ACCENTUATE THE POSITIVE, ELIMINATE THE NEGATIVE? THE VARIABLE VALUE DYNAMICS OF NON-SUICIDAL SELF-HURTING

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ABSTRACT

Medical accounts mostly frame non-suicidal self-hurting as an adverse event, the frequency of which has supposedly increased to a current 'epidemic' level, and which can be predicted probabilistically in terms of risk factors. This set of presuppositions gives rise to the common stigmatisation of those who present to Accident and Emergency services as a result of self-hurting. It is now being challenged in a small but growing body of social science literature which emphasises the diversity of self-hurting, and its range of socially situated meanings for those who self-hurt, family and health professionals. The present paper contributes to this research strand by discussing the accounts of their self-hurting given by a sample of 25 UK adults who had not been in contact with health or other services for this reason. The analysis focused on three value issues: the positive gains which motivated research participants to self-hurt; their own active efforts to mitigate associated risks; and the longer-term downsides which some respondents identified.

Keywords: Lens of risk , risk communication, risk management, self-hurting , non-suicidal self-injury

INTRODUCTION

This paper will discuss some of the findings of a research project, undertaken by the first author, which explored the perspectives of individuals who have cut or otherwise hurt their bodies for significant periods of biographical time from adolescence without coming into contact with health services for this reason. The study to be discussed thus focuses on 'everyday' non-suicidal self-hurting which does not lead to the person becoming a patient. It is particularly relevant to the theme of this special issue, that values are always ascribed to events (Rescher, 1983). The paper will analyse some of the circumstances in which causing oneself pain can be positively valued. It will go beyond the current social science literature in two ways, both related to value dynamics: firstly, by exploring research participants' accounts of their active efforts to mitigate risks which they associated with self-hurting; and, secondly, by identifying the negative value recalibrations which some respondents reported over the longer-term.

Self-hurting, particularly among adolescents and young people, has been flagged up as an increasingly serious health problem, for instance in the UK *National Inquiry into Self-Harm Among Young People* (Brophy, 2006). Even a cursory glance at the practice-oriented literature points to the packaging of self-hurting as a 'problem', and the direction of attention away from the tacit cultural work of categorising and valuing which this risk delineation entails (Heyman *et al*., 2010, pp. 59-85). For example, an editorial on the aforementioned *National Inquiry* in a widely read professional nursing journal (Youngman, 2006, p. 353) depicts a '*frightening spiral*' facing young people who self-harm, and cautions that '*negative, frightened reactions (which would be most people's first reactions) can turn the young person away from help*'. Such pre-packaging of self-hurting as a devastating and also terrifying condition which invokes revulsion projects negative value onto a behavioural event category, excluding consideration of the cultural contexts in which meaningful social actions are legitimised or rendered deviant (Chandler, Myers and Platt, 2011).

Quantification of the prevalence of, and risk factors for, self-hurting requires prior definition of the term and consideration of assessment issues. Terminology varies, with phrases such as 'self-hurting', 'self-injury', 'self-harm' and even 'self-mutilation' used interchangeably. This paper, which focuses on value issues, will refer to 'non-suicidal self-hurting' (self-hurting) as the least pejorative of the commonly used expressions. Another advantage of this terminological choice is that it highlights the main positive value for the present research participants, namely the use of physical pain to mitigate severe emotional distress. The definition of self-hurting requires a line to be drawn in terms of the level of severity above which an action will be classified as self-hurting, rather than merely symbolic, and for inferences to be made about intentions. Because parasuicide, body modification and sexually motivated masochism are excluded from the definition, the same behaviour, e.g. cutting oneself, might or might not count as self-hurting.

The '*natural attitude*' (Schutz, 1962) to risk '*virtual objects*' (Van Loon, 2002) prevails in the clinical literature, with self-hurting mostly viewed as an objective entity rather than a label for a category which differentiates and homogenises a range of disparate phenomena. Some definitions are briefly reviewed below in relation to the

implicit or explicit value judgements on which they are predicated. Sutton (2007, p. 23) defined self-hurting as:

> *a compulsion or impulse to inflict physical wounds on one's own body, motivated by a need to cope with unbearable psychological distress or regain a sense of emotional balance. The act is usually carried out without suicidal, sexual or decorative intent.*

This rendition contains an implicit negative value judgement in relation to the linguistic choice of '*compulsion or impulse*', both of which convey an inability to avoid acting in an undesirable way. Other definitions make more explicit value statements, so that social deviance is incorporated into a clinical 'condition'. Walsh (2006, p.4) defined self-hurting as:

> *intentional, self-effected, low-lethality bodily harm of a socially unacceptable nature, performed to reduce psychological stress.*

Klonsky and Muehlenkamp (2007) in their guide for practitioners also make societal disapproval a central feature of their definition of self-hurting.

> *Non-suicidal self-injury is the intentional destruction of body tissue without suicidal intent and for purposes not socially sanctioned.*

Self-hurting, on this view, acquires the status of an adverse event because its form or purpose is '*socially unacceptable*'. From this perspective, attempts to generate alternative forms of social validation through internet support groups appear particularly dangerous (Rodham, Gavin and Miles, 2007). However, in different social contexts, risking serious self-delivered bodily harm, e.g. through fashion-modelling size zero, climbing Everest, extreme sports, religiously legitimated self-hurting, would not be framed as medical problems. A small amount of clinical work has been concerned with providing safer outlets for self-hurting such as self-administered acupuncture (Davies *et al*., 2011). But most has started from the unexamined presupposition that self-hurting is an inherently adverse event, and therefore a risk which needs to be assessed and reduced as much as possible.

With respect to its manifestations, an array of self-hurting behaviours can be identified. Although the category label lumps them together into one homogenised adverse 'event', substantial differences in form and underlying intentions can be identified, particularly between self-poisoning and 'working' directly on one's own body (Chandler, 2012). The latter includes, most commonly, cutting, and also, scratching, , head-banging, hitting and skin-burning (Paivio and McCulloch, 2004; Carlson *et al*., 2007). Self-hurting can be focused on many parts of the body, but is most likely in places such as the upper arm where its effects can be concealed by clothing (Carlson *et al*., 2007). Prevalence estimates will depend upon how self-hurting is defined and measured. Research suggests, this relativity notwithstanding, that it is a common feature of growing up in developed societies, with about 15% of adolescents self-hurting at least once in the USA and Canada (Klonsky and Muehlenkamp, 2007). Prevalence rates are higher in Northern than in Southern Europe (Schmidtke *et al*., 1996) and the UK has been identified as a European epicentre (Cole-King *et al*., 2011). Brophy (2006) estimated that 142,000 visits per

annum to Accident and Emergency departments in England and Wales occur because of self-inflicted injuries. Since most incidents do not lead to injury requiring hospital attendance, these referrals capture only a small proportion of the underlying incidence[i].

Self-hurting prevalence peaks during adolescence. A rate of about 7% has been found in early adolescence, 11-14 years, as against 18% in the 14-17 year age group (Hilt, 2008), a trend confirmed at the individual level in a small UK longitudinal study (Hankin and Abela, 2011). However, self-hurting also occurs at older ages, with personal durations of up to 25 years identified (Outside the Box, 2008). Although females are more likely to present to health services with self-hurting (Schmidtke, *et al.* 1996), their underlying rate may, contrary to common belief, be similar to that for males (Klonsky and Muehlenkamp, 2007). Articles on the 'problem' of self-hurting often use the term 'epidemic' to refer both to high prevalence (e.g. Miller and Smith, 2008) and a trend assumed to be rapidly increasing (e.g. Shapiro, 2008). The small amount of historical research undertaken (Alderson, 1974; Kessler *et al*., 1999) is consistent with this view. Whether a major increase in the prevalence of self-hurting is occurring in developed societies must be considered an open question because comparisons over time are often invalidated by unnoticed changes in the definition and recording of events.

A substantial body of research literature has been concerned with the 'causes' of self-hurting via studies of statistically associated 'risk factors'. The usual problem that covariation makes it difficult to disentangle cause from correlation even with multivariate analysis applies particularly to self-hurting on account of the strong interrelationships between candidate risk factors (Prinstein, 2008). People who have self-hurt are up to 30 times more likely to commit suicide than those without such a history (Cooper, 2007). In consequence, both actions will be associated with the same risk factors despite their very different intentions[ii]. Research into attempted suicide has identified predictive links (referenced below only by examples) with psychological attributes, e.g. negative emotionality (Enns *et al*., 2003) and cognitive style (Abramson *et al*., 1989); interpersonal issues such as lack of family support (Lewisohn *et al*., 2001) or being separated/divorced (Petronis *et al*., 1990); and environmental stressors like experiencing abuse (Evans *et al*., 2005), socioeconomic deprivation (Schmidtke *et al*., 1996), and homelessness (Haw *et al*., 2006). Overall, social stressors of any form appear to increase the 'risk' of self-hurting. The probability of a person self-hurting is also strongly intertwined with culture in complex ways which are little investigated or understood. For example, in the UK, among those of South Asian origin, females are more likely, and males less likely, to self-hurt than the general population (Husain *et al*., 2006). Although a wide range of personal, interpersonal, environmental and cultural associations have been identified, the field is dominated by psychiatry, and medically-oriented researchers have tended to over-emphasise psychological risk factors (Chandler, 2012).

There has been a dearth of work concerned with the perspectives of people who self-hurt (Masten, 2004; Brophy, 2006). Redley (2003) argued for a redirection of research focus away from causal antecedents towards actors' prospective reasons for self-hurting, from *Naturalwissenschaften* to *Geisteswissenschaften* in the language of Weberian sociology. The present paper will contribute to a modest and fragmented but growing body of qualitative research on this topic (e.g. Solomon and

Farrand, 1996; Harris 2000; Taylor, 2003; Cresswell, 2005; Wertlieb, 2006; Inckle, 2007; Horne and Csipke, 2009; Chandler, 2012). Researchers have documented socially situated reasons for self-hurting, including relieving mental pain, releasing endorphins[iii] in response to stress, venting anger or self-hatred, creating a sense of autonomy and communicating a cry for help. Solomon and Farrand (1996), in one of the first studies of this kind, found that four young women whom they interviewed expressed views which challenged prevailing medical beliefs. They differentiated suicidal and non-suicidal forms, and self-hurt covertly in order to relieve emotional pain rather than to elicit social support. Harris (2000), drawing on correspondence (pre-internet) with a sample of six female pen-pals, contrasted the blaming attitudes of health professionals with informant '*internal logic*', for instance, the use of self-hurting to manage the emotional pain caused by being sexually abused. Horne and Csipke (2009) investigated their uses of self-hurting with 37 respondents, 34 of whom were female, via the internet. Respondents stated that they self-hurt in order to regulate their affective state. They sought to either damp down distress, or to ramp up feelings in order to tackle the numbness of disassociation, depending upon whether they wanted to increase or decrease their emotional arousal to expected levels. Qualitative research has mostly explored the perspectives of women. One study conducted with five men recruited through a mental health drop-in centre (Taylor, 2003), concluded that their reasons for self-hurting were similar to those of women, and included releasing emotional pain, and expressing anger or self-hatred.

The starting point for the present research was attempting to understand the benefits and costs which those who self-hurt associate with causing themselves pain. The study included only persons with a history of self-hurting who had never contacted health or other services for this reason. The findings thereby sheds light on experiences of the majority whose self-hurting remains officially invisible - the larger, submerged part of a metaphorical iceberg. The study fits particularly well with the work of Chandler (2012) who has recently depicted self-hurting as socially situated emotional 'work' on the body. In the data analysis, various intentions underpinning self-hurting, some of which were outlined above in relation to existing research, will be mapped out. Two consequent value issues which have been little considered to date will be discussed: attempts to mitigate perceived adverse side-effects of self-hurting; and the retrospective identification by some of longer-term unanticipated, negatively valued consequences of self-hurting.

METHODOLOGY

Design overview

An exploratory, grounded theory approach to data collection and analysis was adopted (Strauss and Corbin, 1998). Audio-recorded, lightly structured interviews were undertaken with 25 volunteers who offered retrospective narrative accounts detailing their prolonged experiences of self-hurting. These narratives were explored using a grounded theory approach which provided a structured analytical process for examining data and developing an explicit theory derived from research participants' own expressed concerns. Data analysis was undertaken after the interviews were completed, rather than through cycles of data collection and analysis. However, the interviewer (first author) enhanced his theoretical sensitivity by writing detailed

memos after each interview. The emergent substantive theory is summarised below, and developed in the Findings section of the paper.

The research design, including the contents of an information pack, were approved by the appropriate Research Ethics Committee at the University of Greenwich. Potential participants were asked to confirm that taking part in the research would not induce them to additional self-hurting. This stipulation was carefully discussed with them at the time when they completed the informed consent procedure. Participant anonymity was maintained in research reports and papers, including this one, through the use of pseudonyms and removal of any details which might lead to respondents being identified indirectly.

Sampling

Twenty-five research participants were recruited through a wide network of specialist organisations and support groups, such as FirstSigns (www.firstsigns.org.uk) and the Sirius Project (www.siriusproject.org.uk).

Respondents fulfilled the following inclusion criteria: having self-hurt during adolescence; being presently aged between 25 and 55; and living independently in the community. A particular feature of the present study is that the sample were recruited from the members of the general public rather than via the health service. This sampling approach allowed the meaning of self-hurting to be explored among individuals who had not been medically labelled. Participants confirmed that they had had no contact with health or social care professionals regarding their use of self-hurting. Because the sample were self-selected, it is possible that their injury levels might have been less severe than would be found among those who receive treatment for self-hurting. Although this limit to generalisation must be born in mind, informant accounts demonstrate that many had faced major relational and/or emotional problems, including sexual abuse, and had taken self-hurting to serious levels. Demographic and other characteristics of the sample are summarised in Table 1 below.

INSERT TABLE 1 HERE

It can be seen that the sample were predominantly female, with ages ranging from young adulthood to middle-age. All but four respondents were in skilled or professional paid employment. Nearly half the sample were still self-hurting when interviewed. The most common method was cutting, as found in other studies (Carlson *et al*., 2007), and a few respondents scratched or burned themselves.

Data Collection and Analysis

Data were collected through lightly structured interviews, undertaken between April and October 2008. The aim of interviews was to obtain narrative accounts of respondents' experiences of their prolonged use of self-hurting. The interviews were conducted in private interview rooms on University premises. Respondents were invited to talk through their history of self-hurting, starting with its origins and carrying on until they came to the present, or to a time when they had stopped giving themselves pain. (About half of the sample were not self-hurting at the time of the

interview.) Over 45 hours of recorded interviews were transcribed for data analysis. The average interview length was 1.75 hours, with a range of 1.25-2.5 hours.

Data analysis involved overlapping stages of open, axial and selective coding. Firstly, an open coding process was applied to the corpus of interview data. Constant comparison was used to establish a set of thematic categories which described aspects of participants' uses of self-hurting. Overlapping this process, axial coding involved closely examining the dimensions and interrelationships of thematic categories. Intersecting with axial coding, selective coding entailed generating a core category around a story-line. This story-line drew together three features of self-hurting as a purposeful activity, discussed in the Data Analysis section below: its purposeful use; attempted mitigation of perceived consequent risks; and, in some cases, the exhaustion of self-hurting as a resource overwhelmed by emerging drawbacks.

FINDINGS

The gains from self-hurting

Respondents described the benefits they identified from self-hurting. These accounts can be roughly classified as emphasising personal and/or interpersonal gains. The former referred primarily to stress relief or anaesthetising deeper pain; and the latter to the objectives of managing social situations or asking for help. These perceived advantages of self-hurting will be set against the drawbacks which respondents identified, particularly over the longer term.

Personal gains The pain resulting from self-hurting could be viewed as a simple stress-relieving measure. One research participant drew an analogy between self-cutting and acupuncture, both of which involve breaking the skin, but within very different frames of meaning and societal legitimation.

> *It's* [cutting is] *like acupuncture. I'm relieving tension, giving myself something else to concentrate on, which is physical pain. I want to get away from it* [distress]. *It works for me, and it's never going to go any further than a couple of little cuts*. (Matthew, age 32, still self-hurting)

This account normalised self-cutting as therapeutic tension release. The respondent expressed confidence that, as with acupuncture, serious injury would not be risked. Similarly, another research participant drew an analogy between self-cutting and the normative action of taking a mild analgesic.

> *It's* [cutting is] *easier than, it's quicker and easier than, taking a headache tablet. It dissipates the problem in seconds, and I'm calmer and more able to do what I was supposed to be doing.* (Laura, age 34, still self-hurting)

Laura thus routinised cutting herself as a trivial procedure, less disruptive than consuming a mild analgesic. By using this metaphor, she, like Mathew, quoted above, undermined the division between societally approved and illegitimate methods for coping with mild stress and linked cutting herself to the normal activity which she was '*supposed to be doing*'. However, she also identified gains from self-

cutting which extended beyond the aspirin analogy, in terms of carving out a zone of personal autonomy and creating opportunities for self-care.

> *I need to have control over myself, and not let other people to be able to influence that so it doesn't matter what anyone else does to me - I can cope with it. Also it's* [self-cutting is] *an excuse, because I think I definitely need one. I need an excuse to take care of myself. It's my version of pampering myself*. (Laura, age 34, still self-hurting)

This quotation invoked deeper needs which the respondent felt could be addressed through self-hurting, namely, and somewhat ironically, achieving a sense of personal autonomy, and providing a justification for her looking after herself.

Another research participant compared self-hurting favourably with borderline legitimate mood-altering substance consumption.

> *It's like a fuse. Some people drink, smoke, take drugs, medication. I cut myself. What I do doesn't poison your body - take away life. For me, it gives back life.* (Suzanne, age 29, not currently self-hurting)

Suzanne challenged the negative image of self-hurting by contrasting it with more normal activities which '*poison your body*'. The simile of a fuse is linked to her experience of self-hurting as a method for restoring feelings of vitality. The sense of self-given pain being experienced as a life-giving phenomenon, rather than an adverse event, is vividly conveyed in the next quotation.

> *When I burn myself and the pain goes up in an arch. There's a wave, and, at the top, a moment when you can't think or feel anything, like being blinded by sunlight. I find that really nice, a moment of not experiencing anything other than that one specific - fsssshh!!!* (Tina, age 28, not currently self-hurting)

The pleasurable feeling of surfing a pain '*wave*' was conveyed through a comparison with being dazzled by sunlight, an image associated with joyful aliveness, particularly in the frequently damp climate of countries such as the UK. The pain focussed her consciousness onto one point, a difficult to achieve and life-giving mental state. Tina felt that such experiences helped her to sustain her well-being in difficult circumstances.

> *I don't think I could have managed it without the self-injury. It was my secret prop. It gave me strength, and that was how it worked for me.* (Tina, age 28 years, not currently self-hurting)

Another respondent pointed to a connection between pain and the release of endorphins.

> *Cutting relieving tension, giving myself something else to concentrate on which is pain. It releases endorphins which is calming. There's a chemical reaction that the pain causes. It's calming, the chemicals that are released in your brain. It's calming, and it will relax me.* (Matthew, age 32, still self-hurting)

In effect, Matthew 'prescribed' mood-changing drugs for himself which were administered via his own body's pharmaceutical factory. His account drew attention to a double benefit of self-hurting, with pain both distracting from emotional tension and inducing exposure to a dose of opiates. (As noted above this gain can exist independently of the truth value of the underpinning biochemistry.) Another respondent particularly valued the speed with which self-hurting would bring relief.

> *I used to really enjoy it, cutting, because I used to do it quick. It gets the adrenaline going. The adrenaline is going so much that whatever you've got inside of you, it's all coming out. You're cutting so fast. Everything is flowing out, endorphins, yeah, quick and quick and quick slices.* (Tamara, age 34, not currently self-hurting)

Whilst some respondents normalised self-hurting as equivalent to consuming aspirin or a stiff drink, others identified gains in terms of managing serious mental distress.

> *It* [cutting] *was like balancing the physical pain with the emotional pain. When I was actually cutting, it was calming me. It was like, in my head, I had this pair of scales. And if my emotion was right up here* [pointing above head] *overwhelmed with emotion, and the hurt and the pain, I'd keep cutting and cutting until it was level. Then I could stop.* (Tracy, age 31, still self-hurting)

Tracy uses the vivid metaphor of a pair of scales to indicate that she used cutting in order to achieve a level of physical pain at least comparable to her emotional distress. Since the two forms of suffering are qualitatively distinctive, she used the direction of her attention to calibrate their degree of adversity, stopping only when they felt equivalent and, presumably, the former took her mind away from the latter. As with several other respondents, Tracy identifies a calming effect of self-hurting. In contrast to the account given by Matthew, cited above, this one did not refer to boundaries. If Tracy's emotional distress was sufficiently intense, she might end up cutting herself severely. This response uncouples self-cutting from everyday actions, the framework which previously quoted respondents had utilised.

Some respondents referred to the anaesthetic effect of pain. The respondent quoted below used cutting to numb the emotional pain associated with the experience of being abused.

> *Cut, cut, cut and it worked. I couldn't give a damn about anything. I felt completely numb, like somebody had hit me over the head with an iron bar - concussed, numb and oblivious to it all, to John* [who abused her] *and mum. What mattered was stopping the overwhelming feelings and thoughts dead in their tracks. I would feel detached from my body, safe.* (Zoe, age 38, still self-hurting)

This account resonates with R.D. Laing's existential analysis of the 'divided self' (Laing, 1959). Respondents also used self-hurting for the opposite reason, to counter feelings of disassociation.

> *I became more aware of the times that I would dissociate. And this feeling of being not sure of my reality would be changed by self-injuring which would*

> *make me feel real again. Cutting was keeping me alive.* (Faith, age 40, not currently self-hurting)

Hence, pain could serve either a deadening or enlivening function a duality identified by Horne and Csipke (2009). The last quotation suggests that Faith had drawn upon pain to deal with serious existential problems, in effect hurting herself in order to prove that she was '*real*' and '*alive*'.

Interpersonal gains The emotional gains linked to covert self-hurting could be valued primarily for themselves, as discussed above, or seen as a means of enabling the person to better manage their interpersonal world. These two benefits were conjoined, and distinct from the less frequent employment of self-hurting as a cry for help, discussed below.

> *I used self-injury as a coping mechanism to push that emotion away, calming me down, taking away the upset, and being able to face people, the family, enabling me to live a normal life, to function in every aspect of my life. That's what it* [cutting] *did.* (Faith, age 40, not currently self-hurting)

This tactic allowed intense mental distress to be concealed, so that the person who was self-hurting could present a front of calm normality.

> *I'd built up my defence levels, and had built up this outside persona. And I was a good, well-behaved young lady, and knuckled down, and did my schoolwork because I didn't want anyone to see the hurt. And what I was doing, I'd laugh and pretend everything was fine. And I had it down to a fine art, being this person.* (Faith, age 40, not currently self-hurting)

The employment of self-hurting in order to avoid communicating anger is discussed in the next quotation.

> *If you've made me angry, I don't want to sit and discuss it with you. I really can't be bothered to discuss with you why I'm angry with you, can't be bothered to discuss with you why I'm scared of doing this.* (Abbey, age 38, still self-hurting)

Abbey identified three layers of non-communication. By redirecting her anger into self-hurting, she avoided revealing that she felt angry which removed the need to discuss why she felt that way, and also why she feared revealing her anger. Another respondent reported using self-hurting in order to avoid needing to talk about the trauma of having been raped.

> *It* [self-hurting] *was a safe way of getting rid of all those bad thoughts and feelings without talking about it* [the rape], *and I did understand this.* (Suzanne, age 29, not currently self-hurting)

The metaphor of '*keeping a lid*' on negative thoughts and feelings vividly conveyed the struggle to control intense emotions with the aim of avoiding the distress and embarrassment anticipated from sharing them with others. The coda to the comment documented Suzanne's view that such psycho-social devices could be employed without conscious awareness. The research participant quoted below used secret self-hurting as a means of coping with aggression from others.

> *I was bullied - those day-to-day feelings about feeling different, and not understanding why other kids didn't like me. It* [cutting] *gave me relief and empowerment. And this secret was mine. It gave me tranquillity and control in my life, and they* [bullies] *couldn't hurt me* [emotionally]. (Vincent, age 30, not currently self-hurting)

Paradoxically, by hurting himself, Vincent achieved a sense of '*empowerment*' because he could stay in control, and also own a secret which he placed those who were attacking him in ignorance of.

As noted above, using hidden self-hurting to maintain a facade of calmness opened up a fissure between the private and public self. Some respondents split their self temporarily in this way so as to develop a peak level of performance in relation to achieving a life goal.

> *My GCSEs were coming up, and teachers were saying I'm going to fail. I worked myself into the ground studying, and I self-injured. I cut to keep myself going. It became a way of coping with - I didn't want to feel anything, because, if I did, I might fall apart. And the only way to not get upset was to cut. It became this vicious cycle. It continued right the way through my exams, but after my exams, it stopped.* (Caroline, age 34, not currently self-hurting)

In this case, self-hurting was stopped once a target had been achieved. The depicted line of action can be compared to that of a top sportsperson who takes illicit performance-enhancing drugs just before crucial contests. The notion of a '*vicious cycle*' suggests the respondent's concern about the risk that self-cutting could escalate out of control. However, the risked positive feedback dynamic referred to was cut-off by the ending of a time-limited stress. The next response similarly linked self-cutting to a specific stressor but, in this case, the main concern was to avoid the risk of outbursts causing irreversible career damage.

> *It was a huge build-up. I was working such long hours for very little thanks, the frustrated pressure, and feeling overwhelming. It* [cutting] *regulates how I feel. There were a couple of occasions where I could have probably said something to some people that wouldn't, it wouldn't have been forgiven or forgotten, and it would have impacted and damaged my career. And it* [cutting] *was a way to make me not to do that.* (Lauren, age 32, still self-hurting)

Lauren used self-hurting to '*regulate*' herself in order to maintain compliance with the oppressive demands of others who had power over an important aspect of her life.

The respondents quoted above employed self-hurting to indirectly manage fraught interpersonal relationships through covertly discharging emotional turmoil, and/or compensating for a sense of powerlessness. The achievement of one or both of these aims required secrecy. Less frequently, respondents employed displays of self-hurting as a communicative gambit.

> *I wanted others to know the distress I was feeling. The self-injury, the cutting, was severe. It was me communicating how bad I felt, how much I was in turmoil*

inside, yes, communicating my 'cry for help'. I needed some help. (Tina, 28, not currently self-hurting)

Another respondent resorted to self-cutting as a means of preventing a close relationship from being broken off.

I cut my arms up, and then I waited for the attention, and I got it. It got me her [girlfriend's] *attention. She took me back, to look after me.* (David, age 47, not currently self-hurting)

This account depicted a deliberate, consciously reflective manoeuvre, as David '*waited*' for his self-hurting to stimulate a nurturing response.

Mitigating the downsides of self-hurting

Although placing a high value on self-hurting, research participants variously recognised unwanted drawbacks, but described mitigating measures which they took in order to nullify identified downsides. As noted above, respondents did not merely assess the value of multiple identified consequences, but, in some cases, actively managed them to '*accentuate the positive, eliminate the negative*' as Bing Crosby's popular song put it. The risks which some research participants felt that they could nullify included medically significant injury, escalating loss of control and exposure. These mitigation tactics are illustrated in the next quotation.

I was in complete control of it [self-cutting]. *The self-injury cuts were only small. The worst cut was a centimetre or two, and they were never deep, only surface skin. And I used to move around my body, one arm one week, and the next week my leg.* (Laura, age 34, still self-hurting)

By ensuring that she did not cut too deeply, and systematically rotating the site, Laura strove to avoid serious injury. In order to minimise risk in this way, she had to stay in '*complete control*' of her self-hurting. She had worked out through experience how to generate the most pain for the least bodily injury.

It is important to say that I know some surface skin cutting to specific parts of the body, like under your arm [or] *inner thigh, can hurt more than deeper cutting to other parts of the body. It is something you learn when you self-injure, especially if it needs to be done in such a way as to obtain a real physical pain with limited body damage, with as least blood as possible.* (Laura, age 34, still self-hurting)

Laura had learnt through practice how to optimise the trade-off between the positive 'value' for her mental state of experiencing more intense pain and reducing the level of health risk arising from bleeding and tissue damage. Abbey linked self-care after cutting herself to keeping herself '*safe*' by carefully cleaning her wounds.

Cleaning-up was like cleaning up my mind and soul. It [cutting] *was very controlled, and I stayed safe - no stitches required - and gently clean my damaged skin. It was self-care.* (Abbey, age 38, still self-hurting)

For Abbey, cleaning-up carried spiritual and meaningful significance, eliminating mental along with physical distress. As with other respondents, she emphasised her 'control' over self-hurting, a form of self-governance which, for her, countered the risk that this procedure might escalate to health-damaging levels.

Most research participants specifically valued the secrecy of their self-hurting, an informational status which allowed them to maintain a mask of normality and a sense of autonomy, sometimes in response to bullying or abuse. Concealment mitigated the risk of being stigmatised.

> *Cutting was carefully done. It was private. I would use razors. Nobody knew. It was never deep enough to end up in hospital. It only took a small cut or tear of the skin to get out of it what I wanted. I got to know how to cut without causing lots of blood. I would cut in places where my skin was easily covered - my thighs upper legs.* (Vincent, age 30, not currently self-hurting)

Another research participant used to vary her self-cutting technique in terms of where she was located so as to minimise her exposure risk.

> *Depending on how my day was going, in the girls lavatory I wasn't necessarily dripping in blood. That* [copious blood] *would happen when I was at home, in my own bedroom, and in my own space, where I could manage it. But if I was at college, I would use a needle which I kept on me all the time to stab my arm, or do a small cut.* (Sue, age 38, not currently self-hurting)

Sue's self-cutting at school was pre-prepared in that she took with her the equipment she would need to hurt herself covertly if she decided to do so. Suzanne had striven to re-establish secrecy after her self-hurting was discovered.

> *Although people got to know, I used to just change where I would cut. They would think I had stopped, but I hadn't. I became better at hiding it, better at self-injuring so it wouldn't notice. I changed the area, arms then legs. I kept my self-injury to places on my body I could hide, making it invisible to others, covered by what I wore - a very secretive part of my life.* (Suzanne, age 29, not currently self-hurting)

However, such information games could have a profoundly isolating effect, discussed in the next section. The importance which a number of research participants placed on keeping control over their self-hurting has already been considered. The following quotation illustrates the care taken to avoid escalation to dangerous levels of self-hurting.

> *I definitely do have control over it* [cutting and burning]*. I don't do anything that I would need to go to the doctor* [or] *Accident and Emergency department. I deliberately make sure I do not do stuff like that. I don't do anything that is difficult to control. I would heat something up, and then, because, say, I used a particular piece of metal, I would know how many seconds to count, to heat it up so it would make a certain amount of injury or damage, but not beyond that.* (Tina, age 28, not currently self-hurting)

Like Laura and Vince, quoted above, Tina became an 'expert' self-hurter, learning from experience how far to go in order to keep the risk of needing medical attention acceptably low. As well as possibly causing permanent health damage, exceeding this self-imposed boundary would have led to unwanted exposure of her self-hurting.

Longer-term downsides of self-hurting

Although respondents felt able to mitigate risks which they associated with self-hurting, some also identified longer-term, unanticipated negative consequences which could eventually outweigh the gains which they had welcomed. The longer-term downsides included deep interpersonal isolation resulting from 'living a lie', intensifying escalation, attrition from ongoing unresolved emotional problems, and finding that cries for help involving displays of self-hurting eventually provoked hostile responses.

Alexandria depicted a vicious circle in which social isolation and self-hurting fuelled each other.

> *The worst part or stage of my self-injury was, although I was getting on with my life, I had this big secret. I didn't look at it like this at the time. I looked at it as a habit, something I did, part of me. It became frequent, daily, but worse when I was upset, like when I felt different and lonely, isolated. And the self-injury took this feeling away. But the self-injury made me feel different and alone. And the two things, feeling alone and self-injury fed each other.* (Alexandria, age 43, still self-hurting)

Alexandria thus described a shift in perspective, through which she stopped viewing self-hurting as a taken-for-granted, habitual '*part of me*', and started to see it as exacerbating her emotional and interpersonal problems. Crucially for the present analysis, she discovered that a method for sustaining functional normality which worked for a time eventually made her problems worse. Successful concealment alienated Alexandria from relationships in which others interacted with a persona which she, but not they, knew to be false. Similarly, Jane had come to identify a paradox in which self-hurting as a response to feeling that she did not fit in subsequently intensified her sense of being '*different*', at constant risk of exposure.

> *It pacified my immense frustration, but it didn't help, in that it made me feel even more different. And this is why it was so important that nobody knew, or I would feel ashamed, not normal, and was really worried about the consequences of being found out. Although it was secretly different, it helped me not feel different when I was with my friends. But the paradox was, inwardly it made me feel increasingly different. And in the back of my mind was the growing thoughts about how long can I keep up this pretence that was in fact intensified by the self-injury.* (Jane, age 30, still self-hurting)

Jane found herself trapped in the '*paradox*' that an activity designed to help her to fit in by bringing order to her emotional turbulence made her feel even more deviant. She also found that the mechanics of hiding the signs of her self-hurting became more difficult to manage as she moved towards young adulthood.

> *At 14, I could hide it. I was still a child, and would spend more time on my own at home. Then, as life got busier socially at school, the self-injury increased, became a major part of my day-to-day life and, at 16, a major burden for me. It was hard to manage, a struggle. It was ingrained into my life, the way I functioned.* (Jane, age 30, still self-hurting)

Hence, Jane became trapped in a stress management pattern which she could manage in mid-childhood, but which became increasingly problematic in adolescence as wider social engagement made concealment more difficult. In addition, exposure of self-harming could seem more damaging as respondents grew older and might feel that more was expected from them.

> *As I got older, especially into my late 20s and early 30s, I had to keep it* [self-hurting] *more secret because it felt more shameful. Because people see it as an adolescent thing, and if they find out your still cutting and you're in your 30s - I feel there's shame attached to it.* (Faith, age 40, not currently self-hurting)

Faith felt trapped in a pattern of behaviour which she believed others would consider age-inappropriate for a mature woman. Self-hurting was thus partly legitimated by its probabilistically valid association with adolescent storm and stress. But Faith, and others who continued to self-hurt, did not take into account the time-limited status of this mitigating consideration.

Those who self-hurt for long periods of time may find that the risk of escalation to seriously injurious levels increases. Obtaining emotional benefits may require pain levels to be continually intensified as individuals become accustomed to previous levels.

> *I completely relied on it* [self-hurting]*. To an extent, it did give me relief. It did work for a short time, so it was twice, three times a day and ritualistic. I would be on this track where one cut before school, then I would be okay. Then I would get it in my head that I would need to cut when I got home. And before I went out in the evening, I would need to do it* [self-hurt] *in a particular way, without lots of blood. And this became more and more difficult as I got older. When I started, it helped me more but as time went by, it reversed.* (Jane, age 30, still self-hurting)

Jane found that she needed to cut herself more and more, until eventually it ceased to confer the previously experienced emotional benefit, which '*reversed*' so that it made her feel worse. This pattern seems to match that for other forms of addiction. Another respondent felt that her self-hurting had escalated because she didn't deal with interpersonal issues which cutting allowed her to hide.

> *It* [cutting] *seemed to escalate more when I was frustrated and couldn't get my emotions out. And I did it more and more often at home, especially if I spent a lot of time with my parents - holidays and things like that. It was being with them all of the time, and feeling that I wasn't able to communicate with them. We didn't discuss how we felt.* (Caroline, age 34, not currently self-hurting)

Escalation could tip over into self-destructiveness, with the aim of causing injury rather than obtaining emotional benefit through experiencing pain safely.

> *I felt that I couldn't cope with any of it, my thoughts and emotions, being angry at my parents the way they were treating me, and the challenges. And thinking there was no point to me being in the world - there was nothing I could do, or wanted to do. So it was to cope with all of this barrage of thoughts and emotions at that time I got myself into this place where I wanted to be as self-destructive as possible. I was trying to damage* [by] *cutting myself as much as possible.* (Tina, age 28, not currently self-hurting)

This sort of self-hurting stands in contrast to the measured, calculated forms depicted in the previous sections, placing the person at risk of serious medical harm, as Tina realised in retrospect since she had sought to '*damage*' herself.

A third unanticipated adverse consequence of using self-hurting to contain emotional problems was that underlying difficulties remained unmanaged. Deferring the mental pain of confronting such issues was achieved at the price of having to live on-and-on with them.

> *I began to feel the need to tell someone what had happened to me, but not knowing how to go about that, and the frustration of that. I would be left with these memories over and over again, and cutting and cutting. And at that point, I could see the cycle. I was very aware of the role that self-injury had in my life, that self-injury enabled me to keep all that rubbish buried, and all that emotional distress and everything buried. And if I was going to stop self-injuring, then I would have to talk about that, and get that out.* (Faith, age 40, not currently self-hurting)

Faith referred to eventually recognising that she was trapped in a vicious circle which she could only break out of through learning how to disclose what had happened to her. This dynamic was driven by the increasing difficulty of living with painful memories.

Finally, when self-hurting was used to plead for help, rather than as a covert emotional prop, this interpersonal tactic could backfire, generating only hostility, and thereby exacerbating the initial problem.

> *No-one ever stopped to listen and see how I was feeling and why I was cutting. All anyone ever did was tell me how bad and rotten I was. I couldn't voice it then. I couldn't voice what had happened, what had gone on nor anything else, or how I felt or why I harm.* (Tracy, age 31, still self-hurting)

Unlike David, the older man quoted in the first section of the data analysis whose girlfriend had taken him back in order to look after him when she found he was self-hurting, Tracy's attempt to employ a similar tactic had provoked only revulsion rather than nurturance, contributing to an escalating interpersonal conflict. Further self-hurting was a likely response to this relational dynamic.

I wanted others to know the distress I was feeling. I didn't get the help I needed, so I went back to cutting. (Suzanne, age 29, not currently self-hurting)

Thus, those who self-hurt over a significant segment of biographical time could find that the burden of concealment gradually weighed heavier; that the intensity of pain needed to achieve the desired effect escalated out of control; that methods of concealment might become harder to sustain as they moved towards adulthood at the same time as exposure came to be seen as more socially damaging; that living with the emotional problems which self-hurting was intended to deal with became increasingly burdensome; and that cries for help by means of self-hurting could provoke the opposite reaction.

DISCUSSION

The study considered in this paper is affected by the usual limitations of qualitative sampling. The respondents, who all self-hurt without suicidal intention and had not been in contact with health or other services for this reason, were doubly selected, through their membership of internet support groups and on account of volunteering to participate in the research. However, the research does offer a window onto the large population, around a fifth of 14-17 year olds (Hilt, 2008), who remain mostly invisible to services, and who may not problematise their own self-hurting. Although not necessarily representative, respondents did express a range of positions, with a particular contrast emerging between those who continued to normalise self-hurting and those who felt overwhelmed by longer-term negatively valued consequences. Because the sample specification excluded those whose self-hurting had ever necessitated hospital admission, those who gave themselves serious injuries (e.g. by intentionally breaking their bones) will have been filtered out of the study. Research participants sought primarily to relieve mental through physical pain, although one informant had felt herself shifting towards bodily destruction. Nevertheless, the accounts quoted above demonstrate the intensity of the emotional suffering experienced by many of the research participants. That they were able to manage their self-hurting without causing medical problems does not indicate reduced levels of anguish.

The study contributes to a small but developing body of work which challenges the prevailing pathologisation of non-suicidal self-hurting. As documented in the Introduction, definitions found in the clinical literature often incorporate societal disapproval, so that self-hurting is rendered into an inherently adverse event. This negative framing has two important consequences. Firstly, it stimulates health professional hostility towards those whose self-hurting requires medical treatment. They may be blamed for wasting healthcare resources, whereas those who put themselves at risk for socially acceptable reasons, e.g. of sports injury, are not accused of irresponsibility. Secondly, it fuels a search for predictive risk factors which would not be investigated if self-hurting had not been denoted as inherently undesirable. Thus, the question of risk factors is raised only because a wide range of behaviours and intentions have been unreflectively homogenised into a single adverse event category which is assumed to exist as a singular entity.

The starting point for the present research was the perspectives of individuals who self-hurt. As other studies have found, '*the (good) reasons*' (Solomon and Farrand,

1996, p.111) which motivate self-hurting emerge powerfully from their accounts. Respondents described using self-hurting for a range of intrapersonal and interpersonal reasons. The former included: making emotional suffering bearable; establishing a private sense of autonomy; combating disassociation; and creating opportunities for self-nurturance. All but the latter have been reported in previous research. Although covert and focussed on their own body, this form of '*embodied emotion work*' (Chandler, 2012) was, for some respondents, bound up with traumatic or stressful social experiences such as sexual abuse, bullying or school examination pressure. However, other research participants did not particularly connect their self-hurting to severe stress, but instead normalised it as equivalent to acupuncture, an aspirin or a stiff drink. As well as describing working on their emotions through hurting their bodies, respondents identified conjoint interpersonal gains. One perceived benefit was enabling the person to control intense emotions which, if released, could damage close relationships or employment status. A few informants, in contrast, employed self-hurting in attempts, successful or unsuccessful, to obtain social support.

The findings of the present study may go beyond those of previous research in two ways: by documenting respondents' efforts to mitigate identified adverse consequences of self-hurting; and by drawing attention to the longer-term downsides of relying on self-hurting which some reported. As well as being significant for understanding and societal management, these two components contribute to the problematisation of the concept of 'adverse event' by illustrating the wider dynamics involved in the valuing of outcomes. In relation to mitigation, social actors do not merely estimate expected value by summing the products of probability and value for anticipated consequences of chosen actions, the picture of rationality offered by utilitarian frameworks (Nord, 1999). Faced with an anticipated mix of more or less likely wanted and unwanted consequences, individuals and social groups can opt to either enter downsides on the minus side of their utilitarian calculations, or attempt to reduce risk negativity.

Respondents also identified unanticipated value dynamics which occurred when the directly experienced cost/benefit balance of self-hurting shifted negatively over time. Emergent problems could include: isolation resulting from ongoing 'living a lie'; needing to escalate self-hurting in order to achieve the desired mental release; becoming worn-out by ongoing emotional problems which remained undealt with; and finding that self-hurting failed as a method of eliciting social support[iv]. This process was driven by its own internal dynamics, but could also be affected by culturally specified developmental shifts, as individuals who had left adolescence felt that more was expected of them, and concealment became more difficult to achieve in an adult environment. More broadly, this dynamic illustrates the changeability of values which may change over time under their own momentum or in response to contextual shifts, leaving social actors potentially locked into lines of action which have lost their previous *raison-d'être*.

In relation to the theme of this special issue, the present study provides a particularly clear exemplar of the inadequacy of conceptualising adversity as an intrinsic property of events, the assumption underlying the Royal Society (1992) and many other definitions of risk. Social actors ascribe negativity and positivity to events (Rescher, 1983). Even pain can be positively valued, and downsides can be worked

on rather than merely responded to. But evaluative processes possess internal and externally linked dynamics, often unanticipated, which fundamentally limit the power of calculative rationality.

CONCLUSIONS

Overall, the accounts of their actions given by people who have self-hurt challenged its unreflective pre-packaging as a risked adverse event. They could readily articulate its positive value to them, undermine the cultural division between this stigmatised activity and others deemed socially acceptable despite giving rise to similar or greater injury risks, and describe their approaches to mitigation. At the same time, their engagement with downsides, not always articulated in the social science literature, offers suggestions as to how education, health and social services might engage more constructively with self-hurting. Firstly, services can offer a more structured approach to reducing medical risks associated with self-hurting (Davies *et al*., 2011), although harm reduction strategies can be criticised for legitimating behaviour which is often ultimately self-defeating (Gutridge, 2010). Secondly, through documenting the risks of self-hurting turning sour over the longer term, service providers can help individuals to consider possible futures which they might not otherwise be able to envisage, as argued by Slovic (2012). Thirdly, and perhaps most importantly, they can offer more opportunities for those who self-hurt to safely communicate underlying emotional distress.

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[i] The form of injury differs between those who are and are not admitted to hospital, with the former more likely to have self-poisoned, and those who cut themselves, the most common method, least likely to end up in hospital (Ystgaard, 2009). Research based on hospital recruitment will therefore not generate representative samples of the overall population who self-hurt.

[ii] Attempted suicide can be used as a proxy for self-hurting with respect to the identification of probabilistically predictive risk factors. However, individuals who injure themselves for emotional reasons tend to differentiate their actions sharply from attempted suicide or parasuicide, and may resent being put into the latter categories by health professionals (Solomon and Farrand, 1996; Harris, 2000). Moreover, the rarity of suicide compared with self-injury means that the vast majority of people who self-injure do not intend to commit suicide, a disjuncture which citations of high relative

risk always obscure. Although people who commit suicide are more likely to have previously self-hurt, the chance of people in the latter category killing themselves is very low.

[iii] The common belief that pain stimulates the brain to manufacture opiate-like endorphins is not supported by clinical evidence according to Chandler *et al*. (2011). Nevertheless, self-hurting may be motivated by a belief in this causal pathway which may become self-validating through the placebo effect.

[iv] Although not mentioned by research participants, some of those who use overt self-hurting to elicit social support may find that its efficacy eventually wears off as the sympathy of significant others becomes eroded.

TABLE 1
DEMOGRAPHIC CHARACTERISTICS AND SELF-HURTING STATUS OF STUDY SAMPLE (N=25)

Age	**Average**	**Range**
	36.6	28-52
Gender	**Female**	**Male**
	18 (72 %)	7 (28%)
Education	**Degree or above**	**Below degree level**
	16 (64%)	9 (36%)
Still self-hurting	**Yes**	**No**
	11 (44%)	14 (56%)