

**Experiences of Self-Injury
in Lesbian and Bisexual Women**

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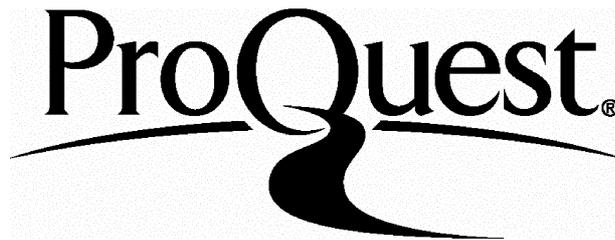
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ABSTRACT

Aims

The term 'self-injury' refers to a specific type of self-harm that involves deliberately inflicting pain or injury to one's own body; i.e. it is intentional, done to oneself, by oneself, and without suicidal intent (Babiker and Arnold, 1997). Drawing on evidence indicating a relatively high prevalence of suicide attempts and self-destructive behaviours such as alcohol abuse among lesbians, bisexuals and gay men, and a relative lack of research focusing on self-injury in this context, the current study aimed to utilise the perceptions of lesbian and bisexual women who had self-injured to explore the functions served by self-injury in this context, and the relationship between self-injury and sexual identity.

Method

Sixteen women who identified as lesbian or bisexual and who had deliberately self-injured on more than one occasion, were interviewed using a semi-structured interview format, for between an hour and an hour and a half about their perceptions of their experiences of self-injury. Participants were asked about the context in which they had started self-injuring, how their self-injury had developed since this time, and the types of situations that triggered their self-injury. They also spoke about their lives as lesbian or bisexual women, the process by which they had come to identify in this way, and their thoughts about the role that self-injury played in this context. The interview transcripts were analysed using a qualitative method: Interpretative Phenomenological Analysis (IPA).

Findings

The analysis resulted in the generation of twenty-eight themes which fell into six higher-order categories relating to the process of self-injury in the context of having a lesbian or bisexual identity.

Conclusions

The study concluded that for the participants, the process of acknowledging their sexual orientation to themselves and others was an added extra source of anxiety or worry on top of existing stressful or distressing experiences. Although self-injury may originate in earlier experiences, the process of identifying as lesbian or bisexual within a heterosexist and homophobic society can be yet another source of stress that contributes to self-injurious behaviour.

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CHAPTER 1: INTRODUCTION

Overview

The research to be presented here is a qualitative analysis of the experiences of self-injury in lesbian and bisexual women. The self-reported perceptions of participants derived from individual interviews were utilised as a way of exploring self-injury within the context of sexual identity. Drawing on evidence indicating a relatively high prevalence of suicide attempts and self-destructive behaviours such as alcohol abuse among lesbians, bisexuals and gay men, the research had two main aims: firstly, to identify some of the functions of deliberate self-injury in women who are lesbian or bisexual; and secondly, to explore the motivations and origins of self-injury within this context. This thesis will consider self-injury within the context of a framework which draws on social constructionist and feminist perspectives, highlighting the collaboration of social and individual factors in the origins and function of self-injury.

The basic tenet of a feminist approach is the placing of a high value on women, considering them to be worthy of study in their own right, not just in comparison with men; and a belief that there is a need for social change on the behalf of women (Wilkinson, 1996). As such, although many of the experiences to be discussed in this study may also apply to gay and bisexual men, the focus is the experience of lesbian and bisexual women.

The term 'feminism' encompasses a plurality of different theories that can broadly be classified as being modernist or postmodernist. According to Zalewski (2000), postmodernist feminism grew out of a critique of modernist feminism, and, as the name suggests, postmodern and poststructural thought (referred to as social constructionism in psychology). From this perspective, traditional notions of truth and reality are rejected, and there is a particular interest in gender and women. Feminist constructionism is not concerned with exploring gender differences, nor is it concerned with redefining the expectations and representations of women. As Zalewski (2000) remarks:

for modernists there is an ultimate core to the self or the subject which inspires modernist feminists to 'tell it like it is' about woman, in other words to say what woman is and should be. Postmodern feminists, on the other hand, claim that there is no vital core and thus prefer to ask 'How do women become or get said?'" (p.24).

This chapter will present background information beginning with the wider context of self-harm, and will review what is known about self-harm and self-destructive behaviours in lesbian women, gay males and bisexuals. It will then focus specifically on self-injury among lesbian and bisexual women.

What is self-injury?

Self-injury has been given various different names, including, among others, 'self-harm' (Smith, Cox and Saradjian, 1998), 'self-mutilation', (Favazza, 1996, Babiker and Arnold (1997), and 'self-inflicted violence' (Alderman, 1997). It should be noted that the terms 'self-mutilation' and 'self-inflicted violence' do not usually refer to non-fatal overdoses or the ingestion of poisonous substances. In this section, I will define self-injury, then go on to provide information about the prevalence of self-injury. People who self-injure tend to use the term 'self-harm' to describe their behaviour; however, in the clinical literature, this term is also used to describe suicide attempts. Throughout this thesis, the term 'self-harm' will be used to refer to a wide range of behaviours such as suicide and parasuicide; the term 'self destructive behaviours' will be used to refer to eating disorders, sexual risk taking, alcohol abuse, and drug abuse. The term 'self-injury' will be used to refer to a specific type of self-harm that involves deliberately inflicting pain or injury to one's own body; that is, *it is intentional, done to oneself, by oneself, and without suicidal intent* (Babiker and Arnold, 1997). This includes behaviours such as cutting, hitting or bruising, skin picking, scraping, the insertion of sharp objects under the skin or into body orifices, swallowing harmful substances or sharp objects. It does not include deliberate alterations of appearance as a form of body enhancement and is distinct from factitious disorders and marginal or indirect self-injurious behaviours such as reckless driving or fighting.

Why is self-injury an important issue?

Research and anecdotal evidence suggests that self-injury continues to be particularly problematic in the context of treatment by staff in Accident and Emergency (A&E) departments at hospitals. Staff in these settings, like General Practitioners (GPs), are likely to be amongst the first professionals an individual may approach in relation to self-injury. Arnold (1995) found that although some of the women who presented at A&E departments had a positive experience, many felt that they were responded to in a harsh or even punitive way. This included criticism and verbal abuse, as well as receiving inadequate treatment such as having wounds sutured without the application of a local anaesthetic.

Staff may perceive people who repeatedly present for treatment for self-injury as 'time wasters' or 'attention seekers' and may not be able to adequately meet their needs. Babiker and Arnold (1997) suggest various reasons for this, reporting that many staff feel that A&E departments are inappropriate for 'psychiatric emergencies', due to a lack of adequate crisis support, resources and staff training to deal with people in emotional distress. In addition, staff in A&E departments have little background information about patients who present themselves, as well as limited time in which to build up a relationship and adequately meet the needs of people in emotional distress. These factors highlight the general disparity between the nature of A&E departments, their perceived role and the complex motivations and needs of people who self-injure.

Clinical and anecdotal evidence suggests that there continues to be a lot of fear surrounding the issue of self-injury amongst lay people and professionals alike, and to some extent, self-injury remains a taboo subject for many (Favazza, 1996). One of the reasons proposed that people who self-injure may not tell others, is because of a fear of people's reactions, especially the reactions of professionals. The taboo of self-injury and dissatisfaction with psychiatric approaches and services has only partially been addressed by an increase in the range of resources available to people who self-injure. Many of these are services provided by people who have experienced self-injury themselves, such as self-help groups. This indicates that further research is needed to explore the motivations and functions of self-injury, working towards informing and educating professionals and services so that the needs of people who self-injure can be met more appropriately.

How many people self-injure?

There is little epidemiological information on the incidence and prevalence of self-injury in the general population. Difficulties ascertaining the prevalence of self-injurious behaviours are due in part to varying definitions of self-injury, with some studies of self-injury being over-inclusive, failing to differentiate between suicidal acts and self-mutilation, or including a wide range of self-destructive behaviours (Suyemoto, 1998); while others are under-inclusive, focusing on a specific form of self-injury such as wrist-cutting (e.g. Weissman, 1975).

It is likely that some cases of self-injury are misclassified as suicide attempts. As Levenkron (1998) suggests, it may be difficult to distinguish between actual suicides

and accidental deaths from self-injury. In addition, as much self-injurious behaviour is carried out in secrecy, it is difficult to gain an accurate picture of the actual number of people who have self-injured in the general population.

Favazza and Conterio (1988) estimate the prevalence of self-mutilation in the general population to be 750 per 100,000. Other studies vary widely, with a review by Favazza and Rosenthal (1993, cited in Favazza, 1996), reporting estimates of prevalence ranging from 400 to 1400 per 100,000 population per year. It should be noted that the majority of statistics regarding the prevalence of self-injury are based on American and British studies, and it is likely that there are variations in prevalence rates across different cultures.

Although there is a relative lack of published research looking at the prevalence of self-injury among lesbians and gay men, drawing on the current literature relating to the prevalence of a wider range of self-harm and self-destructive behaviours among this group, as well as anecdotal clinical experience of those working in this area, it has become clear in recent years that rates of self-harm are disproportionately high amongst lesbians, gay men, and bisexuals (Davies and Neal, 1996; Babiker and Arnold 1997). In this section, I will discuss the prevalence of self-harm and self-destructive behaviour among lesbians, bisexuals and gay men. I will then go on to discuss what is known about the prevalence of self-injury among lesbian and bisexual women.

Self-harm behaviours among lesbians, bisexuals and gay men

Studies of suicide rates among lesbians, bisexuals and gay men

Early studies of suicide and sexual orientation suggested that there were higher rates of suicide among lesbians and gay men than among heterosexuals, and that in particular, suicide was thought to be more prevalent among lesbian women than among gay men. Bell and Weinberg (1978) found that 38% of gay males and 42% of lesbian women had attempted suicide, compared with 5% of heterosexual males and 26% of heterosexual females (cited in Davies and Neal, 1996).

In recent decades, there has been an increase in the incidence of young men committing suicide, resulting in tendency for research studies to explore male suicide. There have also been a consistent denial of, or failure to acknowledge the higher levels of suicidal ideation and attempts by lesbian, bisexual and gay youth compared with heterosexual youth, by some mainstream suicidologists. For example, a book by Williams (1997) *Cry of pain: Understanding suicide and self-harm* claims to explore “the whole issue of suicide and attempted suicide in the light of the latest research findings”, yet only has one paragraph on homosexuality.

Much of the research on suicide among lesbian, bisexual and gay men has originated in the USA. Hammelman (1993) found that of 48 gay and lesbian ‘youth’ aged 15-32 years, nearly half of the sample reported seriously considering suicide, and a third had actually attempted suicide. Nearly 75% of this population cited their sexual orientation as some or most of the reason for their suicide consideration, with the majority reporting that they had attempted suicide before the age of 17 years. In 1989,

a report from the US Department of Health and Human Services suggested that gay youth were 2-3 times more likely to complete suicide than other young people (Harry, 1989, cited in Williams, 1997). Williams however, chose to cite research which indicates that sexual orientation is not a major contributing factor in suicide attempts; arguing that the claim that lesbian and gay young people may comprise up to 30% of annual youth suicides in the USA is not backed by any evidence.

Much research looking at suicide among lesbians and gay men has indicated that the prevalence of reported suicidal attempts is higher than that of heterosexual individuals (Bridget, 2000). Trenchard and Warren (1984) found that 19% of the London Gay Teenage Group had attempted suicide. Davies and Neal (1996) report higher levels of depression, self-harm, and suicide attempts amongst gay and bisexual people than amongst the general population, particularly among younger members of these groups. This pattern is supported by numerous studies that indicate that there are factors directly and indirectly related to having a stigmatised sexual orientation that may contribute to the aetiology of suicidal behaviour and that there may be some gender differences in motivation for attempting suicide.

Self-harm behaviours among lesbians and bisexual women

In response to a dearth of specific information about lesbian health status, an American national study utilising self-report questionnaires from 1, 633 lesbian women was conducted in Boston, USA. Sorensen and Roberts (1997) discuss the results from the portion of the survey that dealt with mental health services and life experiences. Of significance, they found that 67% of the sample reported having had suicidal thoughts at some point in their lives, and 18% stated that they had made an actual suicide attempt; 50% of these attempts occurred before the age of 18 years. The most commonly reported method was overdose (more than 46%) but 10% reported cutting; approximately 5% had attempted suicide in an unclassified way, and approximately 25% had used multiple methods. It may be argued that the range of methods used indicate that some of these 'suicide attempts' may actually be more appropriately classified as self-injurious behaviour.

Other studies have been able to provide possible indicators of the types of issues that may contribute to the prevalence of self-harming behaviours in lesbian and bisexual women. For example, in her (unpublished) study of women in Australia, Barbeler (1992, cited in Bridget, 2000) distributed questionnaires in support groups, coffee shops and licensed venues. Her analysis of 200 returned questionnaires indicated that 63% of the women had contemplated suicide, 30% had attempted suicide, 60% had felt 'very depressed' because of their sexuality, 27% had experienced physical violence because of their sexuality, and 85% had experienced rejection from their parents. These studies indicate that suicide attempts and suicidal ideation is higher than that of heterosexual women, and that lesbian women may be more likely more vulnerable to suicidal ideation during adolescence.

Alcohol abuse among lesbians and bisexual women

Other studies have looked at other types of self-destructive behaviour. Researchers, clinicians and lesbians themselves believe that substance abuse problems among lesbians are more prevalent than among the general population (Hall, 1992). Gay communities tend to be organised around a social 'scene' which is usually comprised of bars and clubs and it has been hypothesised that the high prevalence of alcohol abuse is partly due to the management of living with a stigmatised identity, and the fact that alcohol in particular is a socially acceptable anxiety remover (Davies and Neal 1996).

Compared to a 1982 study of the US general population where 8% of women and 16% of men reported having had problems with alcohol (Clark and Midanik, cited in Davies and Neal 1996), some studies of lesbians indicate that between 27-35% of lesbians have alcohol problems (Hall, 1992). Qualitative research conducted by the Lesbian Information Service found that of 20 participants, 17 used alcohol, and 10 of these had serious problems which included passing out after drinking too much, being hospitalised for drinking too much, attempting suicide under the influence of drink, and not being able to socialise without being drunk (Bridget, 1996).

In summary, the research evidence in this area indicates that the relatively high prevalence of self-destructive and self-harming behaviour among lesbians, (and bisexuals and gay men) is a problem that requires further investigation. The research evidence in this area is based largely on American studies, but does appear to indicate that lesbians and gay men drink more and experience more problems with their

alcohol use than the heterosexual population (Davies and Neal, 1996). In the next section I will go on to discuss the prevalence of self-injury among lesbian and bisexual women.

Prevalence of self-injury among lesbian and bisexual women

Although studies have focused on the increased prevalence of suicide attempts among lesbians, bisexuals and gay men, there is a relative lack of research specifically looking at self-injury (referring to a specific type of self-harm that involves deliberately inflicting pain or injury to one's own body). Research looking at self-injury among lesbian and bisexual women could potentially be undertaken in the context of either mainstream self-injury research, or within research focusing on the experiences of lesbian and bisexual women. Chung and Katamaya (1996) conducted a content analysis of how sexual orientation was assessed in the Journal of Homosexuality from 1974 to 1993. While completing their analysis, they found that gay men were the most frequently studied group during this time (34.7% of studies), research focusing solely on lesbians represented 20.1% of the studies and only 2.8% of the studies were comprised of lesbian and bisexual women studied together. In mainstream self-injury literature, although much has been written about the gender implications of self-injury, there is an absence of an extensive consideration of the occurrence of self-injury in the context of sexual identity; despite an awareness that lesbian and bisexual women may have particular issues that may lead to a vulnerability to self-injury (Babiker and Arnold, 1997).

As previously mentioned, research and clinical documentation indicates that self-injury appears to disproportionately affect women. It could be hypothesised that some

lesbian and bisexual women may be at greater risk of engaging in self-injurious behaviour, on the basis of the additional pressure of having a stigmatised sexual identity. Despite this, there appear to be very few published studies that have focused specifically on self-injurious behaviour among lesbian and bisexual women. As with mainstream research, many studies of self-harm in lesbian and gay communities have not distinguished between self-injury and attempted suicide, and it is possible that some of the incidents categorised as suicide attempts would be more appropriately classified as self-injury.

Studies of self-injury among lesbian and bisexual women

Woods (1992, cited in Bridget, 2000), in her unpublished survey of lesbian women in Manchester, England, found that of the 68 returned questionnaires, 38 had been completed by lesbians aged 25 years or under; 63% of the participants had suffered from extreme stress; 45% had periods of depressions; 43% had hurt themselves deliberately; 39% had thought about killing themselves; and 21% had tried to kill themselves. Although, information about the exact nature of the self-injury is not available, these statistics provide some support for the claim that there is an increased prevalence of self-harm and self-injury among lesbian women.

Between 1990 and 1991 Bridget interviewed 20 lesbians of which 17 were 25 years or under, in Lancashire, England. She found that 85% had experienced depression; 70% had attempted suicide; 55% had 'abused self' in other ways including:

- 'cutting up with razor blades';
- 'banging fist against a wall';
- 'putting fist through window';
- 'throwing self against wall/down stairs';
- 'biting chunks out of self'.

In terms of contributing aetiological factors, these young women were very isolated and multiply oppressed; 50% had been sexually abused or raped, 55% had been homeless, 40% had been badly treated by an 'older lesbian/woman' (*sic.*) (Bridget, 1992). Although based on a relatively small sample, these statistics provide important information about the types of issues faced by young lesbian and bisexual women that may be implicated in the aetiology of self-injury in this group.

It is important however, to recognise that lesbian and bisexual women who self-injure are vulnerable to factors that affect other women, as well as having particular issues related to their sexual identity. It is therefore important to bear in mind that although there may be issues specific to lesbians and bisexuals, there is likely to be some overlap with the origins and motivations for self-injury indicated by mainstream theories. Further research is needed to highlight possible commonalities and differences in this area.

In the next section, the current models of the aetiology and function of self-injury based on general research studies will be provided. A critical appraisal of these perspectives will be provided, in terms of the relative lack of emphasis on the importance of factors relating to one's gender and sexuality. The focus will then return to self-injury in the form of a discussion of the framework used in the current study for conceptualising self-injury in the context of having a lesbian or bisexual identity.

How has self-injury been explained?

In this section, I will first provide a brief account of research in the area of self-injury, before going on to discuss psychiatric perspectives and psychological models of self-injury. I will then go on to introduce feminist and social constructionist frameworks that can be used to understand self-injury.

Background

Many myths have been attached to self-injury; for example, it is often thought that people who episodically or repeatedly self-injure do so in an attempt to kill themselves or that people who self-injure are manipulative ‘attention-seekers’. The conflation of suicidal and self-injurious behaviour has occurred for decades. In 1938 Menninger presented the most comprehensive piece of work in the area of self-mutilation at that time, in his book *Man Against Himself*. From a psychoanalytic perspective, Menninger conceptualised self-mutilation as a ‘partial suicide’, or a ‘compromise’, and categorised it in four ways: neurotic, psychotic, organic and religious (Menninger, 1938, cited in Favazza, 1996). Menninger was ahead of his time and very few of his colleagues paid any attention; as such self-mutilation continued to be thought of as a type of suicidal behaviour. It was not until more than two decades later that ‘self-cutting’, in particular wrist cutting, became a focus of psychiatric interest in the 1960s in the USA and Britain. Case studies and research reports from this time indicated that it was felt that there was a ‘typical self-cutter’ who was:

“an attractive, intelligent, unmarried young woman, who is either promiscuous or overtly afraid of sex, easily addicted and unable to relate to others... She slashes her wrists indiscriminately and repeatedly at the slightest provocation, but she does not commit suicide. She feels relief with the commission of her act” (Graff and Mallin 1967, p.41).

In the last decade interest in self-injury has been growing, and in particular, there has been an increasing focus on the psychological aspects of self-injurious behaviour. There has been an increase in research, leading to the development of models of the functions of self-injury and intervention programmes, such as Dialectical Behaviour Therapy (Linehan, 1993). There has been an increase in available resources for mental health workers dealing with self-harm with the development of specialist self-injury forums and conferences. There are also more resources available to people who self-harm, such as self-help groups and services, partly reflecting their dissatisfaction with traditional psychiatric approaches. In the next section, psychiatric and psychological models of self-injury will be discussed.

Psychiatric Models

Traditionally, the explanation and treatment of self-injury has been dominated by psychiatry. Psychiatric diagnoses stem from a structuralist approach, with a strong emphasis on classification and diagnosis as informing the type of treatment indicated. Psychiatric models tend to conceptualise self-injury as being pathological, that is, caused by an underlying physical or mental disorder. The clinical correlates of self-injury include a history of being subjected to child sexual abuse, physical abuse or other early trauma; aggressiveness; impulsivity; and suicidal behaviour. Favazza (1996) classifies self-mutilation as follows:

- *Major self-mutilation*: refers to frequent acts that involve the destruction of significant body tissue, such as eye enucleation;
- *Stereotypical self-mutilation*: refers to repeated, rhythmic acts such as headbanging or eyeball pressing;
- *Moderate/superficial self-mutilation*: refers to behaviours that lack rhythmicity and usually have what Favazza describes as ‘symbolic referents’ such as skin cutting and burning. This category of is further sub-divided as follows: *compulsive* (occurs many times daily and is repetitive and ritualistic, e.g. hair -pulling); *episodic* (occurs every so often); and *repetitive* (assumed to develop from episodic self-mutilation, the behaviour becomes an overwhelming preoccupation and individuals may describe themselves as addicted to their self-harm).

Some authors, such as Favazza, are keen to propose that self-injury be defined as a disorder of impulse control, with biological underpinnings that may be related to

lowered functioning of the neurotransmitter, serotonin. Research investigating the biological aspects of self-injury has tended to focus on episodic and repetitive self-injurious behaviour. Biological theories of self-injury have tended to focus on the role of neurotransmitters, in particular low levels of serotonin activity, which has been implicated in 'impulsive aggression' (Asberg, Traskman, and Thoren, 1976; Brown, Elbert and Goyer, 1982; Coccaro, Siever and Klar, 1989).

A group of neurotransmitters called enkephalins have also been implicated in self-injury. These are opium-like substances that are thought to have pleasurable effects, thus it is suggested that a person who self-injures will continue to do so in an attempt to induce their production (Favazza, 1996). Abnormalities in the dopamine system have also been implicated in stereotypic mutilation, as presented, for example, in Lesch-Nyhan syndrome. Other studies have looked at differences in pain perception and brain wave recordings and it has been proposed by Russ, Roth, Lerman, Kakuma, Harrison et al. (1992), that people who meet the criteria for Borderline Personality Disorder may be differentiated according to various factors, including their perception of pain and mood improvement after self-injury.

Self-injury has been associated with a wide range of other diagnoses including depression, eating disorders, schizophrenia, anxiety disorders and personality disorders. The correlates of self-injury include dissociation, intolerable affect that the individual is unable to verbalise, impulse-control problems and poor self-soothing strategies (Favazza, 1996). From a psychiatric perspective, the majority of cases of repetitive self-injury are seen as being indicative of a personality disorder, with the most commonly associated diagnosis being Borderline Personality Disorder (BPD).

Borderline Personality Disorder

The diagnosis of BPD is described in the Diagnostic and Statistical Manual of Mental Disorders, (4th ed.) (DSM-IV) as:

“a pervasive pattern of instability of interpersonal relationships, self image, and affects, and marked impulsivity beginning in early adulthood and present in a variety of contexts” (American Psychiatric Association, 1994).

The diagnosis of BPD according to DSM-IV specifies the following criteria:

1. frantic efforts to avoid real or imagined abandonment;
2. a pattern of unstable and intense interpersonal relationships;
3. identity disturbance: markedly and persistently unstable self-image or sense of self;
4. impulsivity in two areas that are potentially self-damaging;
5. recurrent suicidal behaviour, gestures, threats or self-mutilating behaviour;
6. affective instability due to a marked reactivity of mood;
7. chronic feelings of emptiness;
8. inappropriate, intense anger or difficulty controlling anger;
9. transient, stress-related paranoid ideation or severe dissociative symptoms.

The diagnosis of borderline personality disorder is controversial and has been the subject of much criticism and debate. It has been suggested that many women are so diagnosed simply because they exhibit behaviour at variance from that expected of

their gender, and that psychiatrists and other mental health workers have no other easy label for women who are angry or are otherwise difficult to deal with (Becker, 1997).

During the last few years there has been an increasing focus on the social and psychological aspects of self-injurious behaviour. It has increasingly been recognised that self-injury can be more appropriately understood as a maladaptive coping mechanism for dealing with difficulties or distress. This is not to negate the fact that many women who self-injure do meet criteria for other mental disorders, but rather to emphasise the role of psychological and social factors that contribute to the aetiology of self-injury. In the next section the development of psychological perspectives and models of self-injury will be discussed.

Psychological perspectives

Functions of self-injury

Although there are a number of psychological theories relating to self-injury, the underlying conceptualisation many have in common is that self-injury serves a function. Suyemoto (1998) found in her review of the research literature, that the different models of the functions of self-injury could be summarised as follows: models based on behaviour and systems theory; drive models based on psychoanalytic theory; affect-regulation models based on psychodynamic explanations; and boundaries models based on object relations theory. It is likely that self-injury serves multiple functions. These functions are summarised in Table 1: 'Functions of self-injury'.

Table 1. Functions of self-injury

Environmental Model	<ul style="list-style-type: none">• Focuses on the interaction between the individual and their environment.• Self-injury is perceived to create an environmental response that serves to reinforce the self-injurious behaviour.
Drive Models	<ul style="list-style-type: none">• <i>Anti-suicide</i>: Self-injury is perceived to be a suicide replacement.• <i>Sexual</i>: Self-injury stems from conflicts over sexuality and menstruation.
Affect Regulation	<ul style="list-style-type: none">• <i>Affect Regulation</i>: Self-injury stems from the need to express or control anger, anxiety or pain that cannot be expressed through other means.• <i>Dissociation</i>: Self-injury is a way to end or cope with dissociation.
Interpersonal Models	<ul style="list-style-type: none">• <i>Boundaries</i>: Self-injury is an attempt to create a distinction between self and others.

Adapted from Suyemoto (1998)

Babiker and Arnold (1997) summarise the functions of self-injury in a way that acknowledges the experience of the individual, yet does not frame such behaviour as being inherently pathological. They acknowledge the validating and supportive effect of 'user/survivor' perspectives of self-injury, but warn that such approaches may fail to acknowledge the problematic nature of self-injury and the emotional distress that underlies it. The functions identified are as follows:

- functions concerned with *coping and surviving* , e.g. the regulation of distress and anxiety; dealing with anger;
- functions concerning *the self* e.g. increasing none's sense of autonomy and control;
- functions concerned with *dealing with one's experience* e.g. demonstration or expression to oneself of one's experience;
- functions concerned with *self-punishment and sacrifice* e.g. punishing self; dealing with confusion about sexual feelings;
- functions concerning *relationships with others* e.g. communication; punishing others.

Origins of self-injury

According to Babiker and Arnold (1997), for most individuals, self-injury seems to be associated with difficult and distressing life experiences that often started in childhood. This is supported by a number of studies; for example, Arnold (1995) surveyed 76 women and found that almost two-thirds of the sample attributed their self-injury to childhood experiences alone, for example, physical or sexual abuse; a further quarter felt that childhood and adult experiences were implicated, while just 14% attributed their self-injury solely to adult experiences. Suyemoto (1998) in her review of the self-injury literature, notes that research suggests that people who self-injure are more likely to come from families characterised by divorce, neglect or parental deprivation. According to Smith, Cox and Saradjian (1998), for women who self-injure for the first time in adulthood, although negative childhood experiences may have occurred, it is likely that this behaviour may have been triggered by an event in adulthood, such as assault or rape.

Babiker and Arnold discuss the links between life experiences and self-injury, proposing that traumatic experiences have two major effects that may give rise to self-injury:

“firstly, they force the child (or later, the adult) to experience very complex, distressing emotions in the absence of autonomous means of coping. Self injury may then develop as the only alternative to feeling that one may not survive the experience. Secondly, such experiences, maltreatment in particular, often result in feelings of low self-worth, self-loathing, guilt and

shame, which may lead someone to a tendency towards self-destructiveness”

(p. 61-62).

In summary, psychological perspectives have highlighted that self-injury serves multiple functions that may be conceptualised as being central to the individual's ability to cope and carry on with life. This emphasis on the individual as the starting point for understanding and treating symptoms of distress is inherent in many psychological models. Other approaches however, such as feminist perspectives, while also conceptualising self-injury as a way of coping with difficulties, emphasise the societal context, highlighting inequalities between the experiences of men and women, and between members of different social groups.

A feminist social-constructionist approach to self-injury

As previously mentioned, the research presented here draws on social constructionism which has influenced elements of feminist psychology. In the next section I will discuss feminist and social constructionist perspectives emphasising the importance of exploring and questioning the current meaning of the term 'self-injury' and how it has evolved. I will then introduce conceptualisations of sexual identity, leading to an overview of the framework which integrates these different theories that will be used in the research presented here.

From a feminist perspective, Smith, Cox and Sarajdian (1998) point out that self-injury is, in the main, a female phenomenon. This is not denying the fact that many men self-injure, but rather reflects certain aspects of a woman's life experiences that

may lead to self-injury. There may also be gender differences in the nature and motivations of self-injury between men and women. It is interesting that despite the well-documented higher rates of self-injury among women than among men, it is only fairly recently that self-injury has been explored in the context of the differential experiences of women and men. Such explorations have focused on different aspects of women's experiences, including childhood socialisation and the different social perceptions and expectations of men and women in adulthood (e.g. Burstow, 1992; Babiker and Arnold, 1997; Smith, Cox and Sarajdian, 1998).

From a psychiatric perspective, self-injury is a pathological behaviour indicative of an underlying mental disorder which is situated within the individual, and therefore necessitates treatment that focuses on individual personal development, change and adaptation. Adopting a social constructionist framework in which to understand self-injury is not necessarily antithetical to psychiatric conceptualisations of self-injury, as a psychiatric diagnosis itself is not inconsistent with a social constructionist perspective, given that it originates from accounts of the individual's experience (Stoppard, 1997). However, feminist approaches have highlighted the ways in which psychiatric models of distress are biased in various ways.

The tendency for 'madness' to be perceived to be situated within the individual has been criticised (e.g. Kitzinger and Perkins 1993). Cook (1985) is quoted by them as saying:

“psychiatric illness is not an individual problem - it is the responsibility of us all. Its prevention and care is neither physiological or psychological - it is political” (p. 105).

It is arguable that psychiatric models of self-injury are strongly influenced by psychiatry's origins. As Burstow (1992) remarks, “psychiatry is a white patriarchal European invention” (p.22), and:

“psychiatrists as a group...see what their lens allows them to see. That lens has been specially fashioned out of their own professionalism, that is, out of their own gender, position and mandate - to pathologise women's resistance/thought and to filter out women's reality” p.36.

From a feminist perspective, the diagnosis of Borderline Personality Disorder (BPD), a diagnosis most commonly associated with repetitive self-injury among women, is influenced by society's expectations of gender appropriate behaviour in areas that include sexuality and relationships. The sexual aspect of a BPD diagnosis includes 'symptoms' related to frequent changes in sexual partner and confusion over identity and/or gender. However, it appears that it is not solely within this diagnosis that behaviour or feelings perceived to be divergent from the norm are pathologised.

Favazza (1996) notes that:

“many female self-mutilators report disgust over menarche, menstruation, and intercourse, sometimes accompanied by fantasies of prostitution and sexual humiliation... Both male and female self-mutilators typically experience sexual guilt. They often have difficulty dealing with sexual relationships and assuming an appropriate masculine or feminine role (my emphasis). Some have patterns of childhood and adolescent hypersexuality and promiscuity” (Favazza, p.269).

In Favazza’s seminal book ‘Bodies Under Siege’, lesbian women are mentioned only in passing, in the context of body piercings and fashion. With regard to male sexuality, he remarks that:

“a recurrent finding among male self-mutilators is long standing confusion about their sexual identity, as manifested by envy of females, desire to be a female, repudiation of their penises, bisexuality, cross-dressing, and concerns about homosexuality” (Favazza 1996, p.269).

In the next section, I will discuss the ways in which self-destructive behaviour among lesbians, bisexuals and gay men has been understood, leading to a focus on self-injury among lesbian and bisexual women. Rather than conceptualising issues relating to sexuality and sexual identity as part of the underlying pathology of self-injury as implied by some psychiatric models, an attempt is made to understand the origins and motivations for self-injury within this group.

How has self-destructive behaviour in lesbians, bisexuals and gay men been explained?

Internalised homophobia

According to (Davies and Neal, 1996), internalised homophobia is a central clinical theme in working with lesbian, gay and bisexual clients. They suggest that

“lesbians, gay men and bisexuals spend every day of their lives knowing that some sections of society wish they did not exist” (Davies and Neal, 1996, p.54).

The potential effects of this are indicated in the following quote by Gonsiorek and Rudolph, (1991, cited in Davies and Neal, 1996):

“negative feelings about one’s sexual orientation may be over generalised to encompass the entire self. Effects of this may range from a mild tendency toward self-doubt in the face of prejudice to overt self-hatred and self-destructive behaviour” (Gonsiorek and Rudolph, 1991, p.166).

If not resolved, negative feelings about self may extend into adulthood, and anxiety, depressive symptoms, alienation, self-hatred, and demoralisation may result. It has been proposed that homophobia may be internalised, resulting in further difficulties in identity development. Numerous factors have been suggested as contributing to the aetiology of self-destructive behaviour among this group. These include multi-oppression e.g. being black, minority ethnic, working class, disabled (Bridget, 1992);

the experience of externalised homophobia (Davies and Neal, 1996); discrimination; stress; the need to feel confident and assertive in an unwelcoming society; violence; and isolation (Babiker and Arnold, 1997; Signorile, 1996).

Specific issues related to bisexuality

There is great deal of resistance to bisexuality - perceived as threatening to heterosexuals because of the homosexual component, and threatening to gays/lesbians because of the heterosexual component (Davies and Neal, 1996). Bisexuals may therefore be vulnerable to both internalised homophobia and 'biphobia':

“for the bisexual person moving from a heterosexual identity there is a double coming out with the tasks of acknowledging same sex feelings and attractions as well as establishing a bisexual identity. For the lesbian...who may have fought over many years to establish this identity, there is the threat of disruption to it if they are to acknowledge and act on their bisexual feelings” (Davies and Neal 1996, p.69-70).

In addition, there is a relative absence of organised support systems for bisexuals and bi-positive systems, with existing organisations tending not to be aimed at young people coming to terms with their bisexuality. It can be argued therefore, that young people who are in the process of identifying as bisexual may have an even more difficult task and less support due to the absence of an established support network.

Understanding self-injurious behaviour among lesbian and bisexual women

Naturally, the aetiology of self-destructive behaviours in lesbians, bisexuals and gay men also includes events that are not inherently related to their sexual orientation. These include, as previously mentioned, childhood experiences such as sexual abuse, physical abuse and neglect; and adult experiences such as homelessness; assault, indecent assault and rape. However, there are also issues specific to having a stigmatised identity that may be implicated in the aetiology of self-injury.

Interviews carried out for a national gay newspaper with people who identified as gay or lesbian who also self-injure found that common themes were a feeling of having no-one to turn to for advice on their emotional and physical experience and a tendency to blame self for being 'abnormal'; shame about non-conformity; family hostility about one's sexuality; the experience of anti-gay discrimination; and homelessness (Pink Paper, 16th October 1998). Vulliamy (1999), writing about her experience of self-injury as a lesbian, claims that:

"for so many young lesbians and gay men, our sense of self is distorted, uncomfortable or confused as the world tells us that this central part of who we are is disgusting, sick, pitiable or unacceptable" (p.6).

Babiker and Arnold (1997) briefly explore issues faced by particular groups within society who may be more vulnerable to self-injurious behaviour. They cite a number of reasons why lesbians may be particularly vulnerable to self-injury, including the

conflict between sex-role stereotypes and expectations; homophobia, discrimination and abuse; isolation; lack of family and peer support.

Socialisation and societal norms

In this section, I will go on to further discuss gender and sexual identity in terms of a social constructionist framework, highlighting how these issues contribute to our understanding of self-injury in lesbian and bisexual women. Babiker and Arnold (1997) suggest that the unequal ratio of self-injury among men and women indicates the presence of gender-specific issues that contribute to the causes of self-injury; for example, Smith, Cox and Saradjian (1998) highlight the tendency for socialisation to lead to different expectations of men and women, whereby females are often taught how to manage the feelings of others at the expense of their own. Women tend to hold less power than men and are more likely to be made to feel less important (p.15).

Babiker and Arnold note the expectations of women to make themselves attractive, suggesting that:

“mutilation of the body is absolutely the opposite of what an idealised woman is supposed to do: to make great efforts to be attractive and perfect. In injuring her own body, a woman spoils the thing which society both values and despises. Perhaps this ‘spoiling’ expresses not just her self-hatred and despair, but also her protest at the contradictory expectations and perceptions placed upon her, and so contains deliberately proud and angry elements” (p.40).

Lesbian norms and expectations

It has been argued that lesbian beauty norms are broader than traditional beauty norms (Cogan and Erikson, 1999). Myers, Taub, Morris and Rothblum (1999) point out that lesbian beauty norms have changed over time, as have beauty norms for the dominant culture. They argue that lesbian beauty norms have a dual purpose in developing a distinct standard of beauty that rejects oppressive and sexist norms that over-emphasise western standards of beauty for women; and in enabling lesbians to recognise each other. However, Cogan and Erikson suggest that these norms can be metaphorically described as merely 'building a bigger cage' whereby lesbian beauty norms are equally as oppressive and restrictive as those of the dominant culture.

If, as Babiker and Arnold suggest, the pressure for women to strive for a prescribed and oppressive standard of attractiveness can contribute to the development of self-injury, then it follows that the pressure for lesbian and bisexual women to conform with a different yet still restrictive set of norms may also be implicated in the aetiology of self-injury. From a social constructionist perspective, these beauty norms are just one aspect of the wider social category of 'lesbian' which is comprised of a range of meanings and sub-categories.

According to Jennes (1992) the adoption of a lesbian sexual identity represents a transition from 'doing' lesbian to 'being' lesbian, representing a developmental process that begins with an awareness of the social category 'lesbian' and involving an understanding of one's self as an instance of that particular construct. As Jennes points out, one's understanding of the nature of the social category 'lesbian' is based

on sources fairly removed from one's own direct experience which typically consist of over-simplified opinions, and neutral or negative connotations. One example would be the largely negative portrayal of male and female homosexuality by the media. In addition, the process of adopting a lesbian or bisexual identity usually involves deviating from society's expectations and prescriptions of 'normal' sexuality, i.e. heterosexuality.

Adrienne Rich (1980) used the phrase 'compulsory heterosexuality' arguing that heterosexuality has both been forcibly and subliminally imposed on women by various societal forces that suggest that marriage and sexual orientation towards men is inevitable, resulting in other alternatives being perceived as deviant. When heterosexuality is thought of as the natural emotional and sensual inclination for women, those who do not conform are seen as "deviant, pathological or as emotionally or sensually deprived" (p.652). Rich claims that:

"the lie keeps ... women psychologically trapped, trying to fit mind, spirit and sexuality into a prescribed script because they cannot look beyond the parameters of the acceptable...The lesbian trapped in the 'closet' [and] the woman imprisoned in prescriptive ideas of the 'normal' share the pain of blocked options, broken connections, lost access to self-definition..." (p.140).

From this perspective, the bias of compulsory heterosexuality results in lesbian experience being perceived on a scale from deviant to abhorrent, or simply rendered invisible. The process of identity formation which involves the transition from 'doing lesbian' to 'being lesbian' would inevitably involve the reassessment of these

'typified understandings' of the social category of lesbian which are, by definition, inherently general, indeterminate and capable of revision (Jennes, 1992). In the next section I will go on to discuss theories of sexual identity formation.

Sexual identity formation and self-injury

It has been suggested that lesbian, gay and bisexual people are particularly vulnerable to mental health problems during the process of 'coming out' (e.g. Davies and Neal, 1996). As previously mentioned, it has been suggested that individuals may be particularly vulnerable to mental health problems during the realisation process of their sexual orientation. In a study by Bridget and Lucille (1996), these problems included depression, attempted suicide, self-harming behaviours and alcohol misuse, as well as isolation and social rejection. Baetz (1984) succinctly describes the difficulties that a woman may experience during this process that might conceivably contribute to self-injurious behaviour:

during the realisation process, she may have to deal with a loss in self-confidence, self-hatred, physical illness, nervous breakdown, alcoholism, marriage attempts, realisation of wasted years trying to be someone she isn't, numerous therapy sessions and suicide attempts. This is euphemistically called coming out to yourself (Baetz 1984, p.46)

Some models of sexual identity formation take into account the stigmatisation of lesbianism and male homosexuality and propose that this stigma needs to be integrated into identity through the coming out process. In this section I will outline

selective models of sexual identity formation, before going on to discuss the implications for an understanding of why this process may lead to psychological distress and self-injury in some people.

Essentialist definitions of sexuality, including sexual orientation and identity emphasise biological underpinnings and sexual behaviour. Both sexual orientation and sexual identity are conceptualised as being largely consistent and stable. For example, Savin-Williams (1990) provides the following definitions:

“a preponderance of sexual or erotic feelings, thoughts, fantasies, and/or behaviours...It is present from an early age - perhaps at conception. Sexual identity is defined as “a consistent, enduring self-recognition of the meanings that sexual orientation and sexual behaviour have for oneself” (p.3).

Following from an essentialist position, the term ‘coming out’ is usually used to refer to the complex process by which an individual becomes aware of one’s sexual orientation and discloses this to others (Markowe, 1996). However, this definition is problematic for some researchers and clinicians. In the next section I will discuss theories of this process, providing a social constructionist critique, then outlining how it is conceptualised within the research presented here.

Social constructionist theories of sexual identity

Kitzinger and Wilkinson (1995) note that a large body of work makes the assumption that lesbianism and male homosexuality are essences, determined prenatally or in early childhood. The very expression 'coming out' can be perceived to be at odds with a social constructionist perspective as it suggests that the lesbian has always resided within the individual, 'awaiting debut'. Kitzinger and Wilkinson argue that models of identity formation based largely on essentialist theories fail to address the experience of any women who, for example, identify as lesbian following a long period of identifying as heterosexual, or vice versa. They, on the other hand, start from the following assumption:

“that adult women who made such transitions are no more driven by biology or subconscious urges than when, for instance, they change jobs; such choices could be viewed as influenced by a mixture of personal re-evaluation, practical necessity, political values, chance and opportunity” (Kitzinger and Wilkinson, 1995, p. 96.)

In accordance with a conceptualisation of all meanings being arbitrary, social constructionist theories of sexuality have no interest in biological underpinnings. Rather, one's sexuality is conceptualised as being both shaped and regulated by social and cultural factors. In this model, social and historical contexts shape and circumscribe the possible ways in which people understand themselves and others. Categories such as lesbian, gay and bisexual are also seen as social constructions that are not necessarily stable and that some people may have experiences that do not fit with these category definitions. Rust (1993) argues that:

“social constructionism teaches that self-identity is the result of the interpretation of personal experiences in terms of available social constructs. Identity is therefore a reflection of socio-political organisation rather than a reflection of essential organisation, and coming out is the process of describing oneself in terms of social constructs rather than a process of discovering one’s essence (1993, p.68).

Material-discursive approaches to sexual identity

Bridget (1996) provides a critique of feminist perspectives, arguing that many feminist academics who write about female homosexuality are constructionists who have little interest or understanding of the experiences of non-feminist lesbians as they do not identify with them. While I do not totally agree with this statement, it can be argued that a pure social constructionist perspective may be antithetical to the experience that many people have of being aware of an underlying sexual orientation that is at odds with that of a heterosexual society.

Attempts have also been made by other authors to find a middle ground between essentialism and social constructionism (e.g. Epstein, 1987). Epstein conceptualises sexual orientation as being similar to ethnicity in that both have essential and socially constructed components. Ussher (1997a) discusses a material-discursive approach to lesbian sexuality that acknowledges that one cannot separate material (essential) and discursive (constructed) factors in an analysis of sexuality.

Within a material-discursive framework of understanding sexual identity the term 'coming out' can be used to refer to the process by which an individual initially becomes aware of, and interprets their thoughts and feelings, and possibly behaviour, in terms of the social categories 'lesbian', 'bisexual' or 'gay'. The individual recognises themselves as an instance of this category and discloses this to others in their social network. Using the model proposed by Jennes (1992) the process of identifying as lesbian would involve an implicit and/or explicit assessment of their behaviour, emotions and thoughts through their understanding of what it means to be a lesbian. Jennes proposes that the process of 'detyfication' central to this transformation can be defined as follows:

“detyfication is the process of redefining and subsequently reassessing the social category 'lesbian' such that it acquires increasingly concrete and precise meanings, positive connotations, and personal applicability” (Jennes 1992, p.66).

The research presented here draws on a material-discursive approach, conceptualising sexual identity formation as being internal to each woman, yet embedded within a socio-historical context. Forming and labelling one's sexual identity is perceived to be influenced by the availability of the social category 'lesbian' (or bisexual) and what this means within a particular culture (Morris, 1997). The following definition of sexual identity is utilised. This definition highlights the potential fluidity of sexual identity, and is in accordance with other studies which have indicated that identity is not necessarily stable (e.g. Reiter, 1989; Eliason, 1996).

“sexual identity is a term for the ways in which a person living in her or his particular cultural and historical context experiences, makes sense of, labels and lives out her or his own combination of sexual orientation, biological sex and gender” (Wishik and Pierce, 1995, cited in Perez et al., 2000, p.167).

Models of sexual identity formation

Cass (1979) cited in Davies and Neal, 1996) proposes an interactionist model of sexual identity formation, based on the assumption that sexual identity is acquired through a developmental process, and that our behaviour is influenced by the interaction between ourselves and society. An individual is proposed to progress through up to six stages of identity development. The first stage is *‘identity confusion’*, during which there is proposed to be inner turmoil between lesbian or gay identity and what is considered to be ‘normal’ sexuality. The next stage, *‘identity comparison’* is characterised by feelings of difference and isolation. *‘Identity tolerance’* is characterised by a desire to overcome the isolation of the incongruity of identity, represented by the thought ‘I am probably a homosexual’; *‘identity acceptance’* is characterised by the thought ‘I am homosexual’; and *‘identity pride’* is characterised by feelings of anger at the oppression of lesbian and gay people, leading to an embracing of activism. The final stage, *‘identity synthesis’* appears to be characterised by a rejection of this anger and activism, and an integration of personal and public sexual identity. Based on what is currently known about the functions and motivations for self-injury, within this model such behaviour could be

hypothesised to be more likely to be engaged in during the first two stages: at times of inner turmoil and when one is feeling different or isolated.

A model proposed by Woodman and Lenna (1980) focuses on the individual's internal world and psychological processes, and is comprised of four stages: '*denial*' whereby the individual may engage in homosexual activities but would not perceive their feelings or behaviour as being gay; '*identity confusion*' whereby the individual is aware that they may be gay, but are unhappy or uncomfortable with this; '*bargaining*' refers to the next stage whereby the individual is overwhelmed by the implications of their homosexuality and wishes to become heterosexual or to revert to their previous identity; '*depression*' is the final stage entered by individuals who for various reasons, have been unable to find workable coping mechanisms. This stage is characterised by the individual experiencing feelings of guilt and anger at oneself. In this model, resolution of depression results in a healthy integration of their sexual orientation (Woodman and Lenna, 1980, cited in Davies and Neal 1996). It can be argued that self-injury may occur during all these stages, but particularly at times of confusion, when the individual feels overwhelmed by their feelings and during the '*depression*' stage.

Researching sexual identity and self-injury: why is further research needed?

Despite the apparent higher prevalence of self-destructive behaviour among lesbian and bisexual women, there are few published studies that specifically focus on self-injury within this group. As Babiker and Arnold (1997) claim:

“individual experience and circumstance may underlie the distress which gives rise to self-injury, but social relations shape such experience...If we are to fully understand and work effectively with people who self-injure, we need to address the contribution of social and political factors to their situation and to the forces which drive them to express themselves by hurting their own bodies” (p.37).

Studies have suggested that lesbians, gay men and bisexuals may choose not to disclose their sexual identity when accessing mental health services for various reasons. Golding (1997) found that 78% of participating lesbian, gay and bisexual service users expressed reservations about feeling safe enough to disclose their sexual orientation in a mainstream mental health setting, and 84% feared prejudice or discrimination, or thought that their sexual orientation would be pathologised. This suggests that there may be many professionals who are unaware of the needs of some of their clients and indicates a need for more research exploring the mental health issues and needs of lesbian, bisexual and gay service users. Such research could lead to the facilitation of the development of mental health service provision that can meet the needs of these groups more effectively, as well as to raise awareness among clinicians who work with clients who are lesbian, gay or bisexual.

In summary, it seems evident that there is a need for greater research in this area. In the next section I will discuss how the framework of the current research determines the nature of the research methodology and questions.

The research framework

The research presented here is approached using a feminist standpoint position which, as previously mentioned does not strive for objectivity and neutrality, but argues that all knowledge incorporates and reflects the values and assumptions of the researcher. Such approaches suggest that research can never be totally objective, and that existing conceptual schemes may not fully capture women's experience (Stoppard, 2000). Since it is believed an unmediated perception of reality is impossible to obtain, this standpoint advocates an interpretative-phenomenological approach which permits women to give their own conception of their experiences, rather than perceiving the researcher as the sole expert in making sense of the participant's world (Riger, 1992). In line with this approach, this study conceptualises women who self-injure as being 'primary experts', having a wealth of knowledge and experience that can be utilised in the development of theories and models of understanding self-injury; and that mental health professionals who work in this context, are 'secondary experts' in self-injury (Pembroke, 2001).

A qualitative research paradigm emphasises the importance of understanding and interpreting the meaning of experience and behaviour through the perspective of participants. The researcher is not the all-knowing expert, and is sensitive to the

participants particular situation, being interested in their perceptions as valuable accounts of their experience. As such, subjectivity is an essential part of the analytic process. According to Stoppard (1997) qualitative methods provide an appropriate avenue for the exploration of individuals' subjective experiences and the meanings attached to these experiences. The use of qualitative approaches is advocated by feminist researchers as a method for revealing the character of women's experiences in the context of their everyday lives. It is therefore important that research exploring self-injury in the context of sexual identity allows lesbian and bisexual women who self-injure to speak for themselves.

There are a number of different methods available to qualitative researchers and different theoretical positions have been associated with particular research methodologies. Discourse analysis has traditionally been associated with poststructuralism and postmodern theorising (Henwood, 1996). However, it was not felt appropriate for the current study due to its fundamental assumption that verbal reports do not reflect underlying cognitions (Potter and Wetherell (1987). The specific method of qualitative analysis used in the current study is Interpretative Phenomenological Analysis (IPA).

IPA is a method of qualitative analysis that is increasingly being used in health psychology, and, having a theoretical basis in phenomenology, attempts to get an 'insider's perspective' of a particular topic area (Conrad, 1987). Smith (1996) suggests that IPA may be conceptualised as having a useful function in mediating between the opposed positions of social cognition and discourse analysis. IPA, unlike discourse analysis, is concerned with cognitions, and specifically aims to ascertain

the participants' thoughts and beliefs about the topic under investigation, IPA acknowledges the dynamic nature of such a process, and recognises that, as such, research that attempts to get close to the experience of an individual can never be completely objective, due to the researcher's preconceptions of the topic being investigated. Whereas grounded theory is beneficial in developing existing theories, IPA is advantageous in the research of areas that have not been extensively researched, or where there is not an established or cohesive theory or model. It was therefore felt to be particularly appropriate for an exploration of self-injury within the context of having a lesbian or bisexual identity as little research has been undertaken to explore the aetiology and functions of self-injury specifically in this context.

Qualitative research makes use of empathy with participants as an observation strategy (Stiles, 1993). In the research presented here, this empathic understanding draws on two main factors: the interpretations of the participants' varied experiences based on reports of their thoughts, feelings and beliefs, and the researcher's own beliefs and understanding of such experiences. Recommendations of good practice advise that the researcher is open about their preconceptions and theoretical commitments. My professional and personal perspective is in accordance with psychological perspectives of self-injury that conceptualise such behaviour as serving many functions, and as primarily a coping mechanism for many women. It is expected that some, but not all of the motivations for self-injury are related to direct and indirect consequences of having a sexual identity that is perceived to be stigmatised by society.

Research questions

The specific questions to be addressed by the study are as follows:

- What do the perceptions of lesbian and bisexual women tell us about the possible relationship between self-injury and sexual identity?
- What functions does self-injury serve in this context?
- What are the issues that lead the participants to self-injury and how do these compare with those reported in the literature?

CHAPTER 2: METHOD

In this study sixteen women who identified as lesbian or bisexual and had self-injured on repeated occasions, were interviewed for between one and one and a half hours using a semi-structured format. The tapes were transcribed verbatim by the researcher. The transcripts were then analysed according to the methods of Interpretative Phenomenological Analysis (IPA). This resulted in twenty-eight themes captured by six higher order categories which covered the participants experience of self-injury in the context of having a lesbian or bisexual identity.

Ethical approval

Ethical approval was granted by the Joint UCL/UCLH Committees on the Ethics of Human Research under the 'healthy volunteers' category (see appendix 1).

Recruitment process

Methods of recruitment

A combination of methods were used to recruit participants, using poster advertisements and short letters in two magazines. An example of a poster advertisement is in appendix 2. As the initial plan had been to include heterosexual women in the study, the advertisements asked for women who identified as lesbian, bisexual or heterosexual who had self-injured, to contact the researcher if they would be willing to talk about their experiences.

Participants were recruited by placing advertisements in the following places:

- four libraries in North London, two book shops and on London University notice boards;
- 'Diva' magazine, a magazine aimed at a predominantly lesbian and bisexual female readership;
- 'SHOUT', a national newsletter for women who self-injure;
- The 'Pink Paper', which at the time of advertising, was a free newspaper distributed in libraries, gay bars, clubs and cafés;
- an internet website aimed at gay and lesbian consumers;
- 'Time-Out magazine' a weekly popular magazine in London, and 'Open Mind' mental health magazine.

Responses to advertisements

Seventy-four women expressed an interest in the study by making contact with the researcher by post, telephone and e-mail. For most participants, a response was made in the same mode in which the contact was initiated. The majority of the women reported that they had seen the advertisement in Diva magazine or in The Pink Paper. Of these seventy-four women, five requested information and did not resume contact after this was provided. Three women did not meet the inclusion criteria; one because she suffered from an eating disorder in the absence of any other form of self-injury, and the other two manifested self-harm that was associated with suicidal intent only. Seven others were not able to be contacted for various reasons, for example providing insufficient contact details.

A deadline was decided for the interviewing period which lasted for three months. Sixteen lesbian/bisexual women contacted who met the inclusion criteria and lived near or in London, or who were visiting London, were invited to be interviewed. Three heterosexual participants were also interviewed in the initial stages but these interviews were not used in the current analysis, as the decision was made to focus the study on the experiences of lesbian and bisexual women.

Respondents who were unable to be interviewed, for example because of practical difficulties such as geographical location, or because they had responded after the deadline, were invited to send written comments to the researcher if they wished. The written comments sent by individuals were read and discussed by the researcher and supervisor but were not included in the analysis and will not be presented here.

Inclusion and exclusion criteria

The inclusion criteria were that the individual had self-injured on more than one occasion, and that the type of self-injury was in accordance with the following definition:

“an act which involves deliberately inflicting pain and/or injury to one’s own body, but without suicidal intent” (Babiker and Arnold, 1997, p.2)

The following exclusion criteria were applied to ensure a relatively similar group in terms of the type of self-injurious behaviour engaged in:

- individuals whose manifested behaviour is predominantly self destructive rather than self-injurious, for example, behaviour such as drug/alcohol abuse or sexual risk taking in the absence of any other self-injurious behaviour;
- individuals who have taken harmful substances with a declared intent to kill themselves, not as a means of self-injury;
- individuals who present with eating disorders in the absence of any other self-injurious behaviour.

Information about the participants

Participants provided answers to a demographic questionnaire that was filled in by the researcher after the interview had finished. The mean age of the participants was 29 years (range 18-50 years, s.d. 8.1). Eight identified as white English/British; six were white European; one was white Jewish; and one identified as mixed race/Jewish. The length of time participants identified as lesbian or bisexual ranged from 2 months to 15 years, with a mean of 9 years (s.d. 4.1).

The participants worked in various occupations: five of the participants were students, two worked in day services, one was an office worker, one worked in a mental health, one worked in a hospital, one was a voluntary worker, two were self-employed professionals; one was a manual worker and two were non-employed.

Between them, the participants had utilised a range of services:

- Helplines - e.g. the Samaritans, helplines with specialist experience of self-injury;
- Psychiatry services - acute units, secure units, inpatient wards, day hospitals;
- Therapeutic communities or group psychotherapy programmes;
- Therapeutic interventions, including individual psychotherapy, counselling, behavioural therapy and cognitive-behavioural therapy;
- Crisis services - drop in centres, some had used centres specifically for lesbian and gay clients;
- Services specifically for survivors of abuse - rape crisis services, incest survivors groups, Women's Aid, women's refuges.

Individual participant descriptions

In order to maintain confidentiality, the names of all participants have been changed, and the information given has been kept to a minimum.

Bettina	In her mid thirties and had identified as lesbian for 8 years. Her self-injurious behaviour included cutting and hair pulling and had occurred intermittently over a period of 21 years.
Cassandra	In her mid thirties and had identified as a 'dyke' for 7 years. Her self-injurious behaviour included burning, cutting, and using chemical substances to burn; and had occurred over a period of 7 years.
Emily	In her late twenties, and had identified as lesbian for 11 years. Her self-injurious behaviour involved cutting and had occurred over a period of 12 years.
Fiona	In her mid twenties and had identified as lesbian for 11 years. Her self-injurious behaviour included cutting, scratching, and taking overdoses and had occurred over a period of 7 years.
Glenda	In her late twenties and had identified as lesbian for 12 years. Her self-injurious behaviour had included cutting, overdoses, and occasional strangulation. This had occurred in episodic phases over a period of 15 years.
Imogen	In her late teens and had identified as lesbian for 4 years. Her self-injurious behaviour included cutting, scratching, and hitting walls, and had occurred over a period of four years.
Josephine	In her mid twenties and had identified as lesbian for 13 years. Her self-injurious behaviour included cutting and burning, and had occurred over a period of 10 years.
Kelly	In her late twenties and had identified as lesbian for 12 years. Her self-injurious behaviour included cutting, burning, and overdoses, and had occurred over a period of 7 years.
Laney	In her mid twenties and had identified as lesbian for 2 months. Her self-injurious behaviour included biting, hitting wrists and head against objects, and had occurred over a period of 7 years.
Amanda	In her late teens and had identified as gay/bisexual for 2 years. Her self-injurious behaviour included cutting and scalding, and had occurred over a period of one and a half years.

Nell	In her late twenties and had been aware of her bisexual orientation for over ten years, and identified as gay. Her self-injurious behaviour included cutting and excessive alcohol use, and had occurred over a period of 8 years.
Phoebe	In her early twenties, had described her sexual orientation as bisexual for 7 years and identified as gay. Her self-injurious behaviour included cutting, burning, starving/vomiting and overdoses and had occurred over a period of 8 years.
Roberta	In her mid twenties and had identified as lesbian for 7 years. Her self-injurious behaviour included cutting, burning with acid, overdoses, headbanging and anorexia/bulimia and had occurred over a period of 13 years.
Sally	In her early fifties and had identified as lesbian for 10 years. Her self-injurious behaviour included cutting and inserting sharp objects into skin, and had occurred since she was a child, over a period of 41 years and had reduced significantly in frequency during the last decade.
Tamsin	In her late thirties and had been aware of her sexual orientation as lesbian for 23 years. Her self-injurious behaviour included cutting, overdoses, starving self, and alcohol abuse and had occurred over a period of 26 years.
Ulrika	In her mid thirties and had identified as lesbian for 11 years. Her self-injurious behaviour included cutting, scratching, and head banging and had occurred over a period of 8 years.

Summary of types of self-injury

A wide range of methods of self-injury were reported in the interviews, and most of the participants reported using more than one method. Table 2 shows those behaviours that the participants felt were forms of self-injury or self-harm. These have been categorised as direct forms of self-injury, referring to behaviours that in accordance with a definition of self-injury as deliberately inflicting pain or injury to oneself; and indirect/other forms of self-harm.

Table 2. Types of self-injury and self-harm reported

Direct forms of self-injury	Indirect/other forms of self-harm or self-destructive behaviour
cutting	jumping from windows
burning with matches/lighters	solvent use
non-fatal overdoses	alcohol abuse
use of chemical substances to burn skin	anorexia/bulimia
scratching	induced vomiting
strangulation	non-eating for long periods of time
hitting walls with fists	sleep deprivation
head banging against hard objects	eating poisonous plants
injecting surgical spirit	violent sex
poking sharp objects into skin	
burning with hot metal	
punching walls	
hair pulling	

Interviews

The majority of the sixteen interviews were carried out at University College London. Two was conducted in the participants' own home, and another was conducted in a women's drop in centre. The interviews lasted for between one hour and one and a half hours All interviews were audio-taped and later transcribed verbatim by the researcher.

Ethical issues

As the nature of the study necessitated participants discussing very personal and potentially upsetting issues, a number of safeguards were put in place to ensure that they felt safe, and to minimise any distress.

Firstly, participants were fully briefed about the nature of the research and interview:

- Participants who were to be interviewed were given the opportunity to ask questions and discuss the purpose of the study over the phone, or by e-mail, prior to their interview. This information was based on details provided on the information sheet.
- On meeting, prior to the interview itself, the research process was explained again and the participants were given the information sheet (see appendix 3). They were given the opportunity to ask any further questions before signing the consent form (see appendix 4).

The researcher acknowledged that the interviews may be difficult for the participants and developed a number of groundrules regarding confidentiality and boundaries:

- The participants were reassured that they were not obliged to answer any questions or discuss any issues that they felt uncomfortable with, and that they could stop for a break at any time. In accordance with the consent form, they were also able to stop the interview at any time and could withdraw from the study without giving a reason.
- After the interview, approximately 20 minutes of informal contact time was spent going through the demographic information sheet and arranging travel expenses if appropriate. (See appendix 5 for copy of demographic information sheet). This also provided an opportunity for the interviewer to check out how the participant was feeling and that they felt comfortable and safe with regards to what they had said during their interview.
- Information regarding contacts and services was available for participants if they wished. This contained information about literature, helplines and websites related to self-injury.
- It was arranged that any participants who felt distressed and wished to discuss this further, would be given the opportunity to meet with the interviewer's research supervisor, an experienced clinical psychologist. In practice, none of the participants needed this.

Participants' engagement with the interview process

In general, the participants formed a good rapport with the researcher, and were keen to share their experiences of self-injury. Some found it difficult to open up at first, and as a result these interviews were significantly longer than an hour. The participants varied in the extent to which they had discussed their self-injury with others, with some reporting that it had been useful to think about their self-injury in such detail. A few of the participants were curious about whether they were 'typical' of other self-injurers, for example in terms of methods used, and whether the answers they were providing would be helpful. Some were intrigued as to why a research study was being set up to explore self-injury in the context of having a lesbian or bisexual identity, whilst others felt that their identity directly or indirectly impacted on their self-injury.

Interview process

Interviews commenced by asking the participant to tell the researcher about times that they had harmed themselves. Although the content of interviews was predominantly determined by what the participant spoke about, there was an interview schedule which followed a semi-structured format of questions. These focused on the following areas:

- The participants' thoughts on what led them to self-injure, in terms of underlying issues and triggers.
- The process by which they had come to identify as lesbian/bisexual and any difficulties at this time or in living as a lesbian/bisexual woman.

- The participants thoughts about their self-injury in the context of their sexual identity.
- The participant's views of services they had been in contact with.

(See appendix 6 for interview questions)

This schedule was used as a guide for the interviewer to check that all areas had been covered.

Data analysis

The interviews were transcribed verbatim by the researcher. All information relating to details that might identify the participants, such as family names, names of towns and places of employment were omitted to ensure confidentiality. The transcripts were then analysed using Interpretative Phenomenological Analysis (IPA), a method of qualitative analysis.

Initial process of looking for themes

In the initial stage of the process, the transcripts were each read in turn, one after the other, to become familiar with the data. Then each individual transcript was focused on in more detail. This involved a cyclical process of reading and re-reading the transcript several times, noting down initial thoughts and summaries. At this initial stage, the comments closely reflected the data. An example of this initial stage of the process is illustrated overleaf:

Quote	Preliminary notes
<i>"I just think it makes you feel better, there's too much going on, like a hundred things going on at once and it's just like a bright light, a focus, just one thing and everything else shuts out for the next few minutes or however the pain lasts really..."</i>	makes you feel better too much going on like a bright light, a focus everything else shuts out pain

After this next stage, the transcript and initial notes were read again, with the aim of identifying emerging themes. Themes can be defined as key words or phrases that capture the essence of what is being said. On a separate piece of paper emerging theme titles were noted. At this stage, the themes were kept at a broad level, due to the number of other transcripts from which to ascertain themes. In adherence to recommendations for good practice (Elliott, Fischer, and Rennie, 1999) the research supervisor also examined transcripts at this stage in order to check agreement with the researcher's themes. An example of this stage of the process from another transcript is illustrated below:

Quote	Theme
<i>I would never have committed suicide, I thought it was my duty to stay alive no matter how impossible staying alive was, and I would never have had a nervous breakdown because I was terrified of having a nervous breakdown, so I would have done everything to avoid both of those things</i>	survival/staying alive

Deriving a master list of themes for the group

Once a list of themes and quotes had been ascertained, credibility and verification checks were undertaken by the research supervisor who examined each table to ascertain the 'goodness of fit' between the evolving themes and the original data.

Once each transcript had its own table of themes, the process of deriving a master list of themes began.

As the interviews were particularly dense, containing lots of rich details, the number of themes ascertained for each transcript varied from approximately 15 to 25.

Individual theme titles from each transcript were written on individual strips of paper and were considered in conjunction with themes from other transcripts. Initially themes were categorised broadly, for example in terms of themes relating to the reactions of others and themes relating to the experience of self-injury. The themes were then categorised more specifically, with more detailed consideration of their commonalities. In line with recommendations regarding validity in qualitative research, this process was undertaken by researcher and supervisor who negotiated the categorisation of themes. It was found that some themes were essentially the same across transcripts, for example, themes relating to self-injury as a coping mechanism. Other themes had a common overarching theme in common; for example themes relating to ways in which self-injury was used as a way of blanking out or 'shutting down' feelings were re-titled 'numbing'. These themes were then further considered to see if higher order categories could be created that would encapsulate the lower-order themes in a meaningful way. This process resulted in six higher order categories being ascertained which will be discussed in the next chapter.

CHAPTER 3: RESULTS

This chapter describes the themes that were ascertained from qualitative analysis of the participant's interviews. There were twenty-eight themes that fell into six higher-order categories, as follows:

- A: Bad things** - background and underlying issues;
- B: Just doing it** - the context in which self-injury initially occurs;
- C: It helps me cope** - the functions and uses of self-injury;
- D: Role expectations** - conflicts with society's expectations, coming out and homophobia/heterosexism;
- E: Pride or shame** - the feelings associated with self-injury; reactions of others;
- F: Moving on or slipping back** - decisions to stop self-injurious behaviour and the associated difficulties.

In this chapter, the themes within each higher-order category will be described and illustrated with quotations from participants. An indication is given of how many participants mentioned issues relating to the theme. '*Frequent*' indicates ten or more participants, '*moderate*' indicates between five and nine participants, and '*infrequent*' indicates less five participants. Figure 1 presents the higher-order categories and themes.

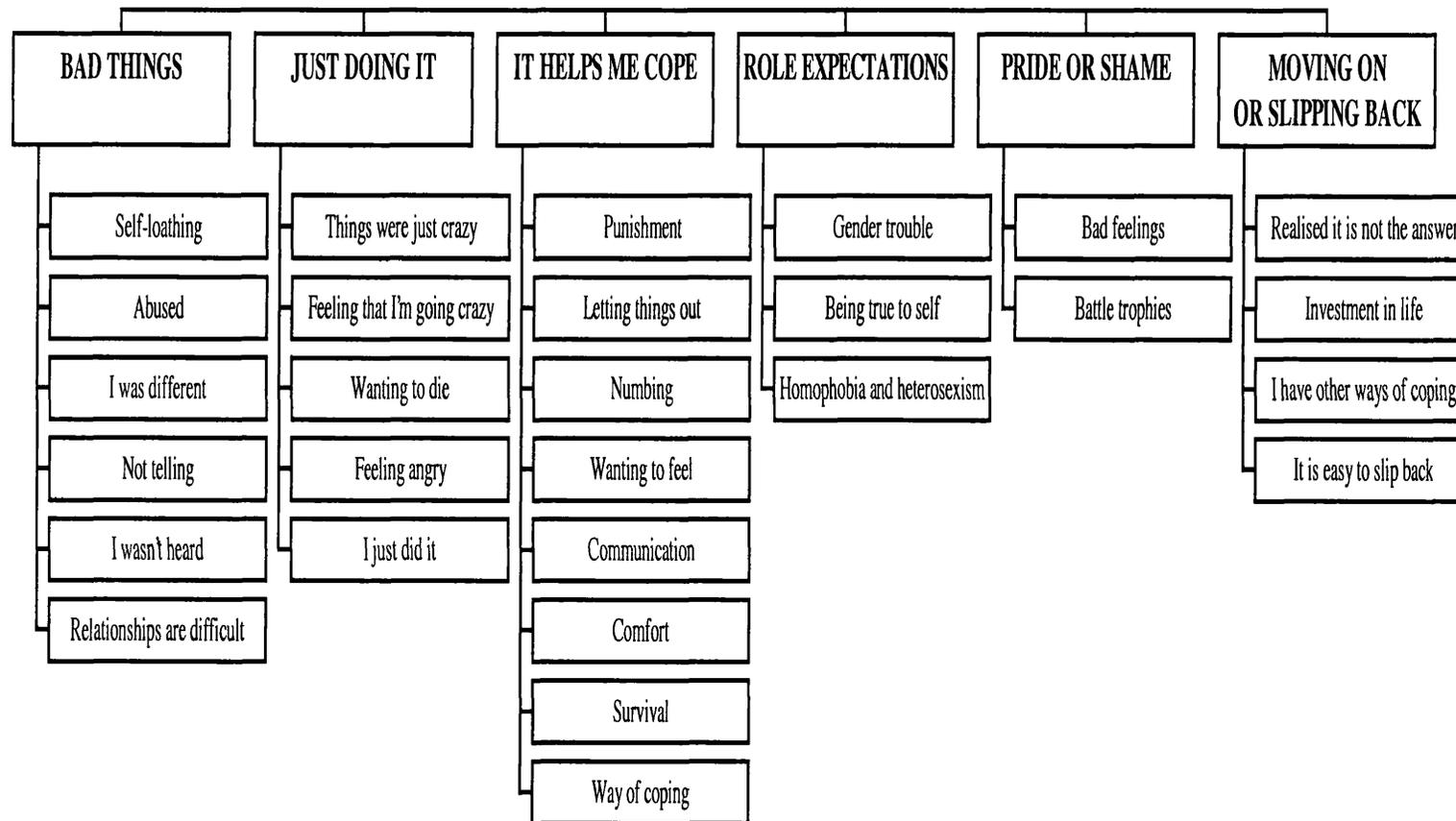


Figure 1. Higher order categories and themes

A: BAD THINGS

This category comprises six themes that emerged from the data, relating to the background and underlying issues contributing to self-injury. These themes encompass external experiences reported by the participants, including distressing childhood and adulthood experiences such as being abused physically, sexually or emotionally, or being excessively criticised by their family or partners. Other themes that emerged are related to the participants' internal experiences; for example, feeling that they had to suppress their emotions, or that their feelings were not validated by others. These themes are summarised in Table 3: Themes relating to 'Bad Things'.

Table 3. Themes relating to 'Bad things'

Themes	Prevalence
Self-loathing	medium
Abused	medium
I was different	frequent
Not telling	frequent
I wasn't heard	frequent
Relationships are difficult	medium

A.1 Self-loathing

Definition of theme: This theme emerged from the participants' reports of intense negative feelings about themselves. Some of the participants reported hating themselves; for some this was related to negative perceptions about their physical appearance. For many, childhood experiences led to feelings of self-loathing; for example, being negatively compared with siblings, bullied, criticised, made to feel inadequate, or being abused. The theme 'self-loathing' contains the following sub-themes: 'no self-worth', 'I hate myself', 'I'm too much for others' and 'I don't matter'.

No self-worth

Some participants said they had low self-esteem, and had felt that they were worthless and inadequate since childhood:

I just don't remember having any self worth or anything like that, I didn't know what it was like to be confident. I'd walk around with an unreal smile on my face, and I wouldn't speak to anyone unless they spoke to me. (Sally)

As adults, some participants gained more confidence and were more positive about themselves, while for others, low self-esteem and negative feelings about themselves continued to affect different areas of their lives, including their work and social life. For some, their negative feelings about themselves affected the extent to which they interacted with, and attempted to form relationships with, other women:

Because I've got very very little confidence I don't believe that any woman could be attracted to me or like me in that way. (Kelly)

I hate myself

I hated myself when I was a child, I thought everybody else hated me. (Ulrika)

For Ulrika, feeling hated by her peers at school while being made to feel inadequate by her family meant that she began to expect to be hated by others. One consequence of feeling hated at such a young age could be that the reasons for this experience are not questioned or challenged. For some participants, self-injury was consequential to their feelings of self-hatred. In this context self-injury could be a way of attacking or punishing themselves for being, in their eyes, ugly or repulsive:

I do hate myself...whenever I look in the mirror I see something really fat and ugly. (Cassandra)

For others, self-injury served a dual purpose in self-punishment and in providing a way of getting away from the intense feelings surrounding self-hatred. In this context, self-injury could be a way of confirming their feelings of self-disgust. Some participants felt that they were burdensome to others and that the fact that they self-injured was further proof of their inadequacy, further fuelling the cycle of hate.

I'm too much for others

Some of the participants felt that they were 'too much' for others, that they were 'draining', or that their problems were overwhelming for others. Such beliefs contributed to their negative feelings about themselves. A few participants reported that they had tended to be 'the listener' for their friends. Feeling that they could no longer fulfil this role could be a source of self-loathing:

I saw less people coming to me for support, and me going to other people for support; so I felt that I was a parasite, I felt like I was draining people.

(Amanda)

Feeling that their problems are too much for others could affect an individual's use of services. One participant in particular commented that she felt that her problems had been too much for her counsellor to cope with. For others, it was difficult to talk about their self-injury with their friends, through fear of burdening them or causing conflict within the friendship, as one participant commented:

I don't like to put that sort of shit on their shoulders. (Emily)

I don't matter

Some participants felt that they did not matter and that harming their bodies was not a “big deal”. Often, when participants reported these feelings, they also reported other forms of self-destructive behaviour such as starving themselves, bingeing or vomiting, or alcohol abuse. One participant in particular reported that as a young adult she had resented having to look after herself physically or practically, and for example, would go for long periods without eating. In this context, the concept of doing harm to oneself may be seen as neither salient nor important:

Part of the anorexic attitude is that you can do anything and beat your body; and your body doesn't matter [...] So the word harm hadn't come into my head because it didn't matter. (Bettina)

A few other participants were not concerned about getting wounds attended to medically. One participant in particular felt that people who cut themselves tended to have stitches for aesthetic rather than medical reasons.

Some participants had experienced early childhood abuse that had left them feeling that they did not matter. In such situations they had been helpless and unable to control what happened to them. Self-injury could be a way of making an individual feel that she did indeed matter:

I always felt like I didn't matter, I think cutting myself made me matter really. That's the thing that people don't understand, that it's done because you do actually like yourself in a funny way, you know, because for me it was a way of saying that I mattered in a strange way. (Tamsin)

A.2 Abused

Definition of theme: this theme refers to the types of abuse mentioned by the participants - sexual, physical and emotional. It also illustrates some of the wide-ranging consequences that the participants felt were related to having been abused. These consequences varied between participants. The following sub-themes are presented here: 'I was abused', 'damaged boundaries', 'wanting to regain control' and 'confusion about sexuality'.

I was abused

Many of the participants had experienced abuse in either childhood or adulthood, sometimes both:

With my family it was mental and sexual, but later on it was mental and physical and sexual... it was everything later on, I was treated really badly.

(Tamsin)

Physical abuse could be perpetrated during childhood by siblings or, as a young adult, by abusive men:

My sister bullied me physically [...] when people weren't looking, being violent to me and stuff. (Ulrika)

People were very very violent to me and quite a few people tried to kill me.

(Tamsin)

Others had experienced emotional abuse from partners; for example, being excessively criticised or experiencing physical abuse from male or female partners in relationships. Some participants had experienced repeated episodes of violence, sexual assaults or rape as adults.

Some of the participants felt that having been sexually abused in particular, was directly linked to their self-injury:

I definitely think that if I hadn't been abused it's very unlikely that I would be a self-harmer. (Roberta)

Experiencing sexual abuse in childhood could have long-lasting and wide-ranging effects that were not specific to self-injury, for example, problems with eating and sleeping. In this context, having been abused could lead to a range of difficulties and issues that were difficult to disentangle, including anxiety regarding boundaries, wanting to be in control, and feeling confused about their sexual feelings.

Participants sometimes felt confused about boundaries and about acceptable ways of being treated. This sometimes led to relationships being formed in which participants were physically and emotionally abused. As Tamsin commented:

I didn't know that you didn't have to be abused. (Tamsin)

Damaged boundaries

Some participants talked about their abuse representing a violation of their boundaries, and said that as a consequence, they were anxious about boundaries; for example, being territorial about their personal space, or being particularly sensitive to situations in which they felt their boundaries were being invaded. For some participants, in such situations, self-injury could occur spontaneously, or as a way of dealing with the intense emotion that this raises:

I was saying I'm going to go to bed, and he didn't need to but he started undressing me, and that was it I just flipped my lid and screamed the place down, and was self-harming left right and centre. (Glenda)

Self-injury could also be a way of reaffirming boundaries; a way of having something that was private. Tamsin indicates how self-injury could be a way of defining the boundary between herself and her abuser:

It was almost like to make me 'me' [...] he tried to take everything over in my life, my head and everything, he tried to make me feel like I belonged to him.

(Tamsin)

Confusion about sexual feelings

A consequence of being in sexually abusive situations as children or adults could be a tendency to suppress and avoid issues to do with sex and sexuality:

I had just pushed away anything at all to do with sex and sexuality, thinking this is really bad, just you know...really horrible, and to be avoided at all costs. (Laney)

Others felt scared and confused of their sexual feelings, feeling that perhaps they were not attracted to men because they had been sexually abused. For Tamsin, having been shown violent pornography by her stepfather for many years, an increasing awareness of her attraction to other females made her scared:

I always fancied women, even then, but I didn't like it, because I didn't know that you could feel things like that, all I knew about lesbians was what I was taught by my mum and my step-dad and that was like pornography. (Tamsin)

A.3 I was different

Definition of theme: this theme refers to the various ways in which participants had felt different from others in a way that had negatively affected their sense of self.

Being perceived as 'different' from early childhood could have detrimental effects on one's self esteem. Some participants retained this feeling of being flawed, to the extent that they felt that there was something inherently different or wrong with them:

I grew up taking it for granted that there was something wrong with me.

(Ulrika)

Approximately half of the participants who mentioned issues relating to this theme indicated that feeling different could be related directly or indirectly to sexuality or gender issues; for example being bullied for being gay, not conforming with gender or lesbian stereotypes. Other reasons included being unfairly compared with siblings, or feeling that they were not accepted by their peers. Some of these feelings could resurface in adulthood, particularly when participants attempted to fit in with other lesbian and bisexual women. This theme contains the following sub-themes: 'I never measured up', 'not fitting in', 'I did not conform' and 'feeling different from other lesbian/bisexual women'.

I never measured up

Some participants felt that they were negatively compared with siblings or peers, which contributed to, and reinforced their low self-esteem. This could be for reasons related to academic ability, such as performing less well than their siblings or peers at school, or personality differences, for example, being quieter than others. These factors could lead to scapegoating within the family:

I was the bad one, I was very much the bad one of the family. (Ulrika)

Not fitting in

Some participants felt that, for various reasons, they did not fit in with their peers. One reason could be feeling alienated from one's peers as a result of being unhappy at home. For some, seeing others being more confident and outgoing led to feelings of envy and inadequacy, thus reinforcing negative feelings and self-loathing. Others felt that they did not fit in with their peers at school because they had different backgrounds, they were cleverer than others, or not clever enough, or were from a less financially privileged background. The sense of isolation and self-loathing that may arise from such experiences could lead to a strong desire to fit in and be accepted. For some, fitting in seemed impossible and led to self-attack:

I sort of was aware that I was different and aware that I wasn't wanted [...] and I think it made me angry at myself more than anyone else, so I took it out on myself. (Imogen)

However, self-injuring could result in individuals feeling even more alienated and different:

I thought obviously at the time I thought I was mad because I didn't know anyone else who had done this sort of thing. (Emily)

I didn't conform

Even if you're ok with your sexuality and things, the way things work, especially during educational years is that if you don't conform [...] even if you're ok with being gay you're still different, you still feel different.

(Imogen)

Some participants felt that were not like their peers; in some cases this was related to not being interested in talking about boys and make up, or for others, feeling that they did not conform to the expectations associated with being female. Some participants were targeted by their peers for being gay. A few participants felt that their internal perception of their gender was not consistent with that of a female. Such feelings could lead to behaviour that seemed odd to others; for example, dressing in a boyish manner as a child, or aligning themselves with boys at school when girls and boys were divided. For others, although they were comfortable with their female gender, they did not conform to gender stereotypes. Some of these described themselves as having been a “tomboy” or “one of the lads”.

Feeling different from other lesbian women

The feeling of being different also arose for some participants when they attempted to fit in with their local lesbian scene or community. A few participants reported that initially they had felt that they were different from the others on the scene, and had been concerned about whether they would be accepted. These reports mainly centred around feeling unsure how to approach people, and issues relating to physical appearance and the feeling that there was a code of dress and appearance that most other people seemed to conform to:

I did feel a bit of pressure, the first time I went to youth group, everyone had really short hair, and looked really dykey, and the men looked the same.

(Roberta)

Some participants felt they had to conceal their scars and wounds and therefore could not conform to the dress codes. As one participant commented, she could not wear the “little vest tops” that many others wore when they went to clubs. Some participants reported feeling concerned that they would be judged negatively or rejected by other women if it was found out that they self-injured. Others feared rejection for having had relationships with men or for having had children. One participant who was a mother chose not to tell others unless she felt it was safe to do so. For some participants, ‘not telling’ was a significant factor in the origin of their self-injury.

A.4 Not telling

Definition of theme: this theme refers to difficulties in identifying, expressing and verbalising emotions. Issues relating to ‘not telling’ were universally mentioned, with the majority of participants finding it difficult to express or tolerate intense emotions. Participants talked about the complex ways in which ‘not telling’ affected their self-injury and the way they handled crises and emotions. This theme contains the following sub-themes: ‘not ok to express emotions’, ‘suppressing feelings about sexuality’, ‘could not talk to anyone’, and ‘not telling in treatment situations’.

Not ok to express emotion

For some participants, the expression of emotion was discouraged; for example, as children, it was acceptable for their parents to get angry, but they were not allowed to get angry or shout. Others were only able to express their emotions through aggression. In adulthood this led to responses that were experienced as punishment:

When I was in hospital they used to take away my privileges and every time I acted out, and even if I didn't act out they seemed to be taking them away [...] they took everything away from me in the end, even if I raised my voice or cried or anything, they would say right, injection, injection. (Roberta)

One consequence of not being able to overtly express emotion could be a difficulty in identifying or verbalising intense emotion when it occurs:

When I cut my wrists I don't know if I'm angry or if I'm sad or if I'm frustrated or stressed. (Josephine)

Some participants were unable to talk about their feelings due to a general family tendency to not discuss such matters, or because they wanted to protect others by not talking about their problems:

I looked after my grandmother by not telling her how unhappy I was and practically as well, and looked after my parents in the same way. (Bettina)

Keeping it shut in

For the participants, one consequence of not having an opportunity to express feelings and emotions was the suppression of such feelings. With the benefit of hindsight some participants felt that their self-injury had started partly as a result of having suppressed their emotions arising from earlier upsetting or traumatic

experiences. For Roberta, being punished for “acting out” during times of distress contributed to a tendency to suppress her emotions. Inevitably, such feelings did not stay suppressed, and she felt driven to alleviate her distress:

When I finally got out of that situation I thought every time I have a bad feeling instead of going mad, I've got to self-harm or something. I started burning myself and doing all kinds of things really bad. (Roberta)

Some participants felt that their self-injury was something to be kept secret, “a private thing”, that when spoken about, caused conflict in relationships, affected friendships and upset family members. Therefore, in order to protect others from any further damage, they had to ‘keep it all in’:

I tried to keep it all to myself so that I couldn't hurt any more people, because I'd lost my best friend, and I'd hurt my family, and my friends weren't interested and I just wanted to try to keep it all to myself so I couldn't do any more damage. (Imogen)

For individuals who had been abused, repeated traumatic experiences could affect their ability to deal with intense emotion. This, in addition to having learned to suppress rather than express emotion, could leave the individual confused and overwhelmed by distress:

[Being sexually abused] brought up feelings of anger, feelings of loss, feelings of guilt, shame, all these different things, I didn't know what to do with them, I didn't know if I should be feeling them or not, I had to suppress everything. (Roberta)

Something funny going on

The tendency to keep things in influenced the way in which the participants dealt with their increasing awareness of their sexual orientation. Some participants were scared of any sexual feelings, regardless of whether they were for males or females. Others were particularly concerned about being attracted to females. Having been accustomed to feeling different from their peers, one consequence of an increasing awareness of sexual and emotional feelings for other females could be the interpretation of these as being yet another indication that something was wrong with them:

I knew then that there was something funny going on, I couldn't understand why I was attracted to women [...] so I pushed it aside, I kept pushing it down whenever I had an attraction for anyone. (Sally)

Other participants denied their feelings to themselves and others, for example, through forming relationships with men.

For other participants, even though being gay was not perceived to be inherently negative, they felt that focusing on this aspect of themselves was an unwanted added source of stress. One consequence could be that such feelings and thoughts were pushed away. However, as participants discovered, trying to suppress such feelings did not always work. For some, the feelings would get stronger or would not stay suppressed:

The feelings just were getting worse and worse, I just couldn't deny it anymore. (Glenda)

I couldn't talk to anyone

For some participants, although they wanted to tell others how they were feeling, an appropriate confidante was either unavailable or unapproachable:

I never felt I could talk to her, I never felt she would listen to me when I did talk to her. (Sally)

As a consequence of a variety of reasons, including heterosexism, homophobia and feeling isolated, some of the participants had found it difficult to talk about their growing awareness of their sexual orientation, feeling that being attracted to other females was, to some extent, a taboo. For others, receiving a negative response when they did communicate how they felt could result in them feeling wary and scared of their feelings:

I had difficulties with coming out, being gay, everything. I think with the reactions I got I was very frightened of how I felt. (Glenda)

For other participants, even after acknowledging their feelings, a tendency to 'not tell' continued for various reasons. As such, although they acknowledged their attraction to women, they were unable to discuss this with others. The combination of having difficulty with dealing with emotions and not being able to talk to others could result in despair. Other participants actively chose not to tell people about their sexuality, feeling that it was not relevant or not safe to do so.

Not telling in treatment settings

Participants who received services reported that, in general, they were open about their sexual identity. For some, their experience of having their sexual orientation pathologised earlier on in life, for example in child services, had led to a wariness of talking to professionals about their difficulties:

Five years, every week I had to go there and be told that being gay was inferior, it was terrible. (Josephine)

Being in a residential treatment setting such as a therapeutic community or a group therapy programme often meant that exclusive relationships with other patients were prohibited, resulting in close friendships and relationships between women having to be kept hidden. This could lead to a feeling that one was being oppressed, resulting in a reluctance to discuss issues related to one's sexual identity through fear of reproach.

As Phoebe indicated, not being able to talk about her concerns about her girlfriend's behaviour could lead to urges to self-injure:

I couldn't talk to anyone about her...so once again having this sort of secret relationship meant that I was very close to self-harming a lot of the time, and I wound up hurting myself a couple of times but mostly I stopped eating.
(Phoebe)

The participants reports indicated that 'not telling' was often linked having not been heard in various contexts.

A.5 **I wasn't heard**

Definition: this theme relates to the participants' experiences of having their feelings or difficulties invalidated or not taken seriously. This included upsetting or traumatic experiences in childhood and adulthood failing to be adequately acknowledged by others, as well as issues relating to their self-injury and sexual identity. The theme contains the following sub-themes: 'my feelings and experiences were not validated' and 'not heard in treatment settings'.

My feelings and experiences were not validated

For some participants, their traumatic experiences in childhood were not always validated:

I made the connection about why I had to have such a big drama about my acting out, and it was mostly to do with [...] all the things that went on in my childhood, and I realised that I had to make such a big drama about it because I wasn't heard as a child. (Glenda)

Glenda felt that when she tried to express her distress about her experiences, attempts were made to stifle such communications. Others felt that when they did communicate their experiences, they were not responded to adequately, resulting in the feeling that they had not been believed. A consequence of not feeling believed could be further suppression, as the individual was left alone with her feelings, not knowing how to deal with them:

[Being sent home from care] made me wipe out everything that had happened, and I think all that suppression led to my self-harm because I

didn't know what to do with my feelings, because they were denied to me.

(Roberta)

Not heard in treatment settings

For some participants, the feeling that people did not take their needs and communications seriously could be reactivated in treatment contexts, in particular A&E. Participants reported having received varied responses to their self-injury; some had had positive experiences, feeling that they were being treated with empathy and understanding, but many more had had negative experiences. Participants felt that they had been misunderstood, patronised or treated badly:

Their attitude towards me was really uncaring [...] they were really curt and didn't have any time for me. (Sally)

Some participants talked about feeling that they had been judged as being difficult, merely 'attention seeking' or not being genuinely in need of help:

They just seem to think that I do it for fun, I'm going in there just to wind them up. You go in and it's like oh not you again, like I'm making their life difficult. (Roberta)

Some participants had received inadequate treatment, such as being sutured without anaesthetic. One participant reported having been turned away on at least one occasion, on the grounds that she had already attended twice that week. Others felt that they were being made to feel bad or guilty about their actions.

Many participants reported being aware of the impact that self-injury had on others, and some acknowledged that when they were in distress, their behaviour could be difficult to manage:

I suppose I haven't helped my case by having a few freak outs there and shouting at people and throwing furniture, so I haven't really helped in that way. (Roberta)

A.6 Relationships are difficult

Definition: this theme relates to difficulties forming and maintaining relationships.

Participants talked about the different issues that being in relationships could raise; for example, issues relating to trust, intimacy and boundaries:

I'm really scared about another relationship. I am actually terrified. I think some of the self-harm comes when I think about relationships, I don't feel that I can do relationships. (Tamsin)

For some of the participants, early upsetting experiences could lead to difficulties in trusting others, or a fear of getting close to people or allowing others to get close to them. This could lead to a tendency to have short-term 'flings' with other women, rather than long-term relationships. Some participants found it hard to make friends, or, as a result of having little confidence or self-esteem, felt that no-one would be attracted to them. Others felt that their emotional issues were too much for others, and that they were likely to be rejected if they formed relationships. A fear of getting hurt or hurting others could also lead to a reluctance to have a relationship:

I've never really had a long term relationship with a girl, primarily because I don't trust myself and I don't trust anyone else to not hurt me or me not to hurt them. I don't like being close to other people anymore. (Imogen)

Issues relating to intimacy could result in difficulties occurring within relationships.

Participants reported having felt that were losing themselves in relationships, or that

they felt suffocated or drained by the intensity of the emotional and/or physical intimacy that had characterised some of their relationships. Some felt that such relationships had contributed to an increase in their self-injury for various reasons. In such cases, self-injury could be a way of defining the boundary between themselves and their partner; a way of gaining emotional and physical space within the relationship:

I would go out or lock myself in the bathroom and do it, it was the only space I got. (Emily)

Experiences of having been sexually abused could result in particular problems with sexual intimacy; for example, sexual activity could trigger flashbacks of early abuse or strong emotions. Awareness of this tendency could result in the woman being wary of having another relationship, in case her feelings were not understood or validated by her partner:

I'm really scared about having sex again, in case I cry, because when I first enjoyed sex, I cried. I wasn't crying about the sex, I was crying about everything, and I think I'll probably do that again. I don't want somebody to turn round and make it nothing. (Tamsin)

Experiencing abuse during childhood or adulthood could result in the re-enactment of abuse patterns in adulthood; some participants reported that they seemed to end up with partners that were abusive or exploitative. Alternatively, having to deal with the emotional consequences of traumatic experiences could result in a feeling that engaging in a relationship would be too difficult to cope with.

Some participants found it difficult to form relationships with other women because they were in treatment settings and had little opportunity to meet other lesbians. Being dependent on psychiatric services could result in difficulties meeting and interacting with people outside of the psychiatric system:

I'm finding it hard to meet people because I don't know what to say to people. People always ask you about your job and this and that; I don't want to say I've never been able to work, I've always been on benefits in hospital. I find that really hard, just meeting people, generally, and meeting lesbians especially. (Roberta)

Some of the participants reported feeling wary about potential partners finding out about their self-injury, fearing that they may be judged or rejected. Another fear could be that they would be seen as unattractive and therefore not desirable. Other participants had been in relationships where they feared reproach or rejection from their partner, resulting in them attempting to conceal their self-injury, or being self-destructive in other, less visible ways, such as through not eating.

B: JUST DOING IT

This category relates to the context in which self-injury commonly occurred.

Participants talked about their varied experiences that led to self-injury; for some, self-injury had occurred for the first time when they were children, others had started for the first time in adulthood. The category captures the build up and accumulation of feelings that culminated in the sense that, as the first two themes indicate, ‘things were just crazy’, or that participants themselves were ‘going crazy’. These are summarised in Table 4: Themes relating to ‘Just doing it’.

Table 4. Themes relating to ‘Just doing it’

Things were just crazy	frequent
Feeling that I’m going crazy	medium
Wanting to die	medium
Feeling angry	medium
I just did it	medium

B.1 Things were just crazy

Definition of theme: this theme refers to the build up to the point at which self-injury may occur, and reflects the types of external stress that was experienced by participants. When self-injury occurred or re-occurred in adulthood, it was usually during times of stress or crisis.

For most participants, it was an accumulation of events that led to the first incident of self-injury; as Fiona comments, “things were just crazy”. The reported self-injurious behaviours that occurred in childhood for a few of the participants included poking pins in oneself, hair-pulling or scratching oneself with fingers or sharp stones. Others suffered from eating disorders such as anorexia. The context in which such

behaviours occurred included being raised in dysfunctional families, and/or experiencing sexual, physical, emotional abuse or neglect.

Some participants were faced with difficult home circumstances such as being brought up by family members with mental health problems or who abused alcohol, or living with relatives who were ill. During adolescence, such circumstances could lead to a desire to escape from home through the formation of relationships with others that could end up being abusive or exploitative. For one participant, being in care as a result of allegations against her stepfather resulted in her feeling alienated from and rejected by her family:

I was having lots of problems with my family which was the whole reason why I was in care in the first place, and not having a very good relationship with them. And they were kind of disowning me, and saying they didn't want to see me anymore, those kind of things. (Glenda)

A few participants reported that, as adolescents, they had socialised with other peers who had problems, resulting in them becoming involved with alcohol, drug abuse, prostitution or crime. Self-injury could occur at other times when 'things were crazy'. Such instances seemed to be times when the participants felt that events in their life was becoming increasingly out of their control:

It's like when I don't have any control in my life, things are happening, I just don't know how to stop it - that's when I do it as well. (Cassandra)

I had no control over when she was going to hit me or make me fucking scrub the floor or whatever shit she made me do. (Fiona)

Examples included being in an abusive relationship, an unhealthy relationship or a relationship in which they felt unable to support their partners emotionally; pressure while studying at college; experiencing family difficulties; losing one's job; or being bullied or targeted because of one's sexual orientation. Three participants reported having been homeless, and for one in particular, this was related to being given an ultimatum regarding her sexual identity by her sister. For others, the process of socialising on the scene, and repeatedly putting themselves at risk, could also lead to a sense that things were spiralling out of control:

I went crazy when I first came to [name of city], sleeping with people I didn't want to sleep with, sleeping with abusive people, sleeping all over the place, and putting myself at risk, constantly every night, from disease or from violence. (Fiona)

B.2 Feeling that I'm going crazy

Definition of theme: this theme relates to the inner experience that could lead to self-injury. This was usually characterised by intense emotion that could no longer be tolerated, resulting in strong urge to alleviate it. Such experiences could lead to the feeling that the individual was going mad:

I know not necessarily what the emotions are, but they are too much...and I have that feeling, I'm going barmy, I'm going mad. (Bettina)

Participants described this inner experience in different ways, and it was evident that the amount of time for which the intensity of emotion could be tolerated varied from minutes to days. Many participants described a feeling of an incredible tension inside, described by one participant as a "screaming, aching frustration" that needed to be released:

It's like having something locked up inside me that needs to get out. (Sally)

Just feeling very anxious and very tense and angry, one of the feelings that I used to get was I felt like I wanted to tear my skin off. (Glenda)

Participants reported feeling felt that they were a “wreck”, that they were falling apart and felt overwhelmed by their emotions and thoughts:

Sometimes I feel like I'm going crazy with it, when I'm left with my own thoughts, I do feel like I'm going crazy, because it's just full of these nasty bloody gruesome images that I don't seem to have any control over. (Ulrika)

Such feelings could lead to feelings of desperation and self-destructiveness, resulting in depression.

B.3 Wanting to die

Definition of theme: this theme relates to the feelings of depression and suicidal ideation which could lead to self-injury. For some participants, their social circumstances fed into their self-loathing and contributed to their feeling of depression. Instances included feeling trapped in an abusive relationship with either a man or woman; or bringing up a baby with no support from others; or having to give up a baby for adoption.

For others, their usual methods of getting away from their feelings were no longer available to them; for example, due to having stopped using drugs or drinking alcohol. One consequence of this could be an increase in the intensity of underlying feelings of depression and self-injury could initially occur as a form of self-attack, or as a way of attempting suicide:

I think for me what started it off, it felt very much like it was a suicide attempt without knowing very much about what I was doing. (Glenda)

Self-injury may evolve from this initial suicide attempt when the participants experience their action as resulting in a positive outcome such as relief. Some reported feeling a “buzz” after self-injury, and as such, they tended to self-injure when they felt “empty”, depressed or suicidal. Self-injury could be used as a way of getting away from suicidal thoughts, a way of averting a suicide attempt.

For some, trying to communicate the extent of their distress to others, and not being heard, meant that they became angry, resulting in self-attack and retaliation:

I felt practically a wreck. I couldn't do things that other people did; I felt incapable of having relationships with people; just felt incredibly isolated, and so I became suicidal, and I tried to tell people and they didn't listen, and that's when I started self-harming, because I got angry at being told to pull myself together. (Phoebe)

B.4 Feeling angry

Definition of theme: this theme relates to the participants' different relationships with anger. Some participants reported feeling that as women, they were expected to express their anger in socially acceptable ways:

I think we're taught not to show our feelings outwardly, you know it's not as acceptable for women to shout and whatever and get angry as it is for a man.

(Roberta)

For some, self-injury partly arose from intense feelings of anger and could be a form of self-attack, or a way of getting back at others. Some participants talked about their difficulties with anger, including difficulties tolerating it. In this context, self-injury could be a way of letting angry feelings out:

I know that I have a problem with expressing anger, and that when I used to self-harm I used to feel that I didn't feel that anger anymore. (Glenda)

Other participants reported feeling angry about their circumstances. For example in abuse situations, anger that could not be expressed to perpetrators was turned inwards:

[I was angry at] the people who were abusing me, I mean I really wanted to stab them to be honest, sometimes when I cut myself it was like I was stabbing out somebody else. (Tamsin)

Others felt angry that their feelings and needs were not being acknowledged and were annoyed that their communications of their distress were responded to with platitudes such as being told to pull themselves together. Some participants felt angry with

themselves, as a result of self-loathing, and in this context self-injury could be a form of self-attack:

I don't get angry at anyone else, [I'm] angry that I am this and not anything more. I'm sure I've quite a lot of potential to be something that's quite nice, but I'm not. (Imogen)

B.5 I just did it

Definition of theme: this theme relates to a number of issues regarding the actual act of self-injurious behaviour. For some participants, self-injury began in the context of feeling suicidal, as previously mentioned. Others felt that they wanted help to get out of an abusive situation:

I was being abused at home, and I think I wanted help and didn't know how to say I wanted help to get out of the situation. (Roberta)

Some participants talked about feeling generally impulsive, and how their self-injury was one aspect of this. For others, self-injury started as a self-attack which developed into a strategy for coping that was sometimes impulsive but could also be planned.

Some participants talked about trying to resist self-injury:

It's like I don't want to do it and you're sort of fighting with yourself; like having an angel and a devil on your shoulder like, arguing with each other, like should I, shouldn't I. (Emily)

In general, participants felt that their self-injury was a strategy that they relied on in times of crisis; it was their way of getting through.

C: IT HELPS ME COPE

In the absence of a solution, all I can do is cope with the problem. This is my way of coping. (Imogen)

This category refers to the different uses of self-injury that were indicated in the interviews. The participants indicated that self-injury served a range of functions at different times. The themes in this category were represent the most commonly reported and salient functions in the participants' reports. These themes are summarised in Table 5: Themes relating to 'It helps me cope'.

Table 5. Themes relating to 'It helps me cope'

Punishment	infrequent
Letting things out	medium
Numbing	medium
Wanting to feel	frequent
Communication	medium
Comfort	frequent
Survival	frequent
Way of coping	medium

C.1 Punishment

Definition: this theme refers to self-injury as having a punishment function. For some, self-injury was used as a way of confirming negative feelings about their physical appearance, and could arise from self-hatred:

I kind of like wanted to punish myself...I thought that the burning would hurt a lot more and be a bit more disfiguring probably, and kind of like yeah that's how ugly you are. (Cassandra)

For a few participants, self-injury as a punishment could occur in the context of disordered eating habits; bingeing may make women feel bad about themselves and self-injury may be resorted to as a form of self-punishment.

For some, self-injury could be self-perpetuating; they might harm themselves because of an underlying self-hatred, and then punish themselves for their actions:

I hate myself with a loathing so deep that I would scar myself for life, it is a self-perpetuating cycle of hate. I hate myself so I tear up my arms. I'm pathetic for being weak enough not to stop myself. I hate myself for my failure and I do it again. (Imogen)

The reports of a few of the participants, indicated that a wish to punish themselves could arise in the context of feeling overwhelmed by, and ashamed of, feelings for a female friend. They talked about being concerned about how the person in question would react if they knew how they felt about them; or feeling that by thinking about their female acquaintances in a sexual way they were somehow disrespecting them.

C.2 Letting things out

Definition of theme: this theme relates to the use of self-injury as a release mechanism, described by one participant as feeling like “releasing a pressure valve”. Another participant compared this feeling of release to having an orgasm when particularly stressed; and it was suggested that in such instances, the elimination of feelings could be comparable to the elimination of food through vomiting.

Some of the participants talked about their self-injury as having a function in enabling inner emotional pain to be released. This was usually followed by a sense of relief and a reduction in the intensity of emotion.

The visibility associated with self-injury could be crucial in this context. For example, seeing one's blood could be a way of feeling that inner distress has been released, and, as one participant commented:

It was if when I cut like I seen the blood, that was all the crap coming out.

(Emily)

The majority of participants reported that they felt better after self-injuring. It was reported by some that letting out blood by cutting was like letting out negative emotion, including feelings of anger and self-hatred, and was associated with a feeling of relief. As one participant commented, letting inner pain and rage out was comparable to the valve on a pressure cooker that keeps the container's lid on. In this context inner turmoil could be released, resulting in a feeling of calm:

I feel very calm and I feel much more compassionate with myself, really settled down, kind of relieved and quiet... self hatred and that goes...I can be more kind and gentle with myself. (Ulrika)

Self-injury could be a way of letting out inner pain and taking care of it through tending to the resultant physical wounds. Some acknowledged that they tended to "bottle things up", and conceptualised self-injury as being a way of easing out the emotional pain that was cooped up inside of them. Some participants felt drained and exhausted after self-injury, but this was seen as a positive aspect, as self-injury could therefore be utilised to induce sleep.

C.3 Numbing

Definition of theme: this theme relates to self-injury as having a function in getting away from feelings by shutting down emotion and deadening feelings.

For some participants, there were times when self-injury served a function in numbing the acute feelings of distress related to experiencing flashbacks consequential to abuse. As such, self-injury could be a way of getting away from such feelings or thoughts. Self-injury could be a source of distraction by becoming engrossed in the process and consequence of self-injury:

Bleeding all over the place is quite mesmerising, and you just sort of forget about what ever it was that made you do it in the first place. (Imogen)

Self-injury could be a way of narrowing the range of emotions experienced at a given time; a way of slowing down or stopping the fast flow of upsetting thoughts and images that characterised their distress.

C.4 Wanting to feel

Definition of theme: this theme relates to self-injury as means of enabling one to feel a physical sensation, usually in the context of feeling depressed, numb or empty.

For some participants, the physical pain associated with self-injury could serve a purpose in helping them stay focused in specific stressful situations, while for others it was elicited as a way of getting away from the dissociative feelings that could be consequential to repeated abuse situations:

I didn't feel anything most of the time, it was trying to feel something, because I never felt pain much, I wanted to know that I was alive. (Tamsin)

One consequence of feeling depressed could be feeling unable to appreciate a variety of sensations and sources of pleasure. One participant described this inner experience as being characterised by a feeling that she was distant from others, as if she was in a bubble. In this context, self-injury could be used as a way of inducing the ability to feel once again, thus enabling the individual to feel reconnected with their environment:

I had this craving to feel something and I started doing things like eating lemons, the lemon skin and everything to try and taste stuff [...] then that same day I scalded myself on purpose, yes to feel something. (Amanda)

For one participant, the need for pain in combination with a feeling that her distress was not being acknowledged or heard contributed to the escalation of her self-injury:

If I burn myself with acid or something it might be like a third degree burn it might take several months to heal, so I know what I'm doing; [I know] that

it's going to be serious. I do that when I'm feeling worse and I need pain, you know, I need the buzz. It's like a buzz I get from the pain, sort of euphoric sometimes. (Roberta)

C.5 Communication

Definition of theme: this theme relates to the participants' use of self-injury in communicating their feelings to others. Self-injury could be used as a way of informing others of their inner experience of distress.

Some participants felt that the visibility of their self-injury was a way of making their inner distress real for themselves and others:

It's like look, this is how fucked up I am. I want someone to notice that I'm fucked up, rather than me just knowing how fucked up I am. (Fiona)

You hurt yourself and that is an acknowledgement of the fact that you hurt inside.. it is almost a recognition of the internal hurt that is really there...because a lot of my stuff is that I have no right to feel any pain because it feels like I had a perfectly alright upbringing. I've been quite lucky in some respects. (Bettina)

Self-injury could be an attempt at getting help or support from others, or an attempt to get their difficulties acknowledged. However, for some, the shame associated with their self-injury meant that they were wary of letting others know. Bettina illustrated this paradox:

I think part of it is having the physical wounds to show to the outside world that I have emotional wounds, but then I don't show my body...so I don't know how that works. (Bettina)

In other instances, self-injury could be a way of communicating remorse or anger to someone else, or a way of saying “I need you”. One participant reported feeling invisible as a lesbian in a refuge for women who had been physically abused by their partners. As such, self-injury was an attempt to gain support and validation of her experience:

Sometimes you were really invisible, especially if you were a dyke, it's like 'it's only women that slapped you for god's sake, it's not a man', but at the end of the day, a slap is a slap, a kick is a kick [...] I just wanted someone to say 'oh god are you ok?' (Cassandra)

C.6 Comfort

Definition of theme: this theme relates to self-injury as providing a source of comfort, a way of providing a context in which they could care and soothe themselves or receive comfort and reassurance from others.

Most participants said that self-injury made them feel better, and that they relied on it in times of stress. For some participants, it seemed to be a resource which was reassuring for them:

Sometimes I get like a memory pain, like a remembered ache where the cuts are and that is like having an old friend there. (Bettina)

I just find it really nice sometimes, it's like a comfort blanket. It's like carrying a little blanket around, a comfort blanket. (Cassandra)

Some participants reported that self-injury created a context in which, unlike the rest of the time, they felt good about themselves and could care for themselves. In such cases self-injury may be carefully planned, and the situation in which it occurs may be conducive to self-nurturing:

The second time I cut, I got candles out and I put some nice music on, and had a bath. It was like I'm going to kind of like really enjoy this because I know I'm going to go off to sleep straight away. So yeah, quite a nice setting really. Quite nice, quite romantic. (Cassandra)

As such, self-injury could be an indirect way of self-soothing, a way of creating a situation in which the individual could be kind and gentle with herself. Self-injury could also be a way of creating a context in which they felt cared for by others. For some participants, the knowledge that someone would be attending to their wounds could be comforting:

Feeling I was being looked after, and feeling I suppose safe in a way
(Glenda)

Others were searching for the sort of loving care that they did not feel they received at home, desiring parental or guardian figures to watch over them. For Imogen, her scars were a visible communication that she still needed and desired comfort and looking after:

I hate the thought of everyone thinking that I'm completely ok and I don't need looking after, don't need reassuring. (Imogen)

C.7 Survival

Definition of theme: this theme relates to self-injury as a way of surviving and continuing with life, not ending it. Participants talked about not just feeling better after self-injury, but feeling better equipped to cope with their lives.

Self-injury was universally felt to be a way of coping and getting through crises as well as the setbacks that are part of everyday life. One participant conceptualised her self-injury as a sign of inner strength in the context of extremely traumatic and distressing life experiences:

I've lived through a hell of a lot, and actually I think self-harm was a way of surviving you know, because a lot of people always say to me why aren't you dead, and I think self-harm is one of the reasons I'm not dead. (Tamsin)

Self-injury could have a preventative function in averting an emotional breakdown or a suicide attempt. Although participants had felt suicidal at times in their lives, they generally distinguished between suicide attempts and self-injury. For these participants, self-injury could be a way of saying "I don't want to die". Some participants talked about feeling that they wanted to survive their difficult life by any means necessary:

I would never have committed suicide, I thought it was my duty to stay alive no matter how impossible staying alive was. (Josephine)

Participants talked about the sense of empowerment that accompanied self-injury. In this context, self-injury could be conceptualised as a form of decisive action.

One consequence of self-injury could be the feeling that the individual could cope with anything:

When I used to self-harm it actually felt good and made me feel good... like I can take on the world now. (Emily)

D: ROLE EXPECTATIONS (BEING TRUE TO MYSELF)

This category refers to the participant's experiences in relation to society's expectations in terms of gender and sexuality. Generally, identifying as lesbian or bisexual was felt to be a relief. Many of the participants talked about homophobia and heterosexism, and some mentioned having experiences of trying to conform with the expectations of lesbian and gay communities. The final theme of the category relates to difficulties with maintaining relationships. These themes are summarised in Table 6: Themes relating to 'Role expectations'.

Table 6. Themes relating to 'Role expectations'

Gender trouble	infrequent
Being true to self/relief	medium
Homophobia/heterosexism	frequent

D.1 Gender trouble

When I was little I just couldn't understand how I could grow up to be a woman. (Ulrika)

Definition of theme: this theme relates to conflicts between the participants' internal sense of self, and society's expectations of what it meant to be female. As children, some of these participants experienced their gender to be different from that of their female peers, often resulting in being bullied.

These participants were aware of society's expectations and portrayal of femininity from an early age, but this was often not an image they wanted to strive for:

I felt that they were sort of spiky, [...] peroxide hair and high heeled boots and all of that, and they were talking about diets, you know what I mean, it was quite feminine in quite an artificial way. (Ulrika)

For these participants, during childhood, their perception of themselves did not fit in with their understanding of what it meant to be female. As adults, the possibility of undergoing gender reassignment had been considered. Puberty was a particularly difficult time and some participants attacked their bodies in an attempt to stop these developments that seemed alien to their sense of self:

I would try and like force my body not to [develop], like try and push my breasts back in; or when I was younger I used to try and force my genitals to grow differently sort of thing, almost like I could make my body change, doing that. (Ulrika)

All the participants who reported having felt uncomfortable as females reported that this had gradually been reconciled and that as adults, they felt comfortable with their identity as lesbians.

D.2 Being true to self (relief)

Definition of theme: this theme refers to the participants feelings of relief in acknowledging their sexual orientation. Participants talked about feeling that they were being true to themselves, no longer trying to be something they were not:

I wasn't trying to squash myself into something that weren't right for me anymore. I felt so relieved. (Ulrika)

I think basically I felt better for it, I definitely think that I felt much more comfortable about myself. (Phoebe)

In general, participants talked about acknowledging their sexual orientation and identifying as lesbian or bisexual as being a positive outcome of what was sometimes a difficult process. For some participants, before identifying as lesbian or bisexual, living as a heterosexual woman had been difficult:

I tried to live as an heterosexual woman, I don't do it very well. (Ulrika)

However, identifying as lesbian, as one participant commented, was like having a “second chance” and participants commented that when they identified as lesbian or bisexual, they felt that they fitted in and were a part of a community.

For some participants, identifying as lesbian represented the positive outcome of a process by which they had disentangled their sexual orientation from the feelings of confusion arising from sexual abuse. For some participants, realising that they were

gay came as a shock, while others reported being surprised, but realised that they had been subconsciously aware for a long time. Participants conceptualised identifying as gay as being true to themselves, as if they had found the missing piece crucial to their sense of self:

It just felt like oh this is what I've been looking for. It was if there was something missing and I actually found it. (Emily)

Identifying as lesbian or gay was often seen as a positive source of self-esteem, and participants reported feeling that they were part of a group, and had something to believe in and fight for, and could result in some of sources of their negative feelings and self-loathing being addressed:

It's not that there's something wrong with me, it's just 'I'm like this' and instead I've been trying to be like that and it didn't feel right. (Ulrika)

However, although coming out was a relief, other problems and difficulties remained.

D.3 Homophobia and heterosexism

Definition of theme: this theme refers to the societal context in which heterosexuality is seen as the norm and superior to homosexuality which is seen as deviant by many individuals and societal institutions. The majority of participants talked about the impact of heterosexism on their lives, and the unequal status they felt they held in society. This included the ways in which they felt their experiences were not recognised or acknowledged, and the impact of homophobia on their lives and feelings about themselves. There are four sub-themes: 'gay means bad' 'challenge/break away', 'watch your back' and 'pressure of being gay'.

Gay means 'bad'

Some of the participants reported having been brought up in areas or environments where homosexuality had negative connotations:

I come from a small town where [being gay is] not normal, it would be different if I lived in a city or something, but I didn't, and up there they hardly accept anything that's different. (Emily)

Some participants talked about services presuming that their problems originated in their confusion about their identity, or that having a homosexual or bisexual identity was the cause of their emotional problems. This could result in individuals feeling that yet again they were not being heard. One participant in particular who had attended child psychotherapy until she was 18 years old had been told by her psychotherapist that homosexuality was a pathological state that needed to be overcome:

[my psychotherapist said] everyone goes through a state of being gay whether they're aware of it or not, but some people get stuck in this state because they've got emotional problems [...] they've got to work through their emotional problems to get out of this state because the state's not desirable. It's not a sign of a healthy, mentally healthy person. (Josephine)

Prior to identifying as gay, some participants had been isolated from other lesbian women and had only heard the word 'lesbian' used as an insult, particularly at school. Others did not identify with the portrayal of lesbianism as represented in the

media; or, as a consequence of the emphasis on male homosexuality in the media, were not aware of positive lesbian role models.

Challenge/break away

Some participants talked about the impact of being brought up in a society dominated by heterosexual values, feeling that they had to break away from these values in order to find self-acceptance:

I think when you are coming out as lesbian or bisexual you are challenging everything that you have ever grown up with. (Laney)

For some of the participants, the consequences of breaking away from heterosexual values included having to reject Christianity, losing friends who did not accept their sexual identity, and feeling alienated from their family.

Watch your back

Some participants talked about verbal and physical abuse that they had encountered when they went out. Being targeted was often related to being recognised as being part of a lesbian couple:

Once they see you, if you pass as a man, then that's fine, but as soon as they see you've got tits and there's another woman with you then they're onto you, like fucking dogs after you, they don't like it. (Fiona)

Other participants had experienced being harassed for the way they looked particularly if they were dressed in ways that did not conform with mainstream society. Some felt that they needed to anticipate such attacks in order to protect themselves:

Oh God, there's all this negative stuff, always watching my back, which pisses me off, you've got to watch your back. (Fiona)

Awareness and experience of homophobia could lead to feelings of inner conflict and self-doubt. Alternatively, feelings of anger or helplessness about homophobia could lead to feelings of self-destructiveness:

What does make me feel like self-harming at the moment is the amount of homophobic crap that I hear about, and that my girlfriend gets, and that my friends get [...] I just hear about so much nastiness and violence going on.

(Phoebe)

Pressure of being gay

Although being gay was felt by many participants to be a positive aspect of their lives, some felt that, for many reasons, being lesbian or bisexual was difficult at times. Some participants talked about being affected by particular laws and policies such as Section 28, while others talked about unequal rights for example with regard to marriage, feeling that the lack of equal rights of marriage were signs of oppression. Other issues were related to the process of having children, or a awareness that there was a belief in society, perpetuated by the media, that it was selfish or wrong for lesbians or gay men to raise children. Others felt particularly affected by negative media portrayal of lesbians:

The media say things that they wouldn't dare say about other people [...] all sorts of things about lesbians that are totally offensive; like they shouldn't have children, or that they should be gassed even, they're even allowed to say that! (Tamsin)

Having to conceal their sexual identity could be stressful for some of the participants. Some had felt unable to be open about their identity in particular contexts, such as work environments. Participants dealt with this in different ways; for example, talking about their partners as if they were male; or only mentioning that their partners were female if they were asked directly. Others decided to be open about their identity, being aware of the emotional difficulties that could result from suppressing their identity:

Well I'm a dyke, and at work, it's like they either accept me or they don't, tough shit. I don't care basically. I'm not going to be in the closet, it's too much like hard work for me. I had a friend die because she wore two masks, a complete nightmare. I refuse to be like that. (Cassandra)

Some participants felt unable to tell their families through fear of rejection or conflict. For one participant, having a parent who was religious made it even more difficult to come out to their family. Having been sexually abused meant that a few participants were reluctant to disclose their sexual identity to family members who had abused them, through fear that they would make their identity seem dirty or re-create abuse issues:

With my dad, I don't want him to know anything about my sex life at all, if I came out to him he would be thinking things that I didn't want him to think about what I get up to. I would rather him just think I was straight really.

(Fiona)

Others were concerned about disclosing their identity to friends they had known for a long time, again, through fear of rejection, conflict or being judged. Some participants had had experiences whereby friends had responded negatively to their

disclosure, in some cases this was to such an extent that the friendship no longer continued.

E: PRIDE OR SHAME

This category relates to feelings that participants associated with their self-injury.

Participants reported a mixture of feelings regarding their self-injury, including negative or 'bad' feelings such as feeling guilty or ashamed, judged or pathologised.

Another conceptualisation was that their scars were 'battle trophies', positive reminders of having coped, and that they had few regrets about self-injuring. These themes are summarised in Table 7: Themes relating to 'Pride or shame'.

Table 7. Themes relating to 'Pride or shame'

Themes	Prevalence
Bad feelings	frequent
Battle trophies (no regrets)	infrequent

E.1 Bad feelings

Definition of theme: this theme captures the negative feelings that the participants were left with. These broadly related to the effect on others, and the effect self-injury had on their self-perception.

Effect of self-injury on others

Participants reported that their self-injury often caused conflict within relationships:

Were there times that it affected my relationship? Well there weren't any times when it didn't. (Josephine)

Some participants felt that their behaviour had not been understood by some of their current or past partners. Some said they were perceived to be 'mad' or that they had to keep it hidden from others because of their angry reactions. Other participants reported that their partners took their acts of self-injury personally:

She saw it as an act of violence against her which I thought was really bizarre.(Josephine)

Some participants acknowledged how difficult it had been for their partners, and talked about the strain that their self-injury put on relationships. For example, one participant reported that her partner had sometimes felt responsible for protecting her and would move knives, razor blades or other objects. Participants responded to their partners' responses in different ways; for example, by harming themselves in less visible areas of their body, or by being self-destructive in other ways, such as not eating or abusing laxatives. Some attempted to stop self-injuring altogether; for one participant in particular this was consequential to a fear of reproach from her abusive partner.

Participants tended to feel that self-injuring was preferable to the intense inner turmoil and stress that built up if they resisted it, and that, as one participant described it, self-injury was a "necessary evil". In addition some participants reported that self-injury was preferable to behaviours such as abusing drugs or alcohol. This

feeling, combined with a tendency towards self-loathing, meant that some of the participants did not always comprehend the reactions of others:

My girlfriend, she was the first person to react like it was a big deal, no one had ever reacted like that before, and I was shocked you know, I thought she was very strange for thinking it was a big deal. (Josephine)

Effect of self-injury on self-perception

Some participants felt their self-injury negatively affected their perception of self, including feelings about their physical appearance, feeling that they might be judged by others. Some felt bad about the fact that they self-injured and that they were inadequate or “weird” because of their actions. Some were concerned that people would think that they were ‘mad’:

I hate not being able to wear short sleeves. I won't do it because you just get too many people staring at you, sort of pointing and talking. (Emily)

Other participants did not cover their scars up, but lied about their origin. One consequence of hating one's scars is further self-deprecation when self-injury re-occurs:

At the time it feels quite good, but then afterwards when that effect has worn off, I feel angry at myself [...] thinking after that how stupid I am and I've got more scars now. (Emily)

E.2 Battle trophies

Definition of theme: this theme relates to the feelings of some of the participants that their scars were ‘battle trophies’, a sign of survival:

When I stopped for quite a while I used to wake up terrified in the morning that the scars wouldn't be there anymore, sort of getting through, like sort of battle trophies or something. (Imogen)

As such, scars could be reminders of particular difficult experiences, a comforting reminder that they could cope:

Every time I look at that scar I think about that evening and I think oh well that helped me so much doing that scar, it helped me cope with the upset that I was in. (Kelly)

F: MOVING ON OR SLIPPING BACK

This category relates to some of the participants’ attempts to stop self-injuring, and the associated difficulties of doing so. For many, stopping or reducing the frequency and severity of their self-injury had been a gradual process, arising from some of the bad feelings they had about their self-injury, and maintained by their investment in their lives. Participants reported that it was sometimes difficult to resist ‘slipping back’ to self-injury. There are four themes relating to ‘moving on or slipping back’. These are summarised in Table 8: Themes relating to ‘Moving on or slipping back’.

Table 8. Themes related to ‘Moving on or slipping back’

Realised it is not the answer	infrequent
Investment in life	infrequent
I have other ways of coping	medium
It's easy to slip back	infrequent

F.1 Realised it is not the answer

Definition of theme: this theme relates to the participants' feelings that self-injury was no longer an effective or appropriate way of dealing with their problems.

Some participants felt that their repetitive self-injury was "going nowhere":

I got fed up, I was fed up of having bandages all over; not being able to have a bath when I wanted; not being able to do anything; not able to go swimming. I was just fed up with it you know, it was just going nowhere.

(Roberta)

Another realisation could be that self-injury did not help them resolve the underlying issues that contributed to their behaviour. Through attendance at a therapeutic community or group therapy programme, some participants had developed a greater understanding of these issues, and how to face them rather than try to get away from them.

For others, the changes in the physical sensation of self-injury led them to attempt to relinquish it as a coping strategy:

I started feeling like when I cut, the hurt was still there, or what I was trying to cut to get rid of was still there, so it just didn't have the same effect anymore. (Emily)

F.2 Investment in life

Definition of theme: this theme relates to the participants' perceptions that they had changed since they first started self-injuring, and that they now had more invested in their lives.

Some participants wanted to stop self-injuring because of the nature of their work, particularly if they had obtained work in a hospital or mental health setting. Others were aware of the negative impact that their self-injury had on their partner, and wanted to save their relationship. Others were settled in relationships with partners and wanted to move forward, away from self-injury. For some participants, being in a relationship could be a positive experience in which they felt supported and accepted. Feeling that one has a lot invested in one's life could lead to a wish to maintain this situation, not jeopardise it through self-injury:

When I get the feelings of wanting to self-harm I actually think, well, actually no, if I do this, this is going to happen, I may lose my job, I may be off sick, I've got all these loans to pay off. I can't afford to do it, financially or practically. (Glenda)

Others wanted to get out of hospital or the psychiatric system, and felt that if they were not self-injuring so frequently they would have a better chance of being discharged:

I was very unhappy there and I wanted to get out, and I suppose I started coming wiser and that and thinking if I stop doing things and show I'm better then I'll get out. (Kelly)

F.3 I have other ways of coping

Definition of theme: this theme relates to the participants' development of other ways of coping with difficulties, instead of self-injury.

Some of these strategies involved talking to partners, friends or family about how they were feeling. Another strategy involved verbalising their thoughts and feelings, for example, letting people know that they were annoyed or upset. Others began to express emotions overtly:

That's another reason why I stopped cutting my wrists, because now I cry and get angry whereas I never used to. (Josephine)

Participants talked about being less impulsive, and spending time thinking about what was going on for them:

I'm very impulsive, always act impulsively whether it's self-harm or violence and stuff, whereas now I do take a step back and think and work out what is actually going on, where is the feeling, where's it come from, and analyse it. (Roberta)

F.4 It is easy to slip back

Definition of theme: this theme relates to the difficulties that some participants found while trying to maintain their new coping strategies. Some reported that self-injury was a strategy that they could resort to in times of crisis, even when they did not want to.

For many participants, self-injury had become their coping mechanism, a strategy for getting through things. Some participants felt that they had no regrets about this, while others wanted to move away from self-injury. As Tamsin says, it had become a habit that was difficult to break:

Being gay was a relief; it made me feel strong but it didn't stop me from harming myself completely. I think harming yourself becomes a habit, and that's the worst thing about it, that it becomes a habit even when you don't want to do it. (Tamsin)

For some participants, thoughts of self-injury could easily arise after a long period of cessation:

I can stop for a long time, and then I don't know, I get this urge to do it again, it sort of pops up its head, and goes 'hello still here!' (Emily)

Others felt that they reverted back to self-injury in times of crisis. Such instances included bereavement; the break up of relationships; or dealing with family difficulties such as illness or divorce. At such times, self-injury may be resorted to spontaneously, without thought:

I felt like everything was getting on top of me, and I just did it, and I was really shocked, and it was the only time in my life I was shocked about it, and it was like I didn't want to do it. (Tamsin)

For some, being in counselling or therapy could result in difficult issues being raised, leading to self-injury being resorted to way of dealing with the associated flashbacks or intense emotion.

Some participants felt hopeful about the future as a result of having recently coped with difficulties without reverting to self-injury. Others felt uncertain about the future, unsure how they would cope with unforeseen crises without resorting to self-injury:

Every time I give it up I think to myself I'm never going to do it again, so here's me sitting here saying I'll never do it again, but I shouldn't really say that because I might, you know. I just hope that I won't. (Roberta)

Summary of results

It was found that some of the themes related to underlying issues and the build up to self-injury, and these were therefore drawn together under the category 'bad things', to reflect the predominantly negative or distressing nature of the experiences. The next higher order category was 'things were just crazy', referred to the context in which self-injury initially occurs. 'It helps me cope' contained themes relating to the functions and uses of self-injury; 'being true to myself' covered themes relating to conflicts with society's expectations and coming out; 'pride or shame' contained themes relating to the feelings associated with self-injury and the reactions of others. Finally, 'moving on or slipping back' referred to themes relating to decisions to stop self-injurious behaviour and the associated difficulties.

Analysis of the data indicated that the participants had been subject to various childhood and adulthood experiences that had had negative consequences including self-loathing, low self-esteem and depression. The inner experience of the participants in the lead up to self-injury could be characterised by an overwhelming

feeling of distress that was associated with a strong urge to alleviate this inner turmoil. Self-injury could evolve from an initial self-attack into a coping mechanism that served many uses. Engaging in self-injurious behaviour could lead to conflicts with others, resulting in further self-loathing; or the visible consequences of self-injury could be seen as 'battle trophies', an indication that the individual was a survivor. For the participants, the process of developing an identity within the contradictory expectations of a society dominated by heterosexual values could be conceptualised as an added source of stress in an already difficult life. It was found that the process of dealing with the increasing awareness of one's sexual orientation could lead to a feeling of relief, but that homophobia and heterosexism could lead to the reactivation of earlier patterns of 'not telling' and 'not being heard'. In the next chapter, these findings are discussed in more detail, leading to a model of how self-injury in the context of having a lesbian or bisexual identity might be conceptualised.

CHAPTER 4: DISCUSSION

The aim of this study was to use the reports of women to explore the meaning and use of self-injury within the context of having a lesbian or bisexual identity. There was an interest in the types of issues that had led the participants to start self-injuring, and the issues they faced that maintained such behaviour. Sixteen women were interviewed using a semi-structured interview schedule. Participants were asked about the context in which they had started self-injuring, how their self-injury had developed since this time, and the types of situations that triggered their self-injury. Participants also spoke about their lives as lesbian or bisexual women, the process by which they had come to identify in this way, and their thoughts about the role that self-injury played in this context. Analysis of the data resulted in the generation of twenty-eight themes that fell into six higher-order categories as follows:

- **Bad things** - background and underlying issues;
- **Just doing it** - the context in which self-injury initially occurs;
- **It helps me cope** - the functions and uses of self-injury;
- **Role expectations** - conflicts with society's expectations, coming out and homophobia/heterosexism;
- **Pride or shame** - the feelings associated with self-injury; reactions of others;
- **Moving on or slipping back** - decisions to stop self-injurious behaviour and the associated difficulties.

This chapter reviews these themes, relates them to findings in the existing literature and suggests a model of the process by which self-injurious behaviour evolves from

an initial self-attack to a coping mechanism for women who identify as lesbian or bisexual. The implications of the study for future research will be outlined, including a consideration of the study's limitations. Finally, implications for services including A&E and clinical psychology provision will be discussed.

What do the perceptions of lesbian and bisexual women tell us about the possible relationship between self-injury and sexual identity?

It has been suggested that young lesbians and gay men may be particularly vulnerable to self-harm and self-injurious behaviour as a result of a variety of factors including homophobia, discrimination and isolation. Arnold (1995) found that a number of women reported having self-injured as a response to the conflicts and distress they experienced in connection with their lesbian identity. A report for the Pink Paper newspaper (16th October, 1998) suggested that young lesbians and gay men may self-injure as a direct result of discrimination and homophobia. It was also suggested that young gay people may feel that they have no-one to turn to for advice on their emotional experiences. As a result of isolation from other positive lesbian or gay role models, they may believe that their feelings are abnormal.

The participants in the current study varied in the extent to which they felt that their self-injury was triggered by events related to their sexual identity. Among the participants, a few felt that there were no links between their self-injury and their sexual identity and were somewhat intrigued by the notion that there could be such a relationship. For others, the relationship between their self-injury and sexual identity

was indirect; for example, one participant had to leave home after a family member discovered that she was gay. This resulted in her becoming homeless and quickly becoming involved in an unhealthy relationship with a woman. Other participants hypothesised strong links between their sexuality and self-injury, interestingly talking about scenarios that were not necessarily drawn from their own experience; for example, one participant said that she knew other lesbians who self-injured, and that for some of them, their self-injury was related to guilt originating from childhood experiences and to their hatred of themselves for being gay. A few participants hypothesised that women might self-injure if they had difficulty with the coming out process, for example being rejected by their family or becoming homeless. It was reported that the pressure of being gay was an additional source of stress which could result in self-injury being used as a coping mechanism for the release of unwanted emotion.

It is proposed that for the lesbian and bisexual women in this study, the process by which their self-injury evolved as a coping strategy has much in common with mainstream models of self-injury. For some participants it seemed that the process of acknowledging their sexual orientation to themselves and others was an added extra source of anxiety or worry on top of existing stressful or distressing experiences. The consensus among these particular participants was that they would have self-injured anyway, but that the process of identifying as lesbian or bisexual within a heterosexist and homophobic society was yet another source of stress. These negative feelings could be associated with process by which they reconciled their true self with the contradictory expectations and roles related to different aspects of their identity, as well as being a consequence of homophobia and heterosexism within

society. The majority of participants spoke about the impact that living in a society that held dominant heterosexist and often homophobic values had on their lives. These will be discussed in detail in this chapter.

It was found that acknowledging one's sexual orientation to oneself within a society that was perceived to be homophobic, could be a difficult and painful process that could re-activate earlier unhelpful coping patterns such as suppressing or ignoring unwanted feelings or thoughts. The individual's experience of having not been heard, or having her experiences and feelings ignored or not validated, could also re-occur during the process of disclosing her sexual orientation to others. Identifying as lesbian (or bisexual) was often experienced as a relief, and perceived to be a positive source of self-esteem, representing a move towards self-acceptance and inner peace. Some participants felt that 'coming out' had been the best thing they had ever done, and one conceptualised it as one of the best presents she had ever given to herself. Experiences of direct and indirect homophobia could trigger earlier experiences of feeling different or disliked, or a belief that one does not matter. Self-injury could be resorted to as a way of coping with these issues.

The sense of pride in their identity that many of the participants reported seems inconsistent with much of the literature relating to self-destructive behaviours among lesbian and gay people which conceptualises such behaviours as a clinical manifestation of internalised homophobia (Davies and Neal, 1996). However, Davies and Neal indicate that internalised homophobia may be unconscious. For some of the participants, the process of acknowledging their attraction to other females had involved considerable denial and suppression, factors indicative of some

internalisation of homophobia within society. Being able to talk in confidence to a researcher seemed to offer a safe, contained space in which they could discuss these issues. It is also arguable that there may be some selection bias in the study; individuals who volunteered to be involved in any study considering sexual identity would have to be comfortable enough with their sexual orientation in order to identify as lesbian or bisexual in the first place.

Even after acknowledging their feelings to themselves, some participants chose not to disclose their identity to others; resulting in a situation whereby they were essentially leading dual lives at home and at work. These factors could lead to self-injury as a way of coping with the build up of intolerable emotion. The pressure of concealing parts of one's identity can have implications for one's mental health:

“...the basic predicament of living like a second-class citizen and actively hiding the truth about ourselves diminishes our personal dignity and our self-esteem - even when we might not be aware of it - and our impaired self-esteem leads to many complex emotional problems” (Signorile, 1996, p. xxi).

What are the issues that led the participants to self-injury?

In this section I will review the themes that emerged from the data, presenting a model of the development of self-injury within the context of identifying as lesbian or bisexual.

Bad Things

According to Babiker and Arnold (1997), difficult childhood and adulthood experiences can interfere with the development of a secure sense of self. Consistent with research and clinical literature, some of the participants had been brought up in dysfunctional or abusive families. Other experiences, such as being physically or emotionally abused as children, were reported to be implicated in the evolution of their self-injury. In adulthood, participants had had similar experiences; for example being sexually assaulted or raped, or feeling trapped in abusive relationships.

Contrary to literature that emphasises a history of childhood sexual abuse in the aetiology of self-injury, abuse experiences in childhood were reported by less than half of the participants. However, it should be noted that perhaps other participants had experienced abuse but chose not to mention this in their interviews. As Burstow (1992) comments, the precise nature of early painful experiences is not always known:

“Where a client routinely self-mutilates, we know for a certainty that this woman has been badly intruded on in childhood. What we do not know is how” (Burstow, 1992, p.189).

It is therefore important that the experiences of all women who self-injure are considered in the literature on self-injury, as there is a danger that women who have not been sexually abused may feel further alienated by the books and articles that have been designed to help them. Participants reported a variety of experiences that they felt had contributed to the development of their self-injury. From analysis of the interview data, a strong theme of feeling different from others emerged. For many this feeling had originated in childhood, and participants reported feeling different from their peers and other family members for a variety of reasons. This feeling of being different was related to a variety of factors, some of which related to conflicts between their sense of self and gender role expectations.

Reports based on clinical studies of the associated symptoms of self-injury have identified low self-esteem and self-loathing (e.g. Babiker and Arnold, 1997; Favazza, 1987). Consistent with such findings, a theme related to self-loathing emerged from the data and was related to a variety of experiences. According to Becker:

“Self-blame is the result of the representation of a critical self that is a by-product, over time, of generalising the representation of self mirrored in interaction with important others who have been abusive, dismissive and/or invalidating” (Becker, 1997, p.138).

According to Signorile (1996) and Davies and Neal (1996), self-loathing is common among people prior to coming out. However, although many of the participants in the current study reported feelings of self-loathing, these feelings were not solely related to their feelings about their sexual orientation, and many of the women did not

experience a negative a negative identity as a lesbian; as one participant commented: “I didn’t feel disgusted at myself [...] I don’t think I ever thought ‘I’m a lesbian I must self-harm!’” In fact, identifying as lesbian or bisexual was seen as a source of self-esteem that could address some of these feelings and represented just one way in which they were true to themselves.

As adolescents, many of the participants had learned to keep emotional distress in. The screaming aching frustration that built up inside of them had no outlet. The girls who had learned not to tell and to keep things in turned into adolescents who suppressed their emotions. For many, there came a point at which buried experiences and feelings could no longer be suppressed. The emergence of these issues manifested in different ways, for example through depression or anxiety; or through self-destructive behaviours such as eating disorders, alcohol abuse or drug use. It was noted that for some of the participants self-injury was just one form of self-destructive behaviour that they engaged in. These findings are consistent with the research and clinical literature that indicates that self-injury may often be associated with other self-destructive behaviours (e.g. Favazza, 1996; Sutton, 1999).

Literature on self-injury indicates that girls often start self-injuring in middle to late adolescence (Favazza and Conterio, 1988). Many explanations are based on the assumption that self-injury is absent prior to puberty, and are predominantly based on psychoanalytic theories that propose that self-injury arises from conflicts over emerging sexuality and menstruation. From this perspective self-injury offers sexual gratification, or may be conceptualised as an attempt to control sexuality or sexual maturation (Suyemoto, 1998). However, such explanations do not seem to consider

the fact that sexual feelings or experiences do occur prior to adolescence, nor do they fully account for the fact that some individuals do start self-injuring prior to puberty, as the reports of a few of the participants indicated.

Consistent with reports in the clinical literature, many participants started self-injuring during adolescence. However, rather than representing a time in which conflicts over sexual drives and menstruation became more salient, for the participants, adolescence could be a time when the suppressed 'bad things' from childhood were re-triggered by demands to conform with one's peers as well as the expectations of society. For some participants, adolescence represented a time when the conflict between their inner self and the values of a heterosexist society, combined with the emergence of previously suppressed negative childhood experiences could lead to a crisis:

When people get into adolescence, all this shit that they've been burying throughout their childhood suddenly starts spewing out all over the place. That's when they're also going to start getting rocks chucked at them by their classmates, and getting all the 'backs to the walls' comments and stuff...that's when they're going to start hacking themselves up. (Phoebe)

According to Babiker and Arnold, (1997), during adolescence young people may striving for independence and individuation yet are still dependent on others in many ways. They suggest that self-injury in this context may be a way of experiencing some sense of control in their lives. However, for the participants in the current study, the salient issues tended to relate to feeling that they did not fit in with their peers and were therefore unable to gain support and affirmation from them. During

adolescence there is also increasing pressure on girls to begin the process of adapting to their gender role. Being aware of one's attraction for females at this time can be isolating for various reasons. The perception that one is different from one's peers necessitates a perception that others are similar among themselves. For the participants, this perception had associated value labels, i.e. that others were normal, whereas they were different and therefore abnormal; not conforming to the expectations of society regarding gender roles can also reinforce this feeling of abnormality.

Adolescence is a time in which physical and sexual changes occur rapidly, and adolescent girls may feel alienated from their bodies at this time (Babiker and Arnold, 1997). However, for a few of the participants, a feeling that their inner sense of self was more male than female meant that their issues were not necessarily related to wanting to adhere to the beauty stereotypes perpetuated by the media. Rather, they felt embattled with their bodies during puberty because their developing bodies seemed increasingly alien to them; this was one example of tension between ideas of what it means to be female and their sense of self.

Role expectations vs. being true to self

Gender role expectations are defined by a predominantly heterosexist society that generally conceptualises homosexuality as a marginal or deviant identity. According to Radicalesbians (1970), internalising the definitions of the female role as imposed by a patriarchal society can have negative consequences, resulting in a reservoir of self-hate:

“This is not to say that the self-hate is recognised or accepted as such, indeed most women would deny it. It may be experienced as discomfort with her role, as feeling empty, as numbness, as restlessness, as a paralysing anxiety at the centre” (Radicalesbians 1970, p.3).

The participants dealt with their conflict with the predominantly heterosexual values of society in different ways. Some participants had tried to live their lives as heterosexual women, while others had decided that it was preferable to be asexual and remain single. All of these factors contributed to the cycle of self-loathing.

According to Signorile (1996), self-loathing is imposed by individuals and institutions within society. The values of a heterosexual society are communicated in many forms such as the media, education, religion, families as well as by individuals. It can be further argued that society, dominated by heteropatriarchal values, has an interest in maintaining the perception that homosexuality is abnormal and a source of shame.

Some participants reported that prior to identifying as lesbian, they had only known about the negative connotations of lesbianism, having usually heard the word gay or

lesbian used as an insult. Having been brought up in rural areas meant that some participants had been isolated physically and psychologically from positive gay or lesbian role models.

The process of coming out to oneself could result in many issues that had previously been suppressed becoming more salient. The participants talked about the different ways in which they identified as lesbian or bisexual, usually involving the abandonment of previously held beliefs or stereotypes regarding lesbianism. This could be by joining a social group where they could meet other lesbian and gay people, or by socialising on the scene. The majority of the participants in the current study had access to such resources; having always lived in a city, or moved to a town or city from rural areas. Their experiences may therefore be different from lesbians who remain isolated.

The process of identifying as lesbian seemed to be one of 'challenging and breaking away' from the values they had grown up with; the same values that continued to be held by society and still impacted on their lives, particularly in their interactions with others who were not lesbian or gay. Some of the participants talked about being true to themselves, which usually represented a gradual process of self-reflection and introspection from which could emerge a new sense of self-acceptance. Clinical and research literature tends to emphasise that individuals may be prone to self-harming during the coming out process as a result of internalised and external (e.g. Davies and Neal, 1996). Further to this, it may be argued that, because of one's sexual orientation and people's reaction to it; the period of coming out involves the challenging of, and breaking away from, a wide range of expectations and values that

impact on all aspects of one's identity, not just sexuality. This process could be complex and painful and result in conflicts with the values of one's peers and societal values, as well as inner conflict:

“These needs and actions bring her into painful conflict with people, situations, the accepted ways of thinking, feeling and behaving, until she is in a state of continued war with everything around her and usually herself”
(Radicalesbians, 1970, p.1).

For some participants, indications that they were lesbian or bisexual were responded to negatively by their peers, resulting in being teased or bullied. Others were told that they were going through a phase, or that their feelings were consequential to their emotional problems. As such, yet again, they were not being heard, and their feelings and experiences were not validated. For some, feelings of being different were exacerbated as they realised that they were at odds with not just their peers, but with the messages they received from various societal institutions about the way they should be feeling and acting. As one participant commented, she could not understand how she could grow up to be a woman, because the way in which ‘woman’ was portrayed to her, as feminine and heterosexual, was not an image she felt she would be able to strive for.

Identity trouble: homophobia and heterosexism

As previously mentioned, identifying as lesbian or bisexual involves adapting to a role that is stigmatised by society (Hetrick and Martin, 1987). The participants appeared to adapt to this role in different ways, sometimes involving a gradual process that could begin with suppression and denial of their feelings before acknowledging them to themselves and others. The process of reconciling external expectations with being true to themselves could continue even after they identified as lesbian or bisexual. As Babiker and Arnold (1997) comment, lesbian or bisexual women are not immune from gender-role stereotypes and expectations, yet are clearly flouting them through their choice of partners. Tensions between gender expectations and lesbian/bisexual identity may occur for different reasons. Some participants reported initially feeling some pressure to conform to lesbian culture norms, particularly those relating to appearance, while others felt that identifying as lesbian had freed them from the norms of a predominantly heterosexual society.

Research indicates that the dominant western culture perceives lesbians to be less attractive than heterosexual women:

“Lesbians have long been accused, by straights, gay men, and lesbians alike, of knowing neither how to dress nor how to participate appropriately in the realms of beauty and aesthetics. Lesbian looks are stereotyped as outdated; aesthetically naive; too political, practical, and dull; and divested from traditional feminine beauty. In this context, lesbian beauty is in danger of being perceived as an oxymoron” (Hammidi and Kaiser, 1999, p.56).

Such stereotypes are the result of adhering to a narrowly defined standard of beauty against which all women are measured. Hammidi and Kaiser (1999) conceptualise 'doing beauty' as an active process involving the visual articulation and negotiation of cultural contradictions and personal ambivalences that may arise. Although for some participants, identifying as gay meant that they could free themselves from many of the expectations they felt had restricted them; others had some difficulty reconciling their perception of self and ideas about beauty and attractiveness with dominant lesbian culture norms. Such stereotypes and norms can make it difficult for women who are coming out to identify and fit in with other lesbians; one participant reported that she had initially thought that she was "too feminine" to be a lesbian; again feeling different from others.

Trouble on the scene

When participants first started going out on the scene there appeared to be a tendency for some of them to go out frequently, immersing themselves in lesbian culture; as one participant commented, she "could not get enough of the scene". Repeatedly socialising within a bar and club-oriented gay social settings can lead to a number of associated difficulties. Such settings reinforce the use of alcohol or drugs, which, as these participants reported, led to them engaging in risky behaviour such as being sexually involved with people they did not like, or being vulnerable to situations in which they may be physically or sexually attacked. These reports are consistent with Davies and Neal (1996) who report that lesbian and gay men may depend on the psychologically disinhibiting effects of alcohol or drugs to initiate contact with other gay people in what can be an intimidating environment.

However, for the participants desiring to become more involved in a lesbian scene appeared to be related to the sense of relief associated with identifying as gay. Such participants felt that at last there was somewhere where they could fit in and be accepted, and as such, coming out could be a time for new opportunities; as one participant commented, for her, identifying as lesbian was like having a “second chance”. However, for some participants, the initial phase of going out and meeting other lesbians was difficult and could re-activate self-loathing, and feelings of being different and not fitting in. For some participants, socialising on the lesbian scene meant that they were vulnerable to quickly forming close and sometimes unhealthy relationships with other women.

Difficulty with relationships

Due to earlier negative experiences, some participants were particularly vulnerable to having difficulties trusting others and allowing them to become close to them. As such it could be difficult to form and maintain healthy relationships. Relationships were sometimes formed quickly, turning out to be unhealthy or abusive, leading to self-injury as a way of coping. Within their relationships, sexual feelings could be associated with distress and inner turmoil, particularly when they experienced flashbacks to earlier abuse, thus resulting in self-injury being utilised as a coping strategy. Being involved in an unhealthy relationship, and yet not being able to talk to others about it, meant that adaptive means of coping such as talking to and gaining support from others, were not an option.

Participants commented on the effects of heterosexism and homophobia on their lives, with some reporting that their relationships were not valued by their friends or

family, and nor were they valued by society as reflected, for example, in the media. In addition, some participants felt that some of their experiences were not acknowledged within society, such as violence within lesbian relationships. These aspects of heterosexism and homophobia could have an impact on the individual, re-activating beliefs such as 'I don't matter', resulting in negative feelings or distress.

The participants described their inner experience of distress in different ways. A common experience that emerged from the majority of descriptions was an overwhelming feeling of intense emotion described by one participant as "a screaming inside". In contrast, at other times, the inner experience may be characterised by a feeling of emptiness that could lead to an urge to feel something. This aspect of the experience of self-injury is consistent with Favazza's observation that:

"persons suffering from intolerable tension and anxiety or from an episode of numbing unreality may obtain relief, sometimes instantaneously, by slicing their skin" (Favazza, p.272).

Difficulties self-soothing and talking to others about their feelings meant that the participants had restricted options with regard to alleviating their inner sense of turmoil or emptiness and would tend to resort to self-destructive strategies. Some participants commented on the differential way in which women and men express emotion such as anger; reporting that in general, aggressiveness in women is not tolerated in the same way as aggressive behaviour manifested by men.

These reports are consistent with Becker (1997), who argues that, through the process of gender socialisation, females are encouraged to be passive individuals who act in, not outwardly; and that behaviour that is seen as more masculine than feminine may be labelled as deviant. Anger is thought to be unfeminine and unnatural in women, and therefore the inhibition and suppression of anger is sanctioned. The experiences of one particular participant provided a striking illustration of this. For Roberta, the expression of her distress through aggression was perceived to be unnatural and was discouraged, resulting in her managing her feelings of anger and distress through self-injury. It is arguable that her behaviour was perhaps seen as more pathological as it was manifested by a female rather than a male, and was therefore inconsistent with gender norms.

Just doing it

For many of the participants, self-injury occurred for the first time in the context of feeling depressed, and for some, its use as a coping mechanism evolved from an initial suicide attempt; as one participant commented:

It felt very much like it was a suicide attempt without knowing very much about what I was doing. (Glenda)

As indicated in the literature, some of the participants had felt suicidal at times in their lives, and repeated self-injury could be interspersed with taking overdoses of tablets that was sometimes associated with suicidal ideation. This is consistent with literature that indicates that people who self-injure frequently may be at more risk of suicide than those who self-injure less frequently (e.g. Dulit et al., 1994). However, in their interviews, many participants emphasised that their self-injury was distinct

from suicidal behaviour, and that it was a way of continuing and coping with life, not a way of ending it.

What functions does self-injury serve in this context?

It helps me cope

It was found that self-injury served a range of uses for the participants. There were some idiosyncratic uses, but self-injury was most commonly reported to have initially originated in intense feelings of self-loathing, and then developed into a strategy for coping or getting through difficult times, dealing with intense intolerable emotion and, ultimately, a method of survival. The functions that the participants described were in accordance with the observations of a number of authors (e.g. Babiker and Arnold, 1997; Sutton, 1999).

Self-injury as empowerment

Further to literature emphasising self-injury as being a manifestation of internalised homophobia (Davies and Neal, 1996), self-injury could be seen as a way of reasserting control over one's life, a way of saying, 'I have the right to be who I want to be'. Some participants talked about self-injury in ways that indicated that it could play a role in making them feel empowered; for example, commenting that after self-injury they felt that they "could take on the world" (Emily), or that they "could cope with anything" (Josephine), and that it was a "strong thing to do" (Tamsin). These comments are particularly interesting if considered in the context of having a sexual identity which is marginalised and frequently pathologised by dominant societal

values which serve to make lesbian and gay men feel inferior and ashamed (Davies and Neal, 1996; Signorile, 1996).

The visible consequences of cutting or burning meant that they could acknowledge their inner pain to themselves, and/or communicate this distress to others if they chose to do so. Through this process of 'self-marking' participants were able to make their distress more tangible. For some participants, self-injury was a way of saying that they mattered, were alive, and could preserve control over one aspect of their life. Becker (1999) discusses the concept of the "marked woman", a term used to refer to women who have been shunned by society, usually as a result of exhibiting sexual behaviour in a way that is seen as deviant. Becker comments that:

"as a society, we are accustomed to doing the marking of women ourselves; when "borderline" women mark themselves through self-mutilation , they draw attention to themselves in ways that only they have determined"

(Becker, 1999, p. 141).

The process of self-injury within the context of having a lesbian or bisexual identity

Figure 2 illustrates the proposed model explaining the process of self-injury within the context of having a lesbian or bisexual identity. The figure presents a model of the process of self-injury comparable to mainstream models of self-injury, and also highlights the factors and issues particularly associated with having a lesbian or bisexual that may also contribute to self-injury. The model is based on the reports of the sixteen participants in the current study. Of these, the three women who described their sexual orientation as bisexual, all identified as gay. Two were in long term relationships with women, and the other was single. It is therefore not possible to ascertain any meaningful differences in the application of the model to their experiences.

The issues pertinent to having a lesbian or bisexual identity can be identified within the model by their thicker box lines and include: 'gender expectations', 'feeling different', the 'coming out process', 'homophobia', 'going crazy on the scene' and 'being true to self'. It is proposed that, for the lesbian or bisexual woman who self-injures, upsetting or traumatic experiences or 'bad things' may occur that lead to or reinforce feelings of self-loathing or self-hatred. Society's gender expectations may also contribute to self-loathing and feeling different. Being unable to verbalise or express her feelings - 'not telling', as well as not being heard, can lead to a situation whereby the repeated suppression of emotional distress leads to a tension between 'keeping it all in' and 'going crazy', resulting in unwanted intense emotion. Self-

injury can occur initially as a self-attack and then develop into a coping mechanism that serves many uses.

The individual may have 'bad feelings' about their self-injury that reinforce self-loathing or feeling different, as well as positive feelings about their self-injury, for example conceptualising her scars as 'battle trophies', visible signs that she had coped. Acknowledging one's feelings to self and others may be a way of being true to oneself, being associated with positive outcomes such as feeling relief. However, heterosexism within society can impact on individuals in different ways, leading to a re-activation of a belief that they do not matter, and homophobia can re-trigger feelings of self-loathing. Attempting to fit in with a lesbian and/or gay community may re-activate feelings of being different and self-loathing; and may be associated with negative experiences such as unhealthy or abusive relationships. For many women, identifying as lesbian or bisexual can lead to positive outcomes, such as feeling supported and that they fit in, fostering self-acceptance and inner peace. At this point, the individual may move on from self-injury, as a result of feeling more settled, but she may 'slip back' to self-injury in times of crisis.

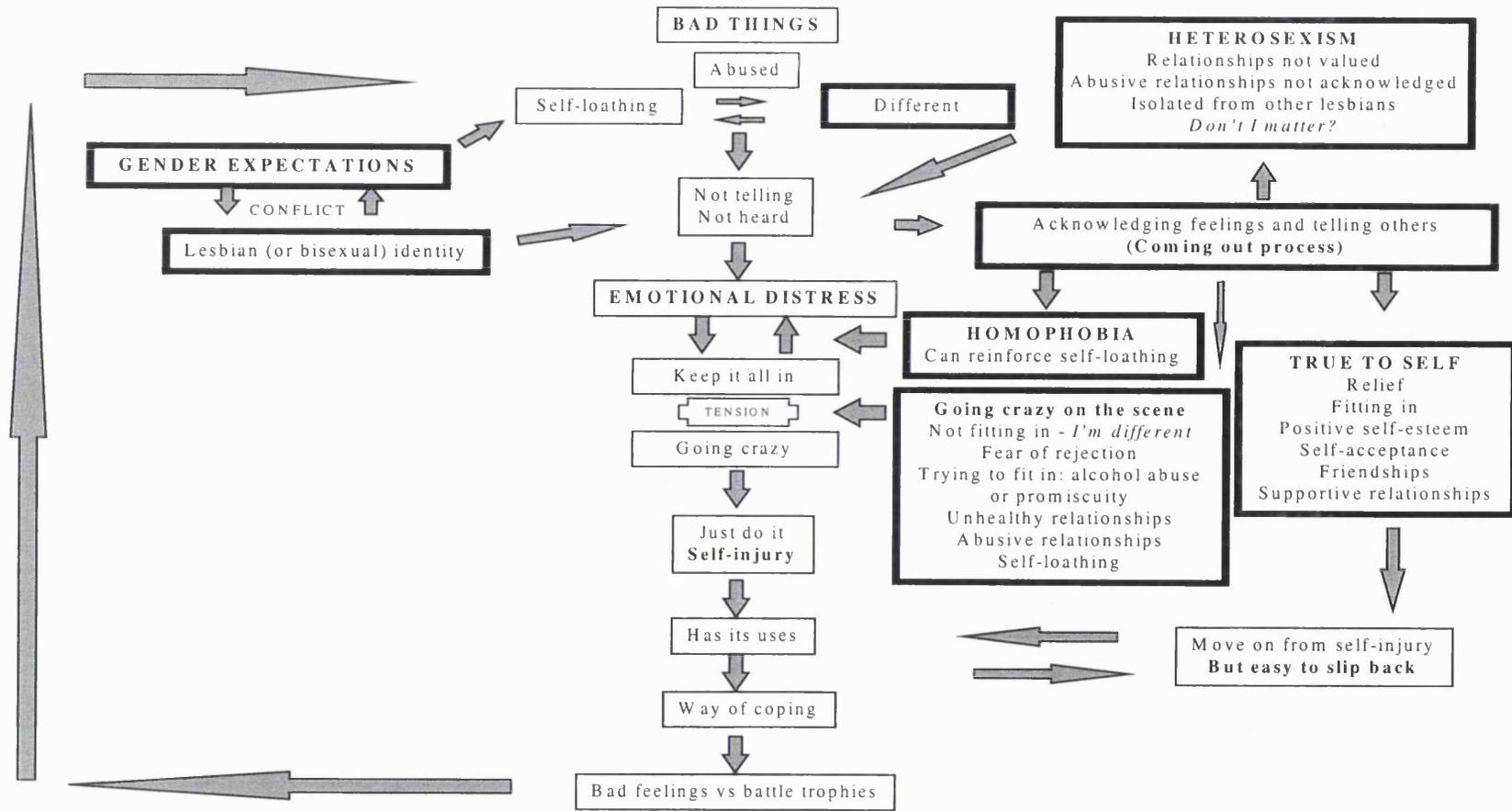


Figure 2. The process of self-injury within the context of having a lesbian or bisexual identity

Quality control: reflection and evaluation

Reflection on the process of research

Prior to undertaking this study, I had some concerns: would women want to talk to me about their experiences? Would I have enough participants to make a worthwhile study? I need not have worried, as there was a large response to the advertisements, indicating that individuals were keen to share their experiences and that a wariness of conducting research in this area may be more related to the researcher's anxieties, than to other factors.

There were a range of different perceptions represented in the conversations and mail I received from potential participants and other interested individuals prior to the start of the interview period. A few were intrigued that research focusing on sexual identity and self-injury was being undertaken. One respondent expressed frustration that professionals she came into contact with seemed to presume that her distress was due to unhappiness with her sexual identity. Another respondent contacted me to express her concern that much of the self-injury literature emphasised sexual abuse, but that this had not been her experience, and she felt that the experiences unrelated to abuse needed to be given equal salience. Many were pleased that such research was being conducted and hoped that it would increase knowledge and understanding among professionals working with people who self-injure; while others emphasised the importance of more research being undertaken within the lesbian and gay population.

Reflexivity and the interview process

It was felt that in general, the participants and researcher formed a good rapport, partly as a result of the researcher's perception that the participants were primary experts in the area of self-injury and that their story of self-injury was important. I had been concerned whether the interviews would be harrowing or upsetting for the participants, and had planned a number of safeguards should they be very distressed. However, these did not need to be used and the participants coped well with the interview process. It is possible that interviewing participants about self-injury is actually preferable to questionnaires or postal surveys that have been used by other studies. During interviews it was possible to check out that the individual participants felt safe with what she was disclosing, and the process felt more collaborative. As such, in the current study, some participants verbally expressed their appreciation of being given the opportunity to talk about their experience and commented that, unlike on other occasions, they did not feel judged or patronised. It was felt that the participants perceived the researcher to be an ally, and this was fostered through a genuine interest in, and acceptance of their views as being important and valuable.

Validity

According to Stiles (1993), "validity concerns whether an interpretation is internally consistent, useful, robust, generalisable, or fruitful" (p.607). One popularly held view is that the validity of qualitative research should be assessed according to a set of criteria appropriate to the nature of the qualitative research process, rather than utilising criteria usually used for quantitative research (Smith, 1996). A number of qualitative researchers have begun to develop standard guidelines for the assessment of the validity of qualitative research (e.g. Stiles, 1993; Elliott, Fischer and Rennie,

1999). Recommendations for good practice in qualitative research recommend a number of methods for checking the credibility of research findings, for example: checking understandings with original informants (testimonial validity); using multiple qualitative analysts or an additional analytical 'auditor' for the verification of the data; and triangulating methods (Elliott, Fischer and Rennie, 1999). Some of these criteria are considered in the following section as a way of assessing the validity of the current research study.

Triangulation

Triangulation is recommended in guidelines for good practice as a way of increasing the validity of the research findings, and refers to the use of a number of different methods or sources of information. For example, a study investigating the effect of self-injury on others could involve interviewing a range of different people such as the partners of people who self-injure, staff members, as well as people who self-injure. It was felt that this method would be inappropriate in the current study, as the focus was on an exploration of the perceptions women held about their experiences of self-injury, and the meaning it had for them. However, the validity of the research findings may have been enhanced by the use of multiple methods.

Independent audit

In the current study, the research supervisor acted as an additional auditor for verification of the emerging themes. This was done the following ways: in the initial phase of the research, transcripts were analysed independently, and the themes generated by the researcher and the supervisor were discussed and negotiated, resulting in consensus regarding the final list of themes for each transcript. After this time, the supervisor acted as a verification auditor, ascertaining the goodness of fit between the emerging themes. On one occasion multiple auditors were utilised as part of a qualitative seminar group to consider one particularly rich section of a transcript in order to verify the themes that had been generated.

Presentation of evidence

Smith (1996) recommends that when reading a report of a qualitative research study, another criterion for the assessment of validity would be the extent to which the reader can take part in interpreting the presented data. In accordance with these guidelines for good practice, the findings in the current study were presented in a comprehensive way that enables the reader to participate in the interpretation of the themes. This was ascertained by providing a balance between the narrative text and the associated quotes. As such, although, for example, biological aspects of self-injury were not strongly represented in the themes, a reader who has an interest in the biological basis of self-injury would be able to utilise the presented material in order to “interrogate the interpretation that is being made” (Smith, 1996).

Internal coherence

This criterion refers to the extent to which the research presents a coherent argument. In the current study, coherence was enhanced by presenting the themes in terms of six higher-order categories and by proposing a model of the process of self-injury in the context of having a lesbian or bisexual identity. Assessing internal coherence involves considering issues such as the way in which possible contradictions in the data are dealt with. As Smith (1996) asks: “are the interpretations that the researcher makes warranted by the data presented? Does the report deal with alternative readings?” It is therefore important to take into account other possible ways of interpreting the data within qualitative research. In the current study the ‘lense’ of sexual identity was used as way of exploring women’s experiences of self-injury. This would inevitably influence the types of questions asked as compared with, for example, a study that was investigating the biological factors involved in the development and maintenance of self-injurious behaviour. However, the theoretical orientation of the research should ideally have a weaker effect on the interpretations made, due to the reflexive and collaborative nature of qualitative research, and the emphasis on the importance of a willingness to revise one’s ideas in the light of contradictory or new information. In the current study, internal coherence could have been further enhanced by using a ‘negative case analysis’ method, whereby individual transcripts are analysed to ascertain the extent to which identified themes are absent. By using this method, a fuller consideration of possible contradictions and ambiguities in the data could have been provided.

Member validation

Unfortunately, due to the pressure of the time for the research, the plan for testimonial credibility checks using the participants themselves had to be delayed. All the participants were asked if they would like a copy of a report of the summary of themes that emerged from the research, and all have requested this. It would have been preferable to have been able to send these at a much earlier stage of the research process in order to check our understanding of the emerging categories and themes with that of the participants, and the analysis could have been improved by this. If time had allowed, it would have been beneficial to use a process of 'recycling' (Stiles, 1993), which involves "repeated encounters of theories or interpretations with the participants or text" (p.605). In the current study, this was undertaken only at the simplest level, by checking that the researcher was understanding what was being communicated in the participants' interviews. The validity of the study would have benefited from a more collaborative process of analysis utilising the feedback and comments of the informants themselves.

Evaluation: good practice in qualitative research

As Stiles (1993) notes, like all research, qualitative research is biased. He warns that validity criteria may be vulnerable to distortion at different stages of the research process. It could be argued that a focus on sexual identity in the interviews may have precluded participants from talking about other aspects of their identity, such as race, age and class. It is possible that the interpretation of the themes that emerged from the interview data in the current research may have been influenced by my pre-existing beliefs. However, the participants were asked general questions about their self-injury and were asked whether they felt there were links between their sexuality

and self-injury. Recommendations for good practice in qualitative research emphasise reflexivity and a receptiveness to having one's ideas challenged and modified. If one's research is accused of being biased, this suggests that one's ideas are impermeable to new information or experiences (Stiles, 1993). Such bias may be minimised by adherence to the fundamentals of good qualitative research practice.

Elliott, Fischer, and Rennie, (1999) note the importance of researchers being open about their values and assumptions, and these were made explicit in the outline of the research framework for the current study. I had expected the participants to perceive their self-injury as a complex coping mechanism serving many purposes. I had also expected there to be some variation in the extent to which people felt that their self-injury was related to having a lesbian or bisexual identity. From the literature, I expected the participants to talk about particular difficulties with the coming out process as well as about issues relating to internalised homophobia. I was surprised by the strength and frequency of the participants' perception that identifying as lesbian had been a relief for them, a positive source of self-esteem; I was also impressed by the way in which some of the participants communicated their feelings about their sexual identity, for example, as "wonderful" or as "the most natural thing in the world". This altered my prior conceptualisation of coming out predominantly in terms of its' potentially negative implications or consequences. Other guidelines for good practice in qualitative research were also adhered to in this study. Themes were closely related to the participants own terminology, and interpretations were grounded using specific examples.

The study has proposed some interesting hypotheses about the development and use of self-injury in the context of sexual identity. The aim of the study was to explore participants' perceptions of their experiences of self-injury in the context of having a lesbian or bisexual identity, and this was achieved. However, there are limits to the extent to which the themes that emerged from the reports of the participants may be generalised to other lesbian and bisexual women who self-injure. In order to have volunteered to participate in the current study in the first place, each participant would have to feel comfortable enough with their sexual orientation in order to identify as lesbian or bisexual. In addition, although attempts were made to ensure that advertisements were widely circulated in a variety of venues, the majority of responses originated from the advertisements that were placed in lesbian and gay magazines or newspapers, thus indicating a possible response bias. Future research could address this by recruiting differently, and discussing issues regarding sexuality and gender issues with all female participants, regardless of their sexual identity.

Implications for future research

Using a sample of sixteen women was advantageous as it enabled a consideration of a heterogeneous group in terms of their age, background and experience of self-injury. Using such a varied group was in accordance with the research aims, which set out to provide a general exploration of self-injury in the context of having a lesbian or bisexual identity. The interview data was particularly rich and extensive, resulting in a large number of themes that reflected the different experiences of the participants. The thematic analysis was able to ascertain the most salient themes that

emerged for the participants, but it would be valuable to have been able to take a more in-depth focus on a few of the transcripts.

As the ages of the participants varied from 18 to 50 years, this was reflected in the nature of the role self-injury played in their lives. Some were caught up in their self-injurious behaviour, and it was very much part of their current lives, whereas for others, their comments were based largely on retrospective accounts. As a result, there was some variation in their reports of their experiences. In particular, many of the participants had identified as lesbian and had self-injured, for many years. As such, their reports were based on retrospective accounts, and they had the benefit of hindsight. Their accounts indicated much insight into the motivations of their self-injury, and the role it played in their lives. Younger participants, however, tended to be more likely to still be caught up in their self-injury, and their reports were therefore based on their current thoughts and experiences. Future research might benefit from focusing on a more homogeneous group for example, considering the experiences of people who are at a similar stage in terms of self-injury or similar stage in terms of coming out.

Due to the small scale and qualitative design of this study, the model is tentative and needs to be explored in larger studies. Research could also be conducted to explore and compare the applicability of the proposed model at different life stages. It would be particularly useful to explore issues of sexual identity and self-injury during adolescence, which appears to be an important time in terms the development of sexuality; as well as being a time when self-injury may occur for the first time. Such research could take an in-depth analytic approach to ascertain the applicability of the

current model in this context, as well as to explore particular issues specific to self-injury during adolescence.

In comparison, it would be interesting to find out how the incidence and process of self-injury among lesbian and bisexual women changes as they get older. Although it has been suggested that self-injury tends to be carried out by younger individuals, it is feasible that some older lesbians and bisexual women may still be affected by some of the issues that may have led them to self-injure when they were younger, such as issues relating to homophobia and heterosexism. However, emotional maturity increases with age, and as some of the participants in the current study indicated, becoming more settled in life may lead to a wish to move away from self-injury. It would also be useful to conduct research looking more closely at the processes by which individuals move away from self-injury as a coping strategy, and the implications that this would have for clinical interventions.

Most of the participants in the current study had access to an established lesbian and gay scene, regardless of whether they utilised it. As such, the model includes issues relating to 'going crazy on the scene' such as trying to fit in with others, and forming unhealthy relationships. Future research could make use of this model to compare how lesbian and bisexual women without an established scene form relationships with others. How do women who are isolated from other lesbians develop a sense of fitting in and positive self-esteem?

Implications for clinical services

In this section, I will provide some implications for clinical services such as A&E. As previously mentioned, literature indicates that staff at A&E departments may have particular challenges and difficulties in responding to, and appropriately meeting the needs of people who self-injure. In the current study, it was found that many participants were reluctant to attend A&E departments, and either ensured that they did not harm themselves to the extent that medical intervention was necessary, or sometimes did not go even when such intervention was indicated. The reports of the participants indicated that staff members, in their attempts to ensure that self-injurious behaviour is not reinforced, for example by not communicating when they suture patients, may inadvertently contribute to the cycle of self-injurious behaviour by not acknowledging the individual's distress.

In terms of their sexual identity, participants highlighted that it is important not to make assumptions about the relationship between their self-injury and their feelings about their sexuality. Some had had experiences whereby it was implied that their self-injury arose from confusion about their sexual identity, others felt that pathologisation of their sexuality by professionals was obstructive to their access to help. It is therefore important that staff members listen to women who self-injure and hear their story of their experiences.

Some participants reported positive experiences attending services specifically for lesbian and gay people with mental health problems. In general, they felt that they were accepted in such places, and that they did not have to explain issues relating to

their sexuality. As one participant commented, she felt she was treated “as if she were normal”. Another participant commented that she felt that some services were not aware of the issues faced by lesbian and bisexual women, such as abusive relationships and transgender issues. This highlights a need for more training regarding issues relating to sexual identity within generic services, as well as an increase in more specialised services that can appropriately meet the needs of lesbian and bisexual women. Awareness of the issues that may affect lesbian and bisexual women is important; for example, partner abuse. It is important that lesbian and bisexual women feel that they can be open about their sexuality and associated difficulties without it being assumed that they are confused or unhappy about their identity. In this way, gay women would feel more comfortable about approaching services and having their mental health needs met appropriately and respectfully.

The reports of the participants regarding how they were treated have important implications for clinical services. Although there has been an increase in training programmes in the area of self-injury for nurses, it is apparent that many individuals continue to have negative or upsetting experiences as a result of their interactions with clinical staff members. As the participants themselves acknowledged, working in an A&E environment can be time pressured and stressful, and individuals who self-injure may be particularly challenging and difficult to work with, due to the nature of their experiences and the manifestation of their distress. It is important that clinical staff who frequently interact with people who self-injure have adequate training and a space to explore their personal and professional feelings about self-injury. The participants’ reports indicated that there was a lack of consistency in the way that they were interacted with; some felt judged and patronised, while others

were treated in a way that made them feel they were being heard, if not understood. It would be preferable for A&E departments to use established policies of working with people who self-injure that have been negotiated in consultation with user groups so that individuals who self-injure are treated in a way that appropriately meets their needs.

The key issues that emerged from the participants' reports were related to needing to be listened to, acknowledged and not judged for their behaviour. Services need to be aware of the level of distress that can lead a woman to self-injure, and that she is not necessarily trying to manipulate members of staff by her actions. Rather, an individual's difficult behaviour at A&E may reflect her distress at having to be there as well as the expectation that she is going to be treated badly. Some participants commented that they often found it difficult to talk about what their self-injury when they were at A&E; in such cases, their silence may be misinterpreted as hostility or an unwillingness to co-operate. The participants emphasised the need for compassion and empathy, if not understanding.

Implications for clinical psychology

The role of a clinical psychologist working with people who self-injure can vary widely according to the context in which he or she is based. The implications discussed below apply to individual work with lesbian or bisexual women who self-injure.

It is apparent that psychologists need to be wary of sticking rigidly to behavioural conceptualisations of self-injury, as these can result in a situation whereby the intervention intended to bring about change may actually fuel self-injurious behaviour through the re-activation of earlier experiences. A desire to be heard and understood emerged strongly from the participants' reports, and has important implications for the nature of therapeutic work in this area. An approach that enables the client to tell their story of self-injury would be preferable to one that is based on prior assumptions and stereotypes of individuals who self-injure as manipulative and difficult 'borderlines'.

It is important that the goals of any intervention are clarified and negotiated, recognising that for the client who self-injures, their behaviour is a coping mechanism, as one participant commented, a "necessary evil" preferable to her overwhelming distress. As such, the client may not be ready to relinquish self-injury as a coping strategy and other strategies would need to be in place before significant reduction in self-injury can occur. Strong themes of feeling different and not being heard emerged from the participants reports, indicating that for an intervention to be effective, it would have to progress at a pace comfortable to the client, and fostering

an atmosphere of acceptance and acknowledgement of their distress. The clinical psychologist's personal, and perhaps professional opinion may not be in accordance with the client's conceptualisations of their behaviour and therefore considerable self-reflection would be advisable during the course of therapy. As one participant commented:

I wouldn't change it, I know it saved my life. I know that at that time it was meant to be and I have no guilt over it. Sometimes you have to do something at that moment to get through something, and if it means doing that, cutting, then cut; or taking an overdose, you take an overdose. You each find your own little way of coping and if you come out the other side then and you're still alive, then hey it worked, you know what I mean, there's no shame in that. (Cassandra).

This quote highlights the potential disparity between the views of the clinical psychologist and the client. The potential disadvantages and advantages of non-self-injury contracts would therefore have to be negotiated on an individual basis. Some participants reported that it was helpful to have such a contract. However it is likely that if self-injury is currently being used as a coping strategy to deal with underlying problems, to insist that the client stops self-injuring prior to starting individual therapy, or during therapy, when difficult issues are being raised, may be inappropriate.

Some participants reported that they felt they were seen as 'self-harmers' or as 'lesbians', and communicated their dissatisfaction at being stereotyped or compartmentalised. Self-injury needs to be considered in a wider societal context, not

just as a behaviour manifested by a particular individual in response to crises.

Consideration of the societal context is particularly important when working with lesbian and bisexual women; as is reflecting on one's own opinions of lesbianism and bisexuality and how these might impact on an understanding of the client's experience. Heterosexual clinicians may need to feel comfortable in their 'not knowing' position regarding the experience of being a gay female, and this may be a useful start to exploring issues with lesbian and bisexual clients. As such, lesbian and bisexual women would have the opportunity to speak about aspects of their sexuality that trouble them, without people presuming that they would prefer to be heterosexual.

In conclusion, the majority of the sixteen women interviewed for this study indicated that their self-injury originated in negative childhood and adulthood experiences that left them feeling overwhelmed by distress that was difficult to manage. Self-injury was seen as a coping strategy that served many uses. Although the process of identifying as lesbian or bisexual was experienced as a relief, living as a gay woman within a heterosexist and homophobic society was yet another source of stress. The women were at different stages of their self-injury; many were moving on, away from self-injury, while self-injury continued to play a survival function in the lives of others. The study highlights the important role that services have in supporting women who self-injure, and some of the ways in which such services can inadvertently fuel self-injury. The study also highlights the importance of conducting research that enables women who self-injure to be heard. As primary experts in self-injury, their perspectives are invaluable in enabling greater understanding of the complexities of self-injury and sexuality.

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APPENDICES

Appendix 1: Ethical approval letter



The University College London Hospitals

The Joint UCL/UCLH Committees on the Ethics of Human Research

Committee Alpha Chairman: Professor André McLean

Please address all correspondence to:

Iwona Nowicka
Research & Development Directorate
UCLH NHS Trust
1st Floor, Vezey Strong Wing
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Ms L Clare
Lecturer in Clinical Psychology
Sub-department of Clinical Health Psychology
UCL
Gower Street

16-May-00

Dear Ms Clare

Study No: 00/0071(*Please quote in all correspondence*)
Title: Experiences of self-injury in lesbian, bisexual and heterosexual women: a comparative qualitative study

Thank you for your very useful letter explaining your methods and previous review for your research project on self-injury. Following discussion at the last Ethics Committee meeting, there are no objections to your proposal, which can go ahead.

Yours sincerely

Professor André McLean, BM BCh PhD FRC Path
Chairman

cc. Professor Fonagy

Appendix 2: Advertisement for participants

Appendix 3: Information sheet



UNIVERSITY COLLEGE LONDON

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Ms Linda Clare
Lecturer in Psychology
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Fax: 020 7916 1989
e-mail: l.clare@ucl.ac.uk

CONFIDENTIAL

Experiences of self-injury in lesbian, bisexual and heterosexual women: a comparative qualitative study

INFORMATION SHEET

You are invited to participate in a study exploring the experiences of self-injury in women, based at University College London. This study will be aiming to explore people's perceptions of their experience of self-injury, allowing participants to voice their own opinions about their experience, and what relationship this has (if any) to the development of a sexual identity.

Self-injury can mean various different things to different people. Examples of self-injury are: cutting or scratching one's skin; burning; swallowing objects; opening old wounds; pulling out hair; swallowing substances; head banging; hitting one's own body. These are just a few examples and there are many other different forms of self-injury. If you have ever self-injured we would like to know your views.

Participation in the study will involve a confidential interview of between one and two hours. This will be tape recorded and later typed out to give a written record of what has been said. This transcript will not contain any names. Participants can have a copy of the written record and/or the summary of main issues that come out of all the interviews overall. Travel expenses within the Greater and Central London area will be paid.

You do not have to take part in this study if you do not want to. If you decide to take part you may withdraw at any time without having to give a reason.

All proposals for research using human participants are reviewed by an ethics committee before they can proceed. This proposal was reviewed by the Joint UCL/UCLH Committees on the Ethics of Human Research.

The research team:

Natasha Alexander – Clinical Psychologist in Training
Linda Clare – Lecturer in Psychology

Please contact Natasha Alexander if you have any questions or concerns about taking part in this study.

Telephone: 0207 679 1844

Email: ucjtnea@ucl.ac.uk

Our Address: Sub-department of Clinical Health Psychology, University College, Gower Street,
London. WC1E 6BT

Appendix 4: Consent form



Sub-Department of Clinical Health Psychology

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CONFIDENTIAL

Experiences of self-injury in lesbian, bisexual and heterosexual women: a comparative qualitative study.

CONSENT FORM

- | | |
|--|--------|
| Have you read the information sheet about this study? | YES/NO |
| Have you had an opportunity to ask questions and discuss this study? | YES/NO |
| Have you received satisfactory answers to all your questions? | YES/NO |
| Have you received enough information about this study? | YES/NO |
| Do you understand that you are free to withdraw from this study at any time and without giving a reason for withdrawing? | YES/NO |
| Do you understand that your interview will be audio-taped? | YES/NO |
| Do you agree to take part in this study? | YES/NO |

Signature: _____

Date: _____

Signature of researcher: _____

Date: _____

Appendix 5: Demographic information sheet

INFORMATION FROM PARTICIPANTS

Age.....

Ethnicity.....

Occupation.....

Sexual orientation.....

Sexual identity (if different).....

Length of time identified lesbian/bisexual.....

Out?.....

Type/s of self injurious behaviour.....

Duration.....

Ever had treatment for injury? (E.g. stitches).....

Psychiatric history?.....

What services have been involved?.....

Would like summary of overall themes?.....

Address to send summaries to:.....

Appendix 6: Interview questions

Interview Questions

1. Can you tell me a bit about yourself, particularly relating to times when you have harmed yourself?

2. What do you think leads you to self-injure?

What do you think were some of the factors that led you to self-injure for the first time? What was going on in your life at this time? What responses/reactions from others did you get? Could you tell me about how you think your self-injury developed and continued?

3. How do you identify yourself?

Can you tell me something about the process by which you came to identify as lesbian/bisexual. Did you experience any difficulties at this time? Can you tell me about some of the important relationships in your life? Have these affected, or been affected by your self-injury?

4. Link between sexuality and self-injury?

Do you think there is a link between your self-injury and your sexuality? If yes, in what way?

5. View of services/help received

Have you accessed services for help with self-injury? Which services? What sort of help have you received? Was this a service specialising in gay/lesbian clients? Have you ever been given any labels/diagnoses/names for your behaviour? What support/help have you found helpful? What sort of support do you think you needed/need from services?

Any other comments