is rarely defined with any precision, but is taken in general terms to relate to a disjuncture between the values of 'traditional Asian' culture with those of 'British'/'Western' culture (Babiker and Arnold, 1997). The 'clash' has been documented as occurring particularly around aspects of young people's lives pertinent to observing Asian cultural and religious customs and traditions, for example, where parental expectations are for arranged marriages but where those marriages have been unwanted by the young people concerned. For example, Biswas' (1990) analysis of case notes of 34 'White' and 38 'Asian' 13–17 year olds presenting with self-poisoning to an Accident and Emergency unit of a Bradford hospital concludes that cultural conflicts were a precipitating factor to self-harm for 36% Asian participants. She uses a definition of *cultural* conflict as 'conflict over traditional customs or racial prejudice which was seen by the patients as being at least part of the reason for self poisoning' (Biswas, 1990, p. 190).

But, the adoption of the notion of 'culture clash' as causative of distress leading to self-harm is open to criticism on methodological, conceptual and political grounds. Methodologically, research studies rarely examine the self-accounts of women who are self-harming but rely on the researcher's assessment of 'culture' as causative of self-harm. The coding of factors alleged to be culturally linked and leading to self-harm is most often conducted in retrospect and it is not possible to assess from the research reports the precision of the original notes nor to scrutinize how the researcher has moved from data set to research interpretations and conclusions.

Conceptually, the term 'culture' in 'culture clash' is limited in its explanatory potential in that it inevitably singularizes 'Asian' and 'British'/'Western' culture. In so doing cultural diversity in views, values and behaviours is masked and the possibility of cultural interaction and fusion is negated (Brah, 1996; Marshall *et al*., 1999). Alternatively, culture can be conceptualized as complex, relational and diverse: inclusive of 'a collection of customs and identifications that structure personal and community histories, as sometimes also structured by racism' (Burman *et al*., 1998, p. 233). From this perspective a cultural community and associated cultural views, values and expectations are not static but dynamic, experienced in diverse ways (Fernando, 1991).

For some of the reasons above, some researchers have been more cautious in their treatment of 'culture' in relation to self-harm. For example, Handy *et al*. (1991) have pointed out that 'discordance between peer group and parental views may be expected in both Asian and Caucasian families'. Hence their analysis utilizes the notion of

'culture clash' only where inter-generational conflicts revolved around particular issues of 'religious, moral or traditional expectations which differed from those expected by Caucasian families'. Similarly, in explaining the increasing incidence of suicide and self-harm in Asian young women some researchers have argued that there are specific aspects of Asian cultural traditions which place particularly high demands on young Asian women and men to perform well educationally and career wise (Soni-Raleigh and Balarajan, 1992). They attend to the intersection of gender with culture in arguing that Asian women experience greater pressures than men owing to the 'rigidly defined roles in Indian society' and through 'submission and deference to males and elders' (Soni-Raleigh and Balarajan, 1992, p. 367).

However, even when inter-cultural approaches to mental health specify particular aspects of 'Asian culture' thought to influence the manifestation of distress, a danger remains that ethnocentric notions of 'Asian' culture as rigid and repressive are reproduced. The issue here is not only the way in which culture is conceptualized but the frame through which different cultures are understood (Fenton and Sadiq-Sangster, 1996). If 'Asian culture' is set in relation to 'Western culture' (also an overgeneralized and contested concept) the former can show up negatively. For example, in particular 'the south Asian family' can be all too easily characterized as a context in which cultural values and expectations are enacted as restrictive, stifling of individuality and hence oppressive and pathogenic (Hutnik, 1991; Littlewood, 1995). Instead it has been suggested that 'Asian' families are but one site in which conflicting female expressions of autonomy may be manifest. As Littlewood states: 'we cannot, however, assume that because the family provides the obvious everyday locus for expressing ambiguities over female autonomy it should itself be regarded as pathogenic; the ambiguities over female autonomy may be less ''cultural than political'' in a wider sense, less about individual women challenging their family's values than about their economic experiences and action outside the family, including racism and tacitly restricted opportunity' (1995, p. 57).

As can be seen from the examples above, the explanations for self-harm and suicide invoked in relation to 'Asian' communities differ in focus from those most usually drawn on for the indigenous 'White' population. The latter make brief or no mention to Western or European cultural practices, values or expectations regarding causal factors involved in self-harm (but for exceptions see L. Johnstone, 1997; Malson and Ussher, 1996).

Our research project was located in Newham, east London, UK, where mental health and social care providers have expressed concern that Asian young women are experiencing high (and possibly increasing) levels of distress as expressed through self-harm. It has been suggested that Asian women do not find support services accessible at the stages when early intervention may prove effective and hence when they do make contact with (mental) health and therapeutic services it is at crisis points. A local study conducted at Newham General Hospital Accident and Emergency Department found that admission figures for Asian women who had self-harmed were over represented, and that their average age tended to be younger than for other ethnic groups (Howard, 1997). Clinicians note also that for various reasons not all cases for self-harm in the general population, and in Asian women in particular, may be reaching Accident and Emergency Departments.

The study reported here is part of a larger research project on young Asian women and self-harm, reported in full elsewhere (Newham Innercity Multifund and Newham

Asian Women's Project, 1998). A main aim of the research project was pragmatic: to develop and improve service provision for young Asian women who self-harm. In this endeavour, it was taken as crucial that the accounts from women known to be self-harming, the meanings, experiences and needs around self-harm should be made a starting point, rather than pre-existing (clinically/medically based) categories as in quantitative self-harm research (outlined above). In this sense our approach to the study, the analysis and our considerations for service development was informed by critiques of 'professionalized' research/treatments of self-harm. And in focusing especially on young Asian women's accounts, we were concerned to look at the ways in which cultural elements were implicated in their accounts, as leading to self-harm, influencing their access to, and/or their assessment of the appropriateness of support services. Here, our analysis was influenced by arguments about the limitations of notions of 'Asian' culture as homogenous, as pathogenic *per se*, and as inevitably involved in self-harm. We contextualized these accounts of self-harm in relation to existing service provision (especially for members of minority ethnic groups), with reference to the accounts of service providers working in the borough of Newham (see details later).

In practical terms, attempts to put into action suggestions for the development of services, were made through the dissemination of the final report throughout the UK to Commissioners and providers of Health, Social Services and Primary Care Services. Additionally, the research report has formed the basis for localized discussions of action initiatives. A second and related aim of this research study, was to consider these self-reports of self-harm in relation to 'professionalized' approaches to the conceptualization and understanding of 'self-harm' and 'Asian' culture, and their inter-relationship.

BACKGROUND TO THE STUDY

The borough of Newham, east London, UK, faces high levels of social and economic deprivation. The high levels of poverty, unemployment, homelessness, overcrowding, substandard housing and families on low incomes indicate this. Compared to other London boroughs, there is a large minority ethnic population. The official estimate from the 1991 Census states that 44% Newham's residents are from Black and minority ethnic communities, although it is thought that the actual percentage may be slightly higher. South Asian communities represent the largest sector of the minority ethnic population comprising in order of size, Indian, Pakistani and Bangladeshi communities. The Census data also indicates that a large proportion of minority ethnic communities in Newham are under the age of 44 (83%, compared with 61% White communities). It is estimated that by the year 2001 69% of all people aged 0–14 will be from minority ethnic communities, and in the 15–64 years age group the figure will be around 57% (Newham Council Social Services, 1996).

The interviews

Seven in-depth, semi-structured interviews were conducted with Asian women known to have self-harmed. In each case Anjum Yazdani acted as the interviewer who

Table 1. Details of participants with a history of self-harm: self-definitions of age, ethnicity, religion and marital status

	Age	Ethnicity	Religion	Marital status
Ayesha	18	Indian	Muslim	Single
Meena	20	Bengali	Muslim	Single
Salma	16	Pakistani	Muslim	Single
Rohima	15	Bengali	Muslim	Single
Fareeda	16	Pakistani	Muslim	Single
Sunita	21	Indian	Hindu	Divorced
Lubna	28	Indian	Muslim	Divorced

Table 2. Details of service providers showing job title and organization

Job title	Organisation
Consultant psychiatrist (adult mental health)	Newham Community Health Services NHS Trust
Senior social worker (working with clients under 18)	Child and Family Consultation Service
Consultant child psychiatrist (working with clients under 18)	Child and Family Consultation Service
Counsellor (working in Further Education 16–19 year olds)	Education Service
Counsellor	Voluntary Sector
Caseworker	Voluntary Sector (providing targeted service to Asian women)
GP	Newham Innercity Multifund
GP	Non-multifund

identified herself as working in conjunction with Newham Innercity Multi-Fund and Newham Asian Women's Project.

Participants were contacted through mental health and social care providers including clinical psychologists, counsellors, refuge caseworkers, youth workers, staff at the Newham Child and Family Consultation Service and staff in Further Education colleges. Each participant was given an information sheet outlining the nature and purpose of the research and required to sign a consent form once she had agreed to participate. Participants under the age of 16 were required to have parental consent in order to take part (Table 1).

Each woman was asked to talk about how she had come into contact with mental health/social care services and in so doing to account for her experiences of and ideas about self-harm. The interview questions directed specific attention at awareness and evaluations of various support services (statutory and voluntary) including those the women had accessed. Participants were invited to contact the researcher after the interviews if they wished to discuss further any of the issues raised in the interview.

In addition, eight interviews were conducted with service providers in the health, social services and voluntary sectors, some of whom work directly with Asian young women (Table 2). These interviews focused attention on the reported identification of

Asian women as a high risk group for suicide and self-harm. Interviewees were asked about the factors they considered might be associated with distress and their ideas about issues facing young Asian women seeking support and ways in which service provision might be developed.

Interviews were used in order to:

- Explore the meanings of self-harm as recounted by Asian women known to have a history of self-harm.
- Examine the narratives (past, present and future lives) so as to consider the broad circumstances within which participants locate self-harming behaviour including whether, when and how self-harm is linked specifically with aspects of Asian culture.
- Consider the implications of these accounts with respect to how health, counselling/psychotherapeutic and other services might be improved for Asian women.

In line with a now well established qualitative research tradition in psychology, the interviews in this study are not taken as eliciting 'the facts' about self-harm. Instead the accounts are viewed as particular, produced within the interview situation: in response to the questions posed, in relation to the interviewer and with a consideration of her agenda and purpose in asking about certain concerns but not others (Griffin and Phoenix, 1994; Malson and Ussher, 1996; Marshall *et al*., 1998). In these respects the interview is far from a neutral information collecting exercise. Instead, of issue here is the interviewer's professional background in her interaction with the interviewee—her identification and association with Newham community/medical/clinical organizations involved in a research project that is framed within clinical/academic concerns. These considerations are likely to be pertinent, in conjunction with the interviewer's cultural background, to whether or not she is perceived as an 'insider' belonging with south Asian communities living in the UK and similar to or different from the interviewee, and hence to what is 'sayable' within the interview setting (Song and Parker, 1995).

Analytic technique

In line with discursive analyses, our reading of the transcripts started from the assumption that self-harm and culture are constituted through language, rather than taking the language in the accounts as directly reflecting (like a mirror), their experiences of self-harm. We take the perspective that in 'making sense' of self-harm, our participants draw on already existing, socio-cultural accounts and narratives, to formulate, frame and construct their experiences (Wetherell, 1995).

The analysis proceeded by means of close and repeated readings of the interview transcripts, guided by the specific interests and aims of the research study. First, we directed attention at implicating meanings of self-harm, by taking out every instance of talk of self-harm from the transcripts, and gradually building up groupings or patterns in meanings, within and across the transcripts. Second, we examined ways in which culture figures in the narratives, whether in relation to distressful circumstances, self-harming behaviours, and/or 'pathways to care' for distress, giving particular consideration to instances where 'Asian' culture or ethnicity was specifically referenced. Our intention was not to generalize from these accounts to broad

formulations of Asian women's self-harm but instead to consider more specifically some implications for service provision and development, as guided by our aims and with a knowledge of existing services.

In our examination of whether, when and how construals of self-harm in the accounts are associated with aspects of 'Asian' culture we are working with possible relationships between two contested and somewhat 'slippery' conceptual categories, 'self-harm' (as discussed above) and 'Asian' culture. While we begin the study by using the pre-existing category 'Asian' (as in our participant descriptions above), we note this category as heterogeneous, inclusive of diverse religions, ethnicity, ages and marital status, as obvious from Table 2. But also, we approach the analysis of the accounts with a concern for variation in the meanings of self-harm and in ways in which 'Asian' culture or cultural elements figure (or do not figure), in relation to self-harm, as contextually located within the narratives.

ANALYSIS

The analysis is structured in three sections, which relate to the research concerns:

(i) An explication of four meanings of self-harm as related by those with a history of self-harm;
(ii) A consideration of ways in which aspects of 'Asian' culture are associated with self-harm in accounts and narratives of women engaged in self-harm and service providers;
(iii) Discussion of some implications of the construals of self-harm as associated with aspects of 'Asian culture', for the development of service provision for young Asian women.

The extracts in the analysis section are presented with the participant's (changed) name in italics, the interviewer's questions and interjections indicated by Int: and instances where part of the transcript is omitted as . . . .

Meanings of self-harm

Four meanings of self-harm are presented here: self-harm as (a) release from distress: a coping strategy, (b) ending it all, (c) effecting change, and (d) (taking) control.

Release from distress: a coping strategy

> *Meena*: I remember one time when I had an argument and I couldn't find anything else and I dug a screw driver into myself so badly that I made a dent into my elbow, I made a really bruising, bruising until it cut into my skin. It was really painful afterwards but it helped me to feel good.

In this first extract, self-harming, through cutting, although described as physically painful is associated with relief from emotional pain. In this respect, in the exercise of cutting the body is implicated as a vehicle through which emotional distress can be released. Ayesha and Fareeda locate their self-harm within situations of extreme degrees of emotional pain and distress sufficient to create an experience of 'going mad'. Located within such socio-emotional contexts self-harm is positively associated

with coping, an aid to 'calm down', and of avoiding a breakdown, hence, a way of coping so as to enable day-to-day survival.

Ayesha: I don't know, at that time it looked like I was just messing up inside. If I hadn't done anything [i.e. self-harm] I think I would have just blown up. It's like your head was so full of so much, you wanted something to calm you down and if I hadn't done anything, I would have just gone mad.

Int: What do you think would have been the worse thing that could have happened to you if you hadn't taken those pills?

Fareeda: I felt I was going mad. I felt you know, I felt very blocked up inside, I didn't feel normal I felt different from everyone else. I felt angry and confused and empty, very empty inside, so I felt I was going mad, very much. I thought I was going mad.

In the extracts above the physical/bodily pain experienced from cutting is contrasted with the positive consequent feelings of release. In this sense self-harming the body is rendered a way of channelling anger and emotional pain, hence facilitating a transition 'from emotional pain to physical'.

Meena: When I started cutting myself then it sort of, all my anger gets channelled into that cut and I look at the blood and I think it's a release ... from emotional pain to physical, and the physical's at least over and done with. The emotional is so hard to deal with.

This construal of self-harm is not culturally specific but resembles closely self-reports of self-harm of women from the majority White population (see, for example, Babiker and Arnold, 1997; Spandler, 1996) and as illustrated in the extract below:

> I'd go for a while then it [the pain] would build up again and eventually I would explode like a volcano, smashing everything in sight. Only when the blood poured out of me was I able to let go and cry, like the bad was coming out of me. (Woman B reported in Arnold, 1995, p. 15)

An account of cutting the body to enable a release from distress, a 'let[ting] go' (as marked by the presence of blood) is evident in the two extracts above. Unlike in psychiatric analyses where self-harm is construed as problematic in itself, here, self-harm is a means of dealing with distressful circumstances.

Ending it all. Attempted suicide is sometimes juxtaposed with self-harm in the accounts. Meena related her attempted suicide in relation to an abusive relationship with a boyfriend, but on whom she relied. She describes taking an overdose on an occasion where her boyfriend had 'disappeared', and hence within circumstances she characterizes as lonely, where 'nobody's there anymore'. Lubna narrates her suicide attempts in relation to people harming her, including her boyfriend, and again within situations of loneliness and isolation. In this sense, in the extracts later, attempted suicide is set in contexts of despair not dissimilar from the distressful circumstances in which self-harm is situated. Meena draws a contrast between cutting and taking an overdose, associating the latter with a clear statement of an intention of self-annihilation.

Int: So you took an overdose?

Meena: Yeah, because I basically thought, well nobody's there anymore, I haven't got anyone now and then I don't know. I mean I've done things like cut myself and things like that as well before but that like I really, really wanted to die.

Lubna: It was the time when I had left my boyfriend again and I felt very lonely, very isolated. I didn't know which way to go, I was very low in myself. Yeah, it's the situations that happened, that's why it leads to suicide, yeah, that it's an escape ... They pushed me down and down and down in the dumps, so when I got into my shell I just wanted to finish it all you know. Finish my life, I couldn't care about anybody but just myself.

The accounts above resonate with the clinical/academic distinction drawn between suicide attempt and self-harm as qualitatively different. Similar to the construal of self-harm as release, these construals of attempted suicide place a focus on the self, letting the body 'escape' from a desperate situation.

Effecting change. Within contexts where verbal communication is difficult, for example, regarding the disclosure of distress to other family members (see later), self-harm and, as narrated by Salma, cutting the body, acts as a form of expression, a message which serves to open up 'outside' support and help. This construal of self-harm differs from those above, as a form of communication with others rather than a self-focused coping strategy.

Meena: But at least doing that [self-harm], I've got some counselling, at least I've got somewhere I can come and talk, unload a little bit. But unless—if I hadn't done that, I don't think I would even had had that and I would have lost all channels of contact with everyone outside.

Salma: We were in drama ... I took my top off ... and she [the teacher] saw these cuts on my arms and that and she sort of started talking to me about it and then she said, 'Oh well I think you should see someone' ... I just sort of went, 'Okay then, I'll give it a shot' and that's how it started.

Constructed in this way as a 'trigger' for the involvement of external forms of support such as referral to specialist mental health, counselling or psychotherapeutic services, self-harm shows up positively as an effective means of communication. This construal of self-harm is substantially more than 'attention seeking behaviour', as described in some clinical research (along with advice that such behaviour should be ignored). A dismissive construal of self-harm as 'simply' a childish call for attention likely contributes to distress, rather than its alleviation and also, undermines understandings of self-harm as entangled with issues of control.

(Taking) control. Accounts of self-harm are located in circumstances where participants report a lack of control. Viewed within such circumstances cutting, not eating and/or overdosing are associated with taking control. In this sense the body is rendered a last site where a degree of self-determination can be exercised.

Meena: While I was cutting I felt more in control, whereas before I'd cut I sort of felt like 'Oh God', there's nothing I can control.

Salma: So it was sort of like taking control of yourself. Like you think OK, if everyone else can hurt me, then at least I can hurt myself more than they can.

Control is multi-faceted, and registers also in terms of engaging in behaviours which others cannot control, for example, as in Salma's narrative of making decisions about (not) eating and (not) accepting a general practitioner's (GP's) anti-depressant prescriptions as matters for her rather than her GP to decide. Hence, she construes self-harming as a means of establishing her control over and ownership of her body.

Salma narrates being in control regarding the degree, frequency and extent of cutting. However, contradictions are manifest in the consideration of limits to the notion of self-harming as taking self-control 'well you can't really control how often sometimes' and 'that's the one thing I had control over, but I knew I didn't really ... I had no control over it'.

> *Salma*: It's like, well it's my body and it's like, if I'm not going to put food into it then I'm hardly going to put these pills [prescribed anti-depressants] in it am I? It's a control thing again. It's this whole thing's about you have to have control of what you put in your body if nothing else ... when you cut yourself you can control that because you can decide how deep, how much, how many, how often, well you can't really control how often sometimes.
>
> *Ayesha*: It was a way of me having a little control, because that's what it is that I need a lot of control to me, as a person, I have to be in control ... now this taking the pills it was like that's the one thing I had control over, but I knew I didn't really because if I saw the pills I'd be drawn to them. I had no control over it.

We do not claim to have exhausted all potential meanings of self-harm but have presented four meanings to illustrate ways in which the self-harm is not construed as problematic in itself, but shows up in the accounts as positively associated with taking control and managing or escaping from distress. In this respect these accounts of Asian women closely resemble those reported in other research studies based on the meanings of self-harm from the perspective of those self-harming (Babiker and Arnold, 1997; Arnold, 1995; Spandler, 1996). This offers support for the importance of exploring commonalities in the accounts of the meanings of self-harm across cultural communities rather than starting with the expectation of cultural differences.

It is important to note also, that in the extracts presented above, Ayesha's narrative includes incidents of cutting and taking pills, Salma's includes cutting and not eating, and Meena's cutting and overdosing. In this respect their accounts raise questions regarding the usefulness of the 'professionalized' preoccupation with categorizing different forms of self-harm. Also, the accounts illustrate participants' deployment of more than one meaning of self-harm in the course of their interviews. For example, we have presented extracts from Meena's interview to illustrate her use of four different construals of self-harm. We take this as illustrative of the complexity of self-harm (sometimes helping Meena to cope, to communicate her distress to others, to end it all and/or to take control) as built into her narrative of various experiences within particular circumstances in her past and present life, in relation to (boy)friends and family, which we explore further in the second section of the analysis.

Locating culture in the accounts of self-harm

Researchers have argued that self-harm can be interpreted as instrumental, a bodily communication of distress which cannot be understood outside the cultural communities of its existence (Hodes, 1990). In our study, participants locate self-harm within narratives of long histories of abuse which include sexual abuse and rape from a young age, in many cases with the abuser a member of the family. Alternatively/additionally emotional and/or physical abuse from boyfriends is reported within these histories as pre-cursors to self-harm. In this respect these narratives are not specific to Asian women and show many resemblances with the self-accounts of White Caucasian and Afro-Caribbean young women (Arnold, 1995;

Walsh and Rosen, 1988). The details of the abuse will not be discussed further here. Instead we shall move to look at ways in which participants associate elements of Asian culture with self-harm, in accounting for distressful circumstances, the maintenance of distress and/or obstructing its alleviation. In order to consider practical and achievable recommendations for developments in mental health and social service provision for Asian young women this section will include extracts from service providers' accounts.

The articulation of self-harm with Asian culture is manifest in varying ways in the narratives. Sometimes this is by reference to a generalized notion of 'Asian culture', but more usually particular pressures emanating from cultural expectations and values, many of which centre around the family, are construed as problematic in a manner anticipated by other researchers (Littlewood, 1995). The individual as positioned as a family member within the context of the family's standing within the cultural community is central to these accounts. These considerations set the frame for the contruals of (un)acceptable relations within the family, between the family and 'outsiders', between family members and their cultural community and within the broader socio-cultural/political context of the UK. The inter-section of gender with culture figures as significant within these various relationships. More specifically the body signifies in the accounts as a site of cultural contestation over ownership and control; the body as belonging within a family/community or the body as individually 'owned'. This dispute shows up in terms of prescriptions for keeping matters within the family/seeking help from 'outsiders', the manifestation and treatment of physical and/or mental health problems.

The narratives link traditional 'Asian' familial expectations with particular stresses such as gendered and cultural expectations for Asian young women to get married by a certain age which are explained by means of reference to pressures exerted on the family from the broader community. In this respect *izzat* and *sharam*, honour and shame, are made central to the construal that failure to fulfil gendered familial expectations is not simply an issue for the individual or their family but related more widely to the family's standing within the community.

> *Meena*: My mother's thing is, 'So long as you've got a man there for supporting you' and my father's, 'I try to shut the community up and the community won't shut up until you get married because you're 20 now and you're not married, and at the time it was only 19, what about when you're 20 and still not married'. ... The family problems are still ongoing at the moment, they're probably one of my big stresses at the moment, but they believe that the answer to everything is just get married, everything will be fine, you're an Asian girl, just get married ... They basically disowned me until I got married and then things did get better with them for a while, but at the moment they've done the same again.

Concern for the family's reputation within the broader community is implicated in narratives of the origin and maintenance of distress and of difficulties in disclosing distress within the family, especially with regard to abuse. The negative consequences of an inability to discuss abusive situations are reported as exacerbating feelings of depression.

> *Int*: So you didn't tell you parents that you were being abused?
>
> *Fareeda*: No, I told my Mum, my Mum knew about it but she said to, she said just forget about it you know, like it didn't happen and all that ... Asian families

> they just don't want to really get it out, it's not a good thing, reputation and stuff. It was something that was really getting me down, like there was no one there for me and maybe it was my fault and I was very depressed and just felt like life wasn't worth living.

Fareeda deploys a generalized characterization of 'Asian families' as denying the existence of abuse because of negative consequences for the family's reputation, to argue difficulties in disclosing abuse. In turn, a consequence of maintaining a silence around abuse is reported as being to further feelings of isolation and alienation. Fareeda positions 'White people' and Asian young women as perpetuating a construal of the non-existence of abuse within Asian communities.

> *Fareeda*: The way I think is that Asian girls, the way they've been is that, White pepole think that you know, that Asian girls don't get abused full stop. It only happens to White people, and Asian girls, they feel that as well and they feel, you know, we can't talk to no-one about it because Asian girls just don't get abused. It doesn't happen, you know they're too religious and stuff. It doesn't happen to them, but I think you know, people don't realise it does and it's not just White people that it happens to. And Asian girls feel that they can't say that because you know, they'll feel alienated that they've been abused.

The association of abuse with self-harm has been widely noted (Arnold, 1995; Babiker and Arnold, 1997; van der Kolk *et al.*, 1991). Particular to these accounts is the additional difficulties posed for those attempting to voice abuse when those around them, refuse to acknowledge abuse. In the extract above, Fareeda's rendering of Asian communities as 'problem free' raises issues relating to the access of help and support. In the extract below, parents are positioned as upholding values, which prescribe 'sharing' problems outside the family as inappropriate and designate 'outside help' as unacceptable. This constitutes a barrier to the seeking of help from counselling/psychotherapeutic services.

> *Rohima*: My parents, they think if I'm going through any kind of problem I should talk to my sisters and my brothers. I shouldn't talk to anyone in between the family and everything to my friends. I shouldn't go and share my problems with other people like.
>
> *Int*: Like outsiders?
>
> *Rohima*: Yeah, like counsellors and everything like that ... My parents just, they don't exactly approve of counsellors and things like that.

The designation of counsellors as 'outsiders' renders them out-of-bounds as a source of support. The difficulties in seeking help within a 'closed' cultural community is compounded by a concern for the stigma attached to a problem construed as a *mental* health problem. In this respect the usefulness of seeking help from a GP is rendered limited. In part the parameters drawn on appropriate sources of help and support are justified by means of a distinction drawn between a GP's concern with physical but not emotional/mental health problems. Below, Fareeda characterizes her GP as concerned with the physical body in terms of 'hormones', and in her treatment of her eating behaviour by means of vitamin pills. In this respect bodily manifestations of self-harm and their medical treatment are the focus. This sets a contrast with the Interviewer's questions which direct attention to the distressing circumstances within which self-harm occurs and Fareeda's repeated rejection 'of the idea that she might discuss her distress or 'the emotional side of the situation' with her GP. A

individual-physical/socio-emotional dichotomy is implicated here in Fareeda's report of a GP's lack of concern for locating self-harm within socio-emotional circumstances which renders her potential support and help limited.

Int: Okay so, what about say your GP, your doctor, would you have felt at the time [when self-harming] that you could have gone to the GP and explained the situation, said that you were feeling upset or, you know, distressed?

Fareeda: I don't think so because my doctor seems to think that everything's caused by hormones ... It's like 'Oh girls'.

Int: So, is your doctor aware of the fact that you have experienced or were experiencing difficulties at home?

Fareeda: No, I mean they know about my eating, because I've been on vitamin tablets and stuff now.

Int: Oh I see.

Fareeda: But I don't really take them.

Int: So you're doctor's been informed?

Fareeda: Yeah, of that. And I'm due back this month anyway because I have to go for monthly checkups now ... But I mean I don't talk to my doctor about it or anything you know. She just does the medical/physical side of it to make sure I don't drop dead or something.

Int: Yeah, I see, so she hasn't talked to you at all about any of the emotional side of the situation?

Fareeda: No, not really. She's only ever talked about sort of, they don't want to put me on anti-depressants or anything because I'm only 16 and they don't want me hooked young or anything.

Int: Oh I see.

Fareeda: Otherwise they would be considering it, and it's not a good idea because of my age and I don't really, I don't like the idea of people trying to make me take pills anyway, because I don't even take the vitamins they give me or anything ... They seem to think, 'Oh yeah, you know, she might have problems but we can control it, we can sort of give her this and make it all better and forget about it', and it's like, well it's my body.

In the extract above, simultaneous with the distinction made between the physical/medical and emotional/psychological body is the construal of self-harm as associated with control. Here, in drawing on a meaning of self-harm as taking control and establishing ownership of the body, the GP's efforts to provide medical treatment are read as an attempt to take away control, and which are resisted and rendered irrelevant and unhelpful. Help offered by professionals including GPs is rendered problematic in other respects when that professional is located within cultural community. In this respect the demarcation drawn between those 'in' and 'outside' the cultural community shows up in this narrative of accessibility of sources of help and support. Professionals living and working within the Asian community who share a similar cultural background and values as their patients are taken as being 'insiders', whose potential for offering help or support is limited.

Meena: Even after my suicide [attempt], you know I experienced quite a few professionals even after, whose approach of it all is just go back to your family. I even had one tell me to get married. I was supposed to go back for a second

> appointment and I didn't. He was an Asian male, I don't know whether he was Indian or Bengali. I didn't even want to see him [psychiatrist] again because I knew what he was going to say and there's no point. Because he's like my father and he understands what my father's doing and he understands [it's for] the right reasons.

Construed as an insider likely to take up a position and values similar to a father, by reiterating the centrality of family and advocating marriage (factors that Meena associates with distress, see above), the advice and support of a professional (GP, or psychiatrist) is negatively evaluated, as pointless. But also, seeking help from a family Asian GP is taken as being 'unsafe' in terms of fear of broken confidentiality. In this respect there is contestation evident in the demarcation of bodily boundaries between the individual's body/health as a private matter—an issue of self—and the individual (body) as part of a family within which matters should be shared—the social/shared body. The professional ethics of GPs as a matter for debate regarding 'sharing' health/bodily information about their patients with other family members is illustrated below.

Counsellor working in further education with 16–19 year olds:

> When I've offered to refer people to Asian projects or services, sometimes they've said, 'I don't want to see an Asian person'. I think it's because of fear of connection to the community or family and I'll tell you one thing that comes up time and time again, is doctors have told the family of abortions or contraception.

The extracts above, can be read to suggest that a construal of the body as 'owned' by an individual is simplistic and limited. There are parallels here with critical debates on the self regarding the particularized and ethnocentric construal of the self as self-contained in contrast with the self as embedded or inter-dependent (Markus and Kitayama, 1991; Sampson, 1993; Shotter, 1989). A young Asian women who self-harms, or, as above, has an abortion or uses contraception can be construed from a 'self-contained self/body' perspective as matters for her as an individual. In contrast, where the self/body is taken as embedded within family/community these same acts can show up as cultural/moral concerns, as shameful in terms of having been withheld from the family and as a violation of cultural/religious based prescriptions. These contestations over the boundaries and ownership of body (as a matter for and belonging to the individual or the family within the broader community) can show up as central to concerns regarding (mental) health support and care.

As we have illustrated above, there are various ways in which the accounts suggest the ready availability of a discourse of Asian culture as pathogenic and implicated in self-harm. In this sense this discourse can be taken as 'ready at hand' for women to use in accounting for self-harm. However, although the prevalence of the discourse is noted, there is evidence of diversity with regards to the extent to which it is accepted as feasible and adequate in accounting for self-harm. In some accounts contestation and rejection of the discourse are manifest.

Salma: One thing that sort of annoys me, it's like everyone makes it into this issue, 'Oh it might be because you're Asian but you're growing up in a British society'.

Int: Is this when they talk about culture clash?

Salma: Yeah, and I think obviously there's going to be a bit of a culture clash with your parents but I mean that might just be put down to the age difference

> between your parents ... because I mean if I was White and my parents were White and my mum beat me up, would that make any difference? ... But I mean with me, it's just, it's not because my parents don't want me to mix with White people. Because I have lots of mates who are White and stuff like that, I mean they don't want me to like you know, change my religion or like you know, do anything that's against our religion obviously. But I mean you could say that for a Catholic who's really religious. So I don't think that's the problem, because I mean it does come up and it does cause problems, but I mean I could deal with it if it was just that, it would't affect me as much, but it's just the fact that they treat me like crap most of the time that is the problem.

In the extract above the prevalence of the use of an explanation of 'culture clash' as associated with self-harm is stated yet contested. Reference is made to inter-generational conflict as associated with 'Asian' culture, but resisted and a more generalised link with age presented alternatively. Salma disassociates herself from construals of cultural expectations as restrictive by stating her ability to 'mix' with White people and by refusing a characterization of her parents as making cultural/religious demands. She resists the idea that the unacceptability 'doing anything that's against our religion' is particular to Asian cultural/religious prescriptions by means of drawing a parallel with other religious communities 'you could say that for a Catholic who's really religious'. In these respects the notion of inter-generational culture conflict as prevalent in the research literature is manifest in these accounts, although, as above, sometimes thoroughly disputed. In this respect diversity in the meaningfulness of 'Asian' culture as implicated in self-harm, is evident in the accounts.

The prevalence of use of 'culture as pathogenic' in relation to minority ethnic communities is perhaps unsurprising as historically, in the UK, its circulation is widespread in accounting for a range of 'problems' within a (mental) health arena as documented in relation to academic clinical and social science, medical/clinical literature, research and practice (as reported above) and as extant in service providers' accounts (Marshall, 1992). Indeed, in this study construals of 'culture clash' and 'Asian' culture as pathogenic, is evident in service providers' accounts of self-harm (although we have not devoted space to this in the analysis). In this respect these interviews served as a forum for the reproduction of over simplified notions of culture. Simultaneously in the service providers' interviews there is a sometimes notable absence of consideration of issues around sexual abuse and domestic violence in association with self-harm as young women themselves articulate. The emphasis on culture to the detriment of other accounts is problematic and a potential hindrance to the provision of effective care and support.

Implications for service provision

In this third section we focus primarily on developments in service provision for *Asian* young women's self-harm. We work from suggestions extant in the accounts, in addition to *our* analysis of the accounts and consideration of their consequences and implications.

Where the communication of distress within the family is construed as difficult or impossible the need for 'outside' support becomes an issue. A case can be made for the development of easily accessible services where confidentiality is assured, as initial points of contact and sources of support such as telephone help lines. The prevalence

of first contact with Accident and Emergency Departments in the narratives of pathways to care and the frequent reports of not knowing about voluntary sector organizations suggests the need for better publication of sources of support in order to decrease the incidence of self-harm leading to crisis situations. Publicity material which provides details of local services (both statutory and non-statutory) and means of access, could be made available in GP practices, community centres and schools/Further Education colleges.

Where a stigma is associated with mental health problems there are implications for appropriate sites for outreach work regarding preventative issues in mental health and for the provision of support. The accounts suggest the usefulness of educational contexts for initiatives such as drama and role-playing, in addition to more specific courses/workshops around self-assertiveness, conflict management and negotiation skills. Initiatives such as these afford the exploration of abuse/distress/self-harm which in turn can open up possibilities for alternative ways of managing distress and seeking help.

Schools/colleges are construed in the accounts as safe places to discuss distress, self-harm and mental health issues more generally, as well as for accessing counselling support. As illustrated above, making contact with counselling support constitutes a turning point in some of the narratives of self-harm. Increasing counselling support to make it available during school/college holidays is an additional suggestion extant in the accounts.

> *Lubna*: There should be more counselling, actually I believe that youngsters, Asian girls they do need counselling at school time, because school time is the worst time they are passing through because that is their teenages, they can't talk about any single thing, even about their sexual relationships, they can't talk to their family.

Narratives of initial support from teachers and counsellors can be interpreted as endorsing arguments for the advantages of developing counselling services within schools/colleges. The construal of a school/college context as 'safe', because those seeking help are not immediately visible is reiterated in service providers' accounts.

> *Counsellor at Sixth Form College*:
>
> I bet I see more Asian young women than a lot of people in Newham because ... because I'm in a place where they can come and see me without anybody knowing that they've seen me, because they're already at college, their time is accounted for and if they slip away from a lesson to see me, even if there's members of the family in the college that they need to avoid, they can do that. And when I've asked, you know, young Asian women about going to other places or tried to refer them somewhere else, they will say, 'Oh no, I won't go there because it's too visible you know, it's like, Stratford, so I could easily be seen'.

For those no longer within the education system the availability of alternative sources of support is of issue. We have presented some of the varied construals of the usefulness of GPs and psychiatrists above. The reported worries about GPs breaking confidentiality and 'telling' the patient's family suggests the need for information on patient rights to be available in primary care surgeries, including information on how to register at GP practice other than where the family is registered, to alleviate possible anxieties around the disclosure of emotional/mental health problems. The construal of GPs as concerned only with the physical body, suggests the need for

information about the role of the GP including as enabling access to further support for emotional/mental health needs (which may be via counsellors and psychologists attached to the primary care surgeries/centres).

The particular concerns regarding situations where a service provider is an 'insider', sharing cultural community with their patient/client, are raised also in regard to cultural preferences within counselling/psychotherapeutic settings. The assumption that young Asian women will always want to receive services from a professional of the same cultural background and that cultural 'matching' equates with culturally sensitive care is challenged by the diversity in these accounts. In the extract below, the usefulness of sharing a cultural background with a service provider is negotiated with reference to their particular views and values. In formulating a preference for 'someone White' consideration is given to gender, the individual's views and values as well as culture.

> *Meena*: I think I would have preferred to see somebody White, but I don't know as long as whoever I did, if I did see someone Asian, then it had to be somebody who looked at it with an open mind. I didn't want another, 'Oh, you're like my daughter', and 'Go home, your family knows best' sort of thing.

Meena renders a service provider's cultural background as less significant than their having 'an open mind'. In this respect her account can be read as offering support for the importance of avoiding homogenizing conceptualizations of culture within service provision. The uniform advocation of cultural matching as enabling an 'understanding' between client and practitioner, and as always equating with culturally sensitive care is over simplistic. Instead it can be suggested that, where possible, clients should be offered a choice as to the cultural/gender background of the counsellor/psychotherapist. Finally, we argue for the importance of service providers attending closely to their client's agenda and her specific needs, to guide the care that is offered.

DISCUSSION

We have utilized these accounts to argue for the need to engage with diverse meanings of self-harm as articulated with 'Asian culture'. We have suggested that in the act of self-harming the body signifies as a site for the taking of control, and of resisting control by others; as a strategy for coping and in the translation of emotional into physical pain, enabling relief from distress; and as a means of communicating distress to facilitate support and 'outside' help. In explicating this diversity, we have argued for the importance of considering meanings of self-harm in relation to those extant in the accounts of women across cultural communities. In this respect our conclusions echo those of other researchers, 'it is ... important to recognise differences and commonalities between people who are socially constructed as belonging to the same group as well as across groups' (Phoenix, 1994).

In our explication of four meanings of self-harm it is pertinent to note that the women in this study constituted a particular population who had experienced 'crisis' situations resulting in their contact with clinical/mental health services. Our participant population did not include women who engage in cutting, particular patterns of eating and/or drug using whose behaviours would likely be diagnosed as

self-harming from a clinical perspective yet who do not request help or support. Consequently, these accounts are not inclusive of construals of 'self-harm' as 'unproblematic', nor of meanings less likely to have been professionalized and medicalized through clinical and psychiatric discourses. Also, this research study, set within the remit of Newham Innercity Multifund, with its agenda of developing service provision is open to the accusation of reproducing a notion that self-harm is of issue for only a small pathological sector of the population. We have played no part in interrogating meanings of self-harm to consider ways in which behaviours such as heavy drinking, smoking, exercising and/or overworking might equally well be labelled 'self-harming', yet are usually left outside the parameters of the definition. If we had made this our focus the communities of concern would likely shift to include professional bodies—academics, medics, psychiatrists and clinical psychologists—those currently disciplining self-harm and whose definitions, 'knowledge' and interventions we have questioned in this paper.

As a related concern, the agenda of the interviews called for participants to produce narratives which located meanings of self-harm over time and within different circumstances, including those leading to self-harm and those opening up pathways to care and support. It is perhaps unsurprising given this research focus on problematic concerns—self-harm, distress and obstacles to accessing care and support—that 'Asian' culture is most often negatively implicated in the narratives. Positive construals of living within 'close knit' and involved families and communities are less evident. The centrality accorded experiences (and silencing) of physical, emotional and sexual abuse in adolescence and/or adulthood as creating distress in these narratives contrasts with the noticeable silence/marginalization of consideration of abuse in service providers' accounts. Nevertheless, the latter accounts suggest their ready use of explanations that centre around 'Asian' culture as pathogenic. We interpret this discrepancy to highlight the need for caution in not privileging cultural explanations and attending to the various factors that may play a part in accounting for Asian women's self-harm.

The juxtaposition of Asian women's accounts of self-harm with those of service providers makes manifest other contrasts. Asian young women's accounts engage in diverse ways with 'culture clash' explanations of self-harm and deploy, endorse and reject notions of Asian culture as pathogenic. In comparison, a neglect of conceptualizations of minority cultures as complex and as experienced in diverse and potentially contradictory ways by those living within them, is noticeable in service providers' accounts. We interpret these contrasts in construals of culture between the two sets of accounts as suggesting a need for further training initiatives around culturally sensitive care which make clear that there is no fixed cultural template to be applied when working with Asian clients/patients requiring support for distress/self-harm. These could usefully build in discussion of ways of engaging with the multiple meanings of self-harm and which explore ways of integrating notions of culture as complex and relational into practice. We suggest that the diversity of these accounts reiterates the importance of service providers working from their clients' perspectives and needs rather than their own assumptions regarding the place of culture in accounting, supporting and caring for Asian women engaging in self-harm.

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