Mapping Clinicians' Discourses: Conceptualising And Treating Self-Injury In An Irish Context

Dissertation

By

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Submitted to the Department of Education, St. Patrick's College, Dublin City University in Fulfilment of the Requirements for the Award of the Degree of Doctor of Philosophy.

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September 2010

Declaration

I hereby certify that the material, which I now submit for assessment on the programme of study leading to the award of the degree of Doctor of Philosophy, is entirely my own work and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

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Abstract

To date, very little research has focused specifically on exploring clinicians'

understanding and treatment of self-injury. My study was an attempt to address this

gap in the literature and to fill in perspectives and voices not previously articulated.

In this study I explored clinicians' understanding of self-injury, their discourses about

their treatment models and their perceptions of their clinical effectiveness and failures

in their work with self-injuring clients. I also examined the sources of knowledge that

contributed to clinicians' understanding of self-injury and of those who engage in this

behaviour. Eight participants were selected using snowball and criterion sampling

methods. These participants were all mental health clinicians from a variety of

professional disciplines and who practiced a range of different treatment modalities

with self-injuring patients. Qualitative in-depth interviewing was the primary method

of generating data and discourse analysis was the mode of analysing the data in this

research study. The findings of my study suggested that the majority of the clinicians

did not have a distinct model for considering self-injury and treatment approaches for

working with self-injuring clients. Rather, they created discourse communities of "an

other" to formulate their beliefs about self-injury and its treatment. They also relied

predominantly on their clinical practice with self-injuring patients for comprehending

and treating self-injury. In relation to their current treatment practice effectiveness

and failures the clinicians seemed to draw on two distinct discourses, an "expert

discourse" and an "inquiry discourse" and appeared to have little or no systematic

way of thinking or conceptualising "progress" with regard to self-injury. Implications

for the education and training of clinicians about the phenomenon and treatment of

self-injury are discussed, with particular reference to the application of an inquirer's

discursive approach. In addition, recommendations are made for future research and

directions in this field, in terms of replicating this study in other countries beyond Ireland and also including the narratives of self-injuring patients' discourses about their experience of various treatment modalities.

Chapter One

Context for My Research Study

Inspiration for this Dissertation

The phenomenon of self-injury first came to my attention as a graduate psychology student via an enlightening and informative lecture, "Writing on their bodies: Understanding self-mutilation with adolescent girls through creative writing in psychotherapy" by a visiting academic to my university, Professor Annie G. Rogers (1996). During this period of my professional life, I was training as a counselling psychologist, and I was at the beginning of my final clinical placement which was based within a psychiatric service.

Prior to taking up my placement in an outpatient service, I was required to spend my first week shadowing one of the psychiatrists working there. I attended client case conferences and patient consultations with the psychiatrist. It was at one of these case conferences that I encountered an individual who self-injured. This was not the first time I had been exposed to self-injury. My first encounter was as a young graduate student, fresh out of college, when I worked with a young autistic boy, Josh (pseudonym). So I did not experience shock, repulsion, disgust or any other negative feelings articulated in the self-injury literature, toward the young woman, Fiona (pseudonym), who had cut her arm, and was in attendance at a case conference in the psychiatric hospital. What horrified me was the judgmental response from the psychiatrist and the two members of the nursing staff, who were present at the meeting. They told Fiona that her behaviour "was attention seeking". Much to my surprise, they did not explore her reasons for engaging in self-injury and what had precipitated this recent episode of self-cutting.

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Reflecting on Professor Rogers' lecture, and this reaction of the mental health professionals to Fiona, I became intrigued by self-injury, and wanted to know more about clinicians working with self-injuring patients, particularly in the Irish context. I therefore selected self-injury as my research topic for my Master's thesis. During the late 1990s, when I conducted my Master's research study, the published literature pertaining to the treatment of self-injury predominantly relied on single case reports. In an attempt to shift away from this over reliance in the literature on single case reports, I decided to conduct a postal survey to explore therapists' approaches to and experiences of working with self-injuring clients in Ireland. I randomly selected 60 participants from two databases of counselling psychologists, counsellors and psychotherapists working in Ireland. Fifty therapists returned my questionnaire. The findings of this study suggested that therapists working in Ireland might have had limited exposure to self-injuring patients, since only 19 participants indicated that they had experience of working with self-injuring clients. These participants indicated that they employed a variety of treatment modalities with self-injuring patients, that appeared to reflect the original model they had trained in, such as client-centred therapy, reality therapy, cognitive-behavioural therapy, gestalt therapy, gestalt systems therapy, humanistic/integrative therapy, narrative therapy and solution focussed therapy.

Since completing my Master's research, I have retained my clinical interest in the subject of self-injury. Reading the literature as a clinician, I became more intrigued by the unresolved debates and controversies, and the missing discourses of clinicians. In addition, I wanted to interview clinicians, who had experience of working with self-injuring patients, and to gather more in-depth information about their treatment approaches, than my earlier research had uncovered.

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As a clinician-researcher with a keen interest and curiosity about the phenomenon of self-injury and its treatment, I bring my own assumptions and expectations to this research study. For instance, my education and training as a counselling psychologist and my exposure to other modalities (e.g. sensorimotor psychotherapy) beyond my initial training have influenced the way I approach self-injury and its treatment. In contrast to the clinicians that I interviewed in my research study, I approached self-injury from a very different starting position to the clinicians that I interviewed. I began with a conceptual framework for understanding and treating self-injury before I worked with my first self-injuring client.

In terms of my expectations, I began this research process with hopes of finding experienced clinicians who would provide me with knowledge about self-injury and its treatment that has not been previously reported in the literature. Indeed, I wanted to learn new and creative ways of conceptualising and treating self-injuring patients that I had not known. Therefore, I decided to interview clinicians from diverse mental health disciplines and who employed a variety of treatment approaches to self-injury, some of which are not documented approaches in the literature.

Background to the Study

A number of factors have influenced the focus of my research study in relation to clinicians' conceptualisation and treatment of self-injury. These relate to the Irish context and the literature in relation to the treatment of self-injury.

Irish Context. Unlike the international literature on self-injury from countries such as America, Canada and Britain, research on the phenomenon of self-injury is severely limited in Ireland. There is a lack of published material on self-injury in the Irish context. A comprehensive search of the published literature revealed only two

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published studies (Hilary & Mulcahy, 1997; O'Donovan & Gijbels, 2006). Hilary and Mulcahy's (1997) study focused on self-injurious behaviour in a sample of Irish people with a "mental handicap". They specified, "A need for Irish data on this problem..." (Hilary & Mulcahy, 1997, p. 12) as the objective of their study. O'Donovan and Gijbels' (2006) study explored "...the practices of psychiatric nurses with nonsuicidal self-harming patients in the acute psychiatric admission setting..." (p. 186).

In addition to Hilary and Mulcahy's (1997), and O'Donovan and Gijbels' (2006) studies, a handful of scholarly masters and doctoral dissertations (e.g., Duffy, 1998; Keane, 1997; Mulhern, 1999; Rashleigh, 2003; S. Shaw, 2002) have explored self-injury in the Irish context. However, it is difficult to access these, because the authors have not published their findings, and Irish university libraries do not tend to publish graduate dissertation titles and abstracts, in Dissertation Abstracts International. Therefore, there is a need for more published Irish research studies on the phenomenon of self-injury. In light of this absence of Irish discourses on self-injury, I wanted to conduct an exploratory study of how clinicians in Ireland are navigating this terrain, in terms of understanding self-injury, treatment approaches and effectiveness.

Another reason for this study is the widespread acknowledgement that "deliberate self-harm" is a significant problem in Ireland (National Registry of Deliberate Self Harm Ireland Annual Report 2009). In relation to the incidence of self-injury in Ireland, Tighe (as cited in Ingle, 2007) noted, "Incredibly, there is currently no statistical evidence around self-harm in this country" (p. 6). Yet, media

reports, anecdotal evidence from clinicians and my own study Keane (1997) suggests that self-injury is prevalent in Ireland.

This lack of statistical data in relation to self-injury in the Irish context is related to a number of factors. Annual statistics are published in the *National Registry of Deliberate Self Harm Ireland Annual Report* by the Irish Association of Suicidology. These statistics cannot be interpreted as reflective of the incidence of self-injury in Ireland for a number of reasons. The data reported are "based on persons presenting to hospital emergency departments as a result of deliberate self harm in 2009 in the Republic of Ireland" (National Registry of Deliberate Self Harm Ireland Annual Report, 2009: p. 1). The international literature suggests that self-injury is prevalent among clinical and non-clinical populations (Himber, 1994). It is especially common in psychiatric units (Hawton, 1990), prisons (Haines Williams, & Brain, 1995; Wilkins & Coid, 1991), adolescent facilities including juvenile detention centres (Ross & McKay, 1979; Chowanec, Josephson, Coleman, & Davis, 1991) and residential treatment units (Walsh & Rosen, 1988). Self-injury has also been reported among third level college students (Favazza, DeRosear, & Conterio, 1989; Gratz, Conrad, & Roemer, 2002) and post-primary students (Ross & Heath, 2002). However, it is difficult to ascertain the number of people who engage in self-injury in the population at large or in specific clinical populations because there is considerable under-reporting of this behaviour.

Another problematic feature with the statistics published by the *National Registry of Deliberate Self Harm Ireland Annual Report* 2009 is the employment of a broad definition of deliberate self-harm which does not distinguish between "self-cutting" acts that are suicidal in intent and those that are not. In addition, the inclusion

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and the exclusion of deliberate self harm behaviours in this report is interesting. The report includes statistics on overdose, alcohol, poisoning, hanging, drowning, cutting and does not mention other categories listed in the self-injury literature such as burning, self-hitting and interference with wound healing. I return to these issues of defining, categorising and distinguishing self-injury from suicide in Chapter Two under the subheadings "Definition" and "Classification".

This study is timely in light of the establishment of a new treatment centre Pieta House CPSOS (Centre for the Prevention of Self-harm or Suicide) in 2006. This is a privately funded charity and is based in Leixlip, Co. Kildare. Pieta House provides therapy for individuals who have attempted suicide and those who engage in self-injury. Treatment consists of four to six weeks of "intensive therapy" (Ingle, 2007, p. 16) and is described as "holistic" (Ingle, 2007, p. 16) involving the client's family and friends. To date, there are no studies of the clinical effectiveness of this particular treatment model. This is consistent with the absence of studies in the international literature exploring clinical outcomes of treatment models with self-injuring clients. While the present study does not investigate treatment outcomes or the efficacy of programmes in relation to self-injury, it does explore clinicians' understanding and discourses in relation to effectiveness, failures and partial failures of their treatment modalities.

Finally, recent developments in the field of psychotherapy have provided increased opportunities for clinicians to receive specialist training in Ireland in new forms of treatment such as Dialectical Behaviour Therapy (DBT), Eye Movement Desensitisation and Reprocessing Therapy (EMDR), Mindful Based Cognitive Therapy (MBCT), and Sensorimotor Psychotherapy. These diverse treatment models

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may be employed by clinicians treating clients who self-injure. This diversity may lead to confusing ways of thinking about self-injury and the employment of incompatible and conflictual treatment strategies. For instance, EMDR and Sensorimotor Psychotherapy are usually used with clients who have a trauma history (Wilson, Becker, & Tinker, 1997; Ogden, Minton, & Pain, 2006) and not all self-injuring clients have such a history. DBT is a treatment for borderline personality disorder (BPD) and may be an incompatible and an inappropriate model of treatment for individuals who self-injure but who does not have such a diagnosis. While this study does not directly address issues of incompatibility, it does examine how clinicians do and do not consider the issue of compatibility and incompatibility of various treatment techniques.

Treatment Approaches. There are a number of interesting points in relation to the range of treatment approaches documented in the literature for working with self-injuring patients. There is a lack of empirical studies investigating the clinical effectiveness of these various treatment models. These treatment options have been mainly developed in the U.S.A. and to a lesser extent in Canada and in the U.K. In addition, treatments have evolved mainly from clinicians' work with white American females and often in clinical settings. Finally, there is a lack of studies exploring the extent to which clinicians use any of these treatment approaches in their work with self-injuring clients. Furthermore, it seems that clinicians who have written books about working with self-injuring patients have developed these frameworks from years of clinical practice. Examples of such works include Levenkron (1998), Connors (2000), Selekman (2002) and Walsh (2006). However, it is not clear what factors other than their clinical training and experience have influenced the development of these clinicians' current treatment practice and their current

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conceptual frameworks for understanding self-injury and their clients who engage in this behaviour.

In relation to treatment effectiveness and failures it is not apparent from the treatment literature which explanations or models clinicians use to understand these outcomes and how they measure or gauge such outcomes. These issues are to date unanswered by the current literature. Therefore, they warrant attention and are the focus of this research study which examines clinicians' conceptualisation of self-injury, their discourses about their treatment practice and their perceptions of their clinical effectiveness. I review the literature in relation to these issues in Chapter Two.

Researcher-Clinician Gap

Many authors have referred to the chasm between research and clinical practice (Ogilvie, Abreu, & Safran, 2005). Indeed, Kazdin (2008) contends that, "A central issue is the extent to which findings from research can be applied to clinical practice" (p. 146). As a researcher-practitioner, I am attempting to bridge this gap between clinical research and practice, with particular reference to self-injury. Kornfield and Feldman (1996) stated that, "Listening to the stories of others, learning from them, brings a ray of light to our understanding" (p. 2). I hope that my research study, with its focus on listening to clinicians' discourses in an Irish context, will bring a "ray of light" to other practitioners who are searching to broaden their frameworks for understanding self-injury and who wish to enhance their treatment practice with self-injuring patients.

Purpose of this Research Study

In this study, I attempt to map the uncharted territory of clinicians' discourses, that relate to their understanding and treatment of self-injury within the Irish context. The contours of this landscape, that I am interested in, centred around clinicians' thinking about self-injury, what discourses they drew on to articulate their ideas about this phenomenon, and the clients who engage in this behaviour. In addition, I intend to focus on how they spoke of their treatment approaches with self-injuring patients, and the sources of knowledge that influenced their thoughts and ideas in relation to self-injury. The final area that I examine is the clinicians' perceptions of their success and failures with self-injuring clients and how they gauged this in their clinical practice.

Terminology

Throughout this dissertation, I use the terms "counselling" and "psychotherapy" interchangeably, because I subscribe to the discursive position articulated by Spinelli (1998). He argued that:

> ...it is not possible to make a generally accepted differentiation between counselling and psychotherapy and that it is clear that, regardless of the many and varied distinctions that some have sought to impose on them, the terms may be employed interchangeably. (Spinelli, 1998, p. 39)

He further contended that:

> ...it may well be the case that the desire to impose or avoid distinctions has more to say about the allegiance of the institution in which a practitioner has trained, the setting in which he or she might typically work, and the

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personalities involved, than about specific distinctive features of practice. (Spinelli, 1998, p. 39)

Consequently, I use the term "treatment" in my interview schedule with the clinicians that I interviewed, regardless of the mental health discipline they belonged to, the theoretical orientation they trained in or practice and the setting they worked in. I did this because I wanted to explore how the clinicians would respond to my discursive term "treatment".

I also use the terms "client" and "patient" interchangeably throughout this dissertation, because these are discursive phraseology that clinicians use to refer to the individuals that seek their help. Traditionally, these discursive terms tend to be associated with particular professional disciplines, and theoretical orientations. For instance, psychiatrists and psychoanalysts tend to use the word "patient", while psychologists and psychotherapists are more likely to say "client".

For clarification purposes, I have distinguished four authors (A. G. Rogers; C. R. Rogers; S. Shaw; S. N. Shaw) by their initials when referring to them. I have chosen to do this to eliminate confusion over authors, who share the same surname and in two instances, also share the same year of publication. This practice is in keeping with the recommended guidelines of the *Publication Manual of the American Psychological Association* (6th ed.).

Significance of this Research Study

My research study is unique in terms of its specific focus on clinicians' discourses, which to date, have not received attention in previous studies. Another important feature of this study is the exploration of clinicians' understanding and

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treatment of self-injury, which to a large extent has been neglected by researchers, with the exception of a few unpublished scholarly dissertations. The fact that this study specifically centres on clinicians working in an Irish context is also significant due to the lack of published studies on self-injury in Ireland. Finally, this exploration of clinicians' discourses about their conceptualisation and treatment of self-injury is noteworthy, because it has potential implications for the education and training of psychologists, psychiatrists, psychoanalysts and psychotherapists. I will discuss these points further in the forthcoming chapters.

Overview of this Dissertation

This dissertation consists of eight chapters. In this chapter, I provide an introduction, offering a brief context for my research study. In particular, I outline the influences that led to my research inquiry into the phenomenon and treatment of self-injury, the Irish context in relation to self-injury, the chasm between the researcher and the clinician, and finally, the purpose and importance of my research study.

In Chapter Two, I examine the available literature where it has relevance to my exploration of clinicians' discourses in relation to understanding and treating self-injury. I specifically examine the discourses of debates and controversies in the literature with respect to conceptualising self-injury. I also mark out the discourses in the literature in relation to the various self-injury treatment options, treatment success, failure and partial failure, responsibility for outcome of treatment and sources of knowledge, that relate to my research study.

In Chapter Three, I sketch the mode and experience of my inquiry. In particular, I describe the qualitative design and give a rationale for the employment of this method. I also provide details of the selection procedures and sample size of the

participants, the interview process, the pilot study, and the method of data analysis used. In addition, I review the ethical considerations that pertain to this research study.

In Chapters Four, Five, Six and Seven, I present the major findings of my research study. Specifically, I mark out and discuss the clinicians' discourse patterns, that emerge from their narratives, with respect to the research questions. In Chapter Four, I explore the clinicians' discourse patterns in relation to the research questions: "What conceptual frameworks do clinicians draw on to understand self-injury and their current treatment practice with self-injuring patients?", and "What sources of knowledge, including both personal experience and professional training have influenced/shaped the development of clinicians' explanation(s), or working model(s), of treating self-injuring clients?" My examination in Chapter Five centres around a pattern that emerged across the clinicians' narratives, where they tended to create discourse communities of "an other", to formulate their beliefs about self-injury and its treatment, rather than articulating particular theoretical or conceptual models. In Chapter Six, I discuss the research question that relates to the explanations or models, that the clinicians drew on to understand their current treatment practice effectiveness and failures, with self-injuring clients. I conclude with a deliberation in Chapter Seven of the clinicians' discourses that pertain to the ways in which they gauged or measured their clinical effectiveness in their current treatment practice with self-injuring patients.

In Chapter Eight, I draw this dissertation to a conclusion, with a discussion of the five major findings of my research study, and interpret them in the context of the literature. In addition, I consider the co-construction of the discourses of the

participating clinicians in the wider context of Irish society. I also examine the

limitations of my research study and I explore the potential implications that the

findings of this study have, for the education and training of clinicians, in the

disciplines of psychology, psychoanalysis, psychotherapy and psychiatry where they

deal with conceptualising, and treating self-injury. Finally, I conclude by making

recommendations for future research, and directions in this field.

Chapter Two

Literature Review

In this study, I attempt to map the landscape of a small group of clinicians' discourses, which pertain to their conceptualisation and treatment of self-injury within the Irish context. In particular, my study addresses clinicians' understanding of self-injury, their discourses about their treatment models, and their perceptions of their clinical effectiveness and failures, in their work with self-injuring clients. A further purpose of this study was to identify the sources of knowledge that contribute to clinicians' understanding of self-injury, and of those who engage in this behaviour.

Self-injury is a multi-faceted phenomenon. To date, the research has predominantly focused on investigating its epidemiology and phenomenology. These research studies have largely focused on self-injury in female clinical populations. A small number of studies have employed in-depth interview methods to explore the experiences of those who engage in self-injury (Himber, 1994; Hyman, 1999; Lindgen, Wilstrand, Gilje, & Olofsson, 2004; Reece, 2005; Rissanen, 2008; S. N. Shaw, 2006). However, relatively few studies have paid attention to clinicians who work with self-injuring patients. A comprehensive search of the literature revealed five such studies (Huerta, 2006; Keane, 1997; Roberts-Dobie & Donatelle, 2007; Suyemoto & MacDonald, 1995; Williams, 2005). Three of these five studies used a survey method (Keane 1997; Roberts-Dobie & Donatelle, 2007; Suyemoto & MacDonald, 1995), thus highlighting the lack of research studies, employing qualitative in-depth interviewing methodology, to explore clinicians' experiences of treating self-injuring clients. Huerta's (2006) and Williams' (2005), unpublished scholarly dissertations were exceptions. Surprisingly, no study has examined

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clinicians' discourses about self-injury with respect to their understanding, treatment approaches and/or their gauging of their success and failure with self-injuring patients. This is remarkable considering the proliferation of books and journal articles on self-injury and the amount of controversy surrounding this phenomenon in the literature. These controversial issues primarily relate to conceptualising and treating self-injury. While tracing the historical context of the study of self-injury, S. N. Shaw (2002) noted, "...a series of perplexing shifts in how this behavior has been conceptualized and treated" (p. 192). In light of these historical shifts and controversies in the literature, we cannot take for granted that clinicians working in practice are clear in their conceptualisation and treatment of self-injury. In the remainder of this Chapter, I mark out and discuss these discourses of debate and controversy that centre around understanding and treating self-injury and how they are of particular relevance to my research study. In addition, I also explore the literature in relation to treatment success and failure, as it relates to my exploration of clinicians' discourses about their perceptions of their clinical effectiveness and failures, in their work with self-injuring clients. To conclude my discussion of the literature, I review work concerning how clinicians locate responsibility for the treatment outcome, and their sources of knowledge about conceptualising and treating self-injury.

Conceptualising Self-Injury

The literature focusing on understanding self-injury is predominantly marked by discourses of debate and controversy, in particular, issues related to terminology, definition, classification, functionality, causation and gender. These unanswered debates and lack of consensus on significant features in relation to conceptualising the

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phenomenon of self-injury are relevant to clinicians' understanding, and have implications for their treatment approaches. Indeed, Briere and Gil (1998) argued that self-injury "…is one of the more perplexing of clinical phenomena" (p. 609). A British psychotherapist, Turp (2002) contended that self-injury "…is not, as is sometimes assumed, a phenomenon that can be readily identified and circumscribed" (p. 197). Therefore, it is essential to explore how clinicians' understand self-injury and those who engage in this behaviour, and to begin contextualising the debates in the literature. I will now elaborate on these discourses of controversy and debate under the following subheadings: terminology, definition, classification, functionality, causation and gender.

Terminology. The discourses of controversy in the literature concerning problems with respect to terminology, centre around the range of terms employed, as well as points of ambiguity and confusion. Some terms, such as self-mutilation, self-harm, and self-injury are used interchangeably, while others can be conflated with suicide. In addition, there appears to be little consensus in relation to an agreed term in the literature to refer to self-injuring behaviours.

This difficulty in naming self-injury has plagued the field for many years. Since its first appearance in the literature with the publication of Emerson's case study in 1913, a myriad of terms have been employed to refer to self-injury. In 1979, Ross and McKay cited 33 different names for self-injury (see Appendix A) in the literature which probably accounts for Woldorf's (2005) comment that self-injury "…may hold the record within mental health for the most names for a single phenomenon…" (p. 196). Sample terms from the literature include "self-cutting" (Greenspan & Samuel, 1989; Himber, 1994; Suyemoto & MacDonald, 1995), "self-wounding" (Tantam &

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Whittaker, 1992), "deliberate self-harm" (Morgan et al., 1976; Pattison & Kahan, 1983), "self-destructive behaviour" (van der Kolk, Perry, & Herman, 1991), "self-mutilation" (Favazza & Conterio, 1989; Favazza, 1996; Ross & Heath, 2002; Ross & McKay, 1979; Walsh & Rosen, 1988), "self-inflicted violence" (Alderman, 1997), "self-injury" (Connors, 2000; Conterio & Lader, 1998; Hyman, 1999; Walsh, 2006), "self-harm" (Farber, 2000; Selekman, 2002; Turp, 2003), "non-suicidal self-harm" (Muehlenkamp, 2006, O'Donovan & Gijbels, 2006) and "non-suicidal self-injury" (Heath, Toste, Nedecheva, & Charlebois, 2008).

Indeed, many researchers and clinicians have articulated the need for global consensus and adoption of the use of an agreed term (Nock, 2009; Rodham & Hawton, 2009). Some contend that the term self-cutting is too narrow as it only refers to one form of self-injury. Others argue that another difficulty is the use of multiple terms used interchangeably to refer to self-injury. For example, self-mutilation, self-injury and self-harm appear to be the terms employed most frequently in the current literature, and are often used interchangeably to mean the same thing. Many authors argue that self-harm is a broader construct than self-injury (Heath, et al., 2008). They contend that self-injury is a definite subcategory of self-harm (Connors, 2000; McAllister, 2003; Sebree & Popkees-Vawter, 1991). In contrast, others make no clear distinction and employ self-harm as a broad and inclusive term (Bohn & Holz, 1996; Middleton & Butler, 1998; Turp, 2003). However, McAllister (2003) argued that when the term self-harm is used synonymously with self-injury, confusion arises because one is unclear whether a reference is being made to self-injury, and/or parasuicide and/or a broad range of other self-destructive behaviours (such as eating disorders, alcohol abuse, substance abuse, risk taking behaviour, failure to engage in self-care and/or medical care, and so on). Deliberate self-harm (DSH) is another term

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that also tends to cause some confusion because it is often used to refer to suicide-related behaviours such as self-poisoning, or self-cutting, irrespective of the intention to die (Hawton & James, 2005).

A number of clinicians (e.g., Connors, 2000; Hyman, 1999; Simeon & Favazza, 2001) have argued that self-mutilation "…is too extreme and pejorative a term…" (Walsh, 2006, p. 3). In addition, they have noted that in most cases the injuries inflicted range from mild to moderate in terms of level of severity and rarely result in mutilation of a body part except in cases of psychosis or organic disorders. Proponents of the term "self-injury" such as Connors (2000) contended that, "It is the most descriptive and least pejorative of the common phrases" (p. 7). Recently, the term "non-suicidal self-injury" (NSSI) has been proposed in the literature as an attempt to distinguish between suicidal and non-suicidal acts of self-injury. This term, NSSI lends itself to less confusion and more clarity than previously proposed terms.

In conclusion, there is no generally agreed terminology in the literature to refer to behaviours that constitute self-injury. As stated previously, the literature is awash with a variety of terms, some of which can be conflated with suicide related behaviours. Indeed, Connors (1996) argued that, "The lack of clear terminology has added to the confusion and frequent misconceptions about" (p. 198) self-injury. With respect to the Irish context, we don't know what names clinicians give to self-injury and whether they use terms interchangeably. Indeed, it is not clear how aware or not clinicians working in Ireland are of the numerous terms that occupy the literature and if they are, does this multitude of names that are assigned to self-injury cause them confusion in their attempts to understand this phenomenon. Therefore, I believe it is

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important to explore what terminology clinicians use in their daily practice with self-injuring patients as it has significance for their conceptualisation of self-injury.

Throughout this dissertation I use the term "self-injury" because I believe it is a suitable term for my study since I wished to avoid influencing the clinicians' discourses in a particular direction. It is a specific term, yet at the same time it is vague about the relationship between suicide, self-injury, and other self-harm behaviours. Other terms are employed in this research study to refer to self-injury in such instances they appear in quotations, as used by specific authors in the literature or appear in the extracts from the participating clinicians' interview transcripts.

Definition. There is no standard universally agreed definition of self-injury in the literature. Defining the scope of self-injury has posed challenges and invited some disagreement from both researchers and clinicians. Commenting on this very issue regarding non-suicidal self-injury, Heath et al. (2008) noted, "Defining the exact parameters of NSSI behavior has not been straightforward and interpreting the research in the field can be challenging due to differences in the operationalization of the definition" (pp. 137-138). Since self-injury first emerged in the literature numerous definitions have been proposed (Favazza, 1987; Menninger 1938/66; Walsh and Rosen, 1988). Indeed, these "Definitions have changed markedly over time..." (Deiter & Pearlman, 1998, p. 235).

In 1987, Armando Favazza defined self-injury "...as the direct, deliberate destruction or alteration of one's own body without conscious suicidal intent" (Favazza, 1996, p. 225). In contrast, other definitions proposed in the deliberate self-harm literature appear to be broader, all-inclusive, and sometimes do not make a distinction in terms of suicidal intention. This blurring between suicide and

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nonsuicidal self-injury seems to be a controversial issue in the literature in relation to defining and classifying self-injury. For instance, in Ireland the *National Registry of Deliberate Self Harm Ireland Annual Report 2009* (the most recent available), employed a broad definition of deliberate self-harm developed by the WHO/Euro Multicentre Study Working Group. They defined deliberate self-harm as:

> ...an act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or expected physical consequences. (National Registry of Deliberate Self Harm Ireland Annual Report 2009, p. v)

This definition of DSH does not make any attempt to distinguish between suicidal and non-suicidal acts of self-injury in terms of intent and therefore creates ambiguity. In contrast, Mangnall and Yurkovich's (2008) definition is more specific in terms of the parameters of DSH which are very similar to those of Favazza (1987) with respect to the physicality of the act and the absence of suicidal intent. They defined DSH as, "...a direct behaviour that causes minor to moderate physical injury, that is undertaken without conscious suicidal intent, and that occurs in the absence of psychoses and/or organic intellectual impairment" (Mangnall & Yurkovich, 2008, p. 176).

To conclude, there is no agreed definition in the literature and self-injury is not always distinguished from suicide with regard to intent. In an attempt to address this problem a group of leading researchers in the field of self-injury established the

International Network for the Study of Self-Injury (ISSS) in 2006 (Heath et al., 2008). They agreed upon the following definition of self-injury:

> The deliberate, self-inflicted destruction of body tissue resulting in immediate damage, without suicidal intent and for purposes not socially sanctioned. As such, this behavior is distinguished from: suicidal behaviors involving an intent to die, drug overdoses, and other forms of self-injurious behaviors, including culturally-sanctioned behaviors performed for display or aesthetic purposes; repetitive, stereotypical forms found among individuals with developmental disorders and cognitive disabilities, and severe forms (e.g., self-immolation and auto-castration) found among individuals with psychosis. (ISSS, 2007, as cited in Heath et al., 2008, p. 138)

This definition appears to be the most recent and comprehensive offered in the literature to date. It goes a long way to addressing some of the shortcomings of previous definitions. Since this is a recently proposed definition, it is not possible to establish whether it has been widely accepted internationally, as enough time has not elapsed since its proposal and the writing of this dissertation.

Therefore, the current controversies and debates about definitions in the literature that I have highlighted, are still current issues and they introduce a complication that may hamper a clinician's attempt to understand self-injury. This in turn may have implications for choice of treatment model and clinical effectiveness. Due to the absence of research in the Irish context, it is not known whether clinicians employ broad definitions such as that of the WHO/Euro Multicentre Study Working Group or more specific definitions of self-injury like Favazza's (1987). This is an

important area to explore because the way clinicians define self-injury has implications for their understanding of and treatment approaches to self-injury.

Classification. The discourses of disagreement in the literature in relation to self-injury revolve around differentiating self-injury from suicide, what behaviours should be considered, and the issue of whether to classify it as a separate syndrome. There appears to be some consensus in the literature that self-injury and suicidality "...are clinically distinct classes of behavior" (Pattison & Kahan, 1983, p. 871). Proponents of this distinction argue that suicide and self-injury differ in regard to intent (Brausch & Gutierrez, 2010; Deiter & Pearlman, 1998; Favazza, 1996; Kahan & Pattison, 1984; Muehlenkamp & Kerr, 2010; Nock & Kessler, 2006; Ross & Mckay, 1979; Simpson, 1976; Walsh, 2006; Walsh & Rosen, 1988). Allen (1996) elaborated on this point, noting self-injury "...is an attempt to alter consciousness by seeking relief from tension and pain, suicide is often aimed at eliminating consciousness, escaping pain once and for all, achieving a state of nothingness" (p. 141). In addition, Babiker and Arnold (1997) argued that, "Self-injury *continues* [sic] the discourse of a person's life, whereas a suicide attempt *separates* [sic] the person from that discourse, removing the individual from their awareness or from being" (p. 2). Indeed, Simeon and Favazza (2001) noted that even those who engage in self-injury make this distinction between suicide and self-injury.

Clinicians may have difficulty differentiating self-injury from suicide as this distinction is not always made in clinical practice (Allen, 1995; Calof, 1995). For instance, Calof (1995) stated, "Clinicians and others often mistake acts of self-injury for suicidal or self-destructive behavior" (p. 11). This may be due to clinicians' lack of understanding of self-injury, and/or a failure to make a distinction in relation to

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intent. Indeed, Mangnall and Yurkovich (2008) argued that, "...many healthcare professionals are not aware of this distinction" (p. 177). If clinicians experience difficulty distinguishing self-injury from other forms of self-destructive behaviour and suicidal intent, it is highly likely that this will have implications for decisions about treatment approaches and/or interventions. Therefore, it is important to explore how and if clinicians working in the Irish context distinguish between suicide and self-injury.

Classifying self-injuring behaviours is another issue that attracts some controversy. While it is widely reported that individuals engage in a broad spectrum of self-injuring behaviours (Favazza, 1996; Favazza & Conterio, 1989; Walsh, 2006), the problem seems to revolve around what behaviours to include as self-injury and what to exclude. Most researchers and clinicians writing in the literature consider cutting, burning, self-hitting, interference with wound healing (also known as excoriation of wounds), severe skin scratching, hair pulling and bone breaking (Arnold, 1995; Briere & Gil, 1998; Favazza & Conterio, 1989; Klonsky, 2007; Muehlenkamp, 2005) as self-injury. Some authors challenge this view and argue that additional behaviours such as, self-poisoning (Hawton & Fagg, 1992), insertion of dangerous objects into body orifices (Connors, 1996), "harmful enemas and douches" (Connors, 1996, p. 2000), "ingesting sharp objects" (Connors, 1996; p. 2000) should also be included. In the Irish context, the *National Registry of Deliberate Self Harm Ireland Annual Report 2009*, included the broad categories of overdose, alcohol, poisoning, hanging, drowning, cutting and other as forms of deliberate self-harm. To complicate matters further, a British psychotherapist, Turp (2002) contended that the current classification of self-injury in the literature is too narrow and proposed the inclusion of a category of hidden self-harm which she calls "cashas" ("culturally

accepted self-harming acts/activities") (p. 204). She included such activities as "...body-piercing..." (Turp, 2002, p. 207), "...self-flagellation or pilgrimages that involve covering long distances over stony ground barefoot or on bended knee" (Turp, 2002, p. 207), "...everyday, low-key activities and behaviours which are nevertheless associated with injury or ill-health..." such as "...smoking..." (Turp, 2002, p. 207) and "...chronic overwork..." (Turp, 2002, p. 207).

Numerous classification schemas (e.g., Favazza, 1987; Favazza, 1998; Favazza & Rosenthall, 1993; Menninger, 1935/1966; Pattison & Kahan, 1983; Ross & McKay, 1979; Simeon & Favazza, 2001; Turp, 2007; Walsh & Rosen, 1988) have been proposed in the literature. However, to date none of these categorisation schemes have been widely accepted, although many authors favour that of Favazza's. This lack of consensus with regard to classifying self-injury as a broad or narrow set of behaviours has implications for clinicians' understanding of and choice of treatment for this behaviour.

Another area of controversy surrounds the location of self-injury within psychopathological categorisation systems such as, the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (4th ed; Text Rev; DSM-IV-TR)* and the World Health Organisation's *International Statistical Classification of Diseases and Related Health Problems (10th Re; Ver for 2007; ICD-10)*. Historically, the literature commonly associated self-injury with a diagnosis of borderline disorder (BPD) (Bohus, Haaf, Stiglmayr, Pohl, Böhme, & Linehan, 2000; Klonsky, Oltmanns, & Turkheimer, 2003; Leibenluft, Gardner, & Cowdy, 1987; Schaffer, Carroll, & Abramowitz, 1982; Simeon et al., 1992; van der Kolk, et al., 1991; Walsh & Rosen, 1988; Zlotnick, Mattia, & Zimmerman, 1999), even though it

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is one of nine diagnostic criteria. This location of self-injury within a psychiatric discourse has been criticised by some authors (Burstow 1992; Johnstone, 1997; Pembroke, 1998). Indeed, Farber (2000) noted that, "It has been suggested that clinicians incorrectly tend to use self-mutilation alone as a sufficient criterion to diagnose BPD" (pp. 80-81). A contrasting critical discourse comes from Pattison and Kahan (1983) who contended that there is no direct association between this behaviour and a specific personality disorder.

Several authors have proposed and called for the adoption of a separate clinical syndrome of self-injury (Favazza, 1996; Muehlenkamp, 2005; Tantam & Whittaker, 1992). To date, none of these have been accepted by researchers, clinical communities, ICD-10 or DSM-IV-TR classification systems.

These different discourses highlight the disagreements, with regard to setting the boundaries and parameters in relation to the inclusion and exclusion of the numerous classes of self-injuring behaviours, noted in the literature. How clinicians construct their patients' self-injury behaviours (either within or outside of diagnostic systems) has implications for their conceptualisation and treatment choices. For instance, BPD may become "...the all-encompassing and circular explanation for every way..." (Neimeyer & Raskin, 2000, p. 31) that clients behave, and this has implications for treatment approach and effectiveness. Considering how clinicians working in the Irish context pathologise or view self-injuring patients is a relevant area for exploration in this study, and particularly the degree to which they may or may not pathologise self-injury patients as it relates to the research questions posed by this study. Another key area to explore in relation to clinicians' discourses about their understanding of self-injury is whether or not they distinguish between suicide and

self-injury, as this also has implications for their conceptualisation and treatment of this phenomenon.

Functionality. The discourse about the functionality of self-injury in the literature speaks of the complex and multi-determined aspects of this behaviour. However, as Suyemoto (1998) noted, "…we continue to lack a clear understanding of the psychological functions…" (p. 531) that self-injury serves. Therefore, this is another aspect of the phenomenon of self-injury that evokes some debate in the literature.

To date, researchers and clinicians have proposed a range of possible functions for self-injury (Allen 1996; Briere & Gil, 1998; Favazza 1996; Favazza & Rosenthal, 1993; Prinstein, Guerry, Browne, & Rancourts, 2009; Sakheim, 1996; Walsh & Rosen, 1988). Examples of these multiple functions reported in the literature include, affect regulation (Davies & Frawley, 1994; Wise 1990), self-punishment (Allen, 1996; Arnold, 1995), re-enactment of trauma (Calof, 1995; Miller, 1994), managing dissociative states (Favazza, 1996), expressing anger (Sakheim, 1996), self-soothing (Allen, 1996), forms of communication (Favazza, 1996) and other personal meanings (Sakheim, 1996). Indeed, Zila and Kiselica (2001) remarked that, "Hypotheses regarding the motivations for self-mutilation are as varied as the acts themselves" (p. 47). Many authors have attempted to organise these functions of self-injury into theoretical models (Bennun, 1984; Connors, 1996; Nock & Prinstein, 2004; Suyemoto, 1998). However, none of these models have been widely accepted and the literature reflects some disagreement about the many and varied functions of self-injury.

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There is an absence of literature exploring clinicians' discourses about the functions of self-injury. Currently, we do not know whether they conceptualise self-injury in terms of intrapsychic, interpersonal, biological or other functions. Therefore, clinicians' conceptualisations about the functions of self-injury are an important feature of clinicians' discourses to explore in this study, because they have implications for their choice of treatment focus, approach, and effectiveness.

Causation. The linking of trauma with self-injury is a long and established discourse in the literature. Some authors have noted the relationship between adult experiences of trauma such as rape and post-traumatic stress disorder (PTSD) and self-injury (Greenspan & Samuel, 1989; Lyons, 1991; Pitman 1990). Many studies and clinicians have reported a correlation between childhood trauma (especially child sexual abuse) and self-injury (Briere, 1992; Darche, 1990; Gil, 1990; Gratz, 2006; Klonsky et al., 2003; Miller, 1994; Shapiro, 1987; van der Kolk et al., 1991; Zlotnick et al., 1996). Indeed, many authors writing on the subject of sexual abuse note self-injury as a symptom found among survivors of child sexual abuse (e.g., Bass & Davis, 1988; Briere, 1992; Courtois, 1988; Dolan, 1991; Gil, 1988; Hunter, 1995; Salter, 1995; Simonds, 1994). However, some authors dispute this discourse and argue that there is an over emphasis in the literature linking trauma and self-injury. A recent study by Klonsky and Moyer (2008) argued that childhood sexual abuse is only "...modestly related..." (p. 166) to self-injury "...because they are correlated with the same psychiatric risk factors" (p. 166). Two studies of college students found no relationship between self-injury and childhood trauma or abuse (Heath et al., 2008; Heath, Schaub, & Toste, 2007 as cited in Klonsky & Glenn, 2009).

In light of the controversy and debate about the role of trauma in the aetiology of self-injury, and as an over emphasised discourse in the literature, it is important to explore what clinicians, working in the Irish context, think about trauma and self-injury and the consequential implications for their conceptualisation and treatment of self-injury. For instance, do they assume a trauma history in clients who engage in self-injury? If so, this emphasis on trauma may be a feature of their clinical model in working with self-injuring patients, and indeed, may not be appropriate where there is no history of trauma, and may possibly contribute to partial or total failures in treatment. Therefore, clinicians' discourses about the aetiology of self-injury are of interest in this study.

Gender. There is some debate as to the prevalence of self-injury among the genders. Some data and clinical reports suggest a higher incidence of self-injury among women and girls (Carmen, Rieker, & Mills, 1984; Miller, 1994; Walsh & Rosen, 1988). These findings have given rise to a discourse in the literature that portrays self-injury as a predominantly gendered phenomenon (A. G. Rogers, 1996; S. N. Shaw, 2002). In contrast, other studies report no significant differences in the rates of self-injury between males and females (Briere & Gil, 1998; DiClemente, Ponton, & Hartley, 1991).

I believe that it is important to explore clinicians' discourses about gender and self-injury for a number of reasons. First, there is an unresolved debate about gender and self-injury in the literature. Second, there is an absence of knowledge about clinicians' discourses and thinking about this issue in the Irish context. Third, this is an important feature of clinicians' conceptualisation of self-injury because it has implications for their treatment practices. For instance, if clinicians believe that self-

injury is a gender specific phenomenon, that only affects females, they may not consider, raise or explore this issue with male clients. On the other hand, this gendered conceptualisation of self-injury could lead clinicians to locate their understanding within a feminist framework, and adopt a completely feminist oriented treatment approach. Alternatively, it could lead clinicians to positioning self-injury within a pathological discourse of BPD, since this is a psychiatric disorder that is commonly associated with females in the literature (Nehls, 1999).

In the preceding paragraphs, I discussed discourses of controversy surrounding the conceptualisation of self-injury that predominantly relate to issues of debate and the lack of consensus pertaining to the naming of self-injury, defining this phenomenon, classifying it as distinct or not from suicide and other self-destructive behaviours, positioning it within or outside discourses of psychiatric disorder classification systems, functional models, the role of trauma in the aetiology of self-injury, and whether or not it is a gendered phenomenon.

Treating Self-Injury

I will now mark out and discuss the various self-injury treatment discourses in the literature that relates to my research study. These include single model discourse, pathological discourse, feminist discourses, multi-modal discourse, distress discourse, relational discourse and affect regulation discourse. To conclude this section on treating self-injury, I will also examine studies that are particularly relevant to this study.

The literature contains a multitude of diverse treatment approaches to working with self-injuring patients. Writing about the treatment of self-injurers, Silver (1985) noted, "The heterogeneity of this patient population is perhaps exceeded only by the

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heterogeneity of the therapist population that treats or writes about them" (p. 359).

Indeed, the literature can appear quite daunting to the novice clinician attempting to

seek guidance on the best form of treatment for self-injury because there are multiple

and diverse modalities. In addition, there is a lack of empirical research to support the

best models to use. In fact, a significant proportion of the treatment literature consists

of accounts of clinicians describing their own particular approaches to working with

self-injuring clients.

In my review of the literature, I have noticed a number of discursive shifts in

relation to treating self-injury. Historically, the initial discourses about treatment

approaches centred on the application of established singular models of

psychotherapy to the treatment of self-injury. Psychoanalytically oriented treatment

modalities were the first discourses to emerge in the 1930s with the publication of

Menninger's (1938/1966) general treatment recommendations (S. N. Shaw, 2002).

Menninger advocated, "…for a holistic approach, involving psychoanalytic

psychotherapy and attention to family dynamics and the social environment.

Psychotherapy centers on the physician-patient relationship and seeks to 'reduce the

self-destructive trend, and increase the capacity for living and loving' (1938: 446)" (S.

N. Shaw, 2002, p. 195).

Interestingly, S. N. Shaw (2002) pointed out that there is an absence of

publications on the phenomenon of self-injury in the clinical literature from 1938 to

the mid 1960s. Self-injury re-entered the clinical literature in the mid-1960s (S. N.

Shaw, 2002). During the period of the mid-1960s to the mid-1970s, the treatment

literature emphasised individual psychodynamic therapy "…'directed at fostering

more mature methods of giving and receiving love' (Graff and Mallin, 1967: 36)"

(Shaw 2002, p. 197) and the clinician's role is constructed as facilitating "...meaning making as 'slashing contains a message not recognised by others in the patient's life' (Graff and Mallin, 1967: 36)" (Shaw 2002, p. 197).

Single model discourse. From the 1980s to the present, a variety of discourses entered the literature probably due to the surge in publications on the phenomenon of self-injury. During this period, discourses about the application of single models of psychotherapy, other than psychoanalytic oriented modalities, to the treatment of self-injury emerged. These included cognitive-behavioural therapy (Kaminer & Shahar, 1987; Rosen & Thomas, 1984), cognitive therapy (Newman, 2009), hypnosis and relaxation techniques (Malon & Berardi, 1987), art therapy (Milia, 1996; 2000), and emotion-focused therapy (Kimball, 2009). Indeed, the discourses about these treatment approaches are primarily based on the writings of individual clinician's single case studies, (e.g., Malon & Berardi, 1987; Milia, 1996; Kimball, 2009). As a result, there is a paucity of research investigating the effectiveness of the application of these modalities to the treatment of self-injury. However, Johnstone (1997) contended that psychological treatments are "...not always experienced as helpful" (p. 424). Indeed, she strongly criticised a CBT approach to the treatment of self-injury. She argued that this modality "...has a firm foothold in psychiatry, where it sits comfortably alongside the positivistic model of medical science" (Johnstone, 1997, p. 424). Therefore, she is locating CBT within a medical discourse. Johnstone further pointed out a missing discourse of explanation for self-injury within a cognitive-behavioural approach. She noted that as an approach on its own it "...has no explanation for why the behaviour emerged in the first place, as opposed to what maintains it; it denies the complexity of the problem

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and ignores the complex personal meanings that self-injury carries" (Johnstone, 1997, p. 425).

Pathological discourse. Another discourse that gathered momentum in the 1980s and continues today is a pathological discourse. This discourse locates self-injury within a psychiatric classification system of mental disorders DSM-IV-TR and ICD-10, noting it as an associated symptom of borderline personality disorder (BPD). Indeed, some authors continue with this pathologising discourse advocating for the classification of self-injury as a separate clinical syndrome (Favazza, 1996; Kahan & Pattison, 1984; Muehlenkamp, 2005; Tantam & Whittaker, 1992).

The treatment models associated with this pathological discourse have been specifically developed as a form of treatment for individuals with a diagnosis of BPD who engage in self-injury. These treatments are known as dialectical behaviour therapy or DBT (Linehan, 1987; Linehan 1993), mentalisation based therapy (Bateman & Fonagy, 2004; 2006), the conversational model (Meares, 2004), and transference-focused psychotherapy (Clarkin et al., 1999; Clarkin, Yeomans, & Kernberg, 2006; Yeomans, Clarkin, & Kernberg, 2002). The following research studies have provided some support for the validity and effectiveness of these treatments of BPD: the conversational model (Meares, Stevenson, & Comerford, 1999; Stevenson & Meares, 1992; Stevenson, Meares, & D'Angelo, 2005), mentalization-based therapy (Bateman & Fonagy, 1999; 2001; 2008), transference-focused psychotherapy (Clarkin, et al., 2001; Kernberg, Yeomans, Clarkin, & Levy, 2008), and DBT (Linehan et al., 1999; Linehan et al., 2006).

There are issues in applying these approaches to the treatment of self-injury. All of these approaches locate self-injury within a psychopathological framework,

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conceptualising it "...as occurring in the context of personality dysfunction..." (Levy, Yeomans, & Diamond, 2007, p. 1106). As such, these models have not been specifically designed to treat self-injury in those clients who do not fit the criteria for a diagnosis of BPD. Indeed, these models have been criticised because they situate "...self-injury within the psychology of BPD, locating it within a particular psychiatric paradigm and ignoring its traumatic roots. To locate it thus, is to miss the complexity and symbolic quality of this form of expression" (Motz, 2001, p. 184).

Brown and Bryan (2007) noted that clinicians offering a DBT approach to self-injuring patients are working from the assumption that these individuals are ready to give up their self-injury at the point of entering treatment. Indeed, these researchers argued that many people who self-injure "...are at best ambivalent and more frequently quite reluctant to stop, and are often unable to make the necessary commitments required for DBT" (Brown & Bryan, 2007, p. 1125). Therefore, DBT may not be a suitable treatment modality for some self-injuring individuals depending on their motivation to stop this behaviour. Indeed, it will be interesting to see if any of these issues about the application of a DBT model to the treatment of self-injury emerge in any of the participating clinicians' discourses.

Feminist discourses. A number of feminist discourses have emerged in the literature in relation to the treatment of self-injury. Some feminist authors such as, Brown and Bryan (2007), Crowe and Bunclark (2002), McAllister (20030 and S. N. Shaw (2002), have been highly critical of discourses that position self-injury within a pathological framework. This illness model of self-injury regards it as a symptom of mental illness, most frequently BPD. Crowe (1996) and A. G. Rogers (1996) have

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offered a different feminist discourse. They have proposed new ways to explore women's self-injury within feminist frameworks.

Crowe and Bunclark (2002) argued that a diagnosis of BDP is often given to individuals who self-injure even though they may not exhibit any other signs or symptoms of BPD. S. N. Shaw (2006) noted that this pathological discourse of self-injury "...often portrays women who self-injure in pejorative terms such as 'manipulative' and frames self-injury through a pathologizing lens of borderline personality disorder" (p. 155). McAllister (2003) contended that treatment approaches that position self-injury within a medical illness discourse of BPD tend towards managing the individual's actions "...with behavioural techniques rather than the person's reasoning and compulsions understood (Haswell & Graham 1996; Miller 1994; Tantam & Whittaker 1992)" (p. 179). McAllister (2003) further maintained that this response to self-injury "...professionalizes the problem which tends to position the service provider as the expert when the client is the one who needs to develop expertise; it individualizes the problem and glosses over or ignores social reasons for self-harm..." (p. 179).

In contrast, a feminist discourse of self-injury "...locates pathology in the realm of the larger patriarchal social structure—outside of the individual, not within —the concept of psychopathology is generally eschewed" (Brown & Bryan, 2007, p. 1123). This feminist discourse offers a different perspective or lens to conceptualise and treat self-injury. Feminist therapists invite self-injuring clients "...to participate in a collaborative process in which the therapist's expertise at creating the conditions under which change is possible joins with the client's expertise at knowing what is best for her or his own life" (Brown & Bryan, 2007, p. 1123).

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Crowe (1996) proposed applying a feminist framework to exploring women's self-injury. She viewed self-injury as "...signifying the unspeakable" (Crowe, 1996, p. 103) and "...as a response to physical or sexual abuse" (Crowe, 1996, p. 103). Locating her understanding within this framework, Crowe "...regards the body as an inscriptive surface that provides an interface between subject/object and explores how women may lack a means by which to signify to others what their experience means to them" (p. 103). Crowe argued that the "...language available to women does not always provide an adequate means of self-expression" (p. 103) and "...often leaves women with no option but the use of non-verbal corporeal inscription" (p. 103). Thus, she constructed women's self-injury as "...a means of establishing a sense of self while perpetuating a sense of the body as a site for abuse" (p. 103). Positioning her understanding of self-injury within this feminist framework, she suggested a treatment approach that, "...acknowledges the women's needs, while at the same time offering the opportunity to signify distress in a manner that does not perpetuate the body's role as an object of abuse" (Crowe, 1996, p. 103).

A. G. Rogers (1996) offered a feminist-relational model for working with self-injury. She located her understanding of how girls and women come to engage in self-injury within "...the complex, internal, interpersonal and cultural contexts in which..."(A. G. Rogers, 1996, p. 4) they "...come to be self destructive" (A. G. Rogers, 1996, p. 4). Her framework was based on research on girls' relational development (Brown and Gilligan, 1992; Gilligan, Brown and Rogers, 1990; Rogers, Brown and Tappan, 1993, as cited in A. G. Rogers, 1996, p. 5) and "...grounded in a 'feminist poetics of psychotherapy' (A. G. Rogers, 1991)" (as cited in A. G. Rogers, 1996, p. 8). She highlighted that adolescent girls and young women who engage in self-injury report similar feelings and experiences. A. G. Rogers (1996) noted how

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they "...speak about their sense of disconnection from their real thoughts and feelings; of doubting their feelings and knowledge; of painful experiences that have not been voiced in relationships—or have been, but were not recognized..." (A. G. Rogers, 1996, p. 6).

A. G. Rogers' (1996) therapeutic approach for working with adolescent girls who engage in self-injury involved the "...translation and amplification of girls' symptoms through dialogue, as well as creative writing..." (p. 2). She based her therapeutic model on the premise "...that what cannot be known or named in girls' experience finds a new language—a knowledge written on her body" (A. G. Rogers, 1996, p. 7). She believed that each therapeutic relationship is "...unique and real, and that all 'boundaries' can be negotiated" (A. G. Rogers, 1996, p. 8). She was unique in inviting her young clients to set the time, pace and location of their sessions.

McAllister (2003) contended that, "...feminist discourse remains on the margins of conventional mental health care and empathy and engagement continue, in the main, to be reduced to rhetoric" (p. 181). In light of McAllister's comments, it will be instructive to note whether the participating clinicians draw on a feminist discourse when articulating their ideas and practices in relation to their work with self-injuring patients in an Irish context. In particular, will they draw on feminist discourses to criticise the pathologising of self-injury and to support a relational, collaborative and empowering oriented treatment approach to self-injury?

Multi-modal discourses. In 1988, Walsh and Rosen noting the difficulty in treating self-injury declared, "...we have consistently found it necessary to use a multimodal approach" (p. 230). Silver (1985) concurred arguing:

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We have to be flexible and eclectic enough not only to implement the

individual treatments that we are best at, but also to add other modalities of

treatment where indicated such as group therapy (Bellak, 1980; Leszcz, 1985),

family therapy (Shapiro, Shapiro, Zinner, et al., 1977), and medications (Cole,

Salomon, Gunderson et al., 1984; Silver, 1983). (p. 365)

Despite these advocates of a new multi-modal approach to treating self-injury,

this discourse disappeared from the literature until 2002 with the publication of

Selekman's book, *Living on the Razor's Edge: Solution-Oriented Brief Family*

Therapy with Self-Harming Adolescents.

Since 2002, a number of other multi-modal approaches to treating self-injury

have been proposed in the literature. These include Stone and Sias' (2003) bi-modal

approach, Walsh's (2006) bio-cognitive-behavioral model, and Farber's (2008)

attachment-based multi-phased approach. This contemporary discourse about multi-

modal approaches to self-injury marks a shift away from previous uni-model

treatment discourses. In addition, these multi-model discursive treatment approaches

conceptualise self-injury within a number of different theoretical frameworks. These

include attachment theory, affect regulation and trauma. Indeed, S. N. Shaw (2002)

noted that, "…many authors understand self-injury in terms of more than one model"

(p. 199). For instance, an American clinical social worker, Walsh (2006)

conceptualised self-injury within a multiple biopsychosocial framework.

Despite this shift towards multi-model approaches a common discourse

emerges where individual therapy and family systems modalities are combined

(Selekman, 2002; Stone & Sias, 2003; Walsh & Rosen, 1988). Sometimes medication

is used as an adjunct to therapy (Stone & Sias, 2003; Favazza, 1996). An interesting

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feature of this multi-modal treatment discourse is the consistent reference to cognitive

behavioural interventions as one of the core components of individual therapy. For

instance, Stone and Sias (2003) proposed a bi-modal approach to treating self-injury.

Their model is a combination of individual and family systems treatment modalities.

The individual component uses cognitive behavioural strategies and behaviour

modification to deal with the self-injury behaviour and the associated cognitive

distortions. The family systems aspect "...is used to identify the client's

interpersonal, internal, and external dynamics that impact the complex situation"

(Stone & Sias, 2003, p. 120).

In contrast, Farber (2008) offered an alternative approach that is grounded in a

range of theoretical perspectives. She proposed an attachment-based multi-phrased

approach to the treatment of self-injury. Her various theoretical frameworks included

attachment theory integrated "...with concepts from psychoanalysis, the

neurosciences, evolutionary biology, cognitive psychology, the psychobiology of

trauma, and chaos theory" (Farber, 2008, p. 63). She argued that self-injury

"...develops when the child who has become attached to those who have inflicted

pain and suffering maintains that attachment by inflicting pain on himself" (Farber,

2008, p. 63). Here we see a marked return to a relational treatment discourse of self-

injury as Farber contended that treatment success:

> ...depends upon the development of a secure attachment to the therapist,
>
> which supports the re-acquisition and re-integration of projected parts of the
>
> self, necessary for self- and mutual affect regulation and the resolution of
>
> trauma and intrapsychic conflict (Bromberg, 1998; Farber, 2000; Howell
>
> 2005; Steiner, 1996). (p. 66)

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Farber (2008) proposed a phased oriented approach to self-injury that in some respects has commonalities with the sensorimotor psychotherapy (Odgen, Minton, & Pain, 2006) approach to trauma treatment. There are "...three phrases with considerable overlap..." (Farber, 2008, p. 67) to her attachment-based multi-phrased approach to the treatment of self-injury: stabilising the client and the reduction of the lethality is the focus of stage one. During this phase she noted that, "The therapist must be firm but flexible about boundaries, inviting the patient to use him as a secure base and transitional object (Winnicott 1953) as needed, for phone contact in off hours and vacations" (Farber, 2008, p. 67). The reduction of dissociation via the desensitisation of traumatic memories, the integration of dissociated parts of the self, and the building of ego functions occurs at stage two (Farber, 2008). During the third and final phase of treatment the clinician and client engage in "...the intrapsychic work of mourning, resolution, reconsolidation, and reconnection" (Farber, 2008, p. 67).

Despite the numerous and divergent treatment options documented in the literature, (psychoanalytic oriented, cognitive-behavioural therapy, cognitive therapy, hypnosis and relaxation techniques, art therapy, emotion-focused therapy, dialectical behaviour therapy, mentalisation based therapy, conversational model transference-focused psychotherapy, feminist-relational model and multi-model approaches), it is not clear which ones are particularly successful in treating self-injury. We do not know what treatment modalities clinicians adopt in their treatment of self-injury, whether they use singular or multi-modal approaches. S. N. Shaw (2002) argued that symptom removal, cognitive-behavioural techniques, medications and contracts are the predominant focus of current treatment models for working with self-injuring patients. Again, we do not know if this trend in the literature reflects the practice of

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clinicians working with self-injuring clients in the Irish context, due to the absence of research studies. We also do not know if participating clinicians' discourses will reflect the earlier documented treatment approaches that emphasised working "…in a holistic and engaged fashion with a focus on intrapsychic dynamics, interpersonal and environmental relations, the clinician-patient relationship, and meaning making" (S. N. Shaw, 2002, p. 199). Therefore, discourses about the treatment models that clinicians use in their current practice with self-injuring clients is central to this study. Furthermore, it will be instructive to see if participating clinicians' treatment models reflect any of these trends noted in the literature.

There are a number of other discourses that emerge in the treatment literature that are important to highlight here, as they may emerge in the discourses of the clinicians participating in my research study. These include a distress discourse, and a relational discourse about treating self-injuring patients.

Distress discourse. There is a prevailing discourse in the literature that portrays the treatment of self-injury as complex, challenging and distressing for the clinician. Indeed, Crabtree (1967) was the first clinician to articulate this discourse, describing self-injury as a "most distressing, challenging, psychotherapeutic problem" (p. 91). Within this discourse self-injury is portrayed as evoking powerful responses from the clinicians who work with individuals who engage in self-injury. Emotive responses experienced by clinicians reported in the literature include shock, horror, revulsion (Ross & McKay, 1979); helplessness, disgust, fury, guilt, betrayal, sadness (Frances, 1987); fear (Simonds, 1994); and feeling "ineffective and overwhelmed" (Himber, 1994, p. 620). A study of psychologists in the U.S.A. by Gamble, Pearlman, Lucca and Allen (1994, as cited in Deiter & Pearlman, 1998) revealed that they

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experienced self-injury as "...the most distressing and stressful client behaviour..." (p. 251) that they encountered professionally. In the Irish context, we do not know whether this distress discourse reflects the thinking and experiences of clinicians working with individuals who self-injure. Therefore, it will be informative to note whether it emerges as a discourse in the participating clinicians' narratives.

Relational discourse. The general psychotherapy literature suggests that the quality of the therapeutic relationship can be a significant factor in determining beneficial outcomes across therapy approaches (Bachelor & Horvath, 2001). Therefore, it is not surprising that the primacy of the therapeutic relationship in the treatment of individuals who self-injure has been noted by many authors (Connors, 2000; Farber, 2000; Levenkron, 1998; Malon & Berardi, 1987; Nelson & Grunebaum, 1971; A. G. Rogers, 1996; S. N. Shaw, 2002; Silver, 1985). Indeed, Malon and Berardi (1987) argued that, "...the key to effective treatment is a strong yet flexible relationship (Nelson& Grunebaum 1971; Doran, Roy & Wolkowitz 1985; Silver, 1985)" (p. 533). D'Onofrio (2007) echoed this discourse noting that clinicians such as Bateman and Fonagy (2004), Connors (2000), Farber (2000), Ivanoff, Linehan, and Brown (2001), and Linehan (1993) "...contend that the quality of the relationship is perhaps *the* [sic] most important single component that allows for the engagement of the self-injurer in the often difficult, long-term healing process..." (p. 97).

What is unique about this relational discourse is the number of multiple theoretical frameworks that authors draw on in support of this perspective. These include attachment theory (Bowlby, 1969), neurobiological research (Shore, 2003), trauma (van der Kolk et al., 1991), and feminist frameworks (A. G. Rogers, 1996; S. N. Shaw, 2002), all advocating and supporting a relationally oriented approach to the

treatment of individuals who engage in self-injury. Interestingly, a central feature of the discourse about treating self-injurers with a trauma history is the notion of, "What has been wounded in a relationship must be, after all, healed in a relationship" (A. G. Rogers, 1995, p. 256), highlighting the therapeutic relationship as a key component in facilitating change and healing in the individual patient.

Commenting on treating self-injury, Norton (2010) calls for the need to "...shift towards a more relational perspective that can deal with the deep crises of meaning, isolation and anxiety that often lead adolescent females to self-injure" (p. 2). This "shift" acknowledges that perhaps a relationally oriented approach to the treatment of self-injury is not a fundamental perspective of all those writing about this phenomenon. Indeed, it will be informative to know if clinicians working in the Irish context will draw on relational discourses in their narratives about their treatment approach with self-injuring clients.

Affect regulation discourse. Many authors have suggested that affect regulation is the primary function of self-injury (Favazza, 1996; Kimbell, 2009; Klonsky, 2007; Nixon, Cloutier, & Aggarwal 2002; Suyemoto & MacDonald, 1995). They construct individuals who self-injure as experiencing emotion dysregulation and as being unable to tolerate or regulate distressing negative emotional states without resorting to acts of self-injury. They argue that these individuals use self-injury to interrupt or terminate intolerable affect states. Nixon et al. (2002) contended that self-injury can "...express, validate, or regulate dysphoric feelings such as depression, tension, pain, or anger, or it may have a role in ending dissociative symptoms" (p. 1334). Therefore, this affect regulation discourse constructs self-injury as "...a

strategy to alleviate acute negative affect or affective arousal (Favazza, 1992; Gratz, 2003; Haines, Williams, Brain, & Wilson, 1995)" (Klonsky, 2007, p. 229).

Gratz and Roemer (2004) proposed that affect regulation:

...is a multifaceted construct involving a) the awareness, understanding, and acceptance of emotions; b) ability to engage in goal-directed behaviours, and inhibit impulsive behaviours, when experiencing negative emotions; c) the flexible use of situationally appropriate strategies to modulate the intensity and/or duration of emotional responses rather than to eliminate emotions entirely; and d) willingness to experience negative emotions as part of pursuing meaningful activities in life.... (as cited in Gratz 2007, p. 1091)

In relation to the treatment of self-injury, this affect regulation discourse is premised on the notion that if clinicians focus on helping clients develop affect regulation skills to deal positively and effectively with distressing emotions, it will lead to a decrease and possible elimination of self-injury. I wonder if participating clinicians' will draw on these notions about self-injury and affect regulation, in their discourses about their particular treatment modality with self-injuring patients?

Relevant studies. There is a lack of research studies exploring the treatment approaches clinicians use when working with self-injuring clients. However, a few scholarly dissertations have shed some light on clinicians' treatment preferences in relation to self-injury. Clinicians in my survey study (Keane, 1997) indicated that they predominately used single modal approaches consisting of client-centred therapy, reality therapy, cognitive-behavioural therapy, gestalt therapy, gestalt systems, humanistic/integrative therapy and solution focused therapy. Similarly, the clinicians that Williams (2005) interviewed reported employing a single model approach

including: psychoanalytic, developmental, eclectic, holistic and client-centred. In contrast, Huerta (2006) reported that the clinicians she interviewed favoured using a combination of treatment approaches. What is interesting about Williams' and Huerta's clinicians is the reference to cognitive-behaviour therapy (CBT). For instance, all five of the clinicians in Williams' study acknowledged that they "...used some form of cognitive behavioural interventions..." (2005, p. 199) with their self-injuring patients, regardless of their treatment orientation. Huerta (2006) revealed a similar finding, noting that nine out of the twelve clinicians she interviewed used CBT in conjunction with another modality.

Huerta (2006), Keane (1997), and Williams (2005) did not include psychiatrists as participating clinicians in their studies. This is interesting considering the usually high exposure of psychiatrists to self-injuring clients in their clinical practice. In addition, traditionally the practice of clinical psychiatry has featured the prescribing of medications and the provision of psychotherapy to patients. However, a discursive shift seems to be emerging in relation to psychiatrists use of a combined treatment approach. Mojtabai and Olfson (2008) reported a recent changing trend in the USA, specifically a decline in the provision of psychotherapy by psychiatrists. Unfortunately, there is a lack of corresponding research focusing on the practices of psychiatrists working in the Irish context. Therefore, it will be informative to observe if practice style variations emerge in the clinicians' discourses in this study and in particular whether or not psychiatrists working with self-injuring clients in the Irish context only use a pharmacotherapy approach.

To date, no research study has explored clinicians' discourses in relation to their treatment modalities of self-injury. In light of this gap, and the various

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discourses and trends that I have discussed with respect to the treatment of self-injury, it will be most interesting to see where the participating clinicians will locate themselves and how this will play out in their discourses. Indeed, it will be instructive to see what discourses will emerge in relation to their models of treatment, and whether they will reflect any or all of the treatment trends I have just outlined. Will these clinicians refer to singular or multiple modalities of treatment in their discourses? What discourses will clinicians working, in the Irish context, draw on when describing their treatment approach to self-injury? For instance, will they draw on relational discourses in their discursive explanations of their treatment approach to working with self-injuring patients? Indeed, clinicians' in this study may introduce new discourses with respect to treatment modalities for working with self-injuring clients.

Treatment Success, Failure and Partial Failure

Considering the range of treatment options I have just discussed in the previous section and the lack of research exploring their effectiveness, it is clear that there is no one pathway to successful treatment of self-injury documented in the literature. While this research study does not purport to explore the effectiveness of clinicians' treatment approaches, I am interested in what they think about success, failure and partial failure in relation to their work with self-injuring patients. A further purpose of this study is to explore participating clinicians' discourses about how they gauge or measure treatment success, failure and partial failure with self-injuring clients. Participating clinicians' discourses about whom they consider responsible for the outcome of treatment, and their sources of knowledge for understanding and treating self-injury, are also part of the exploration in this research

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study. Therefore, I will now discuss the literature in terms of discourses of success, failure and partial failure, discourse markers of success, failure and partial failure, and discourse of responsibility for treatment outcome, as it pertains to my study.

Discourses of success, failure and partial failure. Research studies have provided empirical evidence that psychotherapy is effective (Asay & Lambert, 2001; Hubble, Duncan, & Miller 2001; Weissmark & Giacomo, 1998). However, the psychotherapy literature also reports incidences of failure in psychotherapy; some clients experience no change or improvement, while others get worse. Bergin (1971) reported that data, relating to failures in psychotherapy "...suggest a failure rate that approaches one third and a rate of deterioration that is close to 10%..." (as cited in Stricker, 1995, p. 91). Indeed, Hansen, Lambert, & Forman (2002) reported similar results. They declared that, "...about 35% to 40% of patients experience no benefit and a small group of patients, perhaps between 5% and 10% deteriorate..." (Hansen et al., 2002, as cited in Lambert, 2007, p. 1). While I am not exploring the effectiveness of psychotherapy, or trying to identify the most effective treatment approach for working with self-injuring clients, I am, however, interested to see how the participating clinicians will construct the concepts of success, failure and partial failure in their discourses, and what other discourses they will draw on in their narratives about treatment success, failure and partial failure.

Weissmark and Giacomo (1998) proposed that, "Beyond this global testimony to the effectiveness of therapy..." (p. 18), we know very little about what makes therapy work. In the contemporary literature, an evidence-based treatment research has emerged, in an attempt to identify the most effective psychotherapeutic modality. It appears that this has led to a discourse of competition among practitioners of the

various psychotherapeutic approaches. Hubble, Duncan, and Miller (2001) have noted that, "…behavior, psychoanalytic, client-centered or humanistic, rational-emotive, cognitive, time-limited, time-unlimited, and other therapies were pitted against each other in a great battle of the brands" (p. 5). While evidence-based treatment modalities are not the focus of my research study, I am however interested to see if and how this discourse of competition about the most effective treatment approach will play out in the participating clinicians' discourses about their experiences of success, failure and partial failure with self-injuring patients. Indeed, Kottler and Carlson (2005) reported an interesting finding about clinicians' narratives of their "greatest success stories" (p. 1). They interviewed 27 eminent clinicians about their "finest hours" (Kottler & Carlson, 2005, p. 1). They found that, "The cases presented by several therapists (Brown, Cummings, Doherty, Gray, Keeney, Love, Madigan, Mahrer, Neimeyer, Pittman, & Wheeler) resonate with their commitment to their theoretical frameworks and emphasize how these are applied successfully in the counseling room" (Kottler & Carlson, 2005, p. 273). In light of Kottler and Carlson's finding, it will be instructive to see if and how any or all of the participating clinicians' will use their discourses to espouse the merits and virtues of their particular treatment approach to working with self-injuring clients in response to my questions about their experiences of success and markers of progress. Indeed, it will also be illuminating to note if any of the clinicians will pit their specific treatment modality against another in their discourse as a way of validating and verifying their particular modality.

It appears that clinicians may experience more difficulty selecting and speaking about their experiences of success rather than failure with patients. Kottler and Carlson (2003) documented an interesting finding in relation to clinicians'

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narratives of success and failure. Having interviewed a number of eminent clinicians about their best (2005) and worst (2003) cases, they reported that these clinicians experienced greater difficulty choosing a case that exemplified their finest work, "…yet they could easily identify numerous examples of their worst!" (Kottler & Carlson 2005, p. 269). Two of the interviewed clinicians proposed different explanations for this finding. Keeney (2005, as cited in Kottler & Carlson, 2005) suggested that as clinicians, "…we tend to remember our worst tales of woe, and let the memories of doing the job well fade" (2005, p. 269). Scharff (2005, as cited in Kottler & Carlson, 2005) suggested that it may be due to doubt and uncertainty because, "…there are loads of hours when you are just grinding through therapy wondering whether you are doing anything useful" (2005, p. 269).

Sticker (1995), C. R. Rogers (1954), Persons and Mikami (2002) proposed a contrasting style of speaking about failure, constructing failure as a treatment issue that is rarely discussed in the literature. Despite reported failure rates in the literature Stricker (1995) argued that, "…published case material does not reflect these proportions" (p. 91). Indeed, he concluded, "Psychotherapists are not eager to broadcast their lack of success" (Stricker, 1995, p. 91). C. R. Rogers commented about the absence of such cases in the literature in 1954 and Stricker (1995) argued that, "…the situation has not changed remarkably since that time" (p. 91). In a later publication, Persons and Mikami (2002) argued that, "Treatment failure, although common, is rarely discussed" (p. 139). In light of these contrasting styles cited in Kottler and Carlson (2005) and Stricker (1995) in relation to speaking of failure, it will be instructive to see what will emerge in the participating clinicians' discourses. Will they be forthcoming about their experiences of success and failure? Will they

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experience difficulty identifying and recollecting cases of success and failure in their treatment of self-injuring patients?

Freud (1977) was the first clinician to publish an account of treatment failure. He concluded that he had failed in his analysis with Dora when she terminated her treatment. C. R. Rogers (1954) also published a case of failure that he named, "The case of Mr. Bebb" (as cited in Stricker, 1995, p. 93). What is interesting about C. R. Rogers' case of failure is that the client Mr. Bebb was "...seen by another psychotherapist and that psychotherapist regarded the case as a success" (Stricker, 1995, p. 91). So what does this mean in terms of clinicians' discourses about success and failure? Is one clinicians' failure another's success or vice versa? Or do clinicians' discourses vary in terms of how they think about and construct treatment success and failure? Indeed, I wonder if and how these distinctions will play out in the participating clinicians' discourses about their experiences of success, failure and partial failure in their treatment of self-injury.

There are no direct references to partial treatment failure in the general psychotherapy or self-injury literature. This seems surprising especially in relation to self-injury when one considers the recurring discourse in the literature about the strong reactions self-injury evokes in clinicians. Indeed, Connors (2000) has argued that, "The greatest impediments to useful and effective response to self-injury are the feelings and reactions of helping professionals" (p. 311). Deiter and Pearlman (1998) concurred with Connors (2000), noting that unmanaged countertransference limits clinicians' ability to work effectively with self-injuring patients. Indeed, Mordecai (1991) maintained that empathic failures occur with regularity in psychotherapeutic encounters. She further contended that, "When these failures go unnoticed, they can

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cause considerable disruption to therapy" (Mordecai, 1991, p. 251), and these therapeutic ruptures "...can have a negative effect..." (Mordecai, 1991, p. 251). One could locate empathic failures within the discourse of partial failure, if these were noticed and addressed by the clinician in treatment and then, treatment would thus be prevented from becoming a complete failure.

Ross and McKay (1979) documented a treatment experience with self-injury that one could regard as a partial failure. These clinicians acknowledged that they failed to change self-injuring behaviours in adolescents in a detention centre with "...traditional therapies..." (p. 5). However, they reported that a shift in treatment took place "...only after we were willing to concede that we did not understand the girls' behaviour, when we suspended our clinical judgment, when we grudgingly allowed ourselves to become students. The girls became our teachers" (Ross & McKay, 1979, p, 5). Indeed, these clinicians conceded that, "Not only did the girls teach us how to understand their self-mutilatory behaviour, but they also led us to the development of an intervention technique which enabled them to eliminate self-mutilation in the institution in the space of a few weeks from the inception of *their program* [sic]" (Ross & McKay, 1979, p. 5). In my comprehensive search of the literature, I found almost no references to partial failure in the self-injury literature. Considering this absence in the literature, it will be instructive to see if a discourse of partial failure will emerge in the participating clinicians' discourses. Will they be forthcoming about their experiences of partial failure with self-injuring clients? Indeed, will they even identify with the concept of partial failure, considering it is not widely documented in the literature?

Discourse makers of success, failure and partial failure. We know that psychotherapy works effectively, and that sometimes it fails, but how do clinicians decide what constitutes treatment success, failure, and partial failure? How do they gauge or measure treatment success, failure and partial failure? What criteria do they use as markers of progress, failure and partial failure? These are complex and difficult questions that have evoked a number of discourses. Kottler and Carlson (2005) posed some interesting questions, and articulated the difficulties in deciding what constituted treatment success. They asked, "If a client improves in a single session, but the therapist had little to do with the improvement, is that one's finest hour?" (Kottler & Carlson, 2005, p. 1). In other words, does the clinician mark this as a successful outcome? These authors also pointed out that, "…there are times when a clinician engages in some masterful intervention, or builds a fabulous relationship with a client or family, but there is no discernable progress even after months or years of treatment" (Kottler & Carlson, 2005, p. 2). How do clinicians deal with this conundrum? Do they classify this as a failed treatment due to the lack of improvement, regardless of the wonderful intervention or good therapeutic relationship? Kottler and Carlson raised yet another example to demonstrate the complexity and multiple discourses about constructing the concept of treatment success and failure. They observed that there are times, when the clinician knows that s/he has "…done a fine piece of work that has made a huge difference in a person's life, but the changes won't be acknowledged" (Kottler & Carlson, 2005, p. 2). To further complicate this discourse of success and failure, Kottler and Carlson offered one final variation on this theme. They spoke of instances "…when a client claims that vast improvement has occurred—thank you very much for your tremendous effort—but neither you nor anyone else can see a whit of difference" (Kottler & Carlson,

2005, p. 2). The last two examples raise the issue of who decides whether treatment has been a success or not. Is it the clinician, the patient, or is it a collaborative and mutually agreed outcome by both? Indeed, it will be of interest to see if any of these discourses emerge in the participating clinicians' discourses.

With regard to discourse indicators of progress, Garland, Kruse, and Aarons (2003) reported that clinicians use a variety of markers to gauge patients' progress. These include "improvement in the home environment (eg, family dynamics)", "decreased symptoms", "cognitive changes (eg, improved understanding of problems, ability to identify/express emotions)", "improved school functioning", "improved home functioning (eg, compliance), "improved social functioning", "changes in general mood or affect", "strength-based outcomes (eg, improved skills)" and "individualized client-specific changes" (Garland et al., 2003, p. 399). It will be instructive to note, if any or all of these general markers will emerge in the clinicians' narratives.

There is also a discourse that constructs treatment failure as "…a failure to achieve desired psychotherapy goals…" (Mash & Hunsley, 1993, p. 293). Within this discourse, indicators of a failed treatment outcome result in:

> …client refusal of treatment, premature termination or dropout, nonresponse to treatment, limited magnitude of response to treatment, therapeutic plateaus or diminishing treatment returns, worsening of presenting symptoms, and the failure of treatment effects to generalize over time and across situations. (Mash & Hunsley, 1993, p. 293)

A discourse concerning how useful outcome measurements are by clinicians in relation to treatment effectiveness emerges in the literature. Garland et al.'s (2003)

study of American clinicians' utility of outcome measurement reported that, "...there was great variability in clinicians' attitudes about the extent to which it is possible to quantify the effectiveness of treatment" (p. 397). They found that some clinicians clearly expressed positive or negative attitudes "...regarding the quantitative measurement of treatment effectiveness, many expressed ambivalence" (Garland et. al., 2003, p. 398). Their study revealed that the percentage of the clinicians "...who indicated that it was not possible to quantitatively measure change in treatment was roughly equal to the percentage who indicated that it was possible" (Garland et. al., 2003, p. 398). The clinicians who located themselves within the discursive position, "...that it was not possible..." (Garland et. al., 2003, p. 398) to measure treatment effectiveness "...ranged from those who were ideologically strongly opposed to quantifying the complexity and nuance of human change in psychotherapy (approximately 25% of participants), to those who felt that the measurement of psychotherapy outcome is virtually impossible (also 25%)" (Garland et al., 2003, p. 398). Those clinicians, who expressed ambivalence, were generally in support of the use of outcome measures (Garland et al., 2003). According to these authors, these clinicians' responses reflected "...frustration or recognition of the challenges inherent in measuring these constructs" (Garland et al., 2003, p. 398). Therefore, it will be instructive to note, if the clinicians' discourses in my study will reflect the variations that Garland et al. (2003) reported among American clinicians. For instance, will the clinicians' narratives suggest that they are ambivalent to, totally opposed to, or open to the use of outcome measures, with regard to gauging their treatment effectiveness with self-injuring patients? Indeed, the application of outcome measures may be incompatible with some clinicians' theoretical or practice orientation, and others like those in Garland et al.'s (2003) study may be ideologically opposed to them.

There is another discourse in the literature that relates to the use by researchers and clinicians of formal and informal markers of treatment progress or failure, in their discourse about failure to achieve psychotherapeutic goals. Hatfield and Ogles (2004) argued that clinicians routinely assess the progress of their clients as part of their normal clinical practice. However, it appears that clinicians predominantly, "...assess outcome in an informal manner, based on client report and clinical judgment" (Hatfield & Ogles, 2004, p. 485). Indeed, two studies found that relatively few practising psychologists in the U.S.A. (29%—Phelps, Eisman, & Kohout, 1998; 37%—Hatfield & Ogles, 2004) used some form of outcome measure to track patient progress (Phelps et al., 1998; Hatfield & Ogles, 2004). It is interesting that the psychologists in both studies reported employing a variety of standardised measures. Phelps et al.'s (1998) clinicians reported that they used the Beck Depression Inventory, Minnesota Multiphasic Personality Inventory and the Symptom Checklist-90. Hatfield & Ogles' (2004) clinicians employed a number of additional standardised outcome measures which had not been mentioned by Phelps et al.'s (1998) clinicians. In addition to the Beck Depression Inventory, and the Symptom Checklist-90, the clinicians reported using the Global Assessment Scale/Children's Global Assessment Scale, the Child Behaviour Checklist, the Brief Symptom Inventory, the Beck Anxiety Inventory and the Outcome Questionnaire-45 (Hatfield & Ogles, 2004) as outcome measures, as part of their clinical practice. Indeed, Vermeesch, Whipple, Lambert, Hawkins, Burchfield, and Okiishi (2004) criticised the use of these standardised tests "...as a means of assessing the effectiveness of treatment" (p. 38) because they were not originally designed to measure outcome. I wonder if in my study, clinicians will bring any formal or informal measures into their discourses of failure to meet psychotherapeutic goals.

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In the contemporary literature, there are a number of outcome tools available to clinicians that were specifically designed to measure treatment outcomes. For instance, Lambert, et al.'s (2004, as cited in Lambert, 2007) Outcome Questionnaire, which evaluates four areas of client functioning, "…symptoms of psychological disturbance (mainly depression and anxiety), interpersonal problems, social role functioning (e.g., problems at work or school), and quality of life (positive aspects of life satisfaction)" (p. 2). Clinical Outcomes in Routine Evaluation (CORE) is an outcome measure that was developed in the UK at the Psychological Therapies Research Centre at the University of Leeds. CORE is designed as a continuous outcome monitoring system. There is "…the 34-item version intended for use pre- and post-treatment, two short versions of 17 items each are recommended as alternating repeated measures to tap patient change on a session-by-session basis" (Burton, 1998, p. 176). Indeed, this particular outcome measure is popular with some of my colleagues working in student counselling services in Ireland. However, there is no literature to suggest that any particular outcome measure is widely used by clinicians in Ireland, or elsewhere, to assess treatment success and failure. There is no agreed standard outcome measure that all clinicians use in their clinical practice to track or gauge their patients' progress, and also no agreement about using such measures. It will be instructive to see what will emerge in the participating clinicians' discourses with respect to marking out clients' progress. Will they speak of the use of standardised or non-standardised tests? Indeed, will the notion of using some form of tracking system be compatible or incompatible, with their treatment theoretical orientation and/or their professional discipline? For instance, will the use of standardised outcome measures be more in keeping with a cognitive behavioural than a humanistic, or psychoanalytic orientation? Will the employment of more informal

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markers of progress, such as patients' reports and clinical judgments be more acceptable to some clinicians than others because of their clinical discipline and/or treatment orientation? Indeed, the participating clinicians may engage in discourses where they position themselves as being opposed to the use of any kind of formal or informal gauges of clients' progress in their clinical practice. They may also draw on discourse markers of success, failure and partial failure that are not mentioned in the literature. So, it will be enlightening to see how these themes will play out in the discourses of the clinicians participating in my research study.

There is a further discourse in the literature, that I will refer to as the discourse of not knowing in relation to treatment outcomes. Kottler and Carlson (2005) articulated this discourse when they reported that there are "…very limited times in a therapist's career when the long-term outcome is known" (p. 271). They proposed that, "So often, clients walk out the door and we never hear from them again; the stories remain unfinished, without endings" (Kottler & Carlson, 2005, pp. 271-272). Indeed, they acknowledged that, "The therapist is so often left wondering what changes really took place and how long they lasted" (Kottler & Carlson, 2005, p. 272). I wonder if this discourse of not knowing whether the treatment was a success, failure or partial failure will emerge in the narratives of the clinicians participating in this research study.

Discourse of Responsibility for Outcome of Treatment

Whiston and Sexton (1993) proposed a discourse that locates the responsibility for the outcome of treatment with the clinician. They argued that, "the research suggests that negative results are often related to the therapist" (Whiston & Sexton, 1993, p. 49). Despite this research finding, they noted that clinicians seem to engage

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in a discourse in which they locate the responsibility for negative treatment outcomes with the patient. Whiston and Sexton contended that when treatment yields unfavourable results "…it may be palatable for practitioners to attribute this negative outcome to the client's lack of willingness or motivation" (p. 49). Indeed, Kottler and Carlson (2003) agreed with this discourse. They noted that clinicians "…have a long history of inventing ways to disown our misjudgments and mistakes" (Kottler and Carlson, 2003, p. ix). They reported that clinicians engage in discourses in which "We blame our clients for not trying hard enough or being unmotivated. We ascribe negative outcomes to circumstances beyond our control—meddling family members, organic or environmental factors, time constraints. We call our clients ugly names like *borderline* [sic] or *obstructive* [sic] or *resistant* [sic]" (Kottler & Carlson, 2003, p. ix).

These authors also articulated the ways clinicians can make, "blunders", (Kottler & Carlson, 2003, p. ix) and thus can be responsible for negative treatment outcomes. Kottler and Carlson (2003) listed these "blunders" as, "We pushed too hard too fast; we misread the situation; we missed crucial information. Our own personal issues were triggered. We were less than tactful. We bungled the diagnosis. We were less than skilful in executing an intervention" (p. ix). In these and many other ways clinicians can chase "…the client away" (Kottler & Carlson, 2003, p.ix) or, "…set the treatment back significantly" (Kottler & Carlson, 2003, p. ix). These authors concluded that clinicians engage in a discourse of denial in relation to making treatment "blunders". They proposed, "Denial and defensiveness provide a convenient means to bury our mistakes, sometimes to help us pretend they never happened in the first place" (Kottler & Carlson, 2003, p. ix).

In a contrasting discourse, Bergin and Garfield (1994) argued that, "…it is the client more than the therapist who implements the change process" (p. 825). Indeed, Bohart (1995) contended that, "…all good clients really are their own therapists, and are actively problem-solving themselves as they listen to what therapists offer" (p. 101). Thus, Bohart appears to be locating the responsibility for treatment outcome with the patient once the therapist has provided "…an open, connected, genuine, and collaborative relationship" (1995, p. 101).

How will discourses of responsibility for the treatment outcome with self-injuring patients play out in the narratives of the participating clinicians in my research study? Will they draw on collaborative discourses in which both the client and clinician are constructed as sharing responsibility? Perhaps they will resort to blaming their self-injuring clients, especially for negative outcomes, as Kottler and Carlson (2003) have argued. Indeed, they may even construct themselves as being responsible for both negative and positive outcomes. Either way, it will be interesting and revealing to see how clinicians, working in an Irish context with self-injuring patients think about this issue and what discourses they will draw on.

I will now conclude this chapter with an examination of the literature that pertains to the sources of knowledge, that clinicians access to conceptualise and treat self-injury.

Discourse of Knowledge Sources

Public and clinical interest in self-injury has increased dramatically in recent years. Indeed, the last decade has seen a surge in publications on the phenomenon of self-injury. There are multiple discourses in relation to sources of knowledge about self-injury. These sources range from discursive narratives of individuals who

engaged in self-injury (Kettlewell, 1999; Leatham, 2005; Pembroke, 1994; Smith, 2006), to clinicians who outline their therapeutic approach and provide case examples of their work with clients who engage in self-injury (e.g. Alderman, 1997; Babiker & Arnold, 1997; Clarke, 1999; Conterio & Lader, 1998; Faber, 2000; Gardner, 2002; Hewitt, 1997; Holmes, 2000; Hyman, 1999; Levenkron, 1998; Milia, 2000; Miller, 1994; Ng, 1998; Selekman, 2002; Smith, Cox, & Saradjian, 1998; Strong, 1998; Sutton, 1999; Turner, 2002; Turp, 2002; Walsh, 2006) and research studies.

Additional forms of information on self-injury beyond the clinical and research literature, include published novels (e.g., Coman, 1998; Levenkron, 1997; McCormick, 2000; Stoehr, 1991), numerous newspaper and magazine articles. In addition, many internet web sites, blogs, and You Tube posts feature self-injury and host chat rooms where self-injury is a topic for discussion (Prasad & Owens, 2001; Whitlock, Lader, & Conterio, 2007; Whitlock, Powers, & Eckenrode, 2006). Self-injury has featured in popular British, American and Australian television shows (e.g., *All Saints*; *Bad Girls*; *Beverly Hills 90210*; *Casualty*; *Dangerfield*; *Doctors*; *ER*; *Fat Friends*; *Grey's Anatomy*; *Hatty Waintrop*; *Hollyoaks*; *House*; *Peak Practice*; *Seventh Heaven*; *Silent Witness*; *Taggart*; and *The Bill*). It has also emerged in films such as *Fatal Attraction*, *Girl Interrupted*, *Patch Adams*, *Secret Cutting*, *Secretary*, *The Piano Teacher* and *Thirteen*. In children's literature Dobby, the house elf in J. R. Rowling's *Harry Potter and the Chamber of Secrets*, engages in self-injury; "Dobby shook his head. Then without warning, he leapt up and started banging his head furiously on the window, shouting '*Bad* (sic) Dobby! *Bad* (sic) Dobby!'" (p. 16). Thus, there are multiple sources from which clinicians can source information about conceptualising and treating self-injury.

There is a lack of research in the literature exploring the sources of clinicians' knowledge of understanding and treating self-injuring clients. There appears to be only two studies that explore this subject with regard to therapists, namely Keane (1997) and Williams (2005). It should be noted that psychiatrists were not represented in either of these studies. In my study (Keane, 1997) the majority of therapists reported that their primary sources of information about self-injury were workshops, books and journals. Other sources listed included seminars, personal experience and supervision. Therapists in Williams' (2005) study reported that they did not receive any "...specific education or training on the topic of self-injury..." (p. 189) in their respective training programmes. These therapists reported "reading" (Williams, 2005, p. 189) as their main source of knowledge on the subject of self-injury. Williams (2005) concluded that, "...the general theme is that limited opportunities exist for a formal training in working with and understanding clients who self-injure" (p. 190). Despite these two studies, there is still a lot that is unknown about clinicians' (especially psychiatrists') sources of knowledge, including both their personal experience and professional training, that have influenced their understanding and development of their treatment models, for working with self-injuring patients. Hence, clinicians' discourses about their sources of knowledge about self-injury is a subject of exploration in this research study. It will be enlightening to discover what clinicians will reveal in their discourses about where they source their information about understanding and treating self-injuring clients. Do they actively seek out this information from various sources such as books, seminars and workshops on self-injury? Did they receive knowledge about self-injury in their primary training? Do they rely on their colleagues, supervisors or clinical experience from their work with self-injuring patients as sources of knowledge?

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Summary and Conclusion

To summarise, in this chapter, I outlined the various discourses in the literature that pertains to my research study. These included discourses of debate and controversy that relate to conceptualising self-injury, the various treatment discourses that consist of single model, pathological, feminist, multi-modal, distress, relational and affect regulation. I also discussed the relevant studies in the literature that relates to clinicians' treatment preferences in relation to self-injury. In addition, I examined the discourses about treatment success, failure and partial failure, and markers of success, failure and partial failure in the literature. I concluded with a discussion of a discourse of responsibility for the outcome of treatment, and of the sources of clinicians' knowledge in relation to conceptualising and treating self-injury.

To conclude, the focus of my research study is to explore clinicians' discourses about their conceptualisation and treatment of self-injury within the Irish context. I am also interested in how these clinicians think about success, failure and partial failure and what discourse markers of progress and failure they draw on in relation to their work with self-injuring patients. A further purpose of this study is to identify the sources of knowledge that contribute to clinicians' understanding of self-injury and of those who engage in this behaviour.

Chapter Three

Mode and Experience of Inquiry

This research study is an in-depth exploration of eight clinicians' discourses about their understanding of self-injury, their treatment models, their sources of knowledge, and the ways in which they gauge or measure their clinical effectiveness in their work with self-injuring clients in an Irish context. In this chapter, I discuss the methodology I used and my experience of undertaking this inquiry.

Choice of Self-Injury

As a clinician, I wanted to conduct a research study that would be clinically relevant to clinicians working with self-injuring patients. Therefore, I decided upon the phenomenon of self-injury as my chosen topic for this study in the hope that it would make a contribution to the field of knowledge, with respect to our understanding and treatment, in both the Irish and international literature. My specific focus on clinicians' discourses is a new aspect of research that has not been previously explored in the self-injury literature. In this respect, this research study is unique.

Qualitative Design

Rationale. The use of qualitative methodology was appropriate because in this study I am seeking to understand the clinicians' perspectives. In particular, I am seeking to understand how clinicians' conceptualisations of self-injury are constructed, how their understanding influences their current treatment practices, and their perceived measures of their clinical effectiveness with self-injuring clients. There were a number of reasons why I selected a qualitative research design to

explore this study's research questions. Firstly, qualitative research is concerned with how people make sense of, interpret, understand, experience, construct and are constructed by their worlds (Coyle, 2007; Mason, 1996; Willig, 2001). As a method, qualitative research aims to understand the perspectives of the participants (Maxwell, 2005). Adopting this approach, the qualitative researcher seeks to understand the behaviours and the physical events that are occurring among participants in a particular social context (Maxwell, 2005). In addition, the qualitative researcher is interested in "…how the participants comprehend these behaviours and events "…and how their understanding influences their behavior" (Maxwell, 2005, p. 22).

Secondly, qualitative research studies tend to focus on a small number of participants in a particular context. This allows for the researcher to understand "…the particular *context* [sic] within which the participants act, and the influence that this context has on their actions" (Maxwell, 2005, p. 22). In this study, the particular social context was a face-to-face interview between the participant and the researcher. According to Maxwell (2005), an additional advantage of a small sample is that the individuality of each participant is preserved in the analysis. Finally, qualitative research is open and flexible because it allows the researcher to modify the design and focus of the study during data collection (Maxwell, 2005). This facilitates the understanding of new discoveries and relationships as they emerge (Maxwell, 2005).

Qualitative in-depth interviewing was the primary method of generating data in this research study. Marshall and Rossman (2006) argued that this type of interviewing resembles conversations in that, "The researcher explores a few general topics to help uncover the participants' views but otherwise respects how the participants frames and structures the responses" (p. 101). This is exactly what I was

seeking to achieve in this study, the unfolding of the participants' perspectives on the phenomenon of self-injury. Kvale (1996) proposed that, "The research interview is a specific form of conversation" (p. 19), through which the interviewer asks specific questions to obtain knowledge of the interviewee's world, that relate to the study's research questions. He contended that this knowledge of the interviewee's world "...is constructed through the interaction of interviewer and interviewee" (Kvale, 1996, p. 36) in the research interview. His argument is premised on the belief that as human beings we construct "...both ourselves and our worlds in our conversational activity" (Shotter 1993, as cited in Kvale, 1996, p. 37), and we do this through the medium of language. Consequently, Kvale suggested that researchers should talk with people if they want to know how they understand their world and their life. Therefore, I selected an in-depth, conversational style, interviewing approach to explore clinicians' discourses about self-injury, because this method facilitates the unfolding of participants' perspectives in their interaction with me.

Discourse. Estefan, McAllister, and Rowe (2004) proposed that, "Discourse refers to a way of thinking, talking, or writing about reality (Cherryholmes, 1988)" (p. 27). They further elaborated that, "Discourses act as forms of containment of knowledge, setting parameters and limiting the ways in which a practice can be thought or spoken about and consequently experienced" (Estefan et al., 2004, pp. 27-28). Therefore, the participating clinicians' knowledge of self-injury and the clinical practices they engage in with their self-injuring patients "...is shaped, constrained, and sustained through an interaction between talk in the clinical area (Horsfall & Clearly, 2000)" (Estefan et al., 2004, p. 28), that they are trained and work in. Thus, within this research study the disciplines of psychiatry, psychoanalysis, psychology

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and psychotherapy are discursive practices; practices that are "...subject to and constitutive of discourse" (Estefan et al., 2004, p. 28).

In this research study, I use the term "discourse" to refer to ways of speaking in a clinical discipline, as well as patterns of speaking across disciplines and participants. Finally, I also use discourse to refer to the way speech is used, to address me, or an imagined audience beyond me. For instance, I create phrases and categories of discourse based on listening across the clinicians' discourses in this research study, such as "merging discourses", "discourse community of opposition", "discourse community of verification", "expert discourse", "inquirer discourse", and "shifted to the therapist".

Research questions. This study's research questions were:

1. What sources of knowledge, including both personal experience and professional training, have influenced/shaped the development of clinicians' explanation(s) or working model(s) of treating self-injuring clients?

2. What conceptual frameworks do clinicians draw on to understand self-injury and their current treatment practice with self-injuring patients?

3. What explanations or models do clinicians draw on to understand their current treatment practice effectiveness and failures with self-injuring clients?

4. How do clinicians gauge or measure their clinical effectiveness and partial failures, in their current treatment practice with self-injuring patients?

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I will now discuss the methodology I used to explore these research questions under the following headings: the research relationship, the participants, the interview process, the pilot study, the data analysis and the ethical considerations of this study.

Research relationship. Since this research study involved interviewing my peers in the mental health profession in Ireland, Rubin and Rubin's (2005) concept of "conversational partnerships" (p. 14) was an appropriate model for the research relationships. Conversational partnerships suggest "…a congenial and cooperative experience, as both interviewer and interviewee work together to achieve a shared understanding" (Rubin & Rubin, 2005, p. 14). Thus, this approach acknowledges the partnership between the interviewee and the researcher. Rubin and Rubin's conversational partnerships approach also acknowledges the influence of both the researcher and the interviewee in the research interview. Noting this, they commended this approach as it "…reminds the researcher that the direction of the interview is shaped by both the researcher's and the interviewee's concerns" (Rubin & Rubin, 2005, p. 14). In addition, this approach to interviewing highlights the individuality of each interviewee "…his or her distinct knowledge, and the different ways…" (Rubin & Rubin, 2005, p. 14) in which the interviewee interacts with the researcher. Josselson (2007) also echoed this discourse about the uniqueness, shaping, and co-construction of each relationship: "Every relationship 'feels' different from every other one" (Josselson 2007, p. 4) and, "The way we speak together is unique…" (Josselson 2007, p. 4). This was my experience with each of the clinicians.

Kernberg and Clarkin (1994) noted, "In the area of psychotherapy research, the literature suggests that there is tension and/or separation between clinicians and researchers …" (p. 39). Indeed, Greenberg (1994) articulated a stronger view on this

subject remarking that, "Researchers, …often find themselves at odds with clinicians" (p. 9). She argued that, "…a relationship develops in which therapists are 'insiders' and researchers are sceptical 'outsiders'" (Greenberg, 1994, p. 9) that contributes to "…mutual scepticism and even distrust" (Greenberg, 1994, p. 1). It was anticipated that my transparent approach and disclosure of my background, as both a researcher and a practising clinician, would help to overcome the potential barriers of tension, scepticism and distrust voiced by Kernberg and Clarkin (1994) and Greenberg (1994). Thus, in applying this relational approach, it was my intention that the interviewees would feel more relaxed and comfortable, in order to engage in an open discussion with the research topic. Heppner, Kivlighan, and Wampold (1999) acknowledged the importance of the research relationship when using an interview method, believing "…the relationship is necessary for the participant to share his or her construction in an honest manner" (p. 247).

Participants

    Selection procedures. Purposive sampling was employed in this study in order to select the participants. In particular, I used snowball and criterion sampling. Faugier and Sargeant (1997) noted the importance, and the increased recognition, of the employment of non-random methods of data collection, and the use of innovative sampling techniques, such as snowball sampling, to access hidden populations for research studies. Therefore, my rationale for using this specific method is because clinicians who have worked with self-injuring patients seem to be a hidden group and they are not easily identified, even within their own mental health professional disciplines. Therefore, I began with clinicians who were known to me and who met the criteria for inclusion (see Appendix B) in this study. I then asked each of these

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clinicians to recommend colleagues, who they knew had experience of working with self-injuring patients in the Irish context.

There were a number of reasons for selecting this sampling method. Firstly, it allowed for the selection of clinicians who were known to have a particular level of experience in working with self-injuring clients. Secondly, it facilitated the selection of clinicians who had a range of different professional training backgrounds, namely psychiatry, psychology, psychotherapy and psychoanalysis. Thirdly, according to Lincoln and Guba (1985, as cited in Rudestam & Newton, 2007), it increased the possibility of accessing an "...array of multiple perspectives..." (p. 106) from clinicians on their understanding and treatment of self-injury.

Population and sample size. The participants were selected from mental health professionals working in the Republic of Ireland. Specifically, these included two psychiatrists, three psychologists, two psychotherapists and one psychoanalyst. In keeping with a qualitative research approach, the sample size was small to facilitate an in-depth analysis of the data. Thus, only eight participants were selected for interview.

Interview Process

I conducted the pilot study in August of 2007. The seven remaining interviews took place between March 2008 and March 2009 over a period of a complete calendar year.

The length of time of each interview varied considerably as displayed in Table 1. They ranged from the shortest interview of 1 hr and 12.41 min to the longest at 3 hr and 15.56 min. Initially, at the beginning of this study, I had anticipated that the

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duration of the interviews would vary from 1 hr 30min to 2 hr, and that the follow-up interviews would be approximately 1 hour or less. As Table 1, below illustrates, most of the interviews fitted into this anticipated timeframe, with the exception of Interviews 4 and 5.

Table 1 *Length of Time of Each Interview*

Interview Number	Timeframe of Interview	Pseudonym of Clinician
Interview 1	72.41 min	Eimear
Interview 7	86.55 min	Ciara
Interview 3	88.45 min	Mike
Interview 6	95.11 min	Sinead
Pilot Interview	96.57 min	Niamh
Interview 2	117.12 min	Jack
Interview 4	130.24 min	Mark
Interview 5	195.56 min	David

In terms of location, all eight clinicians were interviewed in their offices at their places of work. Five of the interviews occurred in one session. Due to time constraints on the clinicians' part, three interviews had to be conducted in two separate parts. There was a 5-week gap between part 1 and part 2 of two of these interviews, and a 15-week break during the third one.

Procedure. Once selected to participate in this research study, participants received an initial contact letter (see Appendix C) by postal mail, outlining the research study and inviting them to participate. Within one week of posting the invitation letter, participants received a follow-up telephone call from the researcher. The purpose of this phone call was to assess participants' level of interest in my research study, to ask questions to ensure that they met the criteria for inclusion in this

study (see Appendix B), and to respond to any questions or concerns they may have had.

Once participants agreed to become involved in my research study, we then agreed the date and the venue for the interview. Participants were offered a choice of two venues for the interviews to take place, either the participant's offices (places of work), or my office, thus ensuring that the research interview took place in a private setting.

Prior to initiating the research interview, I asked the participants to complete the informed consent form (see Appendix D), and I answered any pre-interview questions they had in relation to this study. At this point, participants were asked if they wished to request a copy of their individual transcript and a summary of the results of this study. Only one participant asked for a copy of his transcript "out of interest and curiosity". All eight indicated they would like to receive a summary of this study's results upon completion of my dissertation. Once the informed consent form was signed, the participant was asked to complete a background information sheet (see Appendix E). Then, the face-to-face individual interview commenced.

Having read the interview transcripts, I had the option to request follow-up interviews with selected participants. This option was agreed with all of the participants at the time of their consenting to participate in the study. Follow-up interviews were only to be scheduled if there was a need to seek clarification, to follow-up on an interesting point that had been missed by the researcher initially, and/or in the event that the researcher identified sensitive clinical information, that might have been too revealing, or might have led to the identity of the participant, or

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one of their clients. No follow-up interviews were conducted, as they were not necessary.

Instruments. Semi-structured, face-to-face individual interviews was the method selected to gather the data for my research study. The rationale for selecting this particular method was based on a number of reasons. Firstly, the interview method allows the researcher to interact with the participants in a naturalistic setting, and facilitates an opportunity to gather in-depth information from them with a view to answering this study's research questions. As Rubin and Rubin (2005) noted, "...in interviews, the researcher is seeking particular information and so gently guides the discussion, leading it through stages, asking focused questions, and encouraging the interviewee to answer in depth and at length" (p. 110). Secondly, this approach allows for flexibility in that the order and wording of the questions can be varied with each interviewee (Maxwell, 2005). Thirdly, the researcher can ask additional questions to follow up on participants' responses, that allow for rich and detailed responses from participants that are susceptible to cross-case comparability (Maxwell, 2005). Finally, exploring the clinicians' understanding and perspective on their treatment of self-injuring patients was the primary focus of this research study and interviewing allowed me to do this. In the words of Quinn Patton (2002), interviewing allows "...us to enter the other person's perspective" (p. 341).

The interview schedule consisted of 23 questions and 26 probing questions (see Appendix F). Each interview was audio recorded using a digital recorder.

Pilot Study

I conducted a pilot study that involved interviewing one participant (pseudonym Niamh), known to the researcher, who met the selection criteria. Since I

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had developed the interview schedule myself, the purpose of this pilot study was to test its effectiveness, to see if it yielded information relating to the research questions, and to check the timeframe of the interview. The pilot study adhered to the procedural stages outlined in the main study.

The pilot interview was audio recorded and transcribed. Following this, the transcript was analysed using a discourse analysis approach, which I describe in depth later in this chapter. Modifications to the interview schedule, and the research questions, were dependent on the analysis of the data yielded from the pilot study. The analysis of the pilot interview with Niamh worked in a rich and powerful way. Niamh's interview transcript revealed rich data, and discourse analysis illuminated the process of data analysis. This revelation will unfold in the forthcoming findings chapters, in which I will refer to extracts from Niamh's transcript.

Based on my analysis of the pilot study, I did not change the research questions or the discourse analysis methodology. The only modification I made to the interview schedule was the re-ordering of some of the questions, following a recommendation by my progress review committee. They suggested that I place the more open-ended questions about self-injury at the beginning and move the treatment type questions towards the end of the interview schedule.

I decided to include the pilot interview in my main study because there were no significant changes made to the interview schedule or the selected method for analysing the interview transcripts. In addition, I did not want to lose the richness, and unique quality, of Niamh's discourse from this research study.

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Data Analysis

I will now discuss the four processes of data analysis that I engaged in under the following subheadings: transcription and correction, listening and multiple readings, discourse analysis and cross case analysis.

Transcription and correction. The first stage in analysing the data involved the transcription of the audio recordings of the interviews. Hutchby and Wooffitt (1998, as cited in Wood & Kroger, 2000) acknowledged, "The practice of transcription and production of a transcript represents a distinctive stage in the process of data analysis itself" (p. 84). At this initial stage, I employed the services of a professional transcriber who transcribed the audio recordings of each individual interview. On receiving the transcripts, I assigned a pseudonym to each participant. I then checked each transcript against the audio recording for accuracy.

Listening to the audio recordings of the clinicians' interviews, I used an abbreviated version of Jefferson's (1984) transcription notation system (as cited in Wetherell, Taylor, & Yates, 2003, p. 62) to indicate speech errors, pauses, interruptions, inaudible segments and emphasis were indicated in the transcripts, as well as audible intake and outtake of breath (see Appendix G). These are important features to capture because they allow the researcher to identify the function of the text, to read what the speech is trying to do. For instance, the function of the participants' speech may be an attempt to soften what s/he might say, it may indicate a contradiction, an apology or an emphasis.

Listening and multiple readings. In the next stage of the analysis, I engaged exclusively with each participant's audio recording and transcript individually. Thus, I conducted a separate analysis on each individual transcript before moving on to the

next one. During this process, I listened to the audio recordings of the interviews prior to analysing the transcripts. Then, I read "...the transcripts carefully" (Willig, 2001, p. 94), "...at least once, without any attempt at analysis" (Willig, 2001, p. 94). This reading of the transcripts without analysis allowed me "...to experience *as a reader* [sic] some of the discursive effects of the text" (Willig, 2001, p. 94) and "...to become aware of *what a text is doing* [sic]" (Willig, 2001, p. 94).

Consideration of other methods of data analysis. In place of discourse analysis, I could have employed other qualitative methodologies of data analysis in this research study, such as content analysis or grounded theory. Willig (2001) argued that, "Strictly speaking, there are no 'right' or 'wrong' methods. Rather, methods of data collection and analysis can be more or less appropriate to our research question" (p. 21). Indeed, she noted that, "...the research question, data collection technique and method of data analysis are dependent upon one another" (Willig, 2001, p. 21). Therefore, the researcher needs to select a method of data analysis that will extract the answer to the research questions from the data.

In the following paragraphs, I will outline my rationale for specifically selecting discourse analysis to draw out the data that I required in response to the four research questions, that I posed in this research study.

Discourse analysis. The interview transcripts were analysed using the qualitative method known as discourse analysis. I chose discourse analysis as the method for analysing the interview transcripts in order to trace what each participant tried to do with language, and each participant's location or "stakes" within language. This method seemed to be the most appropriate for this research study for the following reasons. Discourse analysis allowed me to see what the clinicians were

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doing with their language. It also facilitated a reading of how dialogues, such as interviews, are co-constructed, and how the participants are constrained by the language I introduce, as well as the discourses they may use in daily life in Ireland (that are largely the same), and by discourses particular to their clinical training and professional lives. Finally, discourse analysis opens up the possibility of exploring the use of discursive patterns that may shift in a narrative, and to explore similar and variant discourses across a group of participants.

According to Potter and Wetherell (1987), discourse analysis acknowledges that, "…language is not an abstract realm" (p. 14) and that language "…is made up from particular utterances performed in particular contexts" (p. 14). Indeed, Quigley (2000) proposed that, "…language is an instrument for making and conveying meaning (constructed jointly, in conversation, rather than located inside someone's head), that its structure reflects its function, and that therefore it can only be properly understood in terms of its function" (p. 9). Discourse analysis is a method that is designed to reveal how people construct particular meanings in a social context. In particular, it examines how language functions for people, specifically, how people use language "…to *construct* [sic] versions of their social world" (Potter & Wetherell, 1987, p. 33). This construction of versions is "…demonstrated by language variation" (Potter & Wetherell, 1987, p. 33).

Therefore, this next stage of the data analysis involved the process of analysing each interview transcript individually using a discourse analysis approach. When analysing texts, Wood and Kroger (2000) argued, "Discourse analysis requires a particular orientation to texts, a particular frame of mind" (p. 91). Adopting this orientation, the discourse analyst must examine the discourse, "…creatively in all of

its multifarious aspects..." (Wood & Kroger, 2000, p. 91), and keep an open mind "...to entertain multiple possibilities" (Wood & Kroger, 2000, p. 91). Therefore, this stage of analysis involved reading each transcript several times so that I could begin the analytic process. Wood and Kroger (2000) noted, "The overall goal of the analysis is to explain what is being done in the discourse and how this is accomplished, that is, how the discourse is structured or organized to perform various functions and achieve various effects or consequences" (p. 95). Thus, during these readings and re-readings of the transcripts, I was listening for patterns in each individual interview in response to the research questions. Therefore, at this point in the analysis, I wasn't focusing on what the clinicians were saying in the text, but what they were doing with their discourses. Specifically, in this research study, this analysis allowed me to become aware of how the clinicians used language to convey, contest, argue, persuade themselves, and me, about their understanding of self-injury, their conceptual frameworks for treating self-injuring clients, and how they gauge their clinical effectiveness, and partial failures, with this patient group. For instance, I identified patterns in their discourse such as what they spoke about, or didn't speak about, in relation to their understanding and treatment of self-injury.

Discourse analysis aims to make linkages between patterns of speech, and theorising about the wider social context, by focusing on aspects of speaking, in an interview situation, that are not usually conscious or known to the interviewee. Therefore, another layer of the analysis involved identifying subject positions from which the clinicians spoke in their discourses. Edley (2003) defined subject positions "...as 'locations' within a conversation" (p. 210) and they "...offer discursive locations from which to speak..." (Willig, 2001, p. 111). Subject positions can be identified by the particular "...ways of talking" (Edley, 2003, p. 210) by the speakers

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in a conversation. These "...ways of talking can change both within and between a conversation..." (Edley, 2003, p. 210). Every one of us has multiple and natural "ways of talking" in which we revise, contradict ourselves, and respond to different social contexts. These shifting subject positions in which we locate ourselves, are a way that we read aspects of discourse, in relation to what's required in particular social situations. Thus, I traced these subject positions through shifts in the clinicians' discourses. In relation to the present study, the clinicians located themselves within various subject positions, and their "ways of speaking" reflected the wider controversial, sometimes confusing, discourses about comprehending and treating self-injuring patients.

Cross case analysis. Potter and Wetherell (1987, as cited in Wood & Kroger, 2000) suggested that other patterns to be identified in the discourse include "...systematic variability or similarity in content and structure..." (p. 95) within individual participants, and between participants', transcripts in relation to a study's research questions. Following this recommendation, I also examined the clinicians' discourses for patterns of "contradictions", "resistance", "revisions" and "repetitions" (A. G. Rogers et al., 1999) both within individual and across texts. In the final stage of my analysis of the clinicians' discourses in relation to the research questions, I conducted a cross case analysis of all eight clinicians' transcripts, seeking out patterns of variability and similarity among their styles of discourse.

Using a cross case analysis approach, I looked for patterns of contrasts, variability and shifts in discourse across the clinicians' narratives. I also searched to see how they constructed an imaginary audience, and made comparisons of those who shared the same training (e.g., the two psychiatrists, Ciara and David; two

psychologists, Niamh and Eimear). When I identified clinicians as sharing a common discourse pattern, I looked further to see if they were using the same kind of discourse for different purposes.

I chose extracts from the clinicians' interview transcripts to portray their discursive styles. The clinicians spoke largely in the present tense, therefore all four findings chapters are written in the present tense. This has the effect of making the extracts appear vibrant and alive, occurring in the present in conjunction with my analysis.

Relevance of discourse analysis to this study. I will now discuss how these various aspects of discourse analysis are relevant to this research study. As already outlined, the research questions focus on the phenomenon of self-injury, in particular, how mental health clinicians think about self-injury and how they work with self-injuring clients. Potter and Wetherell (1987) noted that the research literature in social psychology has consistently found "...that people modify their behaviour, including their talk, in accordance with different social contexts" (p. 37). In this study, the social context was the various training programmes the clinicians had completed, their clinical settings, and ideas about self-injury in the wider Irish society. In addition, there was the social context of the interview situation.

According to Potter and Wetherell (1987), "...variability is an expected usual feature of conversation and social texts..." (p. 38). Therefore, variability within participants' linguistic content in the transcripts was expected to emerge in the analysis of these texts. Unlike conventional approaches, discourse analysis views variability as "...something to be understood, including the way in which participants use variability to construct their talk for different purposes, for different audiences,

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and for different occasions" (Wood & Kroger, 2000, p. 10). Variability was also expected in the transcripts, for reasons associated with the literature on the phenomenon of self-injury and with the different clinicians' training programmes. As previously discussed in Chapter Two, there is no singular understanding of self-injury, and the literature features a multitude of diverse treatment approaches. Therefore, variability among clinicians' understanding of self-injury, sources of knowledge that have shaped the development of their treatment model, conceptual frameworks they draw on in their treatment of self-injuring patients, and how they measure their clinical effectiveness, and partial failures, were all of direct interest to this research study.

Participants in this study are members of various mental health disciplines namely, psychiatry, psychoanalysis, psychology and psychotherapy. Each of these disciplines has its own individual disciplinary discourse. In addition, participants might also use a common discourse, as they are practitioners who are living and working in Ireland. Clinicians who have trained in psychoanalysis, psychology and counselling may share a common discourse, as well as having their own individual discourses associated with their particular school of psychotherapy. This may be related to the historical origins within psychology. There are five main generally accepted viewpoints or perspectives in psychology, namely, the biological, behaviourist, cognitive, psychodynamic and humanistic approaches (Glassman & Hadad, 2009). Each of these approaches "...differ from each other in terms of their basic assumptions, their methods and their theoretical structures" (Glassman & Hadad, 2009, p. 5). Thus, "...each approach represents a distinct framework..." (Glassman & Hadad, 2009, p. 5).

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Psychoanalysis was the first school of psychotherapy, and it gave rise to the psychoanalytic or psychodynamic approach in psychology. Then, historically, different schools of psychotherapy emerged from four of these approaches. For instance, cognitive therapy had its origins in the cognitive approach; behaviour therapy came from the behaviourist approach; humanistic psychotherapy emerged from the humanistic approach. Discourse analysis is a method that seeks to identify and understand these multiple and shared discourses among participants' transcripts.

Discourse analysis was an appropriate method for analysing the data in this study because "…one of its important elements is its use of participants' own understandings" (Potter, 1996, p. 138), and how they construct their understanding. Participants' understanding are displayed in their replies to the utterances of the interviewer that precede their speaking. How participants constructed their understanding via their discourse was probably unconscious to them, because it was being constructed in the moment of interaction within the context of an interview. This unconscious component could only be identified by the researcher when analysing the transcripts. This inclusion of conscious and unconscious aspects of discourse was an important aspect of the current study, as it aimed to gain an understanding of how clinicians constructed their treatment models, conceptual frameworks, understanding and perception of their treatment effectiveness, failures and partial failures in their work with self-injuring clients. Discourse analysis facilitated this type of exploration.

Philosophical stance towards the inquiry. My theoretical perspective in relation to this research study was drawn from hermeneutics. Josselson (2004) argued that hermeneutics is "…a disciplined form of moving from text to meaning" (p. 3) and

in analysing texts, "...the researchers' task is hermeneutic and reconstructive (Fischer-Rosenthal, 2000) in offering a telling at some different level of discourse" (2004, p. 3). Adopting Ricoeur's hermeneutic interpretive stance, I conceived the process of interpreting the participants' texts in two different ways; by juxtaposing myself within both "the hermeneutics of faith" (Ricoeur, as cited in Josselson, 2004, p. 1) and "the hermeneutics of suspicion" (Ricoeur, as cited Josselson, 2004, p. 1), or as Josselson (2004) referred to it as "a hermeneutics of restoration" (p. 4) and "a hermeneutics of demystification" (p. 5) respectively.

Josselson (2004) noted that a hermeneutics of faith "...aims to restore meaning to a text..." (p. 1), and she described the contrasting hermeneutics of suspicion as "...attempts to decode meanings that are disguised" (p. 1). Applying this theoretical perspective to interview texts, Josselson (2004) proposed that:

> "From the point of view of a hermeneutics of faith, the interpretive effort is to examine the various messages inherent in an interview text, giving 'voice' in various ways to the participant(s), while the researcher working from the vantage point of the hermeneutics of suspicion problematizes the participants' narrative and 'decodes' meaning beyond the text" (p. 1).

Thus, Josselson (2004) proposed that, "...the hermeneutics animated by faith..." (p. 4) is "...a hermeneutics of restoration, since the stance of the interpreter is one of trying to unearth and highlight meanings that are present in the informant/participant's communications" (p. 4). She also referred to the hermeneutics animated by the effort to decode as "the hermeneutics of demystification" (Josselson, 2004, p. 5) because "...the word 'suspicion' carries pejorative connotations and

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'doubt' seems unduly disrespectful to the participant" (Josselson, 2004, pp. 4-5). For these reasons I decided to use Josselson's (2004) terms.

Positioning myself within an interpretive hermeneutics of restoration, I was aiming to distil, elucidate, and illuminate the intended meanings of the participants, while also trying to remain faithful to their original text or narrative. While I cannot assume I understood, or grasped their intended "meaning"—I quote extensively, offering long excerpts so that readers can hear nuanced meanings and draw conclusions about my discourse and interpretations. Shifting my stance to the hermeneutics of demystification, I was seeking to unfold an additional interpretation of the texts, the hidden or unconscious meaning, or as A. G. Rogers et al. (1999) referred to as the "contradictions", "revisions" and "negations", that participants engage in but are unaware of in their narratives. Specifically, I was focusing on a meta-level of interpretation, and not solely on the content of what the clinicians were saying to me, and in this sense I went beyond the content of the clinician's communications.

My orientation to this research study located me primarily within the discursive epistemological tradition of social constructionism. The perspective, that knowledge is socially constructed by human beings as they socially interact with each other, and their world, is a central theme in the social constructionism paradigm. Hoffman (2005) argued that, "...the social construction theorists see ideas, concepts and memories arising from social interchange and mediated through language" (p. 8). Crotty (2003) contended that, "All reality, as meaningful reality, is socially constructed" (p. 54). Thus, underlying this theoretical perspective is the notion that meaning is constructed, and not created, or discovered (Crotty, 2003). Adopting this

perspective as the researcher, I wanted to identify the various ways, that the research participants constructed their social reality in relation to self-injury in their discourses.

Social constructionism is a school of thought that also holds the view "...that there are 'knowledges' rather than 'knowledge'" (Willig, 2001, p. 7) and that "...no absolute truth is deemed to exist but, only socially constructed realities..." (Turnbull, 2002, p. 318). Therefore, in keeping with this perspective, in my analysis of the participants' discourses I am acknowledging that there is no one 'true' interpretation. Indeed, multiple interpretations of their texts are possible but it is not practical to explore all of these in this study. However, I have endeavoured to cover as many interpretations as realistically possible, within the constraints of this doctoral research study.

Philosophical approaches to analysis. My analysis of the clinicians' discourses was a combination of insights from the two major versions of discourse analysis, Foucauldian Discourse Analysis and Discursive Psychology. Indeed, Willig (2001) highlighted the argument that some researchers such as Potter and Wetherell (1995) and Wetherell (1998) has proposed that both of these methods "...are complementary that any analysis of discourse should involve insights from both..." (p. 87).

The concept of subject positions is the only feature from Foucauldian Discourse Analysis that I used in my analysis of the clinicians' texts. Wetherell, Taylor and Yates (2006) argued that, "language positions people" (p. 23) and that, "discourse creates subject positions" (p. 23). They proposed that when we speak, we speak from a position. Willig (2001) noted that subject positions "...offer discursive locations from which to speak and act..." (p. 111). Thus, one can speak from a

particular position or place others in specific positions. Wetherell, Taylor, and Yates (2006) explained that in taking up a particular subject position in a discourse we are drawing on "…culturally recognized patterns of talk such as the 'autonomous woman', the 'mad woman', 'the fragile victim' and so on…" (pp. 23-24). Therefore, they are suggesting that subject positions, "provide us with a way of making sense of ourselves, our motives, experiences and reactions" (Wetherell et al., 2006, p. 24). Davis and Harre (1999, as cited in Willig, 2001) explained this concept:

> Once having taken up a particular position as one's own, a person inevitably sees the world from the vantage point of that position and in terms of the particular images, metaphors, storylines and concepts which are made relevant within the particular discursive practice in which they are positioned. (p. 111)

Discursive Psychology conceptualizes psychological phenomena such as memory, attribution and identity "…as *discursive actions* [sic] rather than as cognitive processes" (Willig, 2001, p. 91). This version of discourse analysis is concerned with the discursive practices that participants engage in "…within particular contexts to achieve social and interpersonal objectives" (Willig, 2001, p. 91). Thus, discursive psychology understands psychological activities such as justification, rationalization, categorization, attribution, naming and blaming as ways, in which participants manage their interests in particular social contexts (Willig, 2001).

In Discursive Psychology, the focus of the analysis is on "…the *action orientation* [sic] of talk" (Willig, 2001, p. 91). Thus, in analysing the texts, I identified the ways in which the participants "…manage issues of stake and interest" (Willig, 2001, p. 92), the discursive strategies they engaged in, and what functions these strategies performed in particular discursive contexts (Willig, 2001).

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Data. The data for analysis in this research study consisted of the researcher's notes documenting the initial contacts and the negotiation of the research relationships with each interviewee, a biographical data sheet on each participant, individual participant's responses to interview questions (transcripts of interviews), and the researcher's field notes of each individual interview. I employed the services of a professional transcriber to produce transcripts of verbatim accounts of the audio recordings of each interview. A confidentiality contract was agreed with the transcriber prior to the commencement of the transcription process. The research participants were also aware of this contract and agreed to this method of transcription, as contained in the participant consent form (see Appendix D).

Ethical Considerations

St. Patrick's College Research Ethics Committee approved this research study prior to any data collection. During every phase of this study, I adhered to the Code of Professional Ethics of the Psychological Society of Ireland, and the Code of Best Practice in Research Ethics of St. Patrick's College. With these codes in mind, I endeavoured to protect participants' rights to privacy and confidentiality. Thus, as in the case of the pilot study, each participant was assigned a pseudonym in order to protect his or her identity. Therefore, participants' real names and any identifying information were not used in any documents related to this research study. In addition, I asked participants to complete the informed consent forms and sought permission to audio record the interviews. Participants' rights to withdraw from the study were respected.

Prior to asking the main interview questions, I reminded participants to use a first name initial or a pseudonym, if they were going to answer the questions with a

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particular patient in mind. This was an additional strategy that aimed at protecting the anonymity, privacy, and confidentiality of participants' clients. However, in the event that some of the data recorded from interviews with participants contained sensitive clinical information, some of which might have been too revealing for participants and their patients, I adopted the following steps. Firstly, I read all of the transcripts to identify clinically sensitive areas that appeared too revealing. None emerged, and therefore I did not have to contact participants to request them to review their transcripts in order to disguise client information, without losing the essence of the initial data, so that patients could not be identified. This process was crucial to protect the anonymity, privacy and confidentiality of clients and participants.

Another ethical consideration related to data retention and disposal. The time frame for the period of data retention is three to five years, or six months after the final submission date of my dissertation, whichever is the shorter period of time. At the designated appropriate time the data will be disposed of by two methods. The transcripts, biographical data sheets, informed consent forms and the field notes will be destroyed by means of confidential shredding by me, the researcher. I will also erase the audio files of the interviews.

While acknowledging that self-injury is a topic that can evoke strong emotional responses, and that some clinicians experience difficulty with regard to treatment, it was envisaged that there would be minimal risk of psychological harm to the clinicians participating in this research study, primarily because the participants were all clinicians who had volunteered to participate in this study, and were invited to speak about their professional work. In addition, most clinicians in keeping with good practice guidelines, tend to have good professional support systems. Finally,

mental health clinicians who are invited to be interviewed as part of a research study, are usually not considered a vulnerable group, and therefore, they can make informed decisions about whether or not to involve themselves in a research study.

Josselson (2004) highlighted some ethical problems for the researcher who adopts a hermeneutics of restoration. She argued that:

> The ethical dilemmas in this approach involve being faithful to the meanings of the interviewee. The implied contract in the interview situation is that the interviewer is interested in learning about and in some way presenting the lived experience of the participant. The participant is the author of and authority on his or her own experience. Participants who read the published report will therefore be expecting to find their own meanings rendered, if not mirrored. (Josselson, 2004, p. 12)

Therefore, I have endeavoured to honour the participating clinicians' time, expertise and their intended meanings in the long excerpts from their interview transcripts that I have included in the findings chapters.

Issues of confidentiality is another ethical dilemma raised by Josselson (2004). She contended that this becomes a critical issue "...since personal detail revealed in the interview situation can have harmful effects on a person's life if they were to be recognized...(Lieblich, 1996; Stacey, 1988)" (Josselson, 2004, p. 12). With this caution in mind, I have changed the clinicians' biographical details slightly, and I have removed some identifying information from their discourses. However, Josselson (2004) also acknowledged that, "Adequate concealment of identity protects confidentiality, but does not prevent narcissistic injury (Josselson, 1996)" (p. 20).

Applying a hermeneutics of demystification, Josselson (2004) noted that, "In going beyond the intended narrative of the participant, many researchers feel uncomfortable with the authority they must take to re-author the meanings of the person who shared their stories with them" (pp. 15-16). Indeed, some participants may react with dismay, surprise and distress at my interpretation, decoding and reconstruction of their narratives. In anticipation of these responses, I will give each participant an executive summary of my research study, and to those who requested it, a full copy of my dissertation. I will follow-up with a telephone call to each participant and confer with them before publication of my research study.

Biographical Information

In this section, I present the "external" characteristics of each participant. This information was acquired via the Biographical Information Data Sheet (see Appendix E), that participants completed at the beginning of the interview. A summary table of this demographic data is illustrated in Appendix H.

Niamh is a woman, aged between 50-59 years. She is a counselling psychologist who has been practising for 17 years. She described her training orientation as "developmental psychology", and her current therapeutic/treatment approach as "humanistic, body centred". She acknowledged that she has worked with approximately 50 self-injuring females whose ages range from 13-19, 20-24, 25-29, 30-34 and 35+. While Niamh's clinical experience with self-injuring clients appeared to be significant, it is confined to one gender. She has worked in a number of different settings with self-injuring patients.

Eimear is a clinical psychologist, a woman whose age range is 50-59 years. She has 15 years clinical experience as a psychologist. Her training orientation was

in, "DBT". She described her therapeutic/treatment approach as "CBT, DBT, mindfulness based CBT". Eimear's clinical experience is confined to females, aged 35+. She did not indicate how many self-injuring patients she has worked with. She has practised in several settings with self-injuring clients, "public community psychiatric services", "private hospital", and "private practice".

Mike is a man, aged between 40-49 years. He is a registered psychologist who has been practicing for 14 years. His training orientation was in "systemic family therapy" and "narrative therapy". He described his therapeutic/treatment approach as "systemic/social constructionist, narrative therapy". He informed me that he has worked with "greater than 20" male and female self-injuring patients whose ages range from 13-19, 20-24, 25-29. He did not give specific numbers for either gender. He has worked with self-injuring clients in a "training organisation, non government organisation community", as well as in private practice.

Jack is a psychoanalyst, a man whose age range is 50-59 years. He described his training orientation as "Freudian/Lacanian psychoanalysis". He has been practising for 16 years. He describes his therapeutic/treatment approach as "psychoanalytic". He has worked in private practice with 11 self-injuring patients; 2 males and 9 females in the age range 20-24.

Mark is a man aged between 40-49 years. He is a psychotherapist who has been practising for 10 years. He originally qualified as a medical doctor. He described his training orientation as "psychiatry—2 years adult psychiatry, psychotherapy— body centred psychotherapy". He identified his therapeutic/treatment approach as being "body centred, integrative & humanistic, primarily concerned with relationship between trauma & somatic symptoms". He has

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worked in two settings with self-injuring clients, "private practice" and "inpatient setting of psychiatric hospitals". Based on the information acquired in Mark's interview, it seems that his experience as a psychotherapist is confined to private practice, and that his reference to an inpatient setting related to his experience as a medical student/doctor. Of all of the participants Mark appeared to have the least amount of clinical exposure to self-injuring clients. He has only worked with 5 self-injuring patients; 3 males and 2 females, aged 20-24.

David is a consultant psychiatrist, a man whose age range is 40-49 years. He was very specific about his clinical experience, revealing that he has been practising for "11 years as a consultant". Therefore, it is unclear how long he was practising prior to receiving consultancy status. He described his training orientation as "broad based—pharmacological, psychodynamic" and his therapeutic/treatment approach as "tailored to individual client". He had a lot of clinical experience with self-injuring patients, having worked with 70, of whom 20 were male and 50 female. Interestingly, his exposure to these types of patients is confined to two age ranges, 13-19, and 20-24, which is surprising for a psychiatrist, considering that the ages most cited in the literature for this behaviour are 12 to 35 years (Favazza & Conterio, 1988). David has worked in various settings with self-injuring clients, "outpatient—hospital based (public & private services), private practice, hospital inpatients".

Sinead is a woman, aged between 40-49 years. She is a psychotherapist who has been practising for 18 years, and she originally trained as a social worker. She specified her training orientation as "constructivist & systemic" and her therapeutic/treatment approach as "primarily systemic constructivist—interest in language, meaning & metaphor & social context—systems, also use mindfulness".

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She has worked with young adults in a counselling service, included 22 self-injuring patients, 2 males and 20 females, aged 20-24 and 25-29.

Ciara is a consultant psychiatrist, a woman whose age range is 30-39 years. She was the youngest of all of the participants. She has been practicing for 11 years. It is not clear if she has been practising for that period as a consultant as she did not specify this as David did. She described her training orientation as "biological psychosocial focus, multidisciplinary care approach". She identified her therapeutic/treatment approach as "outpatient bio psychosocial MDT liase with psychotherapy, occupational, social work". Ciara emerged as the clinician who seemed to have had the most exposure to self-injuring clients, having worked with 70 males and more than 100 females, of the age ranges 13-19, 20-24, 25-29, 30-34, 35+. Her experience of high numbers of self-injuring patients may be as a result of her broad definition of self-injury, and perhaps her exposure to such patients as a medical student/doctor. She stated that she has worked with self-injuring clients in "outpatient day care, inpatient care, A&E setting".

Overview of Findings Chapters

In the following Chapters Four, Five, Six and Seven, I mark out and discuss the clinicians' discourse patterns that emerged in their narratives, in response to my research questions. In Chapter Four, I explore the clinicians' discourse patterns in relation to the research questions, "What conceptual frameworks do clinicians draw on to understand self-injury, and their current treatment practice with self-injuring patients?" and "What sources of knowledge including both personal experience and professional training, have influenced/shaped the development of clinicians' explanation(s) or working model(s) of treating self-injuring clients?" My examination

in Chapter Five centres around a pattern that emerged across the clinicians' narratives, in which they tended to create discourse communities of "an other" to formulate their beliefs about self-injury and its treatment, rather than articulating particular theoretical or conceptual models. In Chapter Six, I consider the research question that pertains to the explanations or models that the clinicians drew on to understand their current treatment practice effectiveness and failures with self-injuring clients. I conclude with a deliberation in Chapter Seven, on the clinicians' discourses that pertain to the ways in which they gauge or measure, their clinical effectiveness in their current treatment practice with self-injuring patients.

Chapter Four

Findings: Merging Discourses

The findings of this research study are presented in the following four chapters. Throughout these findings chapters, I display extracts from the clinicians' transcripts. Each of these extracts contain symbols that I have taken from Jefferson's (1984) transcription notation system (see Appendix G), which is the mode of markers generally used in discourse analysis (Potter & Wetherell, 1987, as cited in Wetherell et al., 2003). Table 2 highlights the specific transcription symbols that I have employed in the extracts and a brief explanation on how to read them. For a more detailed account of these markers consult Appendix G.

Table 2 *Abbreviated Version of Jefferson's Transcription Notation System*

Symbol	Meaning of Symbol
(.5)	A time gap in tenths of a second
.hh	Speaker in-breath
Hh	Speaker out-breath
(( ))	A non-verbal activity
( )	An unclear fragment
Under	Speaker emphasis
[ ]	The onset and end of a spate of overlapping talk

In this fourth chapter, my discussion of these findings centres around the following research questions, "What conceptual frameworks do clinicians draw on to understand self-injury and their current treatment practice with self-injuring patients?" and "What sources of knowledge including both personal experience and professional training have influenced/shaped the development of clinicians' explanation(s) or working model(s) of treating self-injuring clients?"

As the descriptions of the participants revealed in the previous Chapter Three, all eight clinicians represented a range of therapeutic/treatment approaches/models and disciplinary backgrounds. These included dialectical behaviour, narrative, constructivist, humanistic/body centred, Freudian/Lacanian psychoanalysis, a mixture of pharmacological, psychodynamic/cognitive behaviour/dialectical behaviour and a combination of pharmacological, cognitive behaviour and dialectical behaviour therapeutic modalities. In addition, these clinicians come from a variety of mental health professions including psychiatry, psychology, psychoanalysis and psychotherapy. This initial revelation is not surprising considering this was a feature of the selection process as the aim was to choose eight participants who use different therapeutic/treatment approaches with self-injuring patients and who represent a range of clinical disciplines. This range is also consistent with the method of selecting participants via purposive sampling, which was employed in this study.

For the majority of the clinicians, no distinct models for considering self-injury and approaches for working with self-injuring clients emerge, despite the range of therapeutic/treatment approaches/models across the group of clinicians. There are two exceptions to this pattern, namely Eimear and Mark. The other clinicians' (Niamh, Jack, Sinead, Mike, Ciara and David's) models and techniques in relation to self-injury do not appear to be distinct from their primary training model/orientation to treatment. In fact, their discourses seem to merge primary training with treatment of self-injury. Sinead's discourse illustrates this point, as she speaks about conceptualising self-injury. She states, "I would understand it in the context that I would understand a lot of symptoms" (lines 69-70, part 2) and proceeds to locate it in terms of her constructivist "psychotherapy training" (lines 83-84, part 2). Thus, she acknowledges that she does not have a separate model or framework for

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understanding self-injury from other symptoms that her patients bring to counselling. This appears to be the case for the majority of the clinicians.

This merging of clinicians' conceptual orientations to treatment and their understanding of self-injury seems to be driven for some by their theoretical training or a belief system, and for others by their practical training. Jack, Mike and Sinead's discourses suggest that their treatment approach, and their conceptualisation of self-injury are significantly influenced by the particular theoretical modality in which they were trained in. Niamh is the only clinician whose merging of her conceptual orientation to treatment, and whose construction of self-injury is influenced by her strong beliefs. In contrast, David's and Ciara's merging patterns are driven by their clinical training. I will now discuss three clinicians' discourses, using Jack, Niamh and David as exemplars of each style of how this merging occurs.

Discourses of Merging Theoretical Training

Jack is a psychoanalyst and constructs himself as a clinician who is "not particularly conscious" (line 609) of theories in his practice. He explains:

> I mean I I tend not to I if they're there they're there just because they're there you know but I'm not particularly conscious of them um but this the the difficulty then I mean it's it's I um I I sometimes wish I could elaborate the work in terms of the theory uh in a in a more um uh I know contained or a more deliverable way and and I I I find that the whole thing gets mixed up together so much in my mind the the the the practice and the theory are so kind of interlinked that I find it difficult to separate it (lines 863-873) Um what what's a theory from what's what's something else (lines 875-876)

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Thus, even in his own words he acknowledges the merging of his theoretical training and his practice orientation.

His narrative reads as if one has picked up his specific theoretical training orientation framework and literally mapped it directly onto his model for understanding self-injury and his treatment practice. Jack reveals that he uses a psychoanalytic framework in his treatment approach especially "a bit of classical Freudian theory" (line 599) and "a large part of Lacanian" (lines 600-601). Indeed, he captures this discursive merging feature perfectly when he speaks about self-injury and tells me, "I'm making sense of it in with uh through the lens of uh kind of psychoanalytic theory" (lines 756-758). This is exactly what he does. Jack locates his understanding of self-injury within a Lacanian discourse that centres around "the failure of language" (line 850). He elaborates:

> the idea of uh self-harm as a uh an inscription on the body uh that that expresses that says something it's it's a particular kind of writing on one the one on the one side but also it's a cut that cuts through the the internal kind of anxiety and the the sense of pressure that a person experiences so one would might might say that there's a kind of a a uh a it's it's almost an attempt to to enforce a a kind of a cut that has failed to work at some level in language (lines 783-793)

He continues with this discourse and introduces the idea of cutting as a form of diary writing on the body, a concept that was originally coined by A. G. Rogers (1996). Jack does not refer to A. G. Rogers' discourse on this subject matter, as he makes no reference to it. He explains his concept as:

in a kind of a way it's a uh it's both it's kind of uh both addressed to them I mean and it's kind of turning it back on themselves I mean so that they're they're uh at least at some point they're speaking to themselves um that they're they they they're they cut uh because it's not shown it's it's covered up it's hidden away it's something secret so they it's almost like a diary of whatever it is that that troubles them that can't be put into words uh and you know in the same way as a diary is is kind of written down and it might be found it might be uncovered but it's at at the same time hidden away and secret (lines 292-303) The cut is is is is written on the body you know and uh and covered up (lines 305-306) Uh hidden away and and kept as a kind of a uh you know a a kind of a talisman as a uh something that can be can be seen again and can be marked out again uh you know another line can be written (lines 308-311)

Another central feature of his framework is the question of who is being addressed through the self-injury and who will understand. Jack returns to this metaphor of the diary to elaborate on this idea. He informs me that the cut can be:

covered up again until eventually it's discovered and in the same way as the diary is discovered by being left you know in the wrong place you know and uh the the the the cut is discovered by by chance as the sleeve falls back or something like that so then it's addressed to another so uh you'll have to think then in uh in the end the intention is that somebody will see somebody will will and and will understand (lines 313-321)

This application of a Lacanian discourse appears to be a dominant framework on which he draws to understand self-injury and his analytical practice with self-

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injuring patients. This Lacanian framework is repeated throughout Jack's narrative in the form of "something impossible to speak" (lines 270-271) "then uh a a cut at least expresses that impossibility" (lines 273-274) "addressed to another" (line 318) and "the intention is that somebody will see somebody will understand" (lines 319-321).

Jack explains his approach as follows:

You know I don't I don't as I uh said earlier that I don't obviously go in with an idea of a particular approach that I'm going to have because this person self-harms (lines 2129-2132) I I want to hear about what they have to say (line 2134) it has to be it has to be through practice working with with individuals who speak in this way about uh their experiences and and we we attempt or at least I attempt in in that process to make some kind of sense of it uh from the facts (lines 762-766) You know from what's being said you know (line 768) Or what the person is is is is uh describing (lines 770-771)

Thus, he acknowledges that his treatment approach for working with clients who self-injure is not distinctive, separate or different from his theoretical training in psychoanalysis.

He argues that the main focus of the analysis with a self-injuring patient is the shift from "cutting to speaking" (line 845). He claims that this "is the real the kind of the crux of the matter" (lines 845-846). This way of working appears to relate to Lacanian ideas about "the failure of language" (line 850) and the unconscious that is a recurring theme in Jack's discourse. The following is an example of this discourse where he speaks about cutting as an inscription on the body that cannot be spoken:

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in the end there has to be something spoken that couldn't be spoken not in the sense that it was there to be said and the person found it impossible to say it but that it's unconscious or the person does not simply have access to the thing that mustn't be spoken about except through cutting so then it is kind of the only inscription that's possible is on the body and because some element of what must be spoken has been shut off in some way that's not immediately it's not immediately or not accessible to the person (lines 858-867)

This is a very good example of where Jack's psychoanalytic discursive practice with self-injuring clients merges with his theoretical training orientation. Therefore, how he conceptualises self-injury is not distinctive from his original theoretical training in Lacanian and Freudian analysis.

What is striking about Jack's narrative is the absence of outside discourses beyond his analytic training for treating and conceptualising self-injury. Even within his analytic discourse, he does not refer to specific psychoanalytic texts that address the conceptualisation and treatment of self-injury. Thus, he completely relies on his theoretical training to guide him in his understanding and analytic practice with self-injuring clients.

Merging discourses of belief system. Niamh holds definite beliefs about self-injury and how to work therapeutically with patients. These beliefs seem to influence and merge with her treatment practice as she admits, "I just take in from other models what actually contributes to or fits with my belief and interest and love of people" (lines 1540-1542) "And I discard everything else from various models ((laughing))" (lines 1554-1555). Indeed, her strong beliefs surface in her discursive responses to the language of some of my questions. There are instances in her

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narrative when her discourse suggests a sense of dismay at reading and misreading my language. For instance, in Extract 1, Niamh supposes that her response to my question about "what models models or theoretical frameworks?" (lines 449-450) she uses with self-injuring clients is not what I am looking for in my dialogue with her. She assumes that I am seeking particular responses from her and she arrives at the conclusion, "I knew this wouldn't I knew ((laughing)) this would not be useful to you in that mmm okay" (lines 460-461).

Extract 1

Lines 449-462   I: Well what models models or theoretical frameworks

                      C: I <u>mean</u> that would link into a <u>million</u> different theoretical frameworks really

                      I: [Mm–hmm]

                      C: [You know and]

                      I: I think it's I'm curious whether you use any of them or a combination

                      C: Not consciously

                      I: Okay

                      C: (.2) I knew this wouldn't I knew ((laughing)) this would not be <u>useful</u> to you in that (.2) mmm okay

                      I: Okay so em

There is also a pattern in her speech where she appears to be making a protest against my use of certain terms of phrase. For example, when I ask her, "can you tell me how you work with clients who self-injure?" (lines 517-518) she seems to oppose my language in her reply as she informs me, "That's very hard to say" (line 520) "because you're not working with a client that self-injures you're working with a person" (lines 522-523). In addition, Niamh uses her discourse to object to the way self-injuring patients are treated in psychiatric settings. She argues, "they see self-

harming clients in psychiatric terms as looking attention seeking and they have very very negative you know attitudes to self-harm in psychiatric settings I have found anyway" (lines 1013-1017).

Niamh is a counselling psychologist, and constructs herself as a clinician who "works in a very intuitive way" (line 256) with self-injuring clients. She explains, "so I don't tend to even put words for myself as I'm working" (lines 256-258). She acknowledges that she has received training in different conceptual frameworks but does not consciously use them or hold them in her mind as she works with her clients because this is not compatible with her "personal philosophy". She argues, "I don't tend to" (line 429) "think of people in terms of frameworks really although I have trained in you know various different" (lines 431-433) "therapeutic models" (line 435). She elaborates on these points as she articulates:

> I suppose I believe that in training we actually absorb into well for me it's not
> really always consciously held and cognitively held at the front of my mind
> but we absorb into ourselves what fits matches our personal philosophy my
> personal philosophy (lines 464-469) and that yes I'm engaging with someone
> out of that place but not in terms of d'you know (lines 471-472) cognitive
> constructs (line 474)

Thus, Niamh admits that she has been exposed to treatment modalities in her training as a psychologist. However, she contends that she does not operate from this position of conscious knowledge in her work with self-injuring patients. Indeed, she questions whether any clinician consciously uses frameworks in their practice as she states, "I don't know does any therapist really have" (lines 1440-1441) "when you're working with somebody all these intellectual constructs going on" (lines 1442-1443).

She reconsiders her position on this matter, questioning, "well maybe they do" (line 1441). She humorously follows this latter remark with "It must be very busy in there you know ((laughing)) it must be ((laughing))" (lines 1443-1444). She concludes, admitting, "I couldn't do this anyway ((laughing))" (line 1447).

She constructs her understanding of self-injury as a "desperate act" (line 267) and sees it as "an indicator of how often a person is in that state of you know desperation to some extent" (lines 238-240) that is "an emotional physical and spiritual pain" (lines 301-302). Niamh views self-injury as "immensely creative" (line 375) and as serving multiple functions such as "it can transform emotional pain into physical pain that's bearable it can bring a person out of a deep state of dissociation" (lines 378-381) "It can punish" (line 384). Because of this she claims, "it's a very complex" (line 398) "response" (line 400). She creates a link between self-injury, trauma and dissociation. She makes the point that, "all children have access to trance-like states and developmentally some children grow out of them except that children who need" (lines 1178-1181) "to keep them as as a coping" (line 1183). She argues that, "trance-like states" (line 1175) "are evidence of something at an early stage" (lines 1175-1176) "it's evidence of early distress of early you know traumatic either developmental or you know" (lines 1185-1186) "trauma" (line 1189). Niamh proposes that self-injury occurs when a person is "at such an edge where they feel a degree of emotional pain which can be emotional disconnectedness" (lines 261-263). Elaborating on this belief, she tells me, "I think it can only happen when a person is in a at a certain level of dissociation" (lines 308-310). Therefore, she views clients who "splits off" (line 665) "are not really in contact with themselves" (lines 624-625). She believes that when this happens the patient is in contact with their "old pain" (line 628).

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In the Biographical Information Data Sheet, Niamh describes her current therapeutic/treatment approach as "humanistic body centred". Her discourse suggests that she draws on humanistic and sensory motor psychotherapeutic frameworks in her work. She acknowledges that she follows a humanistic approach that may not be the current trend in therapeutic circles as she proposes, "humanistic might be now very eh very eh untrendy or it mightn't be the latest but I do believe in people's capacity to heal from anything virtually" (lines 1377-1380). Once again, she refers to the link between her particular treatment orientation and her specific beliefs.

Niamh's discourse also suggests a relational oriented treatment approach. She constructs her role as follows, "And I'm there to be an agent for change in some way to offer other ways and the relationship is the main way I suppose" (lines 645-647). In addition, she argues that the therapeutic "relationship" (line 1741) "contributes" (line 1741) to treatment success. Thus, she holds the view that the therapeutic relationship is an important and significant influencing factor on the outcome of treatment. This is another example of where her convictions merge with her therapeutic practice.

Her references to a sensorimotor approach include the use of "the modulation model" (line 1398), her belief "that awareness of the body is the primary way that we stay out of dissociation" (lines 954-955) and her use of such interventions as "grounding staying in awareness mindfulness and noticing" (lines 650-651). In fact, Niamh is very clear about applying this model of therapy as she informs me, "when people split and are not really in contact with themselves and I'll go the sensorimotor route in the present moment" (lines 624-627). She presents her therapeutic model as working in a way that facilitates clients to increase their body awareness, to stay in

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connection with their bodies in the present moment, to help them become aware of and tolerate what is underlying the symptom of self-injury and to develop self-care, and self-soothing capacities as an alternative to self-injury. She argues that self-injuring patients may not know:

> what the underlying pain is (lines 694-695) And I suppose it is my job to in some way help somebody to get to a level where they can begin to know have awareness of and tolerate what's underlying that symptom (lines 695-698)

Thus, Niamh's strong beliefs and views seem to be the driving force behind her understanding and treatment of self-injury.

Merging discourses of clinical practice and self-injury treatment. David is a consultant psychiatrist, and constructs self-injury as "a coping strategy" (line 235, part 1). So in treating it, he proposes:

> one tries to get to a point (line 1145, part 2) where the need for it recedes (line 1146, part 2) other than simply leaving a person without recourse to a strategy that imperfect and damaging and all as it is nonetheless helps them get through (lines 1146-1149, part 2)

He describes his treatment practice as including both pharmacological and psychotherapeutic approaches. He confesses, "I wouldn't be ideological driven with" (lines 1469-1470, part 3) "a lot of what I do" (line 1470, part 3). He constructs his approach as "somewhat eclectic" (line 15, part 3) and specific to the individual needs of his clients and their clinical presentations. There is a pervasive pattern in his narrative; he conceptualises everything through the lens of his clinical experience. His discourse suggests that the merging of his conceptual orientations to treatment

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and his understanding of self-injury is influenced by his clinical training and his practice.

He engages in a contingent or "it depends" (line 46, part 2) discourse in which he repeatedly introduces clinical case examples to illustrate his treatment approach. Indeed, when I ask David, "can you tell me about your work with patients who self-injure your kind of therapeutic treatment approach and theoretical frameworks you might use" (lines 43-45, part 2), he is unable to separate his theoretical framework from his practice. He replies:

> Well, it depends again on the individual client um frequently again with the young adults like individual psychotherapy sessions if there are uh biological components uh because commonly there may be coexisting uh depressive illness uh or other other disorder um if there is a say an illness phenomenon um one will treat that (lines 46-52, part 2) uh as well uh obviously (lines 54, part 2) And the treatment will depend pharmacological the psychotherapeutic it it it will just vary psychotherapeutic interventions um a pretty broad church depending on the individual case um a lot of support in psychotherapy um cognitive work I suppose one picks and mixes really (lines 56-61, part 2) Uh aspects of DBT (line 63, part 2)

He explains, "So it depends it's it's quite broad" (lines 80, part 2). It is difficult to make generalisations about David's specific treatment approach beyond saying that it is a mixture of pharmacological, psychodynamic, cognitive behaviour and dialectical behaviour modalities.

Extract 2 is a continuation of David's response to my question about frameworks and practice orientation. It is a good example of where his clinical

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practice discourse about his clients continues to merge with his conceptual

frameworks, thus making it difficult to separate them, so much so that they seem

fused together with no demarcation line.

Extract 2

Lines 80-126, part 2   C: Of clients that I have at the <u>moment</u> um (3) what worked very well was a combination of uh supportive (2) psychotherapy (3) <u>understanding</u> what was going on

I: Mm–hmm

C: .hh And forming an <u>alliance</u> with the client um (1) and for the person <u>themselves</u> to develop an understanding of their own difficulties and their responses .hh and <u>also</u> very frequently there's uh a mislabelling of <u>affect</u> that goes on uh that the individual may not be actually they may <u>think</u> that their experience and ( ) where they may <u>label</u> [it]

I: [Mm–hmm]

C: As one thing but when you explore it it may in fact <u>not</u> be that could be a reflection of uh family dynamics when they were [growing up]

I: [Mm–hmm]

C: .hh Uh and very mixed messages so if one simply <u>assumes</u> that what you're being told by the person in terms of how they're feeling if you simply assume that you're talking the same language you can go completely off on the wrong track altogether

I: Mm–hmm

C: .hh Uh but <u>oftentimes</u> calm explanation uh consistency um (2) in terms of <u>de-escalation</u> of uh reactions .hh um

C: .hh And (2) I oftentimes just <u>reviewing</u> what has happened why particular crises have come about (.hh) I'd lean heavily on uh social [work]

I: [Mm–hmm]

C: Um intervention as well <u>commonly</u> like in the <u>hospital</u>
        settings I have the luxury of doing joint work that um
        I'd meet with the individual on my <u>own</u> but I'd also
        meet them with the social worker .hh who'd also meet
        the individual on their <u>own</u> and um we'd do the same
        with the family .hh and then obviously have meetings
        with the family <u>and</u> the uh particular client .hh so that
        that tends to work quite well
I: Mm–hmm
C: I had a a a young woman there um she's doing rather
        well um which is gratifying
C: I know it's a <u>long</u> <u>haul</u> and there are going to be <u>bumps</u>
        but um (2) it was quite interesting because she had a
        three-year history of of uh self-cutting

David describes his treatment approach as "somewhat eclectic" (line 15, part
3). He explains, "it would be somewhere in between" (line 16, part 3) in terms of
structured and directive. He elaborates:

it would be structured (line 17, part 3) because I think when (line 17, part 3)

dealing with individuals who have a considerable amount of uh chaos whether

it be emotionally or behaviourally one frequently does need to be very

structured (lines 18-21, part 3)

David argues that structure "provides a degree of security and also provides uh
clear boundaries" (lines 24-25, part 3). He acknowledges:

Um obviously there is a degree of direction uh in that being a psychiatrist and

working with a multidisciplinary team and also um I suppose prescribing

medication hopefully judiciously there is always going to be a degree of

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directiveness in terms of this is what I think we should do and I think this
would be helpful etc etc so um there is going to be a component of direction as
distinct from purely non-directive exploration as I say maybe in psychotherapy
(lines 39-48, part 3) So that's why I say it's probably somewhere in between
(lines 50-51, part 3)

Here, David is giving a rationale for his "somewhere in between" structured
and directive treatment approach with self-injuring clients. He explicitly tells me
when he would use a more structured approach "dealing with individuals who have
considerable amount of uh chaos" (line 18-19, part 3). He also acknowledges that in
his role as psychiatrist "there is always going to be a degree of directiveness in terms"
(lines 42-43, part 3) of "prescribing medication" (line 42, part 3) and "working with a
multidisciplinary team" (lines 40-41, part 3). David also distinguishes between his
treatment approach as a psychiatrist in which "there is a degree of direction" (line 39,
part 3) and that of psychotherapy which he constructs as "purely non-directive
exploration" (lines 46-47, part 3). Therefore, his construction of psychotherapy fails
to acknowledge the variety of psychotherapy approaches that exist and that include
both non-directive and directive modalities that usually depend on the theoretical
orientation.

He explains, "the sessions themselves with the individual would usually relate
to" (lines 26-27, part 3) "what the individual will bring up" (lines 27-28, part 3) "in
session" (line 30, part 3). David elaborates:

if some behavioural issue has arisen that requires (lines 30-31, part 3) to be
addressed immediately because say for example if a person has attempted
serious self-harm (lines 31-33, part 3) clearly anything that you may have been

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working on (lines 33-34, part 3) a more longer-term agenda (lines 34-35, part
3) very much gets in the immediate short-term gets supplanted by (lines 35-36,
part 3) dealing with whatever crisis has arisen (lines 36-37, part 3)

At this point, David is continuing his elaboration of his "somewhere in
between" (line 16, part 3) structured and directive treatment approach with self-
injuring patients. He draws on a clinical example to explain this style of approach,
which is a recurring pattern in his discourse. He concedes that the sessions can shift
from focusing on "what the individual will bring up" (lines 27-28, part 3) to
immediately addressing "some behavioural issue" (lines 30-31, part 3) that "has
arisen" (line 31, part 3) "say for example if a person has attempted serious self-harm"
(lines 32-33, part 3).

David draws on his clinical training in relation to the psychiatric frameworks
he uses to understand self-injury and its treatment. Speaking of self-injuring
individuals, David confesses, "I don't think in terms of them as being disease entities
or disorder entities" (lines 973-974, part 2). However, he acknowledges that, "Those
models are very useful in terms of having structure and having resistancy and
adhering to what is known to be helpful" (lines 975-877, part 2). Thus, he uses
psychiatric frameworks in terms of disorder from his clinical training. He situates
"self-harm" (line 165, part 1) within a discourse of two categorises:

people who've either (lines 148-149, part 1) due to personality-related risk-
taking behaviours or (lines 149-150, part 1) overdoses or (line 150, part 1)
attempts at self-harm that have gone catastrophically wrong (lines 150-151,
part 1) who end up with serious physical (line 154, part 1) debility (line 154,
part 1) a few who perhaps have somatised their distress and (lines 155-156,

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part 1) when you'd finally get to see them that the problems are emotionally and psychologically based (lines 161-163, part 1)

David admits, that his models or theoretical frameworks for understanding self-injuring patients "depend on the uh diagnostic category" (lines 1367-1368, part 2). He concedes:

> one commonly starts thinking in terms of of those with with with borderline personality when one starts thinking of self-injury of course it's much much broader than that but if one just looks at that group certainly uh Marsha Linehan's work I found very interesting (lines 1368-1373, part 2)

In summation, David's discourse indicates that the merging of his conceptual orientations to treatment and his understanding of self-injury is driven by his clinical practice. Indeed, this is so much the case that his clinical practice discourse and his conceptual frameworks for understanding and treating self-injury fuse together in his narrative. He seems to hold the view that the only way to think about self-injury is through the details of his clinical practice. He appears to come up with concepts inductively from his clinical work that unfolded in his dialogue with me as he speaks through his clinical cases of treating self-injuring clients.

Exceptions. Mark and Eimear both have a distinctive model for understanding and working with self-injury. Thus, in this respect they deviate from the general pattern of the other six clinicians (Jack, Niamh, David, Mike, Sinead and Ciara) who do not appear to have distinct models for considering self-injury and approaches for working with self-injuring patients. Despite having marked frameworks for conceptualising and treating self-injury, Mark's and Eimear's discourses show a merging pattern. What is striking is that their style of merging

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differs from each other. In Mark's case, he began with a humanistic body-centred model of treatment and invented an innovative way of mapping it onto self-injury. In contrast, Eimear clearly began with a specific treatment model, dialectical behaviour therapy; a form of therapy that was developed to treat individuals with BPD who engage in self-injury. Thus, self-injury was already mapped onto this modality of treatment. I now discuss how this merging occurs in each of their discourses with respect to their understanding and treatment of self-injury. What is striking about Mark's and Niamh's discourses is how two clinicians can locate themselves within a particular theoretical modality namely humanistic/body-centred but can have completely different orientations to practice and divergent constructions of self-injury.

Mark is a psychotherapist who informs me that his "orientation is from the humanistic side" (lines 390-391) and "very body-centred" (lines 752-753, part 1). He initially began with this humanistic/body centred model of practice. Once he came in contact with self-injuring clients, he began to apply this way of working with them. In doing so, he developed his own particular treatment practice for working with this patient group and a unique framework for conceptualising self-injury, both of which are absent from the vast clinical literature on self-injury. Thus, Mark invented a distinct form of understanding and treating self-injury that separates him in this regard from the other clinicians in this study. However, similar to the other clinicians, Mark's discourse shows a pattern of merging. In his case, he began with a specific treatment practice and mapped it onto self-injury, thereby forming an original innovative treatment of self-injury.

I now discuss how Mark's conceptual orientation to treatment and his understanding of self-injury merges with this orientation in his discourse. He

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acknowledges, "my orientation is from the humanistic side is that even in something as seemingly pathological as self-harm that there's a there's a kernel of wisdom in the behaviour" (lines 390-393, part 1). He states, "So I start from that position not as a not as an idea but as a reality so" (lines 395-396, part 1) "from a humanistic orientation but it's actually to see that it's true" (lines 398-399, part 1).

From his theoretical orientation, Mark constructs self-injury as:

> a continuum from a build-up of an impulse in some way (lines 363-364, part 1) Around uh a body sense going into you know behavioural elements or pre-impulse forms where people are starting to get uh the habitual form build-up and it's reflected into their thinking as well (lines 366-369, part 1)

He explains, "So that um you know uh there's that lead into it and" (lines 371-372, part 1) "the self-harming behaviour is" (lines 372, part 1) "the inevitable conclusion to everything that's gone before" (lines 374-375, part 1). He argues, "a lot of the genesis to this is coming from the body even if the client is having more images or thoughts" (lines 753-755 part 1). He contends:

> the whole drive of hyperarousal or hypoarousal and then the drive to crack that through symptom management essentially is a body-based drive even if the surface layer of it is articulate through emotion or cognition it's it's the body trying to right itself and the other places joining in to help with that (lines 754-762, part 1)

Mark elaborates on this discourse of patients using self-injury to modulate their physiological arousal levels. He describes this as:

if someone is self-harming at uh in a highly aroused end generally speaking
they're trying to bring themselves back in the window of tolerance or trying to
they're trying to manage their symptoms so in that case it's an aiming so that
that's clever then that that what you do when you self-harm is you stop
yourself from escalating that you bring yourself back down that that's a way
of doing that yeah and similarly if someone is uh is in the dissociative end of
the spectrum in terms of numbness that you can say oh so that's clever what
you're doing that it's to so you actually feel something (lines 421-432, part 1)
So you're bringing yourself back in (lines 434, part 1)

Thus, Mark's conceptualisation of self-injury is firmly rooted, and merges
with his humanistic/body centred theoretical orientation. This merging is also evident
in his discourse about his distinctive treatment practice with self-injuring clients.

He admits that his therapeutic approach is:

fairly structured and directive because I'm holding in mind (lines 1302-1304,
part 2) whatever builds individual's stories (line1303, part 2) we're
considering these physiological responses (lines 1301-1305, part 2) we're
drawing attention to (line 1307) the structure of the nervous system and its
responses (lines 1307-1309, part 2) and it's also directive because (line 1309,
part 2) if you leave someone to their own devices they're going to self-harm
(lines 1310-1311, part 2)

Thus, Mark's treatment practice is highly influenced by his views of how
these physiological responses around self-injury are organised. This is evident in his
description of how he works with the patient's gesture of cutting.

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Mark describes a number of stages to his treatment practice. He informs me that he initially begins with a psycho-education framework that he explains to his self-injuring clients. He appears to use two, namely an addiction framework and the modulation model (see Appendix I). These theoretical orientation models are central to his construction of self-injury and he uses them as a first stage in his treatment approach. He states:

> if someone self-harms I tend to start with addiction first (lines 632-633, part 1) rather than jump right in there just to give them an outside reference (line 635-636, part 2) I think it's a softer landing (line 637, part 1) just to explain (line 638, part 1) what people can do with different drugs legal or illegal (lines 639-640, part 1) to manage these symptoms (line 640, part 1)

The next step involves the introduction of the modulation model and linking it to behaviours. He tells me:

> I'll talk about different behaviours and I'll keep those fairly neutral (lines 649-650, part 1) So I say (line 651, part 2) some people on the high end that's where they leave the house and go off walking for six miles (lines 651-653, part 1) Or they go off running (line 655, part 1)

Mark explains that the rationale behind this psycho-education framework is to "introduce the idea of a range of things that people do with a common theme of" (lines 656-657, part 1) "trying to stay within this window" (line 657-658, part 1) of tolerance. He then speaks to his patients about "self-harming or injurious behaviours as being" (line 659, part 1) "just being a natural continuum of that" (line 660, part 1) and "this is a way to" (line 667, part 1) "help calm this down" (line 667, part 1).

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Referring to the modulation chart, he argues: "where you see either the high end or low end of that as discomforts we do our best to stay away from that level of discomfort" (lines 615-618, part 1). He explains, "there's things we do at the high end there's things we do at low end" (lines 618-619, part 2). He informs me that at this point in his conversation with his self-injuring clients, he introduces the concept of "aspects of trauma response that are designed to maintain our integrity" (lines 620-622, part 1). He elaborates:

> So you can say here's what we do in the face of threat when discomfort going this high or this low (lines 624-625, part 1) and then what we do consciously or unconsciously you're trying to manage these symptoms (lines 630-631, part 1)

Having outlined the modulation model to patients, Mark continues, "And then it's not a big jump from there to discussing" (lines 609-610, part 1) "our body is is predicated on trying to stay within this almost" (lines 610-611, part 1) "kind of homeostatic range" (line 613, part 1).

He asserts that the client's activation "is set in motion through thinking feeling and through the body and off it goes and off it runs" (lines 975-977, part 1). He proposes, "you're looking where do you intervene" (lines 983-984, part 1). Mark maintains that with self-injury "there had to be a period of lead-in" (line 309, part 2). He explains that he explores this with his patients. He instructs them to "turn their attention to the lead-in" (line 327, part 2) to "become aware of their activation" (line 315, part 2). He informs me, "that enabled" (line 329, part 2) the client to "start to pick up the earlier warning signs that they were on their way" (lines 330-331, part 2) to self-injure. He says, it "allowed them to head things off at the pass" (line 332, part

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2) "It became an option of what else can I do with this charge before it rises up to a point where you know our our initial sessions were about cut or not cutting" (lines 334-337, part 2). In this first stage of Mark's work, he attempts to simply decrease the frequency of self-injury.

The next stage Mark outlines as "you're looking at the impulse formation" (lines 1002-1003, part 1) "you're looking at a point where there's activation" (lines 991-1008, part 1) "Then you organise around that and you've a whole series of impulses" (lines 1010-1011, part 2). He cautions, "You can't really look at impulse until they decrease their behaviour" (lines 1003-1004, part 1). Thus, he is arguing that as the clinician you cannot work with the impulse, the precision of the gesture of cutting until the patient has first managed to decrease their frequency and level of self-injury. Once this has been achieved Mark moves on to the next stage of his treatment practice.

This subsequent stage resolves around focusing on the "very specific" (line 14, part 2) "physical gesture" (line 13, part 2) of the cutting action "the speed" (line 15, part 2) the "depth" (line 20, part 2) and "the precision" (lines 24-25, part 2) of it. Mark frames this approach as:

> I'd look at it from a body-centred viewpoint is now the wisdom is in the precision (lines 23-25, part 2) let's look at the precision in this action and help it so I'm going to hold that it's part of that that's generating the relief the speed the precision not just the uh piercing of the skin (lines 29-32, part 2)

So he asks his client to show him precisely his/her cutting gesture with their hand without any instrument that could be used to make an incision in the skin. The next stage in his approach is:

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to take that precision of gesture in its speed and in the kind of line that it made and simply orient it away from the body (lines 80-82, part 2) because this gesture was associated to cutting (lines 84-85, part 2)

He then suggests to his patients that when their activation levels (i.e. hyper-arousal and hypo-arousal, see Modulation Chart, Appendix I) "got to peak of activation where they were going to self-harm that they consider making this gesture but in a way that was away from the body" (lines 95-97, part 2). He also suggests that, "if they felt that they needed pressure with it with skin was that they used a blunt rather than a sharp instrument and just have a pressure effect" (lines 101-103, part 2). Speaking about a particular patient, Mark reveals:

With this person by making the same gesture with the same speed and the same precision except not into the body they're able to begin to divert the gesture"(lines 104-107, part 2) "they could get enough satisfaction from that to buy themselves some time um with with the activation (lines 109-110, part 2)

He acknowledges that, "it wasn't as satisfying as you know as cutting themselves but it did have an effect" (lines 113-114, part 2). However, he states that as the therapist you are "looking for a match round the movement" (line 121, part 2). It is this unique and idiosyncratic way of working with the physical gesture of cutting that distinguishes Mark's discursive treatment approach from the other clinicians.

To summarise, Mark has a distinct model for understanding and treating self-injury. He holds the view that "there's a kernel of wisdom" (line 393, part 1) in self-injury. He conceptualises self-injury as "a continuum from a build-up of an impulse" (lines 363-364, part 1) and that individuals use it as a way of modulating their physiological arousal levels. Mark's treatment practice is very specific in its focus on

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"impulse formation" (line 1003, part 1) and the "physical gesture" (line 13, part 2) of the cutting action.

Although, Mark began with a humanistic-body-centred orientation to practice and then mapped it onto self-injury in a unique and innovative way, his discourse shows a similar merging pattern to the other clinicians in which his conceptual orientation to treatment and his conceptualisation of self-injury merge.

Eimear is a clinical psychologist who employs a dialectical behaviour therapy (DBT) approach to working with self-injuring clients. Referring to DBT, she admits, "as soon as I started to see in self-injury I started to look for evidence" (lines 1484-1485) "based interventions and even before I had the training I had the book" (lines 1487-1488) and "It lead me to the dialectical behaviour therapy" (lines 418-419). Here Eimear is referring to Marsha Linehan's book, *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. Thus, she acknowledges that she began with self-injury and then went searching for a specific modality of treatment in relation to this behaviour. So when she discovered DBT it became her primary approach to treating self-injury.

Her construction of self-injury is firmly rooted in a dialectical behaviour therapy discourse that situates this behaviour within a psychological construction of borderline personality disorder. Eimear locates her understanding of self-injury within a psychopathological discourse that places self-injury within "a diagnosis of conflicts post-traumatic stress disorder or borderline personality disorder" (lines 600-601). She holds the view that "people who self-injure and who do not have underlying psychopathology are rare" (lines 2219-2220). She constructs self-injury "as a maladaptive coping style that somehow individuals who have experienced a lot

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of trauma have learned that this is a way of self-soothing" (lines 132-134). She proposes that self-injuring clients have a "skills deficit" (lines 150-151) and "That under pressure they would experience more intense emotions that they seem to be unable to cope with and seem to be unable to modulate" (lines 146-148). She elaborates:

> They do seem to be more sensitive than other people and when they get upset they get more upset and it takes them longer to settle" (lines 141-143) "So I'd say they've a skills deficit" (lines 150-151) "in terms of managing distress and managing emotions (lines 153-154)

Eimear argues that self-injuring patients are "sensitive humans in invalidating environments where their needs have not been met" (lines 155-257) "Or have not been adequately met" (line 259). She explains, "needs" as "Emotional" (line 262) "Physical safety and protection those kind" (line 264). She consistently and repeatedly uses DBT language in her narrative such as "skills deficit" and "invalidating environment".

Eimear constructs the central discourse of her treatment model within that of dialectical behaviour therapy. She describes this approach as a combination of individual therapy and group skills building. She explains, "My style of working would be with the individual" (lines 555-556). Thus, she provides individual therapy sessions with self-injuring clients while one of her colleagues provides the group skills building which "is very much psycho-educational format" (line 564). She informs me that the individual therapy sessions and the group skills building occur in "parallel" (lines 577-578). She also tells me that for "out of hours in times of crisis" (line 1034) "There's always somebody on call" (line 1027) to respond to self-injuring

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patients. This team-based provision of an out-of-hours service, individual and group sessions are consistent with a DBT modality of treatment.

She articulates a very structured approach to working with self-injuring patients in terms of both the length of treatment and the therapy session itself. Eimear outlines this approach as "my own personal thoughts is that you're probably talking about you know maybe a four-year commitment to therapy" (lines 607-609). She provides the following description of this four-year treatment model:

> the skill building is very structured (line 629) It would it would probably be structured in the sense that you know I would literally look at what the difficulties are whether it's a skills deficit trauma life goals self-esteem and work towards that but in a flexible sort of way (lines 623-627) That you'd be talking about a year of skill building (lines 612-613) Then maybe a year of working on uh self-esteem goal setting and then trauma if somebody has a history of abuse that needs to be addressed and they're prepared to work on it you'd be talking maybe another two years (lines 615-619)

Thus, in her discourse she alludes to, and skirts around the complexities of trauma treatment, as if it were self-evident that it would take "maybe another two-years" (lines 618-619) of therapy sessions and that the client's trauma would be addressed in the latter two years of a four-year treatment programme. Her discourse about this particular approach to trauma treatment is spoken as a generalised view, as if this is a well-established and accepted practice of treating trauma.

Eimear also describes a structure that she adheres to within therapy sessions with self-injuring patients. She informs me that she sees these clients on a weekly

basis for an hourly appointment "If it is goal setting and self-esteem" (line 1183). However, she explains:

> If you're working on something like um trauma sexual abuse you'd be talking about an hour and a half (lines 1184-1186) so that would be a half an hour to get somebody comfortable (lines 1188-1189) Half an hour to work on it and half an hour to seal things over until the next time (lines 1191-1193)

She also acknowledges that when assessing risk she uses, "a particular um assessment protocol that was developed by Marsha Linehan uh as part of a dialectical behaviour therapy" (lines 221-223).

To summarise, Eimear's discourse suggests that her conceptualisation and treatment of self-injury merges completely with dialectical behaviour therapy. She seems to accept every aspect of this modality unquestioningly. Indeed, she takes every opportunity in her narrative to promote this treatment approach and tried to persuade me of its effectiveness. She is so convinced that this is the definitive way to work with self-injuring patients, that at no point in her discourse does she consider other possible modalities of treating self-injury.

Sources of Knowledge

I turn now to a discussion of the findings that pertain to the question, "What sources of knowledge including both personal experience and professional training, have influenced/shaped the development of clinicians' explanation(s) of treating self-injuring clients?" An interesting revelation emerged among the eight clinicians' narratives in this study in relation to this question. The clinicians make sparse references to conferences, academic readings and workshops on the topic of self-

injury. Indeed, there are surprisingly few references among the clinicians' discourses in which they made deliberate attempts to learn or seek information about self-injury and how to treat it. In fact, their discourses on this issue support my earlier finding that their model/techniques for understanding and treating self-injury are not distinctive from their primary training/orientation to treatment. Jack, Mike, Sinead and Eimear explicitly name their treatment training as a basis for information about how to work with self-injuring patients. For example, Jack states, "psychoanalytic theory" (line 758) especially "Freudian, Lacanian" (line 2128). Of the range of these clinicians' treatment modalities, only Mark and Eimear's approaches provided a particular and distinctive conceptual framework for understanding and working with self-injury.

All of the clinicians list a number of multiple sources from which they acquire their knowledge of self-injury and how to work with self-injuring clients. On the phenomenon of self-injury, Niamh, Jack and Mike acknowledge their patients as fountains of knowledge. Niamh reveals, "where I got most of my information about self-injury is from clients" (lines 483-484) "They're the greatest" (line 486) "educators" (line 488). Jack admits that he acquires information "through practice working with with individuals who speak in this way about uh their experiences" (lines 762-764). Mike informs me, "it's the clients who teach you loads of stuff" (lines 1879-1880). Thus, they appear to rely on their clinical practice with self-injuring patients for comprehending and treating self-injury.

Niamh and David are the only clinicians who make any reference to personal experiences of engaging in self-injury. For instance, Niamh admits that her "own self-harming impulses" (line 491) was another element of information. However, she

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qualifies this statement with, "I wouldn't be in the traditional self-harming modes" (line 492). She does not elaborate further on what these modes of hers are. David's disclosure of his own self-injury surfaces in response to a discussion about one of his cases. He admits, "It is quite anxiety provoking though when you're about to usher somebody out of hospital as they're escalating in self-harm" (lines 245-247, part 2). He explains, "of course you'll find yourself getting irritated frustrated" (lines 272-273) when such a client "is under considerably heightened distress or stress I should say and she needs support" (lines 251-252) "at the moment and assistance in this transition rather than um like a sense of of doom and and failure being conveyed to her" (lines 255-257) by the hospital staff "but the end one has to contain that anxiety within oneself and also contain staff's anxiety" (lines 257-259). I enquire how he contains his anxiety and he humorously laughs as he confesses, "I do my own self-harming behaviour I go off I have a cup of coffee ((laughter)) I have a smoke I have a ventilation and then I go back" (lines 277-279). Thus, one could argue David's discourse is similar to Niamh's with regard to engaging in the non-traditional modes of self-injury. Although David's version of "self-harming" is not cutting, his use of the term however, connects him to his patients.

Training is the most frequently cited source by seven clinicians, Eimear, Jack, Mike Mark, David, Sinead and Ciara. However, this reference to training is not specific to self-injury; it relates to training in their own particular treatment modality. Sinead and Ciara's response captures the thread of some of the clinicians' general and non-specific discourses about accessing multiple sources of information alongside an absence of direct references to self-injury conferences, workshops and specific treatment books. Sinead reveals:

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The most consistent one being as I say my own constructivist systemic framework plus (lines 287-288, part 2) attachment theory (line 289, part 2) and then what you pick up along the way is useful ideas from colleagues (lines 289-290, part 2) or even the internet (line 292, part 2) actually a student giving me a printout of a list of things to do to distract from harming yourself (lines 293-294, part 2) so (line 297, part 2) you come across tools (lines 297-298, part 2) from a variety of different sources (lines 298-299, part 2)

Ciara mentions:

I think you (line 1530, part1) utilise aspects of various forms of treatment that that you can administer given the setting that you're in (lines 1531-1533, part 1) like reading about DBT knowing what the basis of DBT reading about CBT knowing what the basis of it is (lines 1533-1535, part 1) and then trying to incorporate aspects of everything into your patient is the way I work (lines 298-200, part 1)

A reference to Marsha Linehan's work emerges in three (Eimear, David and Ciara) of the clinicians' discourses. Eimear and Ciara inform me that they have read her book. David attended a DBT workshop facilitated by one of Linehan's colleagues. Eimear is the only clinician who has had specific training in DBT. She refers to three books on self-injury in her narrative. She names, "A Bright Red Scream" (line 362) by its title but did not mention the author, Marilee Strong. She provides the full reference for "The Scarred Soul by Tracy Alderman" (lines 479-480). The third and final book she omits the title and refers to it by the author "Marsha Linehan" (line 1506) and informs me that it was "published in '93" (line 1509).

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In this section, I examined the clinicians' discourses in relation to their sources of knowledge that influence the development of their explanation(s) of their treatment of self-injuring patients. The clinicians articulate a number of sources of knowledge about self-injury and how to treat it, such as their clients, their training in their own specific treatment approach and Marsha Linehan's DBT treatment modality. Despite this naming of multiple sources, there is an absence in the clinicians' narratives of references to conferences, academic readings, workshops and a lack of deliberate efforts to seek information about self-injury and how to treat it.

Missing discourses. There is an absence of research and publications in the literature in relation to self-injury and its treatment in the Irish context in comparison to other countries such as the USA, Canada, Australia and the UK (Keane, 1997). As a result of this, it is highly likely that Irish clinicians are not being exposed to current research on the phenomenon of self-injury in their initial training, as well as at their professional conferences and continuing professional development days.

In addition, the lack of direct citations to self-injury workshops, seminars and training among the clinicians' discourses may be due to the scarce availability and difficulty accessing such modes of learning in the Irish context. For example, only the clinicians who had worked or currently work in the psychiatric services mention DBT and had some training exposure to this form of treatment. As a clinician and researcher in the field of self-injury for over a decade, I have only come across one lecture and one workshop on the topic of self-injury, namely Professor Annie G. Rogers' "Understanding Self-Injury with Girls and Women: A New Clinical Approach" at TCD, on the 29th of January, 1998 and Dr. Kay Inckle's "Understanding and Responding to Self-Injury" in Dublin, 4th of January, 2010. Another factor may

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be due to limited advertising of such training events. For instance, I only discovered recently that Dr. Inckle runs a certificate training course, "Understanding and Working with Self-Injury: A Harm Reduction Approach" in Ireland. In addition, the first conference on self-injury in Ireland took place on the 2nd of March 2009. I did not see any advertisement of this conference prior to the event. The first reference I came across was a brief report in the Irish Times, 3rd of March 2009 announcing that it had taken place.

However, this same argument cannot account for the omission in the clinicians' discourses of the numerous texts on the subject of self-injury and its treatment that are available in Dublin bookshops and from various internet book suppliers. Their discourses would seem to suggest that they do not actively engage in self-directed learning activities in terms of searching for direct sources of information and knowledge in the form of books or journal articles on the subject of self-injury.

A further striking finding in this study in relation to the clinicians' narratives about self-injury is the missing discourses that pertain to the aetiology of self-injury. Considering the numerous references in the literature emphasising the link between childhood trauma (especially sexual abuse) and self-injury, it is astounding that only three clinicians (Eimear, Niamh and Mark) briefly mention trauma in their discourse about self-injury. However, they do not engage in a discourse of elaboration on this beyond making the initial connection.

Early childhood experiences of individuals who self-injure in relation to illness, injury and early hospitalisation were completely absent from all eight clinicians' discourses. A further omission is the early loss of a parent through death or separation as a key antecedent to self-injury (Arnold, 1995; Friedman, Glasser,

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Laufer, Laufer, & Whol, 1972; Walsh & Rosen, 1988). References to the familial environments that self-injurers grow up in were not mentioned by the clinicians other than a brief reference by Eimear to "invalidating environments where their needs have not been met" (lines 256-257). Again, this is surprising when one takes account of the various research studies emphasising that those who self-injure are more likely to come from families characterised by parental alcoholism or depression (Walsh & Rosen, 1988), divorce, neglect, parental deprivation (Arnold, 1995; Carroll, Schaffer, Spensley, & Abramowitz, 1980; Friedman et al., 1972; Graff & Mallin, 1967; Grunebaum & Klerman, 1967; Leibenluft, Gardner, & Cowdy, 1987; Pattison & Kahan, 1983; Rosen, Walsh, & Rode, 1990; Simpson, 1976; Simpson & Porter, 1981), emotional distancing through inconsistent parental warmth or the expression of anger being severely restricted (Podvoll, 1969).

While it appears that both men and women engage in self-injury, a lot of the literature leans toward considering self-injury as a gendered phenomenon. This is another missing discourse in the clinicians' discourses other than Ciara's argument that:

> I'd say it's possibly a lot more common in men that we actually believe it to be or know it to be um and I think it probably takes more subtle forms in men or in males so it's not necessarily cutting or overdosing but but could be much more in the sense of kicking the wall or banging their head sore or um being physically aggressive toward themselves (lines 343-349)

Chapter Summary

In this chapter, I explored the clinicians' discourses and provided extracts from their interview transcripts with respect to the research questions, "What

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conceptual frameworks do clinicians draw on to understand self-injury and their current treatment practice with self-injuring patients?" and "What sources of knowledge, including both personal experience and professional training, have influenced/shaped the development of clinicians' explanation(s) or working model(s) of treating self-injuring clients?"

To summarise: the findings of the research question that pertains to the examination of the conceptual frameworks that the clinicians draw on to understand and treat self-injury, demonstrates that all eight clinicians exhibit a range of treatment approaches to working with self-injuring patients. These include dialectical behaviour, narrative, constructivist, humanistic/body centred, Freudian/Lacanian psychoanalysis, a mixture of pharmacological, psychodynamic/cognitive behaviour/dialectical behaviour and a combination of pharmacological, cognitive behaviour and dialectical behaviour therapeutic modalities. In addition, these clinicians come from a variety of mental health professions including psychiatry, psychology, psychoanalysis and psychotherapy. For the majority of the clinicians, no distinct models for considering self-injury and approaches for working with self-injuring clients emerge, despite the range of therapeutic models across the group of clinicians. However, there are two exceptions to this pattern, namely Eimear and Mark. The other clinicians' (Niamh, Jack, Sinead, Mike, Ciara and David's) models and techniques in relation to self-injury do not seem to be distinct from their primary training model/orientation to treatment. In fact, their discourses appear to merge primary training with treatment of self-injury. This merging of clinicians' conceptual orientations to treatment and their understanding of self-injury tend to be driven for some by their theoretical training or a belief system, and for others by their practical training. Jack, Mike and Sinead's discourses suggest that their treatment approach

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and their conceptualisation of self-injury are significantly influenced by the particular theoretical modality in which they were trained. Niamh is the only clinician whose merging of her conceptual orientation to treatment and her construction of self-injury is influenced by her strong beliefs. In contrast, David's and Ciara's merging patterns tend to be driven by their clinical training.

Mark and Eimear both have a distinctive model for understanding and working with self-injury. Thus, in this respect they deviate from the general pattern of the other six clinicians who do not seem to have distinct models for considering self-injury and approaches for working with self-injuring patients. Despite having marked frameworks for conceptualising and treating self-injury, Mark's and Eimear's discourses show a merging pattern. What is striking is that their style of merging differs from each other. In Mark's case, he began with a humanistic body centred model of treatment and invented an innovative way of mapping it onto self-injury. In contrast, Eimear clearly began with a specific treatment model, dialectical behaviour therapy; a form of therapy that was developed to treat individuals with BPD who engage in self-injury. Thus, self-injury is already mapped onto this modality of treatment.

I concluded this chapter with a summary of my discussion of the findings in relation to the sources of knowledge that have influenced the development of the clinicians' explanations of their treatment of self-injuring patients. It seems that despite the fact that all of the clinicians name multiple sources from which they gather information on self-injury and how to treat self-injuring clients, they make few remarks about conferences, academic readings and workshops on the phenomenon of self-injury in their narratives. Indeed, their discourses suggest that they do not engage

in deliberate activities to inform themselves about self-injury and how to treat it beyond their clinical practice and their primary training orientation or perhaps it is due to the lack or availability of same.

Chapter Five

Findings: Using Discourse Communities

In the current chapter, I consider the clinicians' discourses with respect to the research question, "What conceptual frameworks do clinicians draw on to understand self-injury and their current treatment practice with self-injuring patients?" What emerges is an interesting pattern across the clinicians' narratives. They do not speak in terms of theoretical or conceptual models; rather, they tend to create discourse communities of "an other" to formulate their beliefs about self-injury and its treatment rather than simply articulating particular theoretical or conceptual models. I use the term "discourse communities" to refer to the imaginary communities that the clinicians construct and appear to address through me as the interviewer, or an imaginary "other" beyond me.

The clinicians' constructions of imaginary "other" discourse communities in their narratives to formulate their beliefs about self-injury and its treatment reflect and emphasise the divergences among and between their various approaches and disciplines of psychotherapy, psychoanalysis, psychology and psychiatry. For example, two clinicians from the same discipline drew on diverging discourse communities. David, a consultant psychiatrist, creates a discourse of opposition and constructs himself as not conforming to the traditional view of psychiatry. Ciara who is also a consultant psychiatrist, but, unlike David, her discursive clinical language suggests that she conforms to the professional image of a psychiatrist in that she thinks diagnostically about her patients' symptoms, reflects on what to do, uses different techniques such as distraction and mood logs and likes to work as part of a multi-disciplinary team. Thus, she creates a psychiatric community discourse of

verification to support her views and her particular approach to working with self-injuring clients.

The following extract is an example of how Ciara thinks diagnostically about self-injuring patients and her use of "pharmacological interventions" (line 601, part 1).

Extract 3

Line 587-619, part 1   C: (4) .hh And um you know there are significant I feel there's a significant number of people with self-injurious behaviour that that that <u>aren't</u> actually affectively uh (1) driven in the sense that they've a form of depression or a form of manic and mixed mood episode or that are .hh you know (1) necessarily psychotic or .hh fulfil the diagnostic criteria for an anxiety disorder .hh (1) um they're probably more along not all of them but certainly some people would be more along an Axis II diagnosis diagnostic spectrum .hh and and again I think it's important to try .hh (1) and try and establish [that] .hh

I: [Mm–hmm]

C: Because there are certain you know pharmacological interventions that will reduce self-injurious behaviour if (2) you know if if (2) it's Axis I driven.

I: Okay and what sort of medication [would that be]

C: [Well antidepressants] if somebody's depressed and they're self-injuring because they're feeling futile or somebody's extremely anxious and they can't

I: [Mm–hmm]

C: [Neutralise] their anxiety .hh you could use you know an anziolytic in the sense of an SSRI or you could use short-term benzazepine or whatever whatever but um

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I: [Mm–hmm]

C: .hh [But there's] a significant proportion of people who
        wouldn't respond to medication because their primary
        diagnosis is not Axis I and um (1) and I think you can
        give a harmful message that medication will resolve this
        hh when it's when it's when it's clearly not Axis I um
        driven hh

In Extract 3, Ciara's discursive clinical language reflects how she conceptualises self-injuring patients in diagnostic terms. Her use of psychiatric terms such as "affectively" (line 589, part 1), "depression" (line 590, part 1), "manic and mixed mood episode" (line 591, part 1), "psychotic or fulfil the diagnostic criteria for an anxiety disorder" (lines 592-593, part 1), "Axis II diagnosis, diagnostic spectrum" (lines 596-597, part 1), "pharmacological interventions" (line 601, part 1), "Axis I" (line 602, part 1), "antidepressants" (line 605, part 1), "anxiety" (line 609,part 1); "anziolytic" (line 610, part 1), "SRRI" (line 610 , part 1) and "benzazepine" (line 611, part 1) illustrates this.

Two Distinct Discourse Communities

Two distinct discourse patterns emerge from the clinicians' narratives, "Discourse Communities of Opposition" and "Discourse Communities of Verification". Clinicians who construct discourse communities of opposition position themselves as having particular styles of treatment that are different or in some instances, antithetical to the imaginary "other" community. In contrast, they use discourse communities of verification to verify, authorise and legitimise their particular approach. In terms of a global pattern across the clinicians, what is striking is that they all refer to discourse communities. However, for four of the eight

clinicians, namely Ciara, David, Sinead and Mike, this pattern of creating discourse communities only emerges as a momentary or transitory reference, and is not sustained throughout their narratives. For example, Ciara engages in a discursive pattern where she appears to shift from addressing a visible audience such as myself as the researcher to a position from which she seems to be speaking to an imaginary client. In the following Extract 4, Ciara constructs a discourse community of an "other", an imaginary patient, as a way of validating and verifying her treatment approach with self-injuring clients.

Extract 4

Lines 789-812, part 1   C: .hh Um so I try to get you know (2) patients to manage their medication to be responsible for their medication to um (3) to be responsible for making their appointments and those sort of things rather than have it very much uh .hh hand them out I ( ) and say to people when would you like to come again and and I think that can be very helpful because .hh um (2) it gives a sense it gives me a sense of where they feel they're at if they say well I don't need to come back for three months um that can say they can confirm how I feel they're doing but if they say I need to come back in three days then we kind of fell three months hh well that's then that's kind of incongruous [so]

   I: [Mm–hmm]

   C: .hh Um that can be quite helpful <u>clinically</u> to to get a sense of what level of support they need so I really try to hand a lot .hh lot of decision making back to the individual and (1) and responsibility for mood ties and mood logs and if somebody is keeping one it's you know I my <u>general</u> approach is that they bring it to me

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as opposed to I ask them for it that's just the approach
that I use

In contrast, Niamh, Jack, Mark and Eimear's narratives are rich with
constructions of discourse communities that appear as a recurring, persistent and
pervasive style. I discuss these patterns in more detail using extracts from David,
Niamh and Mark's narratives as exemplars of discourse communities of opposition
and verification respectively. It is intriguing how David, Niamh and Mark all engage
in the same pattern of producing discourse communities, yet, they do not do the same
thing with their discourses. I now address their discursive differences in the ensuing
paragraphs.

Discourse community of opposition. I begin with David's pattern of creating
a discourse of opposition. His style of using discourse communities momentarily in
his narrative to articulate his beliefs about self-injury and his treatment approach is
typical of Ciara, Sinead and Mike's narratives. However, David is atypical among
these four clinicians in that he constructs discourse communities of opposition, while
they use discourse communities of verification. He employs this style as a way of
emphasising how his particular treatment approach contrasts with that of traditional
psychiatry. For instance, he constructs himself as not adhering to a medical model
and speaking back to that community of practitioners. Referring to his patients he
confesses, "I don't think in terms of them being disease entities or disorder entities or
anything like that those models are very useful in terms of having structure and
having resistancy and adhering to what is known to be helpful etc etc but not if they
become a label" (lines 973-978, part 2) "That's a disaster" (line 980, part 2).

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In keeping with this oppositional discourse, there are moments in David's narrative where he appears to disagree with his medical colleagues. For instance, he tells me about his colleagues' reaction to his disclosure that he gives his mobile number to his clients. He reveals, "all of my patients have my mobile phone number" (lines 938-939, part 3). He admits, a lot of colleagues will say, "Oh my God I don't believe they have your mobile phone number sure you're hostage uh people will always be calling you" (lines 942-945, part 3). In contrast to this belief of his colleagues', David acknowledges that his clients "tend not to abuse it" (lines 954-955, part 3) and "there are times when you wish they had" (line 957, part 3).

Indeed, at times he almost speaks against his own discipline of psychiatry in the language he uses. Speaking about his disagreement with the diagnoses that his self-injuring clients have received, he states:

> and then there's always (line 155, part 1) a few who perhaps have somatised their distress and (lines 155-156, part 1) will have presented through the medical services perhaps for a number of years and received a whole raft of physical diagnoses which in retrospect may have been quite dubious (lines 156-159, part 1) when it would be clear when you'd finally get to see them that the problems are emotionally and psychologically based (lines 161-163, part 1)

Similarly to David, Niamh creates a discourse community of opposition in her narrative. However, Niamh deviates from David's occasional pattern in that her discourse of opposition was a consistent and repeating pattern. Early in her narrative, she sets up this discourse of opposition when she constructs herself within a discourse community that is oppositional to a cognitive behavioural approach to working with

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self-injuring patients. She acknowledges that her clients "tend to focus on" (line 669) self-injury "an awful lot more than I do" (line 669) in her particular model of therapy. From her perspective she argues, "So it's not about the behaviours in itself" (line 678) "I mean that's much more cognitive behavioural approach" (lines 683-684). Thus, she positions herself as having a contrasting style to CBT and as not necessarily in agreement with this focus on the behavioural aspects of self-injury as she admits, "I wouldn't be really going for that" (line 687).

In the following extract, Niamh sets up another discourse community of opposition when she speaks of her humanistic orientation to therapy as being perceived as "now very eh very eh untrendy or it mightn't be the latest" (line 1378).

Extract 5

Lines 1373-1415   I: Okay em are there what models or ideas <u>guide</u> you in your work with again self-injuring clients

    C: (5) I think we've been here before ((laughing))

    I: ((Laughing)) ( ) Yes

    C: ↑↓ Yeah and I know you know humanistic might be now (4) very very eh (2) untrendy or it mightn't be the latest but (.hh) I do <u>believe</u> that people I do believe in people's [<u>capacity</u>] to <u>heal</u>

    I: [Mm–hmm]

    C: From <u>anything</u> <u>virtually</u>

    I: Mm–hmm

    C: And eh (.2) <u>through</u> their <u>capacity</u> to <u>relate</u> you know

    I: Mm–hmm

    C: (2) Is that a model ((laughing)) well it's

    I: Yeah

    C: It's a core humanistic belief really

    I: Uh-huh

C: And I suppose in the sort (3) of useful constructs <u>you know</u> that some of the sensory motor <u>maps</u> you know

I: Are there any [maps in particular]

C: [somewhere there in] the background you know

I: Mm–hmm are there any [maps in particular you find] helpful

C: [I suppose the modulation] model you know the the first and favourite and you know

I: Mm–hmm

C: But I suppose more so now it's the whole (2) again much more humanistic elements it's only recently that there I think (4) you know (2) describing it as the core of how they see people is d'you know I don't know if you're aware of that map where they show the authentic self

I: Mm–hmm

C (2) And you know (2) then traumatic histories and then the the the the (2) top level of you know personality and coping styles and all that

I Uh–huh

C And I think that's very useful for people to see who <u>feel</u> that all they are all that they know themselves to be is pain and you know .hh em

Niamh initially responds with humour, to my question about models and ideas that guide her work. However, her reply is also a show of resistance, as she reminds me that as far as she is concerned we have covered this ground earlier when I asked her about the models and frameworks she draws on to understand self-injuring patients. As I discussed previously in Chapter Four, she acknowledges, "I don't tend" (line 429) to "think of people in terms of frameworks" (line 431). She speaks about

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the idea that her particular humanistic conceptual orientation to treatment has gone out of fashion and therefore, is not a popular framework from which to work. In this way, albeit with humour, she situates her practice outside of what she perceives as the more common discourse community of clinicians.

The strongest discourse community of opposition surfaces in relation to Niamh's opinions about the psychiatric profession's response to patients who self-injure. In fact, she constructs her subject position as anti-psychiatry and bases her opinions on the narratives of her self-injuring clients' reports of their experiences of the Irish psychiatric services. Her discourse seems highly critical of the psychiatric profession's response to patients who self-injure as illustrated in Extract 6 below.

Extract 6

Lines 1004-1017   I: Okay (2) em do you work with self-injuring clients that have a psychiatric history or psychiatric diagnoses
                                                          C: °Yes yes°
                                                          I: Okay mm-hmm em
                                                          C: (2) Because I don't think psychiatry works with it
                                                          I: Okay
                                                          C: In an effective way at all it's very very .hh hhhhh ah they see self-harming clients in psychiatric terms as looking attention seeking and they have <u>very very</u> negative you know <u>attitudes</u> to self-harm in psychiatric settings I have found anyway

She is very explicit in the strong emotional language she uses to express her disapproval of the treatment individuals who self-injure receive in psychiatric hospitals. Niamh articulates this as follows:

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I have a lot of disdain for the way the people who engage in self-injury are
treated in psychiatric hospitals (lines 1602-1604) yeah it certainly adds to a
person's you know level of distress to have that meeted out that sort of
treatment (lines 1606-1608) And it makes it much harder for people to be open
about it and harder then for people to be open about it and to you know it puts
another level layer in the way really that people have been treated like that in
psychiatric hospital cause they internalise then some of them hospitals
treatment yeah of themselves (lines 1611-1616)

Niamh continues with her discourse of opposition, as she speaks about the
impact on patients of having been in the psychiatric system. She informs me that,
"clients who have been caught up in the psychiatric" (lines 1812-1813) "services"
(line 1814) "they no longer believe in the possibility of you know of of really living"
(lines 1814-1816). She elaborates on this discourse explaining:

the people I would see as lost and have haven't the capacity to get something
out of counselling are people who have been fairly long term involved in
psychiatric services either because early on you know they needed help that
they didn't get (lines 1852-1854) and that they now are dissociated you know
they have that structured dissociation inside themselves but they have the
dissociation because of the level of medication as well (lines 1861-1864)

In addressing me as the interviewer, Niamh also engages in this discursive
pattern of opposition as she positions herself as strongly resisting my discourse. She
establishes this style of engagement with me early in our conversation and repeats it
throughout her narrative. Her discourse of opposition to mine emerges in the initial
moments of our dialogue when she resists the categories I offer her. For instance, she

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rejects the notion of classification of self-injury into mild, moderate and severe. When I ask if she would use such terms as "mild" or "moderate" to describe clients' level of self-injury, she replies, "You see this is why I'm not great on these sort of things because I don't tend to even in my mind quantify" (lines 187-189). Thus, Niamh rejects the idea of classification with her language and emphasises this repeatedly with the following utterances, "I don't" (line 218) "I don't really" (line 220) "Because I don't tend to classify" (line 222) "But in actual practice I don't" (line 230). She also resists the idea of frameworks as a way to help the clinician understand self-injuring clients. She responds, "I don't tend to think of people in terms of frameworks" (lines 429-431).

Niamh also opposes certain terms I use and perhaps, was aligning me to a particular discourse with which she is not in agreement with and therefore, contrasts with her own. When I enquire how often she sees self-injuring patients, she responds by challenging and disagreeing with my discursive term "self-injuring clients". She replies, "you see now again like the self-injury is the identification" (lines 1117-1118). Niamh may be interpreting my utterance as indicating a particular discourse, possibly behaviourist or psychiatric, to which she does not subscribe. Her discourse is person centred and she reads my use of the term self-injuring as labelling a client. She tells me, "there'd be clients that might have at one stage been so do I still call them self-injuring clients I would never call them self-injuring clients anyway" (lines 1139-1141).

She repeats this discourse of opposition pattern when I ask her about treatment success as Extract 7 illustrates, on the following page. Niamh rejects my discursive term "treatment" and informs me, "I mean people who engage in therapy are not

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being treated" (lines 1626-1627). It is possible that she associates the word

"treatment" with a medical discourse that implies a particular subject position for the

individual receiving treatment. Quested and Rudge (2002) proposed that, "A patient

is a person under medical treatment who is expected to endure the treatment, be

subservient and submissive to the dictates of medicine" (p. 556). This medical

discursive practice and subject position of the client is in opposition to Niamh's

relational, person centred discursive practice. It is highly probable that Niamh's

discourse of opposition concurs with that of Denham (2008) who cautioned against

positioning psychotherapy within a biomedical discourse. He contended that,

"Psychotherapy belongs as an adjunct to biomedicine, not within its borders" (Deham

2008, p. 59). Denham noted that:

> In misconceptualizing psychotherapy as *treatment* [sic] or *intervention* [sic]
>
> (Pawson, 2006), resources have been wasted in trying to prove that the
>
> effective component of psychotherapy (the treatment or intervention) can be
>
> discovered and separated from the psychotherapeutic relationship in much the
>
> same way that effective active ingredients of a new drug can be separated from
>
> the placebo effects. (p. 59)

Extract 7

Lines 1620-1637   I: Mm–hmm what would constitute a treatment
success with self-injuring clients

    C: (5) .hh Treatment success (9) .hhh <u>success</u> implies
failure as well ↑ doesn't it

    I: Yes.

    C: (13) .hh And treatment success I <u>mean</u> (3) .hh people
who engage in therapy are not being <u>treated</u>
like you know ((laughing))

I: Mm–hmm

C: They're actually (2) they're actually <u>learning</u> for themselves to (2) <u>recognise</u> and respect what's happened to them and the pain it's caused them and how to <u>tolerate</u> that and <u>share</u> it with you know other people

I: Mm–hmm

C: To actually be <u>able</u> to allow <u>themselves</u> to own it in the <u>presence</u> of other people you know

Niamh is certainly consistent in her discourse of opposition, and as one would expect, she rejects my concepts of success and failure in relation to treatment. She argues:

So I mean the word success the word failure doesn't actually I mean it's like you say to me is your life a success I don't know that my life's a success I'm doing the best to get by and to enjoy and fully live (lines 1642-1648) it's like that with a client too (line 1655)

To summarise, Niamh's pervasive discourse of opposition defines her position within her beliefs about self-injury and her humanistic orientation to therapy. Though, she positions herself as strongly resisting my discourse, her style of engagement with me in our conversation reflects her ease with me. This sense of her relaxation with me is evident in the moments where she draws me into her Irish wit and playfulness in her replies, even when she challenges my discourse. For instance, Niamh's humour surfaces when she confronts me about my use of the word "treatment", "I mean people who engage in therapy are not being treated like you know ((laughing))" (lines 1626-1628).

Discourse community of verification. In contrast to Niamh, Mark predominantly employs discourse communities of verification to support his particular therapeutic approach. This contrasting style is an interesting feature of their respective discursive positions, considering they both describe their individual treatment approaches as humanistic and body centred. Mark constructs several discourse communities namely, psychiatry, addiction, humanism and neuroscience. He draws especially upon a repeating neuroscience discourse to legitimise his unique application of merging humanistic and body-oriented psychotherapies to working with self-injuring clients.

Mark's neuroscience discourse is a dominant feature of his narrative. He establishes this discourse of verification in the initial stages of our interview and it is closely aligned with his conceptualisation of self-injury as previously outlined in Chapter Four. To briefly recapitulate on this point, he constructs self-injury as:

> a continuum from a build-up of an impulse in some way (lines 363-364, part 1) around uh a body sense going into you know behavioural elements or pre-impulse forms where people are starting to get uh the habitual form build-up and it's reflected into their thinking as well (lines 366-369, part 1)

Thus, one can hear the beginnings of a neuroscience discourse coming through in his articulation of his views and the terminology he employs such as "impulse" and "pre-impulse". He continues with this discourse when he speaks of the body trying to right itself through the action of self-injury. He states:

> So uh quite simply the body trying to right itself is trying to feel alive where it's dead so if it's numb and hypoaroused then it's trying to calm if it's

hyperaroused and that's it's trying to remain within its homeostatic settings (lines 665-669, part 2)

Mark employs what he refers to as "the basic pain pleasure principle" (lines 777-778, part 1) to support his argument here. He explains this as follows:

You take a single-cell organism it has two gears it goes towards things that are pleasurable and it backs off things that are painful and that's that basic relation to discomfort or comfort (lines 780-782, part 1) I am talking around the basic principle of of approach or avoid (lines 797-798, part 1)

He constructs his treatment approach as focusing on the "very specific" (line 14, part 2) "physical gesture" (line 13, part 2) of the cutting action "the speed" (line 15, part 2) the "depth" (line 20, part 2) and "the precision" (lines 24-25, part 2) of it. Mark frames this approach as:

I'd look at it from a body-centred viewpoint is now the wisdom is in the precision (lines 23-25, part 2) let's look at the precision in this action and help it so I'm going to hold that it's part of that that's generating the relief the speed the precision not just the uh piercing of the skin (lines 29-32, part 2)

So he asks his patient to show him precisely her cutting gesture with her hand without any instrument that could be used to make an incision in the skin. The next stage in his approach is:

to take that precision of gesture in its speed and in the kind of line that it made and simply orient it away from the body" (lines 80-82, part 2) because this gesture was associated to cutting (lines 84-85, part 2)

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In his explanation of how he works specifically with the gesture of cutting with self-injuring clients, Mark draws on specific terms such as "impulse to cut" (line 6, part 2), "activation" (line 92), "peak of activation" (line 90, part 2), "motor neurons" (line 124, part 2) and "brain" (line 128, part 2) in order to connect to a neuroscience discourse.

Interestingly, his unorthodox style of working with the patient's "gesture as if you were cutting" (lines 127-128, part 2) is not documented in the literature. Neither is it mentioned by any of the other clinicians in this study. I believe that Mark is aware of the absence of documented literature for his unique style of working with self-injuring patients. In light of this, I think he is trying to articulate an argument to legitimise his approach to himself, to me and to the wider therapeutic, scientific and medical communities as he responds to my questions. When working initially with self-injuring clients, he admits, "I didn't know motor neurons at the time" (lines 122-123, part 2). He follows this statement by launching into constructing a discourse community of verification, drawing on a neuroscience discourse to support his treatment approach. Mark argues that the "looking for a match round the movement" (line 121, part 2) "you could even see it in terms of motor neurons" (lines 123-124, part 2). He elaborates on this scientific discourse of verification as he explains:

> if you're taking the gesture as if you were cutting your brain will give you the kickback for that as if you are (lines 127-129, part 2) and so it'll be milder than the than actually doing it but you'll still get an effect as if you are doing it (lines 131-133, part 2) so it'll miss some local release but (line 135, part 2) it will kick off the same neurons (line 136-137, part 2)

He posits:

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I mean scientifically speaking you know so it's just a matter of uncoupling it

from some elements of the action (lines 139-141, part 2) so that um by not

doing the gesture you won't get that effect (lines 143-144, part 2)

In the following Extract 8, Mark elaborates further on the neuroscience

community's discourse about "motor neurons" (line 152, part 2) to validate or endorse

his particular treatment approach in relation to the gesture of cutting.

Extract 8

Lines 152-232, part 2   C: Well motor neurons are this is open to some debate in
terms of human um (1) importance but they're they're
they're a <u>class</u> of neuron that <u>span</u> sensory and <u>motor</u>
um ability .hh I'm not making them sound like much
but that makes them very <u>special</u> because most uh brain
cells are are either sensory or motor so they're all
sensory cortex or motor cortex so they're .hh uh either
you know so incoming information or outgoing
information so these span both so for example if you
were having a cup of <u>tea</u> in fact if we had you in a
sophisticated brain scanner and part of your brain lit up
that uh <u>corded</u> with having some tea right .hh it would
light up if you saw <u>me</u> drinking tea that same part of
your brain would light up and if you <u>imagine</u> drinking
tea the same part of your brain would light up .hh so um
you have and the only <u>difference</u> would be [intensity]

I: [Mm–hmm]

C: So when you <u>imagine</u> doing the thing it lights up a wee
bit when you see me do it it lights up more and when
you actually <u>do it</u> it lights up more .hh but the same area
lights up .hh ((cough)) and uh it also holds context and
intentions it's not simply uh that you had your hand in
this way it would be the <u>context</u> of drinking tea .hh and

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so uh emotionally (1) it'd be considered a neural basis for empathy so we get an <u>immediate</u> read in people's <u>emotional</u> state through uh .hh you know if their face goes into <u>disgust</u> then the part of my <u>brain</u> that registers disgust will light up and I know in a <u>felt</u> <u>sense</u> immediately what it is right .hh so um (1) so if I <u>bite</u> into a lemon <u>myself</u> I feel disgust not nice so if I see disgust in <u>your</u> <u>face</u>

I: Mm–hmm

C: It lights up and if I imagine <u>disgust</u> it lights up again yeah so it's why horror movies work you know the spiders crawling up the (.1) hero's arms or legs the tarantula and we go [Ugh]

I: [Yeah]

C: Right so uh we're uh <u>kicking</u> the football when the match is on and stuff so um (2) and it works you know the idea is that it <u>codes</u> emotionally and also for physical actions and and also for [thinking]

I: [Mm–hmm]

C: .hh as well so (1) um if you look at it uh, if you look at it <u>that</u> way then if I imagine <u>cutting</u> that will have some [effect]

I: [Okay]

C: Right if I <u>see</u> someone else cutting it'll have an effect and it'll be a personal context with that <u>too</u> of course and um if I do it <u>myself</u> there's the greatest effect so if if you if you thought if you think of that <u>skill</u> and you think well what's one what's the smallest increment down from that it would be I make an <u>action</u> like cutting and that would generate a lot of the the associative chemicals now <u>without</u> cutting okay so that would (1) be just about as near as you could get to [it]

I: [Mm–hmm]

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C: (1) So making a you can see in that way that uh just <u>not</u> making a gesture won't do anything

I: Mm–hmm

C: Just say oh don't just don't do [that]

I: [Mm–hmm]

C: Right or saying or not being <u>precise</u> about that gesture then wouldn't do anything because the very precision of that gesture was generating something .hh so you said Instead of doing that just do uh <u>that</u> well they're just not related so how's <u>that</u> and doing <u>that</u> going to have any comparative benefit so if you take <u>that</u> and then make it there well that's pretty close

I: Mm–hmm

C: Just turn it a wee bit this way instead of that way there's a there's an <u>awful</u> lot similar about those so it <u>makes sense</u> to me that that would have a somewhat comparative effect

In the opening sentences of Extract 8, Mark begins his discursive argument by calling on a neuroscience discourse about "a class of neuron that spans sensory and motor um ability" (lines 154-155, part 2). He uses examples from everyday motor and sensory activities such as the drinking of a cup of tea, biting into a lemon, watching a horror film and kicking a football to further his thesis of how the brain responds in a similar way regardless of whether we are engaging in these activities or observing somebody else doing them. By the time he reaches the focal point of his reasoning: "I make an action like cutting and that would generate a lot of the the associative chemicals now without cutting" (lines 209-211, part 2), one is almost convinced that this is the case even though he does not refer to any scientific papers to support this conjecture. His discourse builds the linkages very persuasively, to verify his own position, as he describes how it works.

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Mark uses a psychiatric discourse about patients with borderline personality disorder (BPD) as being perceived as "untreatable" (line 270, part 1) and responded to with a "punitive attitude" (line 248, part 1) within "the inpatient setting" (line 283, part 1). He sets up this discourse initially with the following joke:

there's a joke in psychiatry is how do you ((laughter)) how do you make a near-to-retirement um consultant uncomfortable in one word uh borderline (lines 232-235, part 1) Because they kill themselves as much as depressives or schizophrenics (line 237-238, part 1)

He informs me:

the view at that time (line 257, part 1) wouldn't have been that borderline were treatable (line 258, part 1) and that (line 259, part 1) view would be retained by a number of psychiatrists no matter what Marsha Linehan or anybody else is doing (lines 259-261, part 1)

He seems to be addressing his discourse to a wider community beyond me, including the staff in psychiatric hospitals and whose treatment of particular patients can end up recapitulating clients' traumatic experiences. Speaking of patients with BPD, Mark argues:

they don't get anything like the same uh compassion empathy or support so uh in in an inpatient setting in fact the opposite they're the bane of the life of the staff because they end up chasing them down corridors and they end up smashing windows and their their acting their behaviour is much stronger so they um staff and hospitals um find find them very hard to deal with and so

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they tend to take a punitive attitude towards them and so in that way they

recapitulate the trauma (lines 249-250, part 1)

He follows these comments with the following utterances:

so in retrospect I kind of wonder about that you know you you wonder about

uh chasing someone down a corridor and then being held down and and

something stuck into them it's it's not good so but uh when all you have is a

hammer then that's what you do and that's (inaudible) (lines 250-256, part 1)

He appears to be totally opposed to this form of treatment of patients that he

perceives as normal practice in a psychiatric setting. However, there also seems to be

a note of resignation in his discourse about how things are in these settings as he

acknowledges, "when all you have is a hammer then that's what you do" (lines 255-

256, part 1).

Mark creates a humanistic discourse community of verification to support his

therapeutic approach. However, this is not as strong and repeating as his neuroscience

discourse. He positions himself within a humanistic discourse that he argues views

"something as seemingly pathological as self-harm" (lines 391-392, part 1) as having

"a kernel of wisdom in the behaviour" (lines 391-393, part 1). To my knowledge,

there is no reference to support this view of self-injury in the literature from a

humanistic tradition. Therefore, Mark is constructing this community of verification

in his dialogue with me in the following extract:

Extract 9

Lines 390-416, part 1   C: Because they <u>start</u> from (1) my orientation is from the

                             <u>humanistic</u> side is that even in something as seemingly

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pathological as self-harm that there's a there's a kernel of wisdom in the behaviour

I: Mm–hmm

C: .hh So I start from that position not as a not as an idea but as a reality so that .hh it's not something I sign up to because (1) you're supposed to ((Laughter)) you know if you're from a humanistic orientation but it's actually to see that it's true that

I: So you take it as a given

C: I take it as a given

I: Mm–hmm

C: And and I I take it that that has to be now a starting point when I'm working with someone who's self-harming because uh on on a level that's true for them if we can't engage in that level we're not going to get [much further]

I: [Mm–hmm]

C: Going to lose we're going to lose .hh (2) uh the cooperation of the unconscious you know that there has to be um you know .hh naming where things are at and and seeing that not in a punitive light just don't do that .hh or only seeing that as a wrong thing or a judgmental thing so starting from the the viewpoint of seeing acknowledging the (2) uh wisdom albeit skewed wisdom in their actions first

In Extract 9, I barely comment as Mark addresses me and begins to unfold his interesting and idiosyncratic way of thinking about self-injury and his particular way of working with self-injuring clients.

Mark also constructs a discourse community of verification that centres around addiction, trauma and the body to support his views about self-injury and his

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proffered treatment approach. In the following Extract 10, he critiques addiction

treatment programmes for ignoring the trauma histories of addicts and the absence of

"a strong somatic orientation" (line 383, part 2).

Extract 10

Lines 368-384, part 2   C: I I know we've talked about this before in terms of
addiction you know like the elephant in the room in
addiction is body and trauma (1) right so up until a
couple of years ago if you look at most addiction
programmes they didn't include trauma (1) you know as
an active teaching part of the course and the the most
addicts 80% plus of addicts have active trauma histories
or strong trauma histories and those are one's
documents so I don't know about the other 20%

I: Mm–hmm

C: So you know one of the recent sort of the theory of
rehab is that their traumas get activated .hh and yet
trauma was not part of a joint approach with addiction
.hh ((cough)) even more elephant in the room is body in
that if you look at most approaches to addiction they
don't include a strong somatic orientation .hh and if
addiction isn't tied into the body I don't know what is
((laughs))

He uses the metaphor of "the elephant in the room" as an idiom to refer to the

denial of the existence of the "body and trauma" in treatment programmes for addicts.

His discourse shifts momentarily to one of accusation when he argues that, "most

addicts 80% plus of addicts have active trauma histories or strong trauma histories

and those are one's documents" (lines 373-376, part 2). It is not clear to whom Mark

is addressing his judgment of addiction programmes' exclusion of "trauma" (line 372,

part 2) "as an active teaching part of the course" (lines 372-373, part 2) even though

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"one of the recent sort of the theory of rehab is that their traumas get activated" (lines 378-379, part 2). Is he saying this solely to me, or is he speaking to clinicians working in the field of addiction, or to all clinicians?

At this point in his narrative, Mark begins to link this discourse about addiction to self-injury as he informs me:

> so the the cognitive elements of it are very well looked at and the emotional elements and relational elements and group elements and the body element just isn't you know so those same principles apply um arguably even more so where self-injurious behaviour is concerned because uh the intensity has gone up a few notches you know it's it's similar in many many ways uh around there there's probably going to be a trauma history known or unknown and the symptom profile suggests that the rate of escalation and activation suggests that the the acting out behaviours and and thoughts and images that come in can certainly suggest it (lines 387-399, part 2)

Thus, he uses his critique of addiction treatment programmes to highlight that his approach with self-injuring patients' focuses on their trauma history and has a strong somatic orientation. What is also striking here is that he is not only criticising addiction programmes for not paying attention to the addict's trauma histories and their somatic responses but he is also addressing other treatment modalities that he believes ignore the link between clients' trauma and the activation/arousal levels in their bodies.

Speaking of self-injury and chaos, Mark shifts to a discourse of opposition that was the exception to his more customary discourse of verification. Locating himself within this discursive position of opposition, he creates an imaginary audience who

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have not been through this experience of chaos and who tend to back off when they shouldn't as their clients enter a field of chaos. He addresses a critique to this imaginary therapeutic community whom he constructs as a group of people who do not like being exposed therapeutically to patients' intensity or chaos. He uses this critique to articulate his own views and validate his therapeutic approach and outline the shortcomings of the wider therapeutic community as he sees them in relation to working with self-injuring clients. He argues:

> people can stay away from it because of its intensity either in what happens or blood or uh I don't mean people who are doing it I just mean as a topic as a as a therapeutic engagement as a you know people mightn't necessarily be drawn to the area or want to go near it (lines 770-776, part 2)

He informs me, "I think that's the paradox of it is that when something gets more intense a lot of the complexity drops away" (lines 778-780, part 2). Mark contends:

> in the moment of trigger paradoxically all that drops away and you're into uh you know maybe a skewed reaction but a fairly clean reaction in the sense of um its habitual elements and its predictive elements and uh its physiological elements (lines 786-790, part 2) So it um so the very place people shun or would be startled or alarmed by um you could you would see in a normal setting you would say that's a place of opportunity (lines 792-795, part 2) Because it's the one time when all the complexities are out of the way (lines 797-798, part 2)

However, he admits, "it's a very narrow window of opportunity and and finding a way to um to deal with that is a very strong therapeutic challenge" (lines

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833-836, part 2). Here, Mark is proposing that there is "a very narrow window of opportunity" (lines 833-834, part 2) for the clinician to intervene "in the moment of trigger" (line 786, part 2) when the self-injuring patient reaches a nexus of intensity upon entering "a field of chaos" (line, 862 part 2). He argues that this is the very point where "a lot of the complexity drops away" (lines 778-780, part 2) and "that's a place of opportunity" (lines 794-795, part 2) for the clinician but "people shun or would be startled or alarmed" (lines 792-793, part 2) and "people can stay away from it because of its intensity" (lines 770-771, part 2).

He maintains that when clients reach a:

nexus point the peaks of the activation (line 851, part 2) then therapeutically people are naturally being alarmed by that because we don't like intensity (lines 852-853, part 2) Culturally or socially or uh you know we we want to do it to the intensity what they're already doing do you know which is we want to medicate it and you know you're shaking get rid of it (lines 855-858, part 2) Take the Valium uh it's loud quiet you know you know our our whole orientation is right because you're now in the field of chaos and um it's a very hard thing to be in relation to and our client is exactly is relation to it and you think of other things therapeutic to these an idea that we can embody something and therefore lead our client towards something that's helpful and when most of us come into the field of chaos we we'll run from it before a client does so I would argue that we're the great limiting step around that (lines 860-870, part 2)

At this point in his narrative, he seems to be drawing others, himself and me into a community in his discourse with his address of "we don't", "we want", "we'll

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run", we're great", "our whole", "most of us", "you know", "you're now", "you think", "most of us".

Mark continues with his critique of the "therapeutic world" (line 900, part 2) one in which he is implicated, and then shifts his discourse to distinguish between "them" and "I". He claims:

> it's very poorly articulated in the therapeutic world (line 899-900, part 2) because in if you look at it therapeutically (lines 901-902, part 2) they talk about hyperarousal and going up going up into high arousal states but they don't tend to distinguish between levels of hyperarousal other than to say there's dissociated hyperarousal and there's hyperarousal and I would make a clear distinction between high arousal and a a line being crossed where it goes into chaos pattern (lines 907-913, part 2)

He continues:

> And um so you can look at self-injurious behaviour as being reflective of the level of intensity and being reflective of the level of chaos (lines 945-947, part 2) it probably speaks to high end trauma and it also speaks to the unlucky way their nervous system organises around intensity so that they're going into not just hyperarousal (lines 949-952, part 2) they're probably finding themselves more in a chaos field more than most and that doesn't get differentiated enough (lines 953-954, part 2) It's actually they're they're hitting those peaks more and they're the peaks are worse (lines 958-960, part 2) It's intolerable (line 967, part 2)

He argues:

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I don't think that's articulated enough that they get into they get into a particular quality of hyperarousal which then demands extraordinary means of of management which it does because there's that's an extraordinary organisation of experience it's not ordinary (lines 970-975, part 2) And I I think it needs to be placed in that almost transpersonal language you know because it your body can't tolerate it it's in it's a it's a definition of intolerable so that's the challenge how do you tolerate the intolerable ((Laughter)) (lines 978-982, part 2)

Mark seems to be articulating a language for understanding self-injury that he proposes, "needs to be placed in that almost transpersonal language" (lines 978-979, part 2). He contends that patients who self-injure are at the "high-end of trauma" (line 949, part 2) that they experience a "level of chaos" (line 947, part 2) that's "intolerable" (line 965, part 2) "which then demands extraordinary means of of management" (lines 972-973, part 2) "because it your body can't tolerate it" (lines 979-980, part 2). He attempts to draw on a neuroscience discourse of verification to support this conceptual framework of self-injury by arguing that this is "the unlucky way" (line 950, part 2) that self-injuring clients' "nervous system organises around intensity" (lines 950-951, part 2). Mark seems to be trying to create a language to carry an experience of the "intolerable" and "extraordinary" arousal that he believes self-injury patients feel. He appears to be saying that this very experience cannot be articulated in clinical or therapeutic language other than the transpersonal.

He returns to his critique of the therapeutic community as he addresses therapists through his discourse with me and demands:

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And show me the therapists you know at large or a psychiatrist or a

psychologist who can do that and and they won't fill a room you know

because you have to have had an embodied experience to tolerate the

intolerable in whatever setting that is (lines 982-987, part 2)

Mark criticises therapeutic frameworks that fail to include "a transpersonal

view" (lines 1087-1079, part 2) in relation to understanding the "peak of chaos" that

he believes self-injuring clients experience. He argues:

when you get to that peak of chaos to me you leave ordinary explanations as

the only explanation and so to only explain things through the prism of

therapy or therapeutic field that's not including a transpersonal view is daft

(lines 1075-1079, part 2)

He concludes, "It's like being left-brained about a right-brained thing" (lines

1080-1081, part 2).

Mark is arguing that therapists who haven't entered their own field of chaos

and passed through it, will not be able to provide this space and opportunity for a

patient. He begs the question, "how can you hold a space a therapeutic space from a

humanistic viewpoint (inaudible) viewpoint a body-centred viewpoint that empowers

a person to tolerate the intolerable and you haven't done it" (lines 991-995, part 2).

He contends, "If you haven't you are the rate limiting factor" (line 999, part 2).

Laughing, he proposes as the therapist:

you can encourage it and you can work at a lower level and you can have it

establish a strong therapeutic relationship you can be as warm and

compassionate as you like and if you don't have a relation to that place I think

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you're lost absolutely lost there (lines 1001-1006, part 2) You know so

whatever your medicine is you know and that can be spiritual medicine so you

could be a meditator who has gone into chaos and can tolerate that field

through the agency of spiritual help through prayer and mediation whatever it

is (lines 1009-1013, part 2) Or somebody who's gone through it as an addict

or whatever but somebody who's gone into that crucible and survived it I

think only someone there offers a felt sense in the room safety to that person

that says you can hold it (lines 1015-1019, part 2) That you can you you are

able to there is an option here not an option that I read from a book not an

option that I think is a good idea but actually I am telling you with my body

that there's an option here and there's not many people can do that (lines

1021-1025, part 2)

Here, Mark's discourse shifts subtly toward opposition as he speaks about

clinicians who have no experience of particular bodily states and have not gone

through "that crucible and survived it" (lines 1016-1017, part 2). These clinicians in

his view are "absolutely lost" (lines 1005-1006, part 2).

Another interesting feature of his narrative is his construction of a quasi-

neuroscience discourse of verification to critique other therapeutic approaches that he

believes are influenced by a particular scientific framework. This pattern of Mark's is

apparent in the following extract.

Extract 11

Lines 387-415, Part 2   C: You know and um (1) so the the <u>cognitive</u> elements of it
are very well looked at and the emotional elements and
<u>relational</u> elements and group elements and .hh the <u>body</u>
element just isn't you know <u>so</u> those <u>same principles</u>

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apply um arguably (2) even more so where self-injurious behaviour is concerned because uh (2) the intensity has gone up a few notches you know it's it's similar in many many ways uh around there there's probably going to be a trauma history known or unknown and the symptom profile suggests that the rate of escalation and activation suggests that the (1) the acting out behaviours and and thoughts and images that come in can certainly suggest it .hh and even if you don't you don't have to argue whether that's true or not well that's not my job to do that it's simply noting that it looks like trauma is ((laughts)) is having an influence here (1) .hh uh on the one hand and then saying well as such the body ((snigger)) is um you know is is a central part of this and uh you know uh an overall (.1) understanding of this should include the body's elements of it you know because so much of it's implicit and that's body and emotional it's not cognitive and it's not to divide the cognitive piece just to say that uh .hh you can you can miss the point if you only come at it from a cognitive you know (.3) .hh uh academics are very left-brain people and the problem is a right-brain problem .hh and people present in a left-brain manner and research is a left-brain topic

In Extract 11 Mark employs neuro-scientific terms such as "cognitive" (line 410, part 2), "implicit memory" (lines 448-449, part 2), "right-brain" (line 413, part 2), "left-brain" (line 412, part 2), "sub-cortical reactions" (lines 450, part 2) and "the cortex" (line 454, part 2) to support his argument. He uses this scientific community discourse to validate his humanistic body centred view of how to work therapeutically with self-injuring clients. He argues that, "an overall understanding" of self-injury (line 406, part 2) "should include the body's elements" (line 407, part 2). He posits

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that, "the cognitive elements of it are very well looked at and the emotional elements and relational elements and group elements and the body element just isn't" (lines 387-390, part 2) and "you can miss the point if you only come at it from a cognitive" (lines 411-412, part 2). Mark claims that, "the problem is a right-brain problem" (line 413, part 2) "research is a left-brain topic" (lines 414-415, part 2) and "a lot of treatment programmes are based on a left-brain protocol or a left-brain" (lines 473-475, part 2) "analysis and view" (line 477, part 2). He appears to be constructing a discourse where he is making over generalising comments about research being "a left-brain topic" (line 415, part 2), and self-injury "is a right-brain problem" (line 413, part 2) and "treatment programmes are based on a left-brain protocol" (lines 473-474, part 2). Thus, he is over simplifying a neuroscientific discourse about the functional characteristics of the left and right hemispheres of the brain by engaging in a metaphoric use of neuroscience to validate his argument about why "the problem is a right-brain problem" (line 413, part 2).

Continuing with his quasi-neuroscience discourse of the brain hemispheres to support his body centred approach, Mark posits that self-injuring clients are:

> in nice left-brain mood mode and we can talk then they're hijacked into right-brain mood and that's where the problems occur for them their difficulties are in managing their their triggers and their activations that's entirely been hijacked by implicit memory so up comes all the right-brain reactions you know are all the sub-cortical reactions all that stuff comes up (lines 444-451, part 2) And their management of that even if it's with the cortex is is why they end up in hospital or why they end up in therapy (lines 453-455, part 2)

This discourse of opposition is the exception rather that the norm for Mark's discursive pattern. He criticises science because he proposes that if the clinician moves into a scientific position to comprehend his/her patients, s/he will not be able to understand their first person or subjective experience. He asserts that science "continually elevates objective experience over subjective experience and that's a difficulty when our clients ((Laughter)) with subjective experience you know uh they they're there's a clash in it" (lines 483-486, part 2). Mark uses the metaphor of "applying two different languages" (line 487, part 2) to emphasise his argument that there is "a clash" (line 486, part 2) or "a mismatch" (line 491, part 2) between scientifically oriented treatment approaches and the patients' subjective experience when they get into difficulty trying to manage "their triggers and their activations" (lines 447-448, part 2). He claims:

> So we're you know we're applying two different languages we're saying it has to be through this language and they're saying uh yeah it's fine we talk English but I go into Chinese or Russian whenever I get bothered so it's uh there's a mismatch (lines 486-491, part 2)

In summary, Mark draws predominantly on a discourse of verification and a repeating neuroscience discourse to validate his unique application of merging humanistic and body-oriented psychotherapeutic approaches to treating self-injuring clients. His unconventional style of focusing on the patient's "gesture as if you were cutting" (lines 127-128, part 2) is not documented in the literature and neither is it articulated by any of the clinicians in this research study. He also employs a discourse of opposition, although, it is not as pervasive as his discourse of verification. His narrative suggests that he is searching for a language that describes

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his construction of self-injury and his specific treatment approach and that also traverses his discourse of verification and opposition.

Chapter Summary

In this chapter, I examined the clinicians' discourses that pertain to the conceptual frameworks on which they draw on to understand self-injury and their treatment practice with self-injuring patients. Surprisingly, none of the eight clinicians speak in terms of theoretical or conceptual models; instead, they all seem to create discourse communities of "an other" to formulate their beliefs about self-injury and its treatment. However, this pattern of creating discourse communities only emerges as a transitory reference for four of the eight clinicians (Ciara, David, Sinead and Mike) and is not maintained throughout their narratives. In contrast, the other four clinicians' (Niamh, Jack, Mark and Eimear's) narratives are rich with constructions of discourse communities that appears as a repeating, persistent and pervasive style.

As I illustrated in this chapter with numerous extracts from the clinicians' interview transcripts, their constructions of imaginary "other" discourse communities in their narratives to formulate their beliefs about self-injury and its treatment mirrors and stresses the variances among and between their various approaches and disciplines of psychotherapy, psychoanalysis, psychology and psychiatry. For instance, the examples from Niamh and Mark's narratives demonstrate how two clinicians from different disciplines can share the same therapeutic orientation and yet create different discourse communities to formulate their beliefs about self-injury and its treatment. Niamh is a counselling psychologist and Mark is a psychotherapist. Both of these clinicians subscribe to a humanistic, body centred approach, yet they

construct contrasting discourse communities to articulate their views about self-injury and its treatment. Niamh mostly formulates a discourse of opposition to affirm her own beliefs and practices while Mark composes one of both opposition and verification but primarily verification, as he searches for a language to convey bodily subjective experiences. These patterns reflect not only the diversity and uniqueness of approaches and understanding among this small group of clinicians working in the Irish context with particular reference to self-injury, but also different imaginary and shifting audiences.

Chapter Six

Findings: Styles of Discourse

In the current chapter, I discuss the research question that pertains to the explanations or models that the clinicians drew on to understand their current treatment practice effectiveness and failures with self-injuring clients. However, prior to launching into this analysis, I would like to remind the reader of the range of approaches that these clinicians use. These include dialectical behaviour, narrative, constructivist, humanistic/body centred, Freudian/Lacanian psychoanalysis, a mixture of psychodynamic/cognitive behaviour/dialectical behaviour and a combination of cognitive behaviour and dialectical behaviour therapeutic modalities.

Two Discursive Positions

There are striking differences in the clinicians' discourses with respect to taking a position about their conceptions of self-injury and their treatment approach in the face of questions about the effectiveness of treatment. This questioning leads to either a defensive response, or becomes an opportunity for the clinicians to think deeply, critically and in unaccustomed ways by the fact that they are being asked to think about their current treatment practice effectiveness. Thus, two distinct discursive positions, which I refer to as the "expert" and the "inquirer" emerge in relation to clinicians' conceptual orientations to treatment. Rather than naming or simply explaining their conceptual orientations, the clinicians engage with the interview itself, and with me, to open up an inquiry or to narrow the terms of the conversation. These discourses show specific patterns. For instance, the "expert" discourse emerges as a repeating, clear, constricted, and unquestioning stance among some clinicians. This pattern has the effect of shutting down any exploration of other

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possible conceptual frameworks for treating self-injuring patients. In contrast, the "inquirers" appear to think out loud, muse, wonder, question and revise their discourses in response to my questions. Thus, this discursive position opens up a process of inquiry in which the clinicians engage in a dialogue with me, the interviewer.

To illustrate these contrasting discourses in detail, I refer to extracts from two clinicians' narratives (Eimear and Jack) as exemplars of each style. However, before entering this discussion, I would like to briefly mention the general patterns of the other clinicians, Mike, Niamh, Mark, David, Sinead and Ciara, in relation to these two discursive positions of the "expert" and the "inquirer". Mike, Sinead and Ciara engage in an "expert" discourse, while Niamh, Mark and David speak from within the "inquirer" discourse.

Mike tends to adhere to a strong and narrow discursive frame of narrative therapy throughout the interview. He repeats his discourse about narrative therapy throughout the transcript using the same words and phrases. He circles around answering my questions from his point of view and takes up a position of responding from the patient's perspective. At times, he tends to exhibit a dismissive tone. There are moments in the interview when he seems defensive and engages in a pattern of resistance. Sometimes, he may be attacking of me, or my language and my questions. For instance, he repeatedly challenges my questions, telling me, "I'm not sure what your question is about" (line 881) and "What do you mean what do I think it is" (line 310). There is a recurring pattern in Mike's discourse where he appears to resist engaging in a dialogue with me about his thoughts or views of self-injury. The first instance is in the early moments of the interview. Initially, he asks me to clarify my

question about his thoughts on self-injury. Then, he gives me a very brief reply, "Um it's a it's a some action that somebody's taking in relation to their life" (lines 314-315). He immediately shifts his position to posing the following question, "Um if you're asking what do I think the the the their understanding is behind it or my understanding behind it um" (lines 317-319). I reply, "both yours and theirs" (line 320) and he shifts his discursive position to speaking about his clients' perspectives. Thus, Mike takes up the "expert" discursive position in response to my questions in that he reacts to my open-ended questions by avoiding answering them, and then, responding briefly, curtly, "What do you mean" (line 300).

Mark and Niamh have very definite beliefs about self-injury and their idiosyncratic therapeutic approaches. Yet, they both engage in a discourse of inquiry where they enter a dialogue with me in response to my questions. Mark introduces a number of varying discourses (e.g. neuroscience and quasi-scientific) and ideas throughout his narrative as discussed in Chapter Five. Therefore, he does not take up a repeating and narrow discursive position. An example of his discourse of inquiry emerges in his responses to my questions about his external responses to seeing his patients' injuries. Speaking "of having seen an extreme" (line 1465, part 2) case of self-injury early in his career, he tells me, "I have a normalised reaction" (line 1466, part 2) "to it" (line 1468, part 2). He then shifts his discourse a fraction and begins to question this "normalised reaction" (line 1466, part 2). Referring to his self-injuring clients he wonders, "did I just did they seem too normal to me" (line 1481, part 2) "to the point maybe did they want do they want me to react more" (lines 1484-1485, part 2) "but I didn't" (line 1487, part 2).

Niamh's discursive pattern of inquiry is quirky in that there are two distinct

patterns that deviate from the other clinicians. While her discusive position is

predominantly one of inquiry, there are moments in her narrative in which she

initially appears to be closing down a dialogue by resisting and rejecting the

categories I offer her in my questions. Then, she seems to shift by re-engaging with

the question and responding. For example, when I ask Niamh about treatment

success, she engages initially with the question. Then, she pauses and rejects the

discursive term "treatment" (line 1626) and finally re-engages with the treatment

discourse by speaking about what happens for patients who engage in therapy.

David positions himself within an inquirer's discourse. In fact, his interview

is the longest of all (total of 195.56 min), which is a testament to his level of

engagement in dialogue with me. His responses indicate this discursive position as he

muses and wonders aloud as he answers my questions. For instance, when I ask him

about his experience of treatment success he replies, "Goodness" (line 893, part 3)

treatment success "is an area that we probably don't focus a huge amount on" (lines

893-894, part 3). He acknowledges, "one tends to be very caught up with those who

are" (lines 894-895, part 3) "acutely presenting" (lines 895-896). He then launches

into his familiar passionate discourse about his clients revealing, "there's a few people

that come to mind" (lines 898-899, part 3) "in terms of outcomes" (lines 899-900, part

3).

Sinead seems to engage in an expert discourse despite her funny, engaging,

relational and conversational style of interaction. She uses declarative sentences that

are just short of generalisations on self-injury. For instance, she proposes, "we

language in our behaviour" (line 236-237, part 1) that "behaviour is a way of asking a

question" (lines 95-96, part 2) and that "often" (line 251, part 1) patients who engage

in self-injury "don't know themselves" (line 251, part 1) the reasons or meaning

behind their behaviour. She states, "The other people I see using cutting" (line 176,

part 1) "are people" (line 177, part 1) "particularly young women with eating issues"

(lines 177-178, part 1). She constructs these "young women with eating issues" (lines

177-178, part 1) as moving "in and out" (line 305, part 1) of "the starve binge cycle"

(lines 300-301, part 1) "And sometimes self-harm would be part of that picture as

well" (lines 307-308, part 1). So, Sinead offers these general statements as expert

knowledge in declarative sentences.

While Ciara fully engages with me in the interview, her discursive position is

mostly that of the expert. She consistently draws on her psychiatric training to

support her views. At times she seems to shut down any possibility of engaging in or

exploring other discourses. For instance, Ciara did not directly answer my question

about her experiences of success with self-injuring clients. Therefore, there is an

absence of a discourse about her experiences of success with self-injuring patients in

her narrative. In fact, she avoids answering my question by launching into a discourse

about a general definition of success. She replies:

> Um I mean I think success is a combination of um it's a combination of
>
> factors if it's an affective disturbance that's driving it well then medication can
>
> can be can be helpful um I think age and experience and maturity can you
>
> know can can settle it down without any sort of intervention at all um and
>
> whatever just addressing the addressing the the difficulty whether it's an
>
> interpersonal difficulty showing people coping skills (lines 1298-1306)

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Ciara also closes down a discourse about failure in which she does not consider any other possibility beyond suicide, even though I invite an alternative discourse with the phrasing of my question. I enquire, "Okay and how did you decide that that particular approach was or treatment was a failure I know you've mentioned suicide as the ultimate but if are there any other criteria that you would use" (lines 1424-1427, part I). She responds, "Well I mean that would be the only way I would view a failure" (lines 1429-1430, part I).

Expert discourse. Eimear establishes her expert discourse in the early moments of our conversation. She constructs her subject position in relation to dialectical behaviour therapy. Speaking from this position she expounds the efficacy of this particular treatment approach as the most effective model for treating self-injuring patients. This master discourse repeats throughout her narrative as she portrays Marsha Linehan's ideas about self-injury and DBT as apodictic in that she presents her argument as being categorically true. She appears to accept unquestionably and uncritically the causes of self-injury within a psychopathology framework. She asserts, "the majority of people who self-injure probably have a diagnosis of conflicts post-traumatic stress disorder or borderline personality disorder" (lines 599-601). The possibility that some individuals who engage in self-injury may not meet the criteria for a diagnosis of BPD or other psychiatric disorders and therefore, DBT may not be a suitable modal of treatment does not enter her discourse at all.

In conversation with me, about her understanding of her current treatment practice effectiveness with self-injuring patients, Eimear is firmly convinced that DBT is the most appropriate and effective treatment for individuals who engage in self-

injury. Staying within her expert discourse, she considers herself to be a clinician who "was particularly successful with a limited number of people" (lines 1451-1452) who engaged in self-injury. She claims that in order to achieve this outcome, "it was a a considerable commitment" (line 455) on her part. Thus, she sets herself up as a significant contributor to her treatment practice effectiveness and as such maintaines her expert discourse. Eimear states, "I suppose as soon as I started to see in self-injury I started to look for evidence" (lines 1484-1485) "based-interventions and even before I had the training I had the book" (lines 1487-1488). The book she is referring to is Marsha Linehan's seminal text on DBT, *Cognitive Behavioural Treatment of Borderline Personality Disorder*, which was first published in 1993. Speaking of applying Linehan's treatment approach from a book, she proposes, "I think it was the success from that" (lines 1494-1495) "would have been encouraged you know management to organise training" (lines 1497-1499) within this CBT modality.

Despite Eimear's obvious allegiance to DBT, her discourse suggests a committed clinician who is relationally oriented in her work and adopts a non-judgemental attitude with self-injuring clients. Indeed, she is opposed to the perceived view of these types of patients as manipulative. She points out, "But my own belief is that it's a skills deficit if they had better skills they'd use them" (lines 245-246) "And I'm uncomfortable with the term manipulation" (lines 250-251).

Eimear engages in a discursive pattern of a repeating and narrow stance. She repeats words, phrases and ideas associated with dialectical behaviour therapy in her responses to my questions about her conceptualisation and treatment of self-injury. The most frequently repeating words throughout her narrative emerge as "dialectical behaviour therapy" (10 times) and "skills deficit" (14 times). In terms of a repetition

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of ideas, she constructs self-injury as a "maladaptive coping style" (line 132) and continues to repeat this conceptualisation in different forms throughout her narrative. For instance, she informs me, "I view self injury as a maladaptive coping style that somehow individuals who have experienced a lot of trauma have learned that this is a way of self soothing" (lines 132-134). A few moments later when I enquire about the purpose and functions that self-injury serves for those who engage in this behaviour, she replies:

> I think it's very much self-soothing (lines 227-228) And it's usually affect
>
> modulation (line 234) I think people learn ways of behaving when they're
>
> young that are maladaptive and unfortunately they continue to use them (lines
>
> 241-243) my own belief is that it's a skills deficit (lines 245-246)

Thus, she confines herself to a narrow discourse about the functions of self-injury and does not consider other possibilities with the exception of one brief reference to "self-injury is a form of communication" (lines 284-285).

Eimear's repeating discourse about DBT and her construction of self-injury from within that framework re-emerges in Extract 12 in response to my question about helpful strategies or interventions. Thus, she does not take this opportunity to introduce new information. Instead, she repeats what she has already shared with me earlier in her narrative as the following extract demonstrates:

Extract 12

Lines 1081-1099   I: Okay are there any <u>particular</u> strategies or interventions that you find <u>helpful</u> working with this particular [clientele]

C: [I think] dialectical behavioural therapy is particularly helpful

I: Okay

C: I think the kind of description of self-injury as a self-soothing strategy is you know part of somebody who has kind (.hh) of a very sensitive um emotionnal [system]

I: [Mm–hmm]

C: Is very helpful the notion that these people have a skills deficit and if they had the skills they would use them totally changes how you experiencing somebody

I: Mm–hmm

C: And it takes away the pejorative way that this group of people are often dealt with

She does not engage in a pattern of elaboration or inquiry in her discourse. Eimear's discursive style is predominantly a pattern of short responses to my questions. Indeed, there are moments when I have to use probing questions as an invitation to expand on her brief answers as illustrated in Extract 13.

Extract 13

Lines 128-158   I: Um just in terms of can you tell me how you think about self-injury (1) what you think it is the individuals that engage in it

C: (.hh) I view self injury as a maladaptive coping style that somehow individual who have experienced a lot of trauma have learned that this is a way of self-soothing

I: Okay and are there particular types of trauma (1) you'd consider associated [with this or]

C: [It's very diff]icult to know a very large percentage of the patients have a history of some kind of abuse

I: Mm–hmm

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C: They do <u>seem</u> to be more sensitive than other people and when they get upset they get more upset and it <u>takes</u> them longer to settle

I: Okay and when you say they they're more sensitive in what ways are they more sensitive

C: <u>That</u> under pressure they would experience more <u>intense</u> emotions that they seem to be unable to cope with and seem to be <u>unable</u> to modulate

I: Okay and would you say (1) [that they um]

C: [So I'd say] they've a skills deficit

I: [Okay]

C: [In terms of] managing distress and managing emotions

I: Okay

C: But it may simply be that they have experienced trauma to a <u>degree</u> that their emotion regulation system <u>has</u> become <u>disregulated</u>

In her narrative, Eimear makes a link between self-injury and "a history of some kind of abuse" (lines 138-139). I try to open a dialogue about this but she does not take up my invitation. In fact, all she does is repeat my words verbatim and thereby, shuts down a discourse of inquiry as Extract 14 demonstrates.

Extract 14

Lines 160-164   I: Okay but when you say um abuse do you mean physical sexual [emotional]

C: [Physical] emotional sexual

I: Okay so it's the whole range

C: The whole range

When I broach the question with Eimear, about her experiences of failures or partial failures with self-injuring clients, she replies in her expert discursive mode, "I don't" (line 1578). Here, she repeats once more her familiar expert discourse about the success of DBT and that she has had no episodes of failure using this modality of treatment. She again seizes the opportunity to espouse the virtues of DBT as she claims, "if there was a failure it was in terms of convincing the government that it was worth funding this kind of intervention on a large scale" (lines 1580-1582). Thus, she shuts down the discourse about failure.

To summarise, Eimear's expert discourse centres predominately on dialectical behaviour therapy. In her narrative, she draws on repeating words and phrases associated with DBT in response to my questions about understanding and treating self-injury. Her discursive pattern is chiefly one of non-elaboration, an absence of inquiry and short responses to my questions. In the next section, I explore the inquirer discourse, drawing on Jack's narrative to illustrate this discursive style.

Inquirer discourse. Jack admits that his conceptual orientation to treatment is that of both Freudian and Lacanian psychoanalysis. Unlike Eimear, this does not preclude him from positioning himself within the inquirer's discourse in response to my interview questions. Jack's responses to my questions are predominantly a series of monologues (varying in length from 1½ - 2 pages) with very few exceptions to this discursive pattern throughout his narrative. This is in sharp contrast to Eimear's brief replies to my questions. During these monologues, a number of different things are happening. It is almost as if I am occupying the subject position of analyst for him, while Jack positions himself as the analysand. In addition, there are moments when his discourse almost appears as a stream of consciousness; he seems to be

externalising his inner thoughts when he thinks aloud, muses, wonders and questions his discourse. Indeed, there is also a pattern where Jack tends to elaborate and develop his ideas as he enters these monologues. The following two Extracts 15 and 16 are examples of the longest monologues in Jack's narrative.

Extract 15

Lines 473-597   I: Okay an area you said about um that there's something unspoken for the individual that engages

                    C: Yeah

                    I: In this behaviour um what is that individual that unspoken or are there certain generalising general things that people this population <u>can't</u> speak of that they have in common

                    C: Well I think it's al always these things are <u>particular</u> to the individual although because we're all we we (2) we're all human and we have a certain <u>common discourse</u> if you like there are going to be (2) uh similar <u>themes</u> I think

                    C: Um .hh and like they're always actually more difficult to pick out it's easy to stay with the individual and and and that that this these are the issues for that <u>particular</u> individual or these are the things that they're they're <u>speaking</u> about that are important to them hh uh if I were <u>try</u> and generalise more um (2) .hh the (3) the I I think that there's there's something (3) uh oh where will I begin (2) I guess that there I I begin with the idea of uh an an anxiety and an anxiety about (2) what the the <u>person</u> can speak that (2) will be uh acceptable or unacceptable to those whom they would <u>wish</u> to hear or wish to uh respond .hh um and the the (1) notion that um (2) a a person can (2) either imagine or or it can actually be the case that that something <u>about</u> the way in

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which they uh (2) <u>see</u> themselves um and who which they might wish to express .hh can be can seem to be <u>entirely</u> unacceptable to those who they would <u>wish</u> to uh accept it or to (1) to understand it

C: And and most usually that's there's (2) this in in the <u>first</u> instance uh is addressed to the parents (3) .hh uh that there there's something about <u>me</u> as the person as the as the child or as the the young person growing .hh up uh that I feel is <u>entirely</u> unacceptable uh to to those whom I wish to to (2) whose acceptance I wish to to have

I: Mm-hmm

C: Um .hh uh now and you see (2) then it gets a little bit more complex you can see the kind of the very very straightforward case .hh uh where (3) a in a in a particular in a particular family where there are there have been all kinds of difficulties in terms of of the parental relationship .hh that a uh a a <u>young</u> young girl in her early <u>teens</u> uh at at that kind of uh where where her sexuality is beginning to develop .hh uh (3) <u>takes</u> a a or <u>feels</u> herself to be uh her <u>her particular</u> kind of <u>desires</u> to be completely unacceptable to those to to the (2) to the to the parents

I: Mm-hmm

C: .hh I I I have in mind a uh a young woman who came when she was in her uh (1) .hh early twenties and uh was quite you know was was cutting and uh uh and also had you know some uh <u>eating</u> difficulties and .hh uh whose whose parents had (2) been through a kind of a <u>long</u> and acrimonious uh separation um which hadn't <u>quite</u> come to uh kind of the final stage when she came to me .hh um and (1) who was uh kind (3) of trying to make sense of her own her own desires her own sexual desires .hh um (2) and <u>leaving aside</u> all the kind of

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questions of how she came to have these particular desires .hh in the in the end her her <u>behaviour</u> was apart from the cutting and and the the the difficulty in in .hh uh uh the eating difficulties she was also very uh promiscuous and and was uh (1) you know (2) very condemning of herself in that .hh uh and in the course of uh coming to me she uh (3) began uh a a relationship with another uh woman who was (2) you know slightly older than her so she kind of uh her her the desires the sexual (2) desires that she had began to be expressed in a way that uh for her were was much more um (4) wholesome I guess .hh um and <u>and</u> in the course of that of that change from uh (3) that particular promiscuous kind of behaviour .hh to this this relationship she gave up uh (1) she overcame her her her the the cutting and also .hh her <u>eating</u> difficulties now that's kind of the (3) that might seem that the the <u>answer</u> to it is almost like if you can if if a person can uh allow themselves to uh <u>find</u> a way to express their uh their <u>desire</u> uh (2) without a <u>overcome</u> the kind of the the the the <u>sense</u> of disapproval of that desire if so such a disapproval exists then everything is <u>solved</u> you know but uh but clearly there were there were a lot of (2) historical issues I mean there's the whole kind of particular situation in that family uh the the all the (2) the the lack of um connectiveness between the the the child and the parents because the parents were so <u>engaged</u> in in their in their own uh [struggle]

I: [Mm-hmm]

C: Uh in this ongoing uh <u>war</u> with each other that what what (2) that it was actually it was almost <u>impossible</u> to be uh (2) to effectively engage the parents and for the child to be to to be <u>heard</u> um and and in that kind of situation (4) she turned to uh writing a diary on <u>herself</u>

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in a way nobody was listening to her so she she had found uh a way to do it uh (3) I'm not sure if I'm making myself very very clear on this I'm trying to I'm sort of struggling a bit to trying to uh to to kind of put it all together in a in a in a way that's that's fairly <u>brief</u> you know

I: Mm-hmm

C: But I uh I I I feel I'm probably not doing a doing the the (2) the thing justice really in uh these these things these situations cases like this you know in in these kind of individuals tend to be <u>enormously</u> complex as we all are you know and it is very difficult to kind of break it down to uh (2) strands that can be easily then uh they can be taken out and and used as a as a kind of a measure for other cases for other presentations (3) uh so

I: So are you

C: [There has to be more]

I: [So that's very interesting] so are you saying then that in terms of um that each case is individual to itself

C: <u>Absolutely</u> yeah

Early in this monologue, Jack seems to be addressing himself as he wonders how he would begin to answer the question I have posed to him about "the unspoken" (line 1147). The following utterances from him almost appear as an externalisation of an inner dialogue, a stream of consciousness as he struggles to construct a response:

Uh if I were try and generalise more um the the I I think that there's there's something uh oh where will I begin I guess that there I I begin with the idea of uh an an anxiety and an anxiety about what the the person can speak that will be uh acceptable or unacceptable to those whom they would wish to hear or wish to uh respond (lines 491-497)

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He elaborates on his thesis of the unspeakable and self-injury and he uses a case to exemplify these ideas. Jack does this without any probing questions from me. His speech in this monologue is almost uninterrupted except for my occasional utterances of "Mm-hmm". Towards the end of this monologue, there is a moment where I seek clarification and enquire, "So that's very interesting so are you saying then that in terms of um that each case is individual to itself" (lines 594-596). Jack unusually gives a brief reply, "Absolutely yeah" (line 597). I respond with another question and he answers by returning to his repeating pattern of long responses and to his familiar discourse of inquiry. The theme he returns to is his argument that whatever the individual presents with is:

> always individual they're always particular (lines 604-605) so we still have to find out from uh from each individual at the individual level what is it (lines 633-634) that has that can't be spoken and to whom can it not be spoken (lines 636-637)

This discursive theme of inquiry is illustrated in the latter part of his monologue in the following extract:

Extract 16

Lines 598-658
I: That the common (2) um .hh theme or behaviour may be the self-harm
C: Yeah
I: but the actual triggering factors
C: Yeah
I: And circumstances
C: Yes they're they're always individual they're always particular and I think that that there's uh .hh it's uh .hh I mean the the thing about this is true whatever you know

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whatever kind of presentation you have I think it's just as true in in in the in the case of the the the person the obsessional you know and even the extreme that the person has .hh you know uh extreme obsessional behaviour ( ) and so on it it it's not it's not possible simply to to nail it down to particular traits and then then take those traits as measures of of uh (2) of (2) of other presentations or of ways in which now that we know we've got this case then we can kind of deal with .hh you know this other person who comes with similar uh (1) symptoms because it's there's I mean they this there are there are bound to be similar symptoms because we're you know (1) we're we're we're similar in in that in the sense that we're human and we we find ways to express ourselves within the the culture that that we we uh that we grew up grow up that that are going to there's going to be a parallel kind of a similarity between between one mode of expression and another and at the moment in this in this present age you know (1) uh (2) self-harm tends to be one of the modes of expression that's available to people who find themselves with uh (2) faced with with something that can't be spoken (2) uh so (2) we still have to find out from uh from each individual at the individual level what is it

I: Mm-hmm

C: That has that can't be spoken and to whom can it not be spoken (2) uh you know and uh and and in a way I mean and always there's the question of .hh (2) well the uh the question of of what's what's true in that and true in the sense of actual fact and and what you know how and and and what's understood or imagined by by the (2) um (3) particular individual you know it might be that that uh some that there is if the parent is (1) is

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listening but the the the the the child for whatever reason (1) uh (2) then sees the parent as someone who can't hear (2) um so there's there's that kind of difficulty that uh (3) how do you get over that and you know that it's it's not well I suppose what I'm saying is that that difficulties aren't external uh they're they're they're (2) in the in the first instance um leaving aside cases of extreme abuse and and and uh (2) whether in the first instance there's a kind of an internal uh (.2) struggle for the individual (1) uh (2) about to speak in any case um and then the question of well if I speak (1) who'd hear (2) um so

Jack constructs self-injury within a Lacanian discourse of the failure of language. He describes it as:

there's uh the question of of language and the failure of language in in uh in that whole idea of in in in self-harm or in in the cutting and the failure of language which give which leaves no room except to find another expression (lines 849-853)

This discourse of "the unspoken", "the unspeakable", "who will understand" recurs and repeats throughout his narrative. It appears to be a dominant framework for understanding his self-injuring patients and his analytic practice. Like Eimear, Jack repeats some of his ideas in his narrative. However, he diverges from her pattern in that he does not reiterate the same phrases to repeat his ideas about his conceptual frameworks for understanding self-injury and his current treatment practice. For instance, in Extract 17, this notion of the failure of language resurfaces in Jack's responses to my questions about the models and frameworks from psychoanalysis that he draws upon in his practice.

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Extract 17

Lines 848-884   C: I mean when you think think about there is there's there's uh the question of of <u>language</u> and the <u>failure</u> of language in in uh in that whole idea of in in in .hh self-harm or in in the cutting and the failure of language which give which leaves no room except to find another expression (2) um so that's kind of (4) I've a bit of (2) classical Freudian theory and a bit you know a big large part of .hh Lacan in it I suppose

    I: Okay so you would draw on both

    C: On both yeah definitely yeah I would I certainly would <u>and</u> I <u>think</u> <u>that</u> <u>probably</u> probably that in in the main (3) you know that uh

    C: I'd I'd I'd tend um other (3) other theories (4) like ( ) or whatever attachment theory or whatever all these I mean I <u>I</u> <u>tend</u> <u>not</u> <u>to</u> I if they're there they're <u>there</u> just because they're there you know but I'm not particularly conscious of them .hh um <u>but</u> <u>this</u> the the difficulty then I mean it's it's I um I (3) I sometimes wish I could <u>elaborate</u> the work <u>in</u> <u>terms</u> of the <u>theory</u> uh in a in a more um uh I know contained or a more (2) deliverable way and and I I I find that the whole thing gets mixed up <u>together</u> so much in my mind the the the, the practice and the theory are so kind of <u>interlinked</u> that I find it <u>difficult</u> to separate it

    C: Um what what's a theory from what's what's <u>something</u> <u>else</u>

    I: And you would feel that there's something unspoken about the way one practices (1) um that one can't exactly [describe]

    C: [That's]

    I: Exactly what happened

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C: I absolutely agree with that yeah yeah that's no question

about it that's one of the real difficulties

Jack speaks about how language is failing him in his attempts to articulate responses to my questions and put words on his practice and the psychoanalytic theory he uses in his work. One can hear this struggle to articulate in the following responses where he stammers and repeats a word before continuing as he confesses:

> I am not sure if I am making myself very clear on this I am kind of struggling
> a bit to kind of put it all together in a way that is fairly brief you know I feel I
> am probably not doing the thing justice really these situations cases like this in
> these kind of individuals tend to be enormously complex as we all are and it is
> very difficult to break it down to the strands that can be easily then taken out
> and used as a kind of a measure for other cases for other presentations (lines
> 409-417) I sometimes wish I could elaborate the work in terms of the theory
> uh in a in a more um uh I know contained or a more deliverable way and and I
> I I find that the whole thing gets mixed up together so much in my mind the
> the the the the practice and the theory are so kind of interlinked that I find it
> difficult to separate it (lines 867-873)

I acknowledge Jack's point about this struggle with language as I reply, "And you would feel that there's something unspoken about the way one practices um that one can't exactly describe" (lines 877-879). He concurs with me as he states, "I absolutely agree with that" (line 882). Jack's discourse is unlike the other clinicians in that it is about discourse. He is unique in speaking about "the question of of language and the failure of language in" (lines 849-850) self-injury "which leaves no room except to find another expression" (lines 852-853).

Jack opens a discourse about psychoanalysis as "having a a a particular language a particular discourse which is slightly at odds uh with the rest of the the common discourse" (lines 915-917) "of medicine or" (line 920) "psychiatry or or even psychology" (line 921) which he constructs as "a kind of a way a straight line discourse" (line 922). Jack's inquirer's discourse allows him to view psychoanalysis from outside his discipline. Referring to psychoanalysis, he admits:

> in the main and it has uh a kind of a body of theory that you know can can sometimes seem pretty whacky (lines 887-889) a particular discourse which is slightly at odds uh with the rest of the the common discourse (lines 915-917)

So here, he is talking about the difficulty of describing the analytic practice. Continuing with this theme about a struggle with language he speaks about "the reluctance to speak" (line 939) "I guess on my part but the part of psychoanalysis in general" (lines 940-941). I wonder if Jack's discourse about a reluctance to speak mirrors that of his self-injuring clients and the discourse about who will hear if I speak and whether it will be understood.

There are many instances in his narrative where Jack thinks aloud, muses, wonders and questions his discourse. The following Extract 18 is an example of this pattern of his.

Extract 18

Lines 1495-1539   I: No very interesting um I'm just wondering if you can tell me about your experiences of success with this kind of group

                    C: .hh Um (2) well now that's that's again another difficult question my experiences of what well I this I'd have to I'm starting with more general way I mean my my what

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does it mean to have success to be successful with .hh a a particular (1) client um it it it really means that they go off and they they <u>disappear</u> um and and one hopes that they're living their life (1) reasonably successful (1) somewhere .hh um so that's pretty well what I would expect and what I'd uh I'd I'd hope for for those whom I worked with who who self-harm .hh um all I would <u>know</u> is that the the something has <u>changed</u> in the course of the <u>work</u> and when they leave (3) they're no longer cutting themselves um (1) and they seem to have made some (2) <u>progress</u> and movement in their life you know something has changed and it's usually it's <u>more</u> than simply not cutting themselves there are lots of other external circumstance they'll have they'll have done different things you know um .hh (1) they'll have left home or got a relationship or .hh done whatever they'll so there's a uh a a movement has begun in their life that that seek that .hh they'll seek to uh that <u>allows</u> them some kind of of of (1) enjoyment and and uh (2) progress uh <u>that's</u> <u>as</u> <u>much</u> as I <u>know</u> I mean I (1) otherwise I I don't know it's not I don't do a six-month .hh follow-up you know ((laughs))

I: Okay

C: So I I I take it to be the <u>case</u> and I that that things are are are still fine six-months down the road <u>but</u> I don't know that

I: Mm–hmm

C: You know and the <u>difficulty</u> with that is of course if you start if you go back (1) and you say to someone well listen I'd like to maybe you could come back in six-months they <u>might</u> or might not come back and if they do you know so so what (2) how (2) they'll come back and give you a <u>report</u> but then for <u>whom</u> would they do that (1) for <u>me</u> or (1) or for them .hh um so all I can say

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then is that .hh I think (1) I've been <u>successful</u> but I <u>can't</u> prove it

Jack begins by acknowledging, "that's again another difficult question" (lines 1498-1499). Then, he muses as he poses the question, "what does it mean to have success to be successful with a a particular client" (lines 1501-1502). He provides the following reply:

> Um it it it really means that they go off and they they disappear um and and
>
> one hopes that they're living their life reasonably successful somewhere um so
>
> that's pretty well what I would expect and what I'd uh I'd I'd hope for for
>
> those whom I worked with who who self-harm (lines 1502-1507)

Thus, in his response to my questions about his current treatment practice effectiveness with self-injuring clients, Jack is opening up a discourse of inquiry about what it means to be successful with self-injuring patients or as he states, "a particular client" (line 1502). He speaks about the difficulty of trying to figure out whether one has been successful. Jack reveals:

> Um all I would know is that the the something has changed in the course of
>
> the work and when they leave they're no longer cutting themselves um and
>
> they seem to have made some progress and movement in their life (lines 1509-
>
> 1513)

He acknowledges, "Uh that's as much as I know I mean I otherwise I I don't know" (lines 1521-1522). Therefore, Jack admits that there is a knowing about changes that he observes in his work with self-injuring patients, but he also holds the possibility that there is an unknowing too. He confesses:

I don't do a six-month follow-up you know (lines 1522-1523) So I I I take it to

be the case and I that that things are are are still fine six-months down the road

but I don't know that (lines 1527-1529)

This leads him into a discourse of inquiry about the difficulty with follow-up

sessions. Jack makes some interesting points here. He posits:

if you go back and you say to someone well listen I'd like to maybe you could

come back in six-months they might or might not come back and if they do

you know so so what how they'll come back and give you a report but then for

whom would they do that for me or or for them (lines 1532-1537)

He concludes, "Um so all I can say then is that I think I've been successful but

I can't prove it" (lines 1537-1539). Thus, he acknowledges that he lacks evidence to

support his treatment effectiveness with self-injuring clients other than his own

observations of patient changes but in the course of saying this he questions how he

understands "success" and its limitations.

In summary, Jack locates himself within an inquirer's discourse in which he

appears to think aloud, muses, wonders and examines his discourse in response to the

questions I pose. His pattern of response is mostly a sequence of long monologues in

which he seems to be working out his thoughts in relation to the questions I ask him.

He elaborates on his ideas and even draws on one of his clinical cases to further

articulate his view.

Chapter Summary

In this chapter, I considered the striking differences in the clinicians'

discourses with respect to taking a position about their conceptions of self-injury and

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their treatment approach in the face of questions about the effectiveness of their treatment. Two distinct discourses surface with specific patterns. The "expert" discourse emerges as a repeating, clear, narrow and unquestioning stance among some clinicians. In contrast, the other discourse, that of the "inquirer" appears to think out loud, muse, wonder, question and revise their discourses in response to my questions. I examined two clinicians' narratives in detail (Eimear's and Jack's), as exemplars of both of these discursive patterns. Eimear's narrative illustrates an expert discourse, while Jack engages in an inquirer discursive style.

These findings suggest that some clinicians may be open to engaging in a discourse of inquiry in relation to questioning and revising their conceptual frameworks for self-injury and their particular treatment modality. Others may position themselves within an expert discourse where they are convinced that their particular conceptualisation of self-injury and treatment approach is the best and therefore, shut down any possibility of exploring other discourses. I will discuss these findings further in Chapter Eight.

Chapter Seven

Findings: Discourse on Outcomes

In this chapter, I mark out the clinicians' discourses with respect to the research question that pertains to the ways in which they gauge or measure their clinical effectiveness in their current treatment practice with self-injuring patients. They engage in various styles of response to my question where I invite them to speak about their experiences of and criteria for measuring treatment success, failure and partial failure with self-injuring clients. In addition, the clinicians engage in various discourse indicators of success, discourse indicators of failure and a discourse pattern of assigning responsibility in relation to treatment effectiveness.

Discourse of Success

I begin by discussing the clinicians' initial responses to the first interview question that I had asked them in relation to treatment effectiveness. I commence this section of the interview with a question inviting them to speak about their experiences of success with self-injuring patients. Their various responses suggest that my question causes them difficulty. This is evident from their multiple patterns of response that include a surprised response, a floundering response and a difficulty relating to the question.

David seems to be surprised by my question about treatment success as he responds, "Goodness um I suppose that is an area that we probably don't focus a huge amount on" (lines 893-894, part 3). Here, he appears to be speaking as a collective voice on behalf of himself and other clinicians whom he constructs as not paying a "huge amount" (line 894, part 3) of attention to their experiences of treatment success

with self-injuring patients. He gives the following reason for this absence of focus, "Um one tends to be very much caught up with those who are uh acutely presenting" (lines 894-896, part 3).

Jack flounders as he admits the difficulty of this question. He points out, "Um well now that's that's again another difficult question" (lines 1498-1499). This floundering response of his and his inability to take this discourse any further is in sharp contrast to his more usual pattern of fluent and elaborate responses. He continues to be thrown and disconcerted by my question as he struggles to articulate his response, "My experiences of what well I this I'd have to" (lines 1499-1500). This struggle continues as he attempts to articulate his response, as he states, "I'm starting with more general way" (line 1500) and then he stops and reframes my question as he makes the following address, "I mean my my what does it mean to have success to be successful with a a particular client" (lines 1498-1502). It is not clear to whom Jack is addressing his question, himself, me or some other.

My question about "what would constitute a treatment success" (lines 2071-2072) appears to evoke a strong response from Mike. He exclaims, "Oh Jesus I've no idea" (line 2073). This response suggests that he has no idea how to answer the question I had posed. Then, he shifts the focus away from his difficulty in responding to my question and reacts to my use of the word "treatment". He informs me, "I don't do treatment" (line 2076) and he laughs.

Niamh's discourse also suggests that she is experiencing difficulty relating to my questions about treatment effectiveness. Indeed, she even articulates this problem in her address to me as she admits, "I can't relate to the question Aida to be honest" (lines 1935-1936). She further reiterates her difficulty by repeating her reply, "I really

can't relate to the question" (line 1938) a second time. Despite this obstacle, she tries to engage in a dialogue about treatment success and failure. She begins, "I mean the word success the word failure doesn't actually I mean it's like you say to me is your life a success" (lines 1642-1645). She then opens up a discourse in which she centres around this question she has posed. She acknowledges, "I don't know that my life's a success I'm doing my best to get by" (lines 1645-1646) "and to enjoy and fully live" (line 1648).

Ciara demonstrates a completely different response to my question about her experiences of success. She does not take up this discursive invitation of mine. Thus, there is an absence of a discourse about her experience in this area. Instead, she shifts her discourse by telling me about her thoughts about what success means. She states, "I think success is a combination of" (line 1298, part 1) "factors" (line 1299, part 1). She explains, "If it's an affective disturbance that's driving it well then medication (lines 1299-1300, part 1) can be helpful" (line 1301, part 1). She argues:

> I think age and experience and maturity (lines 1301-1302, part 1) can settle it
> down without any sort of intervention at all (lines 1302-1303, part 1) and (line
> 1303, part 1) just addressing the (line 1304, part 1) difficulty whether it's an
> interpersonal difficulty showing people coping skills (lines 1305-1306, part 1)

I now consider the various discursive patterns that emerge in the clinicians' narratives in relation to treatment success, failure and responsibility for outcome. In mapping out the clinicians' discourses in relation to the ways they gauge or measure their clinical effectiveness, there appears to be little to no systematic way of thinking or conceptualising "success" with regard to self-injury. Rather, the clinicians seem to develop parameters of success by looking elsewhere beyond self-injury itself. What is

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striking about their discourses is that they map out other markers of progress and appear to reach some agreement about these indicators.

Discourse markers of success. As a group, most of the clinicians give a nod to the reduction or cessation of self-injury as an indicator of progress with the exception of Mike, who does not mention this at all. These discourse markers in relation to self-injury range from, "moderation of self-harm" (David, line 1124, part 3) "a reduction in frequency" (Mark, lines 1983, part 2) to "they're less kind of preoccupied about it" (Ciara, lines 1321-1322, part 1) "that the self-injury doesn't become part of their daily routine" (Ciara, lines 1547-1548, part 1) to "they've stopped" (Sinead, lines 350, part 2). Some clinicians such as Niamh, Ciara and Jack all agree that stopping self-injury is not always an indication of progress. Niamh's discursive response to this subject matter is interesting because she tries to read me as she attempts to anticipate the response she believes I am searching for with my question. She does not appear to realise that I am trying to engage in a discourse of inquiry with her as she informs me, "I know that you want me to say that the self-injuring behaviours disappear but I'm I'm saying okay they reduce and they're not the norm" (lines 1789-1791) "But that's only one aspect" (line 1793). Ciara also elaborates on her discourse and makes the point that the cessation of self-injury is not necessarily a reliable gauge of progress. She claims that, "sometimes the self-injury can transfer into into again more subtle forms" (lines 1318-1325, part 1). She explains this point:

> Um well I don't think you can measure success purely on somebody stop stopping self-injuring because they might start writing very black stuff in their diary and it's very worrying and they keep the diary forever and self-injuring

has stopped but the actual psychological trauma hasn't so I don't think necessarily stopping the self-injury is a measure of success or otherwise (lines 1311-1318, part 1)

Collectively, the eight clinicians in this study do not appear to adhere to a shared set of specific criteria for measuring or gauging successful treatment outcomes with self-injuring clients. However, the following markers of success in relation to changes they notice in their patients emerge in their discourses, improved coping skills, more enriching relationships, changes in discourse and knowledge of themselves, increased functioning and active participation in their lives.

Two discursive patterns emerge in the clinicians' narratives as they mark out the indicators of success other than changes in the behaviour of self-injury. These include a discourse of elaboration and a discourse of non-elaboration. A discourse of elaboration refers to the discursive pattern where the clinicians not only speak of markers of progress but also develop their discourses to include an articulation of the changes they observe in their practice with self-injuring patients. Three clinicians, Jack, Niamh and David engage in a discourse of elaboration. In contrast, clinicians who engage in a discourse of non-elaboration do not go beyond merely listing a number of indicators of success in relation to their treatment of self-injury. In this regard, Mark, Mike, Eimear, Ciara and Sinead's narratives emerge as discourses of non-elaboration.

Jack, Niamh and David engage in very different discourses of elaboration in which they develop and articulate a discursive logic around treatment success and markers of progress, which is the antithesis to the other five clinicians' discourse. Their discourses go beyond a mere listing of indicators of success. They speak about

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their views about this subject matter and construct a logical argument to defend their discursive position.

Jack considers my question, "Um I'm just wondering if can tell me about your experiences of success with this kind of group" (lines 1496-1497) and poses his own version, "what does it mean to have success to be successful with a a particular client" (lines 1501-1502). He then responds to this question telling me:

> Um it it it really means that they go off and they they disappear um and and one hopes that they're living their life reasonably successful somewhere um so that's pretty well what I would expect and what I'd uh I'd I'd hope for for those whom I worked with who who self-harm (lines 1502-1507)

However, his discourse does not end there, he elaborates further and enters a discourse about what is known to him as the analyst and what is unknown to him in relation to the client's treatment progress. He admits:

> Um all I would know is that the the something has changed in the course of the work and when they leave they're no longer cutting themselves um and they seem to have made some progress and movement in their life you know something has changed and it's usually it's more than simply not cutting themselves there are lots of other external circumstances they'll have they'll have done different things you know um they'll have left home or got a relationship or done whatever they'll so there's a uh a a movement has begun in their life that that seek that they'll seek to uh that allows them some kind of of of enjoyment and and uh progress (lines 1509-1521)

Jack is the only clinician who names a change in the patient's discourse as an indicator of an advance in treatment. This is not surprising considering he is a psychoanalyst who applies a Lacanian framework and therefore, focuses on the analysand's speech and discourse in his analysis of self-injuring clients. He explains that this discourse marker:

> becomes much more elaborated and uh you know the and and the the uh the focus on uh the the the particular things that might have that are a are kind of tied up with uh with the cutting (lines 1553-1556) Uh that that tends to have fallen away both the both the behaviour but also uh a lot of the other ways in which the person will have made sense of things you know that their their sense of things uh their understanding would have been become much more um multilayered (lines 1558-1563)

In relation to these markers of success, Jack concludes, "Uh that's as much as I know I mean I otherwise I I don't know it's not I don't do a six-month follow-up you know" (lines 1521-1523). He elaborates, "So I I I take it to be the case and I that that things are are are still fine six months down the road but I don't know that" (lines 1527-1529). He admits, "Um so all I can say then is that I think I've been successful but I can't prove it" (lines 1537-1539). Thus, he is articulating that he has no formal systematic way of evaluating his treatment success with self-injuring patients. In addition, he acknowledges that as the clinician, he has no way of knowing if clients' progress has been maintained because he does not conduct "a six-month follow-up" (line 1523). Jack's discourse suggests that he is not necessarily in favour of "a six-month follow-up" (line 1523) as he questions whose interest does this serve, the

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patient, or the clinician, as he wonders "for whom would they do that for me or or for them" (lines 1536-1537).

To summarise, Jack engages in a discourse of elaboration where he initially questions the whole notion of "success" (line 1501) "with a a particular client" (line 1502). He then names some markers of success such as "they go off" (line 1503) "they're living their life reasonably successful" (line 1504-1505) "they're no longer cutting themselves" (line 1511) "they'll have left home or got a relationship" (line 1517) their discourse "becomes much more elaborated" (line 1553). He also articulates a discourse that centres around these markers of success as identified by him as the clinician, in relation to a client's progress. However, he also speaks about an aspect of success that is unknown to him in relation to whether these markers of success are maintained by the patient in six-months time. Thus, he acknowledges that he has no way of knowing because he does not conduct six-month follow-up sessions with self-injuring clients.

Niamh's discourse of elaboration is very different to Jack's on the subject of treatment success. Her discourse suggests that she has a difficulty with the language of my question about, "What would constitute a treatment success with self-injuring clients" (lines 1620-1621). She responds, "Treatment success success implies failure as well doesn't it" (lines 1622-1623). She further elaborates on her discourse about "treatment success" (line 1626) where she rejects my language. She argues:

> I mean people who engage in therapy are not being treated (lines 1626-1627)
> They're actually they're actually learning from themselves to recognise and
> respect what's happened to them and the pain it's caused them and how to
> tolerate that and share it with you know other people (lines 1630-1634) To

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actually be able to allow themselves to own it in the presence of other people (lines 1636-1637) and find ways on a daily basis of coping with it that are not about further you know hurting themselves (lines 1640-1642)

She elaborates further and continues with her objection to the concepts of failure and success and questions their value. Niamh posits, "So I mean the word success the word failure doesn't actually I mean it's like you say to me is your life a success" (lines 1642-1645). She answers this question acknowledging, "I don't know that my life's a success I'm doing my best to get by" (lines 1645-1646) "and to enjoy and fully live" (line 1648). She concludes, "So you know it's like that with a client too" (line 1655). She puts forward the argument that only patients can actually decide whether treatment is successful. Niamh proposes:

It's like we're all looking for greater degrees of freedom and to live more fully (lines 1655-1657) And you know no outside source is going to be able to assess that properly (lines 1660-1661) for me about my you know my life (line 1663)

She contends that:

clients again will be able to say when life has opened up to the degree they are now (lines 1665-1666) able to tolerate respect (line 1675) the pain that's happened to them in their lives and (line 1680) live more fully in the present (line 1683) and the self-harming bit is one aspect of it (lines 1667-1668)

Thus, she appears to be proposing that only patients can judge whether treatment has been a success. She maintains that it is not a therapists' role or function to make a judgement about treatment success and failure. She states, "And and I

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don't think it's a therapist's job to hand out you know you're an A+ you're a B- (lines 1945-1946) "It doesn't have much reality" (line 1948) "for me really" (line 1950). She explains, "D'you see I'm not really thinking in terms of failure pass or fail or honours" (lines 1841-1842).

In summary, Niamh engages in a discourse of elaboration but she appears to encounter some difficulty with my question about treatment success. Her specific problem seems to be related to the phraseology of my question, which she rejects. In her narrative, Niamh objects to the notion of people being treated and the concepts of success and failure.

David's discourse of elaboration about treatment progress is centred around his clinical experience with self-injuring clients and his construction of success as "it's going to depend on the individual" (lines 1109-1110, part 3). This discourse is consistent with a pervasive discursive pattern that repeats throughout his narrative, where he seems to think of everything through the lens of his clinical experience and his contingent or "it depends" (line 46, part 2) discourse. He is the only clinician who provides clinical examples in response to my invitation to speak about experiences of success with self-injuring patients. He replies, "Um well I suppose the I know the there's a few people that come to mind I mean uh in terms of outcomes so is that what you're asking" (lines 898-900, part 3). He continues:

> Like I've had a few different and uh people male and female who've certainly
> moved on very effectively in their lives and uh attend me occasionally now
> largely for uh touching base reasons maintaining contact and um some of
> whom are on medication so it might be once in a six-month period or
> sometimes maybe once in a year (lines 902-908, part 3)

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Thus, David seems to hold the view that treatment can be a success even if the client still has reduced or less frequent contact with him. He appears to use markers other than contact as indicators of success.

He develops a logical argument about his particular construction of treatment success and markers of progress. He proposes that success has different criteria for each patient and is related to the starting base, at which they started when they entered treatment. David tells me that the indicators of progress "would have to be tailored to the individual base really" (lines 1498-1499, part 3). He refers to his clinical case examples informing me:

in those few cases I mentioned people's lives obviously became very we'll say quite aligned towards uh what would be viewed as the average (lines 1110-1113, part 3) for people as a whole that they weren't having a crisis their lives had moved on embarking on relationships there's stability work uh work work going okay etc (lines 1115-1118, part 3)

He argues:

So on those levels I suppose the the uh in those cases the the indications of progress were were great and over a broad number of areas uh another case it can be quite different um an index of success may well be um moderation of self-harm (lines 1120-1124, part 3) Um it could be um a degree of adjustment if they've been moving away from crisis presentations moving away from (lines 1126-1128, part 3) potentially dangerous forms of self-harm um which either by intent or accident could prove fatal um could be establishing oneself in independent living (lines 1130-1132, part 3)

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In keeping with this contingency or "it's going to depend on the individual" (line 1109-1110, part 3) discursive position, he contends, "that being able to bring uh acute problems to the therapy session rather than acting out (inaudible) self-damaging" (lines 1491-1493, part 3) "that will be a success" (lines 1493-1494, part 3).

David uses the analogy of the Special Olympics to emphasise his argument. He begins:

> Um as what will be successful for one may be uh a a small opening for another uh but like the um Special Olympics for example um one could compare to another athlete and say oh well sure that's not particularly high on the achievement stakes but it could be an enormously high on the achievement stakes if one looks at where the person was coming from (lines 1501-1507, part 3)

Thus, he is arguing, "what's a success for one person um maybe maybe seem like fairly limited steps" (lines 1486-1488, part 3) for another individual. So he concludes, with his recurring discursive pattern of "it depends" (lines 1507-1508, part 3).

He also engages in a long and elaborate discourse about four self-injuring patients whom he has worked with over a number of years in his clinical practice to support his discursive position on success. In fact, David's narratives of these clients, extends for nine and a half pages of the interview transcript. He tells me about these four patients and how they have moved from one end of a continuum to another in terms of marked changes in their abilities to cope and engage in life activities. These case examples seem to suggest that he considers treatment to be successful even if the client still has contact with him. For example, he speaks of:

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one young woman (lines 908-909, part 3) who had quite a long history of uh self-harm through overdoses" (lines 911-912, part 3) who had been very emotionally unstable and inclined to respond catastrophically to all sorts of scenarios um stressful scenarios or adversity or perceived adversity (lines 920-923, part 3)

He explains that his sessions with her had moved from a "period of protracted therapy" (line 986, part 3) to "gradually reduced the frequency of attendances and she was now attending me occasionally" (lines 987-988, part 3). David informs me, "then a pretty major life stress arose" (line 989, part 3) and she contacted him "in uh a state of acute uh distress" (lines 929-930, part 3). He notes:

> the response on the telephone um when she called me actually had done uh the trick (lines 934-936, part 3) the contact had acted as a sounding board as an opportunity for her to express her upset but also to formulate a plan (lines 965-967, part 3) she didn't decompensate at all (line 991, part 3)

To summarise David builds his discourse pattern of elaboration around his clinical practice from which he argues that success is contingent or "it's going to depend on the individual" (lines 1109-1110, part 3). He puts forward a discursive logic from which he argues that the markers of success are different for each individual depending on their "individual base" (line 1499, part 3) at the point of entering treatment. He draws heavily on his clinical cases and the analogy of the Special Olympics to elaborate and support his argument.

The other five clinicians, Sinead, Mike, Mark, Ciara and Eimear's, narratives emerge as an unelaborated discourse that rarely goes beyond naming a few indicators

of success other than self-injury itself. For example, Sinead mentions the following markers of progress:

> in terms of self-harm if you're dealing with self-harm has stopped (lines 1389-1390, part 1) that's one marker (line 1392, part 1) the individual has managed to find a way to deal with the adversity whether it's the how they deal with themselves or the their how they manage their emotions or some external adversity (lines 1395-1398, part 1) they feel more able to meet the challenge of that (lines 1400-1401, part 1) they're more confident about how they can move through it (lines 1406-1407, part)

She does not develop her discourse further, other than adding:

So you know in many ways that I mean success is yes and the symptoms are gone (lines 1407-1408, part 1) the story has a happy ending ((laughter)) but you know it's not always that clear (lines 1410-1411, part 1) Sometimes it's simply I've got enough here to feel that I have the skills or the confidence or the strategies to to manage (lines 1413-1415, part 1) from here on in and that I have management rather than it's gone (lines 1417-1418, part 1)

What strikes me about her discourse is the missing reference to changes in patients' relationships. This omission stands out because she specifically mentions attachment theory as a framework that she draws on in her work.

Mike's discourse about markers of progress is brief. Surprisingly, he does not name the cessation or reduction of self-injury as an indicator of success. His indicators of success are broad and general statements and he does not explain what they mean. He articulates:

I just would see success as people sort of leaving with different knowledges about their lives with with with uh a sense of direction in their lives with sort of um a sense of knowing what they need to do rather than what I need to do for them (lines 1648-1652) it's more than somebody just leaving and saying that they're happy you know (lines 2081-2082) Because but it's also me from being happy for them to leave as well (lines 2083-2084) if they're they're they're doing something that's healthier or if they're responding to their experiences in a way that isn't harmful to themselves or others so that would be a success (lines 2086-2089)

Mark is the only clinician whose discourse about signs of success does not go beyond self-injury. Thus, he engages in a limited discourse in relation to gauges of treatment success. He states, "so from a decrease in frequency over time um to extended you know increasing gaps between uh harming right up to practically practical cessation of of of uh harming" (lines 1696-1699, part 2).

Ciara's discourse is also somewhat limited in terms of not elaborating beyond her naming the markers of success that she employs in her treatment practice. She proposes:

I don't think you can measure success purely on somebody stop stopping self-injuring because they might start writing very black stuff in their diary (lines 1311-1313, part 1) So I don't think necessarily stopping the self-injury is a measure of success or otherwise but if somebody's functioning in their day-to-day activities they're subjectively feeling better objectively they look better and they're planning for the future they're less kind of preoccupied about it that would be more of a measure of success than physically stopping the self-

injury because sometimes the self-injury can transfer into into again more subtle forms (lines 1315-1325, part 1)

Eimear's discourse is striking because of its lack of elaboration on an evidence-based discourse considering that she is the only clinician who declares, "Well I think it it you know I'm a great believer in evidence-based interventions and" (lines 1380-1381) "certainly dialectical behaviour therapy is one intervention for which there is a good scientific evidence base in terms of effect" (lines 1383-1385). She lists the following markers of progress, clients are:

no longer patients of a psychiatric service" (lines 1459-1460) "the reduction in self-injury the reduction in time spent in psychiatric hospice the reduction in time spent with the team the reduction in medication and then the success in terms of life goal that people were getting back into academia getting back into work getting back into the life that had meaning for them (lines 1524-1539)

She also adds that "having more rewarding relationships" is another sign of a positive treatment outcome. An interesting feature in relation to her list of indicators of success is the absence of a reference to self-injuring clients learning affect-regulation skills as her construction of self-injury centres around these individuals having a "skills deficit" (lines 150-151) "in terms of managing distress and managing emotions" (lines 156-158).

Her discourse of non-elaboration is more surprising than the other clinicians who engage in a similar pattern of not speaking beyond naming a few indicators of progress. Eimear acknowledges being "a great believer in evidenced-based interventions" (lines 1380-1381) and she claims that DBT has "a good scientific

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evidence-base in terms of effect" (lines 1384-1385). Yet, she does not engage further on either of these points. What is also interesting is that she does not elaborate on progress in relation to patients acquiring emotional regulation skills considering the central feature of her view of self-injury hinges around "a skills deficit" (lines 150-151) in this area.

Discourses of Failure

I now examine the various discursive patterns that emerge in the clinicians' narratives in relation to treatment failure and partial failure. The clinicians' discourses about their criteria for gauging or measuring failure and partial failure, with regard to their treatment effectiveness with self-injuring clients, is in marked contrast to their discourses about treatment success. Indeed, their discourses are wide ranging and unelaborated in terms of not engaging in a dialogue beyond naming a few markers of failure. For instance, Eimear's discourse is a good exemplar of this discursive pattern as illustrated in the following Extract 19 below:

Extract 19

Lines 2115-2131   I: Um and then what would you constitute as what do you think constitutes a treatment failure partial failure with this group

C: Suicide

I: Okay that would be the ultimate [( )]

C: [Mm-hmm]

I: Or would it be related to anything else (2) where a clinician might fail (2) with somebody who self-injures

C: I suppose it it would be that or just failing to engage somebody in [therapy]

I: [Mm-hmm]

C: (9) I can't think of anything else

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There is also a pattern among some of the clinicians' discourse where a level of uncertainty emerges in their narratives in relation to what exactly constitutes a treatment failure. The following Extract 20 from Mike's narrative is a good example:

Extract 20

Lines 1799-1822   I: Okay I was just wondering if you could tell me about your experiences of <u>failure</u> or partial failure in working with self-injuring clients

    C: (4) Um (10) sorry I'm not sure about <u>failure</u> ((laughs))

    I: Mm-hmm

    C: I know there was one person I met who came once and who didn't come <u>back</u> but that's their <u>choice</u> so that's not that's whatever I was doing didn't gel with them or whatever

    I: Mm-hmm

    C: But it's yeah (2) I would have liked if they'd come back because I thought we could have really got somewhere with it um (2) but (3) they didn't come back I <u>invited</u> them back but they didn't come back (2) so um see what's <u>failure</u> ((Laughter))

    I: Well what do you think failure is

    C: Um (1) I think failure would be somebody <u>leaving</u> having attended uh for a while, somebody leaving <u>dissatisfied</u> but if they come for <u>one</u> meeting and then they leave and they don't come back well they're making a <u>choice</u>

    I: Mm-hmm

    C: That this is <u>not</u> for them or this is not what they expected or whatever (2) um

So initially Mike acknowledges he is "not sure about failure" (line 1803). Then, he appears to be trying to work out what treatment failure is, and decides that a

client must attend for a period of time and then stop coming. This teasing out of the concept of failure surfaces in some of the clinicians' narratives.

Discourse markers of failure and partial failure. No singular clear discourse emerges with respect to markers of failure among the clinicians' narratives. However, five discursive patterns surface across the group of clinicians' narratives. These include discourse of failure in relation to suicide, discourse of disengagement in relation to failure, discourse of narrative experience of failure, discourse of partial failure and discourse of remain the same or worse.

Discourse of failure in relation to suicide. The phenomenon of suicide as a marker of treatment failure with self-injuring patients emerges in four clinicians' discourses, Eimear, Sinead, David and Ciara. A possible reason for this missing discourse in the other four clinicians' narratives may be due to their clinical distinction between suicide and self-injury that they reveal in their dialogue with me about their conceptualisation of self-injury. In response to my question, "what constitutes a treatment failure or partial failure with self-injuring clients", Eimear replies with a one word response, "suicide" (line 2118) and does not elaborate further. In contrast, Sinead does not explicitly mention suicide as a treatment failure. However, she does make a reference to the possibility that a patient could die as a result of self-injury and that she would consider this "a real failure" (line 379, part 2). She states, "Um I suppose a real failure would be if if they either didn't want to stop or couldn't stop and/or became seriously ill or died as a result of the self-injury" (lines 379-381, part 2). She concludes, "That would be the ultimate awful outcome" (lines 383, part 2) "Bad outcome" (line 385, part 2). In contrast, both psychiatrists, David

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and Ciara engage in a more open discourse in which they speak about grappling with suicide, and the difficulties and the impact of a client's suicide.

David comments, "the ultimate failure is when a client commits suicide" (lines 1165-1166, part 3). As a discourse marker of suicide as a treatment failure, he admits, "clearly if you're getting a a request from the coroner uh for a report you can fairly gauge that it was unsuccessful in the intervention" (lines 1272-1275, part 3). Speaking of patients committing suicide, he acknowledges that this "has happened" (line 1168, part 3) "in terms of of of patients with a history of self-harming behaviours" (lines 1168-1170, part 3). He confesses, "Um it's very difficult" (line 1170, part 3) Um there were times when you know that somebody you're treating therapeutically may well uh end their life" (lines 1172-1174, part 3). David reveals:

> I mean I have two in hospital at present and I know it's a very distinct
> possibility (lines 1176-1177, part 3) Uh it's extremely difficult it's always
> traumatic um I suppose all you can do is acknowledge it and uh be open about
> it (lines 1180-1182, part 3)

His discourse on suicide ends here with no further elaboration.

Ciara's discourse of failure in relation to suicide is the antithesis to David's. In Extract 21, Ciara engages in a long monologue that is atypical of her usual brief discursive pattern of responses to my questions. She appears to be making a plea to an invisible audience whom she constructs as not understanding the impact and effects of a client's suicide on psychiatrists. In addition, you can also hear her discourse of distress as she speaks about the personal impact that a patient's suicide had on her.

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Extract 21

Lines 1336-1423, part 1   I: Uh and just around in terms of I'm wondering if you can tell me about your experiences of failure or <u>partial</u> failure with self-injuring clients

            C: Oh well failure is suicide

            I: Okay the ultimate

            C: (2) Um I've had people who have attempted hanging and have been caught in the act .hh um so that's very distressing that's very distressing for family for the individual .hh very distressing for the therapist and the doctor the clinician I think people .hh families individuals <u>greatly</u> under underestimate the impact of it on on therapists and um .hh (2) my view is that that individuals patients have a responsibility to their therapist as <u>well</u> emotional responsibilities .hh (2) and um I think it can be kind of important to introduce that into a dynamic um particularly if somebody has recurrent suicidality and and <u>quite</u> often people don't they think as far as the act they don't think beyond the act they don't think about who will find the <u>remains</u> and who will have to identify and the funeral and who will pay for the funeral .hh and who'll be at the funeral and sometimes people fantasise about the eulogy but don't actually think about the first week and the first anniversary and birthdays and how does your brother say when they go to see a doctor any family history of mental illness and um and that can be very helpful that actually can be very helpful in terms of suicidality and people talk about it when you make people walk through (2) if they committed suicide <u>well</u> beyond the the actual act itself and the impact .hh on A B C D E and the psychiatrist or the therapist and um (2) people feel that therapists become neutralised and immune to to

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suicide and they and they <u>don't</u> and um .hh (2) I think it's important to back that up where people have found that that really we don't become immune to it it's extremely distressing um .hh it's much more distressing to lose a patient through suicide than it is to lose somebody through a heart attack and .hh there's a huge degree of personal responsibility assumed and guilt assumed and regret .hh assumed and um again it's not something we in psychiatry talk enough about is is is the .hh um is the huge distress that suicide can cause to us um (2) and quite often it's not something you can share at <u>home</u> because it's people don't really <u>understand</u> it and you don't want to be burdening somebody with that each evening .hh um, and your colleagues can often be quite <u>busy</u> so it's very difficult to to um (2) personally I find it very difficult to to deal and cope with the suicide of a patient um .hh and I find it very distressing and and it comes after you <u>years</u> afterwards um and it never actually goes away and you <u>never</u> actually forget um may move on and get on with things but at the same time it doesn't actually go away and quite often the anniversary of the suicide the psychiatrist thinks of probably as much as the the family members might think about and um .hh I think people aren't aware of that I think patients (1) family members feel that this is part of your day's work and you move on and it's <u>actually</u> not

I: Mm-hmm

C: .hh And um so I try to tell people that particularly to try ((laughs)) and use it as a deterrent in some ways and um that they they might say oh my family have no experience of suicide so they would I wouldn't know what they would expect and I can say well this is my experience and um (2) and again that can be um I <u>mean</u>

I don't use it to <u>manipulate</u> but I I think I use it to try and <u>illustrate</u> that it's not as benign an act as as people think it is so yes I have I haven't had ((laughs)) very many suicides thank God but I've had a few and um I suppose you could view them as failed deliberate self-harm you could view them as suicide it depends (1) you know some some weren't self-harm at all some were some were .hh (1) very deliberate acts of suicide um (3) and I've had a couple of acts that have gone self-harm acts that people didn't intend to kill themselves but that have gone very close to the brink because people have taken too many medication .hh too much medication .hh or you know (2) that they've the the precautions they took to be discovered didn't actually work out or those sort of things (2) so um (3) that's it

In the Extract 21, Ciara enters into a very elaborate narrative about the emotional impact on the professionals involved and holds the view that the patient is responsible for the emotional impact of suicide on the clinician. She constructs failure as suicide as she states, "Oh well failure is suicide" (line 1339, part 1). I reply to her with the following, "Okay the ultimate" (line 1340, part 1). She in turn responds in which she speaks about how suicide is "very distressing for the therapist and the doctor the clinician" (lines 1342-1343, part 1) and her opinion that "patients have a responsibility to their therapist as well emotional responsibilities" (lines 1350-1351, part 1). Thus, it seems that she holds the notion that suicidal clients have an emotional responsibility to their clinicians and are responsible for the impact they leave behind following a completed suicidal act.

Mid-way through this extract, Ciara constructs "people" (line 1370, part 1) as holding the view "that therapists become neutralised and immune to to suicide" (line

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part 1). She challenges this and claims that, "we don't become immune to it" (lines 1373-1374, part 1). She speaks of the emotional impact of this, of how "it's extremely distressing" (lines 1374, part 1) for the clinician and that "there's a huge degree of personal responsibility assumed and guilt assumed and regret assumed" (lines 1377-1379, part 1). She refers to not speaking of this experience of a patient's suicide among colleagues in psychiatry and that "it's not something you can share at home because it's people don't really understand it and you don't want to be burdening somebody with that each evening" (lines 1382-1385, part 1). She confesses, "Personally I find it very difficult to to deal and cope with the suicide of a patient" (lines 1388-1389, part 1) "I find it very distressing" (lines 1389-1390, part 1). Ciara maintains that, "quite often the anniversary of the suicide the psychiatrist thinks of probably as much as the the family members might think about" (lines 1394-1396, part 1). She admits, "it comes after you years afterwards um and it never actually goes away and you never actually forget" (lines 1390-1392, part 1).

This long monologue of Ciara's is an exceptional pattern in her discourse compared with her more usual brief style responses. She seems to be engaging in an elaborate story about suicide, speaking about the emotional impact of a client's suicide on her as a human being. It is almost as if she is seeking out someone to hear how painful it is to experience the loss of a patient as a result of suicide. While her discourse suggests that she is trying to speak about what it is to face failure, she does not get back to my question of failure and her practice in relation to treating self-injury.

Discourse of disengagement in relation to failure. The subject of disengagement as an indicator of failure emerges in Ciara, Sinead, Jack, David and

Niamh's discourses. They all agree that disengagement from treatment is a measure

of failure, yet their articulations of this discourse marker differ considerably from

each other. Ciara's response is a one word "disengagement" (line 14, part 2) with no

further elaboration.

In contrast, Sinead, Jack, David and Niamh's discourses about disengagement

in relation to treatment failure demonstrate a little more elaboration than Ciara's.

What is striking about their discourses is that they appear to be exploring and

considering different constructions of disengagement as a marker of treatment failure.

However, they do not develop and elaborate their discourses beyond making a point

of argument.

Sinead says, "these are the ones where they may not come back and you're not

sure what the not coming back is about" (lines 1423-1425, part 1). She offers a few

brief insights about "what the not coming back is about" (lines 1425, part 1). She

suggests:

> It might be where I have not been able to offer them any alternatives to the
>
> self-harm in terms of resources or strategies but also I think where maybe I
>
> haven't really got a good sense of what's driving it (lines 1427-1430, part 1)
>
> Or we we don't agree (line 1432, part 1)

She explains, "like I might offer ideas about what I think and I would rely on

the client on letting me know whether that or that doesn't even interest them" (lines

1439-1441, part 1). Sinead considers another alternative; "Um or it may not be the

main reason they're here" (lines 1445-1446, part 1). She elaborated, "That's just part

of the picture but what they really want is you to write a letter ((Laughter)) to uh get

an essay extension or uh you know not do their exams or you know" (lines 1449-1452, part 1).

Jack's discourse suggests that he is teasing out the reasons for self-injuring clients' disengagement from treatment. He explains,

> Yeah well I mean failure is where someone simply doesn't you know if they they continue they their uh work hasn't progressed enough so I've failed somehow to uh engage them or you know to allow some kind of a space so that something can be spoken about um and they don't turn up again they they stop coming I uh nothing I can do nothing about that (lines 1568-1574)

Thus, he considers the possibility that he may be a contributing factor to the patient not returning. He proposes:

> Um I have no way of knowing you know in even in like in terms of percentages you know how many am I successful with how many am I there's no way of knowing often the um yeah I mean it it's rare enough for someone to come and say start speaking speaking about cutting themselves and um and then not continue for for a a reasonable period and and and make some sort of progress even if not everything is achieved (lines 1575-1583)

Having acknowledged this, he shifts his discourse, as he wonders, "Um but then it may very well be that people come don't just don't say it and then those don't come back again" (lines 1585-1587). Here, Jack is referring to the possibility that clients may come for treatment and not disclose their self-injury. He informes me:

> Oh I think that that that can happen I mean I've no way of how would I know that (lines 1591-1592) And in that I and I suspect that that must happen in a

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way it it there there must be element just as there are when someone comes and they they they want to speak about something whatever it might be uh and they come once or twice or three times and simply can't find the the the words to say that or or haven't been able to bring themselves to speak about to introduce whatever it is and they they go (lines 1594-1601)

In this instance, Jack is drawing on his familiar and repeating discourse of "the failure of language", what is "unspeakable" and "what can't be spoken" as an explanation for self-injuring patients' disengagement from treatment. He constructs these clients as individuals who "want to speak about something" (lines 1596-1597) "and simply can't find" (lines 1598-1599) "the words"(line 1599) "or haven't been able to bring themselves to speak about to introduce whatever it is and" (lines 1599-1601) "they go" (line 1601).

Speaking of disengagement as a discourse marker of failure, David constructs it as "much less dramatic" (line 1184, part 3) than "suicide" (line 1166, part 3). He describes this failure as "where a person has um for whatever reason uh either fails to engage or having engaged then falls out with you and uh either refuses to return or um just simply vanishes" (lines 1185-1188, part 3). His discourse on this issue is interesting in that he takes up one discursive position and then shifts to another. He initially begins by telling me:

Well clearly it'll depend I mean if a person um if a person uh disengages um but you obviously are notified that the same cycle is continuing (lines 1252-1254, part 3) Um perhaps you're being asked for information from another setting (lines 1256-1257, part 3) Um well then it's fairly obvious that uh there hasn't really been a successful intervention (lines 1260-1261, part 3)

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He then moves his position to consider the possibility that disengagement from one clinician may not be a failure if the patient shows up in another clinical setting. He points out:

> Um if someone you saw but Ireland is a relatively small place so you may
> have been seeing somebody for quite some time uh and then come across them
> in another setting and it becomes apparent that nothing really has changed uh
> then I suppose there's been a a therapeutic failure but it depends on how how
> how one looks at it um maybe you could perceive it as being a failure but then
> the person is still there so maybe that's successful (lines 1260-1270, part 3)

Niamh's discourse differs from Jack's and David's in that she speaks of clients who are unable to engage in a therapeutic relationship, or as she puts it, "I suppose somebody who's so lost that they don't respond to you know they don't respond to relationship" (lines 1807-1809). She reveals, "And I suppose I'm thinking of clients who have been caught up in the psychiatric you know services and have become they no longer believe in the possibility of you know of of really living" (lines 1812-1816). However, she admits that this discourse of hers is general and does not specifically refer to self-injuring patients. Her discourse here suggests that she was working out her position on this as she replies:

> But then I'm thinking of clients generally again I'm not just thinking of self-
> injury (lines 1818-1819) And I'm thinking of you know I mean it's not even I
> believe in a way that people who self-injure are not people who are lost in you
> know sort of the people I would see as lost and have haven't the capacity to
> get something out of counselling are people who have been fairly long term
> involved in psychiatric services either because early on you know they needed

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help that they didn't get (lines 1852-1859) and that they now are dissociated you know they have that structured dissociation inside themselves but they have the dissociation because of the level of medication as well (lines 1861-1864) A dual thing going on (line 1867)

Niamh claims:

And I have met people who just can't access counselling (lines 1869-1870) They don't tend to be people who you know I'd never have said this in my mind before because I don't think you know (lines 1872-1874) about who passes through the system and you know (line 1876) But now that you say it they don't tend to be people who self-harm (lines 1879-1880)

Here, she draws on a contrasting discourse about "those people who have been fairly long term involved in psychiatric services" (lines 1657-1658) to articulate her construction of self-injuring patients whom she views as being able to "access counselling" (lines 1669-1670) and have "the capacity to get something out of counselling" (lines 1655-1656) and they don't "have that structured dissociation inside themselves" (lines 1662-1663).

Discourse of remain the same or worse. The discursive marker of remain the same or worse emerges in five of the eight (David, Sinead, Jack, Niamh and Mark) clinicians' narratives. What is striking about most of their discourses in this regard is the absence of an elaboration beyond naming the marker itself. For example, David responds, "if you are seeing a person and if there's no um discernable benefit in any way any of the spheres whether it be social or personal or whatever" (lines 1277-1280). Sinead's reply is also brief, "what they came in with is still present" (lines 1489-1490, part 1). She does not elaborate on this discourse of "what

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they came in with" (lines 1489-1490, part 1) beyond articulating, "You know be it the bulimia or the um self-harm or whatever" (lines 1493-1494, part 1) "the range of issues are because I find there's rarely one single issue" (lines 1496-1497).

Referring to clients, Jack constructs failure as "their work hasn't progressed enough" (line 1570). However, he does qualify this remark by making the point that:

Often the um yeah I mean it it's rare enough for someone to come and say start speaking speaking about cutting themselves and um and then not continue for for a a reasonable period and and and make some sort of progress even if not everything is achieved (lines 1578-1583)

Thus, he seems to be acknowledging that his self-injuring patients do make progress.

Niamh makes an attempt to elaborate on her discourse of remain the same or worse. She proposes:

if you continue to self-harm at the same level obviously that's something is going wrong (lines 1820-1821) Nothing is happening they're not finding new resource they're not finding you know a way to to process all the experience that have led to that type of behaviour (lines 1824-1827) But I'm thinking of okay something is going wrong if somebody still can't access (lines 1847-1848) you know another route out of this pain (line 1850)

She identifies how they get "worse than they came in" (lines 2050-2051) as a discourse marker of treatment failure. However, Niamh qualifies this latter indicator as she informs me that this appearing worse can sometimes be a sign that the client is actually working on their issues and that this is usually only a temporary state. She

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explains, "cause there are times when people appear worse" (line 2060) "when they're actually allowing themselves to face the other histories" (lines 2064-2065) "Well yeah that's only a temporary" (line 2071) "thing" (line 2073). Surprisingly, Niamh is the only clinician who makes this point, when articulating her discourse in relation to remain the same or worse as a marker of treatment failure.

Mark is the only clinician who develops and elaborates a logical discourse about, "An amplification" (line 1998, part 2) of "symptoms" (line 2001, part 2) as a possible marker of treatment failure as Extract 22 on the following page demonstrates. He posits, "A failure would be things get worse" (lines 2016-2017, part 2). He elaborates on this remark, explaining, "you're tracking for other" (line 2026, part 2) "the intensity of symptoms" (line 2024, part 2) "you know nightmares uh panic attacks other other indicators that the somatic symptoms are uh are amping up" (lines 2028-2030, part 2). Referring to indicators of failure, Mark argues, "if your marker was an increase in simply an increase in self-injurious behaviour it's a very high bar" (lines 2041-2041, part 2). He cautions that as the clinician "you want to keep an eye on the other things" (lines 2045-2046, part 2) in addition to the patient's level of self-injury "Because the strong habit of self-injuries can be one of the last things to go" (lines 2055-2057, part 2) "because it's so strong" (line 2060, part 2). Continuing with his reference to self-injury, he maintains that:

> if someone's harming themselves the same amount of times but other things
> are decreasing then that would be (lines 2046-2048, part 2) you could actually
> see that as a therapeutic success (lines 2050-2051, part 2) if there's less panic
> attacks there's beginning to be more of a handle on different things we're
> moving in the right direction (lines 2053-2055, part 2)

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Extract 22

Lines 1997-2030, part 2 I: And what would constitute a therapeutic failure

C: An amplification

I: An amplification of

C: Symptoms

I: Okay

C: So uh you know I I wouldn't say there's failure if there's still the same frequency actually uh at this [stage] you know

I: [Okay]

C: I would say just that you know we're kind of we're we're on a level playing field we haven't we haven't succeeded but we haven't failed

I: Okay

C: You know because nothing worse is happening

I: Okay

C: I would see a failure as being I know it's ((Laughs)) like wriggle room but that's just how I see it cause you know you're trying to make a difference that would be a success a failure would be things get worse

I: Okay

C: Yeah so I don't uh

I: How worse would they have to get before you consider it

C: Oh just worse if if if uh if the markers because I would see it going up so frequency uh and even prior frequency the intensity of symptoms

C: Uh because .hh you're you're tracking for other

I: Mm-hmm

C: You know nightmares uh panic attacks other other indicators that the somatic symptoms are uh are amping up

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Thus, in his discourse, Mark proposes that "An amplification" (line 1998, part 2) of "Symptoms" (line 2001, part 2) is an indicator of failure. He elaborates on this marker explaining that this would mean "your engagement with this person is increasing their distress" (lines 2037-2038, part 2) "the intensity of symptoms" (lines 2024, part 2) such as "nightmares" (line 2028, part 2) "panic attacks" (line 2028, part 2) and "other indicators that the somatic symptoms are uh are amping up" (lines 2029-2030, part 2).

Discourse of partial failure. Surprisingly, Sinead is the only clinician who engages in a discourse about partial treatment failure, of which she gives two examples. The first she details as, "Um I think if I felt I wasn't able to connect with them and understand the meaning the uh the self-injury had" (lines 365-367, part 2) "Um so that even if they I mean if they were still continuing to do it but I was beginning to get some sense of what what all that was about" (lines 369-371, part 2) "I would consider that more a partial failure I that we were beginning both client and therapist together to understand it" (lines 373-375, part 2) "Even if we couldn't the client couldn't stop" (line 377, part 2). The second partial failure she explains, "Um partial failure sometimes because I think if you can even offer them an experience of therapy in a sense of sitting down and having a conversation with somebody like me was actually okay enough" (lines 1510-1513, part 1) "for them to it was like dipping their toe in the water maybe the first time they've talked to anybody about what they tell you" (lines 1516-1518, part 1) "and what they're feeling and while they may not have got better in the sense of the symptoms changing or going away um I would hope that the experience was good enough that they will come back at another date" (lines 1520-1523, part 1).

Discourse of narrative experience of failure. Mark is the only clinician who shares an experience of a treatment failure with a self-injuring client. He is open and honest in his disclosure about an experience of failure where his misconception about trauma and addiction led to a failure in therapy. He acknowledges that he failed to ask a patient "addiction questions" (line 1801, part 2) because "I don't always check for addiction" (line 1748, part 2). He confesses, "so that blindsided me from the start" (line 1807, part 2). He admits:

> And so I missed when I look back on it I missed quite a few cues or clues around what was going on but I was just uh taking my lead more from what I already knew (lines 1809-1812, part 2)

Here, Mark is referring to the fact that he "already knew" (lines 1794, part 2) "there were trauma symptoms" (lines 1794, part 2). However, he reveals the following misconception:

> I was seeing the symptoms one-way and and really I could have seen them another way if I had known they were actively I was seeing it oh it's just straight trauma symptoms (lines 1814-1817, part 2) But actually they were also withdrawal symptoms (line 1819, part 2) the shaking was the was only a physiological discharge and actually they were actively uh having some detox symptoms (lines 1823-1825, part 2)

Eimear's discourse about failure is striking because of her disclosure half way through her narrative, which could be constructed as a brief reference to a partial failure with self-injuring clients. She admits, "Certainly when I was starting out I made mistakes of maybe not putting in enough things in place when I was taking annual leave" (lines 1146-1148). She elaborates on the impact of this mistake:

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And then the fallout would have been they would have had the kind of feeling

of being abandoned that they might have had earlier on in their own lives and

(lines 1150-1152) would have there would have been an escalation in self-

injurious behaviour (lines 1154-1155)

She reveals, "As in fact just happened to me once on my first holiday when I

was working with this group of people" (lines 1157-1159) "I didn't really realise the

impact" (line 1161) "it might have on them" (line 1163). She acknowledged that she

should have been aware of this. She confesses, "I mean on hindsight it was

completely obvious" (line 1172). It is interesting to note that Eimear does not seem to

equate her admitted mistake with that of a partial failure or rupture in the therapeutic

relationship. This emerges in her responses to my questions in which she seems to be

engaging in a closing down discourse about treatment failure and partial failure. She

replies, "I don't" (line 1578), meaning that she has no experience of this. Thus, she

makes no reference to her earlier declaration of having made a "mistake" with self-

injuring patients. Instead, she enters a wider discourse about failure and government

funding as she states, "Uh I mean if if there was a failure it was in terms of convincing

the government that it was worth funding this kind of intervention on a large scale"

(lines 1580-1582). She appears to be unaware of an earlier disclosure with respect to

self-injuring clients in her narrative in which she admits that she made mistakes when

she first began working with this group.

Discourse of Responsibility for Outcome of Treatment

The clinicians engage in a number of different discursive patterns in response

to this question. They occupy various discursive positions in relation to this question

of who is responsible for the treatment outcome. These include "it depends"

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discourse, shifted to the therapist discourse, shifted to the patient discourse, shifting

discourse of responsibility, and a "mixture" of responsibility in both client and

therapist discourse.

Jack's narrative suggests that he is grappling with my question of who is

responsible for the treatment outcome, as he contemplates how he as the analyst can

fail and then shifts his discourse to include how patients can struggle with the issues

they bring to analysis, as illustrated in the following extract:

Extract 23

Lines 1648-1674   I: And who do you see as as <u>responsible</u> for success or
failure or partial failures um (1) in analysis (1) the
analyst (1) the individual that comes for analysis

    C: Well it I I guess the the you'd always (1) it depends on
which point of view you want to <u>take</u> .hh (1) uh there's
in one way I can say that from the point of view of the
individual the individual doesn't really fail they just
<u>attempt</u> to to uh (1) to speak and find that that they can't
then (1) and maybe they will <u>again</u> at some other point
(1) .hh whereas uh how could you look at that as that as
a failure it's you know (1) they're they're struggling
with whatever it is they're in whatever <u>difficulty</u> or pain
they're in and that's what they .hh (2) <u>do</u> um now as an
<u>analyst</u> I can fail in <u>lots</u> <u>of</u> <u>ways</u> I mean I can just be
simply <u>distracted</u> or tired or .hh uh (1) you know worn
out from too too much work and I'm I'm not <u>available</u>
not listening and I fail to pick up on something and
that's a failure .hh (2) uh so that that can be just that's
my <u>failure</u> uh if someone comes and they they can't
they somehow can't find the words to express <u>to</u> to
begin (.1) um then there's probably not a lot I can <u>do</u>
about that I can <u>do</u> (3) I mean I can be as available as

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possible um but if it doesn't <u>work</u> I'm not so sure (1) in that case is that a failure on either part .hh (2) uh so (2) that's all I can say about that

It appears that Jack is unable to come to a decisive conclusion as to who is responsible for the outcome of the analysis, the analysand or the analyst. This is based on his "it depends" discursive position that he explains as "it depends on which point of view you want to take" (lines 1651-1652). Thus, he considers both subject positions in his discourse, that of the "individual" or client and the analyst.

In contrast to Jack, Mike is very clear in his reply, "I think the, the therapist" (line 2144). He seems to be positioning himself within a shifted to the therapist discourse. Speaking of patients, he elaborates, "In that how we engage with people reflects you know sort of the space we offer them" (lines 2146-2147). Mike then shifts his discourse as he critiques clinicians who blame their clients when the treatment is not effective. He argues:

And I think far too often I've heard it being switched back on the client you know that that person isn't psychologically minded enough for therapy and I think it's really interesting how when it doesn't work out sometimes that we blame the client and I think we need to be looking more at ourselves the spotlight needs to be on our practice and what we do um rather than sort of saying well it didn't work because the client you know they weren't ready (lines 2149-2157) Or they weren't this or they weren't that you know are we the only profession it's like uh that where it doesn't work out that we blame them ((Laughter)) (lines 2159-2162)

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This discourse of critique is surprising in light of Mike's earlier responses to my questions about treatment failure. He appears to be revising his discourse here. In his previous discourse, he constructs patients as exercising a choice if they leave after one session and does not consider this as a failure in treatment.

Mark holds an opposing view to Mike, locating himself with a shifted to the client discourse. He states, "Oh the client" (line 2069, part 2) is responsible for the outcome of the therapy. He is very definite on his opinion and reinforces this with the following comment, "Yeah I mean that's that's my view I'm just yeah absolutely" (lines 2071-2072, part 2). He argues:

> It's uh and that's the double edge um with with um with this because there's
> more intensity and because the stakes are higher in the sense of just what's
> happening that (lines 2074-2077, part 2) you'd be much more inclined to go
> into rescuer mode (lines 2079-2080, part 2) Um but uh you know if you're
> really going to subscribe to the wisdom in in what's happening it's it's really
> not to do with me (lines 2082-2084, part 2) And my job is to try and help them
> do what they can for themselves but it's not me (lines 2086-2087, part 2)

It is interesting to note that it does not seem to occur to Mark that his particular body centred approach may not suit every patient and that this may be a contributing factor to therapeutic failure. In addition, he also appears to be unaware of his earlier admission of how his misconception of addiction and trauma led to a failure in treatment for which he holds himself accountable.

Sinead, Ciara and David all seem to engage in a shifting discourse with regard to the question of who is responsible for the treatment outcome. They shift between holding the client responsible and then moving to a discourse about therapy being a

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collaborative process. Despite this shifting discourse, all three clinicians as their extracts reveal, hold to their belief that the patient is responsible. Sinead begins by declaring that she sees "therapy as a collaborative effort" (lines 392-393, part 2). Then, she moves to a discourse in which she views the client as being responsible for the cessation of self-injury. At the end of her narrative on this subject, she returns to her collaborative argument as illustrated in the following extract:

Extract 24

Lines 388-413, part 2   I: Mm-hmm and who do you think is primarily responsible for the treatment outcome or the therapeutic outcome whether it's positive or negative with a self-injuring client

                         C: .hh Um well I like to see therapy as a collaborative effort you know [that it's both]

                         I: [Mm-hmm]

                         C: Client and therapist working together towards a common goal um but I suppose at the <u>end</u> of the day (2) it's only the client that can <u>stop</u> the self-injury

                         I: Mm-hmm

                         C: (5) Um so I think you know they are <u>responsible</u> for <u>stopping</u>

                         I: Mm-hmm

                         C: I can't do that

                         I: Mm-hmm.

                         C: (3) Um so it might be the responsibility is more <u>weighted</u> towards them in that <u>sense</u>

                         I: Mm-hmm.

                         C: But um (2) in terms of the <u>actual</u> work of therapy and you know (2) striking a an alliance (2) I see that as collaborative (2) and setting (1) goals that are (1) very much um (3) agreed upon and not <u>imposed</u> by the therapist on the client

Ciara's discourse of contradiction centres around her responses to my question about who is responsible for the treatment outcome. Initially, she states, "I think the person primarily responsible for any treatment outcome is the individual rather than the clinician" (lines 121-123, part 2). Then, she appears to contradict herself by saying, "I kind of try and work from from a collaborative point" (lines 124-125, part 2). Surprisingly, she seems to construct working from a "collaborative point" (lines 124-125, part 2) as "whereby the individual is at the centre and everybody else is just an assistant" (lines 125-126, part 2). She appears to be unaware of this constructive contradiction. In clinical work, it is generally accepted that if the clinician and the client work in a collaborative way then, this means that they work together and that both have responsibilities. Ciara's narrative as illustrated in Extract 25, suggests that she does not subscribe to this view.

Extract 25

Lines 117-141, part 2   I: And I'm just wondering who do you think is <u>primarily</u> responsible for the treatment outcome whether it's positive or negative

                       C: .hh hhhh (2) Well I think the person primarily responsible for any treatment outcome is the individual rather than the clinician um one that was kind of the .hh (2) my starting point ((cough)) I kind of try and work from from a <u>collaborative</u> point where whereby the individual is at the centre and everybody else is just an assistant .hh (1) so I think the individual is primarily responsible (1) and unless they take responsibility um despite the best efforts of everyone else it's not going to work

                       I: Mm-hmm

                       C: .hh So hhhh um I think at times people aren't able to assume that responsibility and then at those times

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somebody else has to take greater steer but by and large I think .hh (2) the overriding responsibility is with the individual

I: Mm-hmm

C: And that's with any condition it's not necessarily with a psychological condition where .hh ((cough)) self-harm but it's with medical conditions or whatever else you might have hh um but I don't see the clinician as being ultimately responsible

David also seems to engage in a shifting discourse with respect to the question about responsibility for treatment outcome. Extract 26 illustrates his discursive shift in this regard. He initially holds "the individual" (line 1555, part 3) or patient responsible for the outcome of treatment. When I enquire if he would like to elaborate, he revises his original stance and replies, "I think it's a collaborative" (line 1558, part 3) "process" (line 1560, part 3). Then, he returns to his earlier position and informs me that, "everything is going to hinge on the individual" (line 1563, part 3). Extract 26 demonstrates David's discursive shifting position on this subject matter.

Extract 26

Lines 1552-1574, part 3 I: .hh Um who do you think is primarily responsible for the <u>treatment</u> outcome whether it's positive or negative with self-injuring clients

C: (2) Uh (1) the individual really I think

I: Mm-hmm mm-hmm is there anything else you want to say about that

C: I think it's a colla[borative] process

I: [Mm-hmm]

C: Um (3) I think what when I say the individual (2) uh 1 mean everything is going to hinge on the individual [um]

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I: [Mm-hmm]

C: They do a huge amount of work (2) um (2) one certainly can't (1) <u>impose</u> an outcome on a person

I: Mm-hmm

C: Um (2) sure they may have a lot of input (2) um they have a lot of guidance etc etc but nonetheless it is their <u>engagement</u> (2) that's going to be and <u>their</u> uh working with them that, that's going to be (2) uh the <u>ultimate</u> turnaround so um (1) so I say the the the individual really

Niamh views both the clinician and the client as responsible for the outcome of the therapeutic process. She claims, "It's a it's a mixture isn't it it's a dance" (line 2110) "it's a cooperative venture" (lines 2122-2123). She proposes that as the therapist, "Sometimes you follow sometimes you lead" (line 2113). She also acknowledges that as the clinician "there might be ways in myself that I just don't have the openness for some people" (lines 2112-2116) and she begs the question, "how you measure it" (lines 2116-2117). Equally speaking of patients, she suggests that, "A person's life might not even allow you know there might not be enough safety or space in a person's life a client's life to engage with therapy" (lines 2119-2121). She concludes her argument, "So two people in it" (line 2126) and repeats a variation of her earlier question, "How you measure out portion out I don't know I'm not trying to do that" (lines 2126-2127).

What is striking about Eimear's discourse is the effort I have to engage in to eventually evoke a clear response from her about her thoughts on who is responsible for the outcome of treatment. Her narrative suggests that she positions herself within a "mixture" of responsibility in both client and therapist discourse. She begins her

discourse by telling me what rather than who is responsible for the treatment outcome as she replies, "the quality of the therapeutic relationship" (lines 2150-2151). Then, she shifts her discourse and tells me, "a bit of both" (lines 2153-2154). I attempt to evoke a further more specific response from her with my utterance, "Okay" (line 2155) to which she responds, "Um" (line 2156). Seeking clarification of what she means by the phrase, "A bit of both" (lines 2153-2154), I have to explicitly ask her, "In terms of" (line 2159). She informs me, "The individual and the therapist" (line 2160). Extract 27 illustrates how I have to work at getting a direct and clear response from Eimear to my question about who is responsible for the treatment outcome with self-injuring patients.

Extract 27

Lines 2147-2162	I:	Mm-hmm okay (2) and who do you think is primarily responsible for the treatment outcome
	C:	.hh I think the quality of the therapeutic relationship
	I:	Okay
	C:	So that's probably just sitting on the fence a bit of both
	I:	Okay
	C:	.hh Um
	I:	A bit of both
	C:	.hh Um
	I:	In [terms of]
	C:	[The indi]vidual and the therapist
	I:	Okay to see both as being
	C:	.hh Um mm-hmm

Chapter Summary

In this chapter, I examined the clinicians' discourses in relation to the ways in which they gauge or measure their clinical effectiveness in their current treatment

practice with self-injuring patients. An interesting pattern emerges in their narratives, in that the clinicians engage in various styles of response to my questions about their experiences and criteria for measuring treatment success, failure and partial failure with self-injuring clients. These multiple patterns of responses in the clinicians' discourses suggest that they are taken aback by my questions, which also seems to cause them problems.

There is a striking absence of a systematic way of thinking or conceptualising "success" with regard to self-injury in the clinicians' discourses, in relation to the ways they gauge their clinical effectiveness. Instead, they seem to map out markers of progress beyond self-injury. Collectively, the eight clinicians in this research study do not adhere to a shared set of specific criteria for measuring successful treatment outcomes with self-injuring patients. The clinicians' discourses about their criteria for gauging failure and partial failure with self-injuring clients are in marked contrast to their discourses about treatment success. Indeed, their discourses appear to be all over the map and unelaborated in terms of not engaging in a dialogue beyond naming a few markers of failure.

There is also variation among the clinicians' discourses about who is responsible for the treatment outcome. Indeed, they occupy a number of different discursive positions in relation to this question of responsibility. These include "it depends" discourse, shifting to the therapist discourse, shifting to the patient discourse, shifting discourse of responsibility and a "mixture" of responsibility in both client and therapist.

In conclusion, these findings highlight the complexities and difficulties that the clinicians encounter with regard to the evaluation of their clinical practice with

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self-injuring patients. I believe these findings suggest an absence of a systematic way of thinking or conceptualising "progress" with regard to self-injury among Irish clinicians. This is particularly surprising, considering the large body of research, and current debates on the topic of evidence-based treatments and measuring outcomes. I discuss this point further in the next chapter.

Chapter Eight

Reflections, Conclusions and Implications

In this study, I marked out the discourses of a small group of Irish clinicians' that pertain to their conceptualisation and treatment of self-injury. In particular, my study explored clinicians' understanding of self-injury, their discourses about their treatment models and their perceptions of their clinical effectiveness and failures in their work with self-injuring clients. I also examined the sources of knowledge that contribute to the clinicians' understanding of self-injury and of those who engage in this behaviour.

My research study is unique in terms of its specific focus on clinicians' discourses, which have not received attention in previous studies. Indeed, to a large extent researchers have neglected to focus on exploring clinicians' understanding and treatment of self-injury, with the exception of three unpublished scholarly dissertations, Huerta (2006), Keane (1997), and Williams (2005). In an attempt to address this obvious lacuna in the literature, my study has begun to fill in perspectives and voices not previously articulated.

While this study is a close analysis of a small number of Irish clinicians it still has a contribution to make to the international literature on self-injury. I specifically designed my study to select a group of clinicians that would represent a range of different clinical views on conceptualising and treating self-injury in an Irish context. Indeed, the participating clinicians did not disappoint me with their rich discourses demonstrating a variation across and among their narratives.

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Despite the diversity and richness among the clinicians' discourses, I must admit that I was a little disappointed with the findings of my research study. This feeling relates to an expectation I had at the outset of this doctoral research that I stated in Chapter One. I wanted to discover new and innovative ways of understanding and treating self-injury that was unknown to me as a clinician or was not to date articulated in the literature. Of course Mark's unique and novel approach to working with the gesture of cutting was an exception.

Nevertheless, this study's research findings have produced a few surprises. For instance, the level of difficulty that the clinicians experienced in relation to discourse on outcomes surprised me. I was also amazed by the missing discourses across all of the clinicians considering the proliferation of publications on self-injury. Finally, the clinicians' tendency to create discourse communities rather than speaking in terms of their theoretical or conceptual models of understanding and treating self-injury was an unexpected and interesting finding.

In response to my study's four research questions, five principle findings emerged in this study across two core areas, namely clinicians' conceptualisation and treatment of self-injury and clinicians' treatment success, failure and partial failure with self-injuring patients. The findings of my research study suggest: 1) the majority of the clinicians did not have a distinct model for considering self-injury and treatment approaches for working with self-injuring clients; 2) in place of theoretical or conceptual models they created discourse communities of "an other" to formulate their beliefs about self-injury and its treatment; 3) it appeared that the clinicians relied predominantly on their clinical practice with self-injuring patients for comprehending and treating self-injury; 4) in speaking of their current treatment practice effectiveness

and failures with self-injuring clients, the clinicians drew on two distinct discourses, an "expert discourse" and an "inquirer discourse"; and 5) the clinicians had little or no systematic way of thinking or conceptualising "progress" with regard to self-injury, yet they created "markers" of progress more generally.

In the remainder of this chapter, I consider the multiple explanations for the findings of my research study. Ireland as a social context and its influence on this study is also examined. In addition, the limitations and potential implications of this research study are discussed. I conclude by offering proposals for future research in the area of self-injury and other clinical phenomena.

Based on the results of this research study and the various interpretations I propose in this chapter, it is impossible to reach a conclusion as to the most likely explanation for the findings with respect to the clinicians'discourses in relation to understanding and treating self-injury. The impossibility of settling on a specific explanation or conclusion highlights the need for more research to be conducted in this area as my study signifies several unanswered questions and puzzles in relation to the clinicians' conceptualisation and treatment of self-injury. Indeed, A. G. Rogers (2003) suggested that, "Qualitative researchers typically raise questions that cannot be answered definitely or with a single strong interpretation—and good qualitative research commonly proposes multiple interpretations and raises new questions" (p. 58).

Clinicians' Conceptualisation and Treatment of Self-Injury

Traditionally, self-injury was conceptualised within a psychoanalytic discursive modality. However, contemporary discourses in the literature have shifted towards locating an understanding of self-injury within several models. S. N. Shaw

(2002) suggested that, "...many authors understand self-injury in terms of more than one model" (p. 199). In contrast, the clinicians' discourses in my study did not suggest that they draw on multiple frameworks to understand self-injury beyond their clinical training or practice. Indeed, the findings of my research study suggest that the majority of the clinicians did not have a distinct model for considering self-injury and treatment approaches for working with self-injuring patients. It seems that their conceptual orientations to treatment and their understanding of self-injury merged with their primary training model/orientation to treatment. Thus, they appeared to understand self-injury through the lens of either their particular theoretical training or a belief system, or their practical/clinical training rather than any specific models or frameworks in the literature on conceptualising and treating self-injury. Indeed, Jack the psychoanalyst, captured the essence of this merging discourse as he explained, "I'm making sense of it in with uh through the lens of uh kind of psychoanalytic theory" (lines 756-758).

In contrast, two clinicians, Mark and Eimear, had distinct models for conceptualising and working with self-injuring clients. Yet, despite having these marked frameworks their discourses also showed a merging pattern that is similar to the other clinicians. It is striking how Mark's and Eimear's discursive style of merging differs. Mark began with a humanistic body centred model of treatment and invented an innovative way of mapping it onto self-injury. Eimear's pattern was the complete antithesis. Her discourse suggests that she clearly began with the specific treatment model of dialectical behaviour therapy that is used to treat BPD patients who engage in self-injury.

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In articulating how they understand self-injury and their current treatment practice with self-injuring clients, the clinicians did not speak in terms of theoretical or conceptual models. Jack's discourse may shed some light on the reason for this finding. He acknowledged that he is "not particularly conscious" (Jack, line 609) of theories in his practice. He explained, "I find that the whole thing gets mixed up together so much in my mind the the the practice and the theory are so kind of interlinked that I find it difficult to separate it" (lines 870–873). Is it possible that this experience of not being "particularly conscious" of theories and the interlinking or merging of theory and practice in the participating clinicians' minds is the reason why they didn't refer to theoretical or conceptual models in their narratives? Indeed, it is possible that only those writing about understanding and treating self-injury in the literature draw on theoretical or conceptual frameworks in their discourses.

Curiously, the participating clinicians seemed to create discourse communities of "an other" to formulate their beliefs about self-injury and its treatment rather than speaking in terms of theoretical or conceptual frameworks. As I stated in Chapter Five, I used the term "discourse communities" to refer to the imaginary communities that the clinicians constructed and appeared to address through me as the interviewer and an imaginary "other" that may have included me, but also was beyond me.

All of the clinicians created discourse communities of opposition, or discourse communities of verification, to articulate their understanding and treatment of self-injury. As I discussed in Chapter Five, clinicians who constructed discourse communities of opposition positioned themselves as having particular styles of treatment that were different, in converse or in some instances, antithetical to the imaginary "other" community. In contrast, discourse communities of verification

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were used by the clinicians to verify, authorise and legitimatise their particular approach. What is striking about this pattern is the discursive differences that emerged among and between the clinicians. For half of the group of clinicians, this pattern of referring to discourse communities only surfaced as a temporary or brief mention. A contrasting style emerged in the other half of the group in which the clinicians created narratives that were rich with discourse communities that were recurring, persistent and pervasive. Although, these clinicians produced discourse communities they did not do the same thing with their discourses. For instance, David, a psychiatrist used his momentary style of creating a discourse community of opposition to emphasise how his particular treatment approach differed from that of traditional psychiatry. In contrast, Ciara, another psychiatrist utilised her discursive clinical language to locate herself within the profession of psychiatry. Niamh and Mark, both employed a humanistic-body centred approach to the treatment of self-injury. Yet, they both drew on different discourse communities. Niamh created discourse communities of opposition, while Mark referred to discourse communities of verification. These discursive differences demonstrate the diversity among and between the clinicians in relation to conceptualising and treating self-injury. Curiously, none of the clinicians drew on any discourses from the self-injury literature such as feminist, multi-modal, relational, pathological, competition, and others (which I discussed in my review of the relevant literature in Chapter Two) in their discourses of verification or opposition.

Treatment modalities. Discourses in the literature on the application of models of treatment to self-injury have evolved from early publications on single model psychoanalytically oriented treatment approaches. Over time discourses have shifted to include a multitude of diverse theoretical treatment models ranging from

single to multi-modal approaches. These various discourses were reflected in the clinicians' narratives in my research study. What emerged was a pattern of variation across and among the clinicians whereby some showed a preference for using a single model, while others opted for either a bi-modal, or multi treatment approach to self-injury. This variability pattern among the clinicians in my study was consistent with other studies that have explored clinicians' treatment approaches to working with self-injuring clients. In two studies, one Irish (Keane, 1997) and one American (Williams, 2005), the therapists revealed that they used single modal approaches. In contrast, Huerta (2006) reported that the clinicians in her American study acknowledged that they used a combination of treatment approaches. The design of my study to select a group of clinicians who would reflect a variety of mental health disciplines and treatment approaches to working with self-injuring patients may account for the variability across and among the participating clinicians in my research study in comparison to the lack of variability reported within Huerta's (2006), Keane's (1997) and Williams' (2005) studies.

The findings of my study are in contrast to two American studies on clinicians' use of cognitive behavioural interventions in their treatment approach with self-injuring clients. Both Williams (2005) and Huerta (2006) reported that the majority of the clinicians in their studies acknowledged that they used some form of CBT intervention. Only the two psychiatrists in my study made any reference to using aspects of a CBT model in conjunction with other modalities that they employed. One could argue that Eimear also utilised CBT interventions since these types of interventions form part of a DBT treatment approach which she employs in her work with self-injuring patients. However, the majority of the clinicians in my study did not make any reference to using CBT interventions in their narratives.

This difference to the American studies may reflect the contrasting diversity between clinicians working in an Irish context and those treating self-injuring patients in the USA. Indeed, it may mirror the different discourses that these clinicians are exposed to in their clinical training, the settings they work in, and the availability of continual professional development opportunities to further their knowledge on conceptualising and treating self-injury. It is also possible that some Irish clinicians may contest the use of CBT interventions, as it may be incompatible with their treatment orientation to self-injury. Niamh was the only clinician who voiced this in her discourse as she clearly and strongly stated that she would not use a CBT model. Indeed, her discourse suggests that she was actually opposed to such a treatment approach to self-injury. She argued, "So it's not about the behaviours in itself" (line 678) "I mean that's much more cognitive behavioural approach" (lines 683-684) and "I wouldn't be really going for that" (line 687).

A surprising finding surfaced in my study; some of the clinicians' particular singular and combination models are not articulated in the literature. For instance, the application of the singular models of constructivist and narrative psychotherapy to the treatment of self-injury is a missing discourse in the literature. Similarly, the amalgamation and application of a humanistic and body-centred approach to working with self-injuring clients is also absent from the literature. Likewise, the particular multiple combinations that the participating psychiatrists use are also not featured in the self-injury literature. Interestingly, both of the psychiatrists in my study use almost the same combination of modalities with the exception of David's psychodynamic model. Specifically, David uses a synthesis of pharmacological, psychodynamic, cognitive behaviour and dialectical behaviour modalities. Similarly, Ciara the other psychiatrist employs a composite treatment approach that includes

pharmacological, cognitive-behaviour and dialectical behaviour models. Despite these shared similarities, their narratives suggest divergent discourses in relation to their conceptualisation and treatment of self-injury.

Discourse of competition. In an attempt to identify the most effective psychotherapy modality, a discourse of competition has emerged in the evidence-based treatment literature. It is interesting to note, that no discourse of competition surfaced in the clinicians' narratives in which they pitted their particular model against another approach when they spoke of their experiences of treatment success, failure and partial failure with self-injuring clients. This is surprising considering the variety of treatment modalities that the clinicians use to treat self-injury. Even Eimear, who expounded the virtues of dialectical behaviour therapy as a very effective treatment for self-injury in her discourse, did not set it against another modality so as to demonstrate the superiority of its effectiveness.

Treatment emphasis. S. N. Shaw (2002) noted that the early treatment literature on self-injury recommended that clinicians work "in a holistic and engaged fashion with a focus on intrapsychic dynamics, interpersonal and environmental relations, the clinician-patient relationship, and meaning making" (p. 199). However, she argued that the contemporary discourse on treatment has shifted toward an emphasis on symptom removal, cognitive-behavioural techniques, medications and contracts. Interestingly, at least some among the participating clinicians considered their clinical practice in line with a holistic way of working in keeping with the earlier discourses identified in the literature. This extract from Jack's narrative was just one such example that was reflected across all of the clinicians' discourses. Jack explained his practice with self-injuring patients, "I want to hear them out what they

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have to say" (lines 1500-1501) "it has to be it has to be through practice working with individuals who speak in this way about their experiences and we attempt or at least I attempt in that process to make some kind of sense of it from the facts you know from what's being said or what the person is describing" (lines 536-541).

Relational discourse. Many authors in both the general psychotherapy and the self-injury literature have written about the importance of the therapeutic relationship as a key component in facilitating change and healing in clients. Despite this emphasis in the literature, one could almost miss the relational discourse in the clinicians' narratives in my research study because it appeared more in implicit rather than in explicit forms. It is as if the clinicians took a relationally oriented focus to working with self-injuring patients as a given, regardless of their particular theoretical training practice model. Therefore, they did not need to articulate it explicitly in their narratives. Even Eimear's discourse suggests a relationally oriented approach, which is not particularly synonymous with a DBT modality. Curiously, Niamh was the only clinician who made an explicit comment about the role of the relationship in her treatment approach. She constructed her role as, "And I'm there to be an agent of change in some way to offer other ways and the relationship is the main way I suppose" (lines 645-647).

Distress discourse. There are many references in the self-injury literature about the distress that self-injury evokes in clinicians treating individuals who engage in this behaviour. Surprisingly, this discourse did not emerge in the clinicians' narratives with the exception of Ciara, who referred to a discourse of distress in relation to the suicide and the emotional impact on the clinician. I will discuss this

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discourse further in the next section of this chapter entitled "Clinicians' Treatment Success, Failure and Partial Failure with Self-Injuring Patients".

A possible explanation for the absence of this discourse of distress in the clinicians' narratives is the fact that all of the participants had been practising for over 10 years and had significant experience working with self-injuring patients. Therefore, it may be that for these clinicians, their clients' self-injury may no longer cause them any distress. Indeed, the historic discussions of Ciara and Mark's early encounters with self-injuring patients, would suggest that initially this was a distressing experience for both of them. After years of exposure to self-injury, Mark remarked, "I'd like to think that the blessing of having seen an extreme is it then looks normal to me normal uh it I have a normalised reaction (lines 1464-1466, part 2) "to it" (line 1468, part 2). Ciara echoed Mark's discourse of distress as she remembered an early exposure to a self-injuring client. She recalled a time early in her professional career when she was shocked. Ciara told me, "Um I remember very shortly after starting psychiatry in an inpatient setting a girl who had inflicted I would say 100 fairly significant scars to herself in a hospital setting (inaudible) and um in my naivety I sutured them all rather than sending her to A&E and I was shocked at that because it was really really significant and really really serious" (lines 987-993, part 1). She admitted that her response has changed over time as she explained, "I see so much of it really that I I it it it's not shocking to me any longer um" (lines 983-984, part 1) "I suppose the emotional response has become quite neutralised to it really" (lines 995-996, part 1). However, she acknowledged that her reaction can change if the self-injuring individual does not fit the typical profile for this behaviour. For instance, she confessed, "if you see it in an older person and if it's new that kind of does jolt me from time to time" (lines 997-998, part 1) "in an atypical setting

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somebody who's never done it before" (lines 999-1000, part 1) "that can actually really jolt me into into concern" (lines 1002-1003, part 1).

In conclusion, a discourse of clinicians' distress in relation to self-injury was generally not spoken among these very experienced clinicians' in their narratives despite its articulation in the literature. However, Ciara's discourse suggests that the evocation of a discourse of distress in experienced clinicians may be dependent on whether or not the self-injury is atypical behaviour for the client.

Sources of Knowledge

The third significant finding relates to the sources of knowledge, including both personal experience and professional training, that influenced/shaped the development of clinicians' explanation(s) or working model(s) of treating self-injuring clients. Surprisingly, the clinicians made sparse references to conferences, readings and workshops on the topic of self-injury in their narratives. Indeed, there were surprisingly few references among the clinicians' discourses in which they made deliberate attempts to learn or seek information about self-injury and how to treat it. It appeared that they relied predominantly on their clinical practice with self-injuring patients for comprehending and treating self-injury. Thus, on the whole, they did not tend to draw on external and specialist discourses on understanding and treating self-injuring clients outside of their clinical practice and their primary treatment orientation. They did not seem to actively seek or search for external modes of information on self-injury. This suggests that despite the range and numerous texts on conceptualising and treating self-injury, these clinicians in practice did not seem to be reading them. Is this the case more generally in Ireland? I will return to this question later in this chapter.

This finding is in sharp contrast to the individual clinicians who write about their particular treatment approaches to self-injury in the literature and the clinicians in both my previous Irish study (Keane, 1997) and Williams' (2005) study. In their published books and journal articles, clinicians and researchers predominately refer to the literature on conceptualising and treating self-injury. The clinicians in Williams' study reported that "reading" (2005, p. 190) was their primary source of knowledge on the subject of self-injury. The majority of therapists in my study (Keane, 1997) indicated that they accessed information on self-injury from various sources including workshops, books, journals, personal experience and supervision. This finding differs from that of my current study, which suggests that these clinicians working in the Irish context do not tend to access the literature on self-injury. One may ask why is this the case, considering the proliferation of current publications on conceptualising and treating self-injury in contrast to the relatively small amount that were available in 1997. The reason for this may be related to methodological differences. In my previous study (Keane, 1997), I conducted a postal survey of therapists and therefore, the participants may have been more inclined to tick boxes on the questionnaire that would reflect the type of clinicians they would like to be in the categories offered by the researcher. Thus, the social desirability effect may have been in operation or perhaps, these clinicians did actually consult the literature. In comparison, participants who are interviewed cannot simply tick a box to indicate that they draw on the literature; instead they have to rely on the discourses that they use in their narratives to demonstrate their knowledge.

This absence of deliberate attempts to learn or seek information about self-injury and how to treat it in the participating clinicians' discourses may account for the missing discourses of explanation in relation to self-injury and some issues in

relation to treating self-injuring patients. The clinicians did not really make any inferences as to why individuals may or may not engage in self-injury. Indeed, their discourses did not go beyond naming a few functional reasons for self-injury. Most of the clinicians did not speak of self-injury in terms of causation or the histories of clients who engage in self-injury with the exception of Niamh, Mark and Eimear who mentioned trauma and abuse. However, their discourses were unelaborated and did not go any farther than naming these as contributing factors.

These three findings collectively raise a conundrum as to why the clinicians in my study did not turn to the literature on self-injury in their discourses about conceptualising and treating self-injury. While it is not possible to answer this question from the findings of this research study, it is however conceivable to explore a range of potential explanations for this by returning to the clinicians' narratives for clues. Do they feel there is no need to go beyond what they already know from their clinical training and practice? Perhaps they also think like Sinead, who seemed to hold the view that she can understand her patients' symptoms through the window of her theoretical training. Referring to self-injury, she informed me, "I would understand it in the context that I would understand a lot of symptoms" (lines 69-70, part 2) via my constructivist "psychotherapy training" (lines 83-84, part 2). Indeed, this belief that the clinicians' primary training orientation to treatment is applicable to all clients regardless of their presenting issues may reflect the discourses that clinicians are exposed to in their training in the Irish context. Indeed, Allen (1995) articulated this notion when she declared that self-injury "...has much in common with many of the other difficulties with which our clients struggle, and many of our everyday helping skills are relevant to it" (p. 249).

Another interpretation is the possibility that the clinicians find it satisfying to work with self-injuring patients in their particular way and do not perceive a need to seek alternatives in the literature. This notion of being happy and content with his work emerged in David's narrative as he enthusiastically declared, "I love I love my um I love my work" (line 966, part 2). Maybe these clinicians do not want to be exposed to views in the literature that contradict or oppose their own ideas and beliefs. Alternatively, clinicians working in an Irish context may not get opportunities to question their discourses due to the lack of availability of workshops and conferences on the subject of understanding and treating self-injury. I will discuss this point later in this chapter.

Of course, another explanation could relate to a design limitation of my research study. It is quite possible that the interview schedule may not have allowed opportunities for the clinicians to open up their discourses beyond their clinical training/practice. Therefore, they didn't draw on discourses from the literature because I didn't ask for specific comparisons in this regard. Indeed, my interview schedule invited particular parameters to the clinicians' discourses in that I brought the same questions to all of the participants in my interviews with them. This had the impact of shaping the discourse between each participant and myself. Thus, I am acknowledging that knowledge is socially constructed between the researcher/interviewer and the participant/interviewee, as we socially interacted with each other in the interview context via the medium of language. This is in keeping with a social constructionism perspective that underpined my research study, and it is also a limitation of my study.

A final elucidation on the reason why the clinicians did not access information from the literature may be found in studies that have explored practitioners' utilisation of research in their clinical practice. For instance, a number of studies (e.g., Cohen, Sargent, & Sechrest, 1986; Cooper, Benton, Benton, & Philips, 2008; Morrow-Bradley, & Elliott, 1986; Orlinsky, Botermans, Ronnestad, & SPR Collaborative Research Network, 2001; Skovholt & Rønnestad, 1992) have consistently reported that the majority of clinicians do not read the research literature. Indeed, Ogilvie et al. (2005) noted a similar finding among clinical researcher-practitioners. They found, "...irrespective of psychotherapy research, what psychotherapy researchers themselves have found most useful within their clinical practice is both their ongoing experience with clients and their supervision and consultation with others" (Ogilvie et al., 2005, p. 31). Thus, it seems that interpersonal experiences with patients, discussions with colleagues, supervisors and personal therapy are valued more highly as information sources and influences on clinicians' development than research articles and books. Therefore, it would seem that the finding of my study in this regard is consistent with the general literature on clinicians' lack of utilisation of the research literature. Since clinicians appear to be drawn more toward interpersonal sources of knowledge, perhaps researchers need to look at alternative sources of disseminating their research findings. Such alternative forms might include continuing professional development workshops and conferences, and in-service training. I will return to this point.

Some authors such as Barlow et al. (1984, as cited in McLeod, 2004), have called upon clinicians "...to adopt the role of 'scientist-practitioner' and to use research routinely to help them to reflect on their work with clients" (p. 461). As I discussed in the preceding paragraph, studies suggest that the majority of clinicians do

not read the research literature. One explanation proffered in the psychotherapy literature to account for this, has centred on a discourse about the perceived lack of relevance of research for clinicians and their practice. This discourse has been labelled the "researcher-practitioner gap". It seems that this gap between psychotherapy research and practice has been noted by both clinical researchers and practitioners (Ogilvie et al., 2005). While this may be the view of some practitioners, it is interesting that none of the clinicians in this research study drew on this researcher-practitioner gap discourse in their narratives to explain or offer a reason why they did not access the literature for sources of knowledge on conceptualising and treating self-injury.

Clinicians' Treatment Success, Failure and Partial Failure with Self-Injuring Patients

Two findings emerged in my research study with respect to the clinicians' discourses about their treatment success, failure and partial failure. The literature contains a range of treatment options for clinicians working with self-injuring clients. However, there is a lack of research exploring which approaches are the most effective for treating self-injury. Therefore, the research literature offers the clinician little guidance in this regard. Taking this into account, how do clinicians in practice speak about their current treatment practice effectiveness with self-injuring patients? In response to this question, the findings of my research study suggest that the clinicians seemed to draw on two distinct discourses: expert and inquirer, about their current treatment practice effectiveness and failures with clients who engage in self-injury. In addition, the clinicians did not appear to have a systematic way of thinking about "progress" with regard to self-injury.

Expert and inquirer discourse. In speaking of their current treatment practice effectiveness and failures with self-injuring patients, the clinicians selected two clear and separate discourses, namely an expert discourse and an inquiry discourse. The clinicians seemed to use these two distinct discourses to construct the concepts of success, failure and partial failure in the face of questions about their treatment effectiveness with self-injuring clients. It is striking how the clinicians' discourses differed. Eimear, Sinead, Mike and Ciara all drew on an expert discourse in which they engaged in a style in which their discourse emerged as a repeating, clear, narrow and unquestioned stance. For instance, Eimear employed an expert discourse to endorse and expound the benefits of using a dialectical behaviour therapy approach with self-injuring patients. She never questioned or criticised this approach for its location of self-injury within a pathological framework. Neither, did she consider that this modality may be unsuitable for clients who do not have a BPD diagnosis. Eimear repeated words, phrases and ideas associated with DBT in her narrative. She further maintained this expert discourse by engaging in a pattern of predominantly brief responses to my questions. She never drew on a discourse of elaboration or inquiry in her narrative. In addition, Eimear did not consider the concept of failure or partial failure in her treatment of self-injuring patients. In fact, she considered herself to be a clinician who "was particularly successful with a limited number of people" (lines 1451-1452).

In contrast, the "inquirer" discourses of Jack, Niamh, Mark and David appeared to think out loud, mused, wondered, questioned and revised their discourses in response to my interview questions. For example, in response to my question about his experience of treatment success, Jack engaged in such a discourse. He acknowledged the difficulty of this question of success and then opened up a

discourse of inquiry in which he began to think aloud, mused, wondered and questioned, "what does it mean to have success to be successful with a a particular client" (lines 1501-1502).

Why did the clinicians' discourses tend to divide along the lines of an expert and an inquirer style? Are some of the clinicians more reflective about their practice and more open to various viewpoints that may be in contrast to their own in relation to working with self-injuring clients? Perhaps the clinicians' pattern of drawing on opposing discourses, in the face of questions about their treatment effectiveness with self-injuring patients, reflects the variations in training that the clinicians received in the Irish context, both within and across their disciplines. For instance, those clinicians who positioned themselves within an expert discourse may have been trained in a style that constructed their particular approach as the only effective way to work with self-injury. Alternatively, they may have received instruction during their training that the specific model they trained in is applicable to all problems, issues or symptoms that clients present with and therefore, can be applied to self-injury. In contrast, perhaps the clinicians who engaged in an inquirer's discourse were exposed to this style of reflective practice in their training as clinicians and therefore, were more open to this discourse.

Another interpretation for the clinicians' contrasting expert and inquirer discourses may be related to a difficulty selecting and speaking about their experiences of success with self-injuring patients. Indeed, Kottler and Carlson (2005) noted that the eminent clinicians they interviewed about their best (Kottler & Carlson, 2005) and worst (Kottler & Carlson, 2003) cases experienced greater difficulty choosing a case that illustrated their greatest work but could easily recall numerous

examples of their worst cases. So why was it difficult for the clinicians to talk about their successful cases with self-injuring clients? Scharff (2005, as cited in Kottler & Carlson, 2005) proposed that clinicians' difficulty in speaking of their successful cases may be due to doubt and uncertainty because a lot of the time clinicians "are just grinding through therapy wondering whether you are doing anything useful" (p. 269). So is it possible that the clinicians were unpractised about what success looks like when it came to speaking about their work with self-injuring patients? Indeed, David acknowledged that clinicians generally do not speak about their successful cases. He told me, "Goodness um I suppose that is an area that we probably don't focus a huge amount on" (lines 893-894, part 3). Is it possible that mental health clinicians do not discuss their successful cases with their peers in a similar vein to their medical colleagues? Could it be that clinicians working in the field of mental health do not have spaces or time to reflect on their current treatment practices with self-injuring clients because they are so caught up with the demands of their day-to-day practice? Or are the clinicians' difficulties in speaking about their experiences of success related to the fact that I only asked them about self-injuring patients and therefore, closed off the option of engaging in a wider discourse about all of their successful cases? It seems that from the literature on treatment success and the findings of my research study, we know very little about why clinicians have trouble engaging in a discourse about their experiences of success with their clients generally and also, specifically with self-injuring patients.

An alternative explanation is the possibility that the clinicians may concur with Jack that the concept of success is a difficult question. Indeed, Kottler and Carlson (2005) remarked on the complexity of this construct in clinical practice. Bugental (1988) sheds some light on this difficulty by proposing "…that almost every

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course of therapy has some elements of success and some of failure" (p. 532). He argued that, "Success or failure in psychotherapy is a matter difficult to assess reliably, depending on the time frame within which the judgment is made, and heavily influenced by the perspective of the person making the evaluation" (Bugental, 1988) p. 532). This notion of time frame may have heavily influenced the clinicians' discourses. For instance, I had no idea how recently or how far into the past the various clinicians had to go to recollect memories of their experiences of treatment success, failure and partial failure with self-injuring clients. Is it possible that those who engaged in an inquirer's discourse may have been referring to recent cases while those who drew on an expert discourse may have been speaking of patients they had worked with a long time ago? Keeney (2005, as cited in Kottler & Carlson, 2005) offered memory recall as an explanation for clinicians experiencing difficulty speaking about their successes with their clients. He argued that clinicians tend to remember their worst cases and "let the memory of doing the job well fade" (Keeney, 2005, as cited in Kottler & Carlson, 2005, p. 269).

In the face of this challenging question about their treatment effectiveness with self-injuring patients, some of the clinicians engaged in an expert discourse in which they shut down any exploration of other possible conceptual frameworks for treating self-injuring clients. A possible explanation for this may be due to their perceived view of the language of my questions as challenging the effectiveness of their particular treatment approaches. If so, perhaps they felt they had to engage in a defensive response. Or perhaps they just responded in a similar way to the therapists Kottler and Carlson (2005) interviewed, who in speaking of their "greatest success stories" demonstrated "...their commitment to their theoretical frameworks and emphasize how these are applied successfully" (p. 273).

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No systematic way of thinking about progress. The clinicians experienced difficulty with my question inviting them to speak about their experiences of and criteria for gauging treatment success, failure and partial failure with self-injuring patients. This is hardly surprising considering the varied but limited discourses about markers of success, failure and partial failure in the general treatment literature and the missing discourse in relation to self-injury. It appears that beyond the use of formal markers of progress or failure such as outcome measures, there is very little guidance in the literature to support clinicians to gauge or measure their treatment effectiveness with not only self-injuring clients but with all of their patients. Therefore, it is not surprising that the clinicians engaged in various styles of response to this question which included a surprised response, a floundering response and difficulty relating to the question. Thus, they seemed to have little or no systematic way of thinking or conceptualising "progress" in relation to self-injury. Indeed, their discourses about their criteria for gauging or measuring success and failure with regard to treating self-injuring clients appeared to vary among the clinicians.

Why did these clinicians seem perplexed by my question as for example, Jack did, floundering as he conceded, "Um well now that's that's again another difficult question" (lines 1498-1499). Mike admitted, "Oh Jesus I've no idea" (line 2073) what would constitute a treatment success with a self-injuring patient. Niamh confessed, "I can't relate to the question Aida to be honest" (lines 1935-1936) "I really can't relate to the question" (line 1938). It strikes me that perhaps they have never posed this question to themselves, or have not been asked by another prior to my interaction with them. David's surprised response suggests that this is a plausible explanation. For instance, David spoke in a collective voice on behalf of himself and

other clinicians as he acknowledged that treatment success "is an area that we probably don't focus a huge amount on" (lines 893-894, part 3).

Of course, another explanation may be related to the fact that the clinicians had no idea from my initial contact letter (see Appendix C) inviting them to participate in my research study, that I was going to ask them questions about their experiences of treatment effectiveness and how they gauge this in their work with self-injuring clients. Perhaps if they had had this knowledge prior to the interviews, they may have had different responses to my questions and drawn on other discourses in their narratives.

An alternative interpretation may be that the clinicians had difficulty relating to the discursive language I used to phrase my questions about their experiences of and criteria for gauging treatment success, failure and partial failure with self-injuring patients. For example, Niamh's discourse exemplified some dismay as she informed me, "I mean the word success the word failure doesn't actually mean it's like you say to me is my life a success" (lines 1642-1645) "I don't know that my life's a success I'm doing my best to get by" (lines 1645-1646) "and to enjoy and fully live" (line 1648). It is also possible that the fact that I asked the clinicians specific questions about measuring their treatment effectiveness with self-injuring clients, may have closed off other discourses that they may have drawn on when speaking more generally about what criteria they use in their clinical practice to decide when treatment is a success, failure or partial failure.

The clinicians' discourses suggest that although they do have some markers of success, they did not appear to have a systematic way of thinking about progress with regard to self-injury. All of the clinicians agreed that the reduction or cessation of

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self-injury is an indicator of progress except Mike, who did not raise this in his narrative. What is interesting is that these clinicians seemed to develop parameters of success by looking elsewhere beyond self-injury itself. These markers of progress included improved coping skills, more enriching relationships, changes in discourse and knowledge of themselves, increased functioning and active participation in their lives. As a group, the clinicians did not adhere to a shared set of criteria for measuring or gauging successful treatment outcomes with self-injuring patients. Indeed, the majority of the clinicians (Mark, Mike, Eimear, Ciara and Sinead) engaged in a discourse of non-elaboration in which they did not go beyond merely listing a number of indicators of success in relation to their treatment of self-injury. In contrast, three of the clinicians (Jack, Niamh and David) drew on a discourse of elaboration in which they not only spoke of markers of success but they also developed their discourses to include an articulation of the changes they observed in their practice with self-injuring clients.

A possible explanation as to why the clinicians did not have a systematic way of thinking about and marking out progress, with respect to treatment effectiveness with self-injuring patients, may lie in the narrow discourses in the treatment literature. It seems that the research literature has little else to offer the clinician in the way of thinking about and measuring treatment effectiveness beyond the narrow discourses of the use of outcome measures, evidence-based treatment and evidence-based practice. These discourses may be incongruent or incompatible with some of the clinicians' particular theoretical orientations. For example, Jack acknowledged that he had no formal systematic way of evaluating his treatment success with self-injuring clients. He admitted, "I don't do a six month-month follow-up" (lines 1522-1523). Indeed, he questions the notion of doing a six-month follow-up and whom it benefits.

Jack's discourse suggests that he was not in favour of this method of evaluation. He argued, "You know and the difficulty with that is of course if you start if you go back and you say to someone well listen I'd like to maybe you could come back in six months they might or might not come back and if they do you know so so what how they'll come back and give you a report but then for whom would they do that for me or or for them" (lines 1533-1537). Therefore, it is no wonder that there was an absence of a systematic way of thinking about "progress" among the clinicians and that they floundered about in their discourses in the face of questions about criteria for measuring success and failure with regard to treating self-injuring patients.

Another interpretation could relate to the clinicians' beliefs that the use of outcome measures may not actually be helpful in their practice. Indeed, Kazdin (2008) put forward this very argument, noting that outcome measures "may not necessarily tell us how a patient is doing in the world" (p. 148). He contended that, "Changes on the rating scales, even well–established ones such as the Beck Depression Inventory or the Minnesota Multiphasic Personality and its derivates, are difficult to translate into changes in everyday life" (Kazdin, 2008, p. 148). In fact, Kazdin concluded that in most cases applying the metrics of evaluation such as statistical significance, effect size and clinical significance, "…it is difficult to tell the extent to which patients have been helped in their daily lives" (p. 148) because "A change of one standard deviation on a measure from pre- to post treatment does not clearly portray (or map onto) how the client is functioning in everyday life" (p. 148). However, none of the clinicians drew on this discourse to critique the use of outcome measures in their practice; therefore it is not possible to say whether they concur with this argument.

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Of all of the clinicians, Eimear's discourse was the most striking in its lack of

elaboration, considering that she was the only one who declared, "I'm a great believer

in evidenced interventions and" (lines 1380-1381) "certainly dialectical behaviour

therapy is one intervention for which there is a good scientific evidence base in terms

of effect" (lines 1383-1385). She made no reference to the research that supports

DBT. Surprisingly, she did not refer to the use of outcome measures that one

traditionally associates with research studies in DBT and CBT, and clinical practice

with clinicians who adhere to such modalities. Indeed, markers of success appear to

be a missing discourse in the treatment literature as a whole and not just in relation to

self-injury. Therefore, it is not surprising that the clinicians' discourses suggest that

they have some markers of success but not along the lines of self injury per se.

Futhermore, there seems to be no criteria articulated in the literature that crosses the

mental health disciplines of psychiatry, psychology, psychoanalysis and counselling

in relation to treatment success beyond the use of outcome measures.

There is yet another explanation for an absence of discourse markers of

success. Garland, Kruse, and Aarons (2003) reported that the majority of the

clinicians in their study "...did not experience increased pressure to demonstrate their

effectiveness as a psychotherapist..." (p. 399). Perhaps, this is the experience of

clinicians in my research study and therefore, the whole notion of treatment

effectiveness may not be a discourse to which they need to subscribe. Thus, they do

not have to reflect on or develop a systematic way to think about markers of progress

in their clinical practice with self-injuring clients. Similarly, Andrews and Page

(2005) noted that, "Private psychiatrists and psychologists rarely find it necessary to

measure their patients' outcomes. They presume they know" (p. 650). This is also

another possible reason for the clinicians' lack of a systematic way of thinking about

and marking out progress with respect to treatment effectiveness with self-injuring clients.

Discourse of failure. The clinicians' discourses about their criteria for gauging or measuring failure and partial failure, is in sharp contrast to their discourses about treatment success. Unlike their discourses of treatment success, for the most part, they did not develop their discourses to include articulations around their views of failure and partial failure. Indeed, their discourses appeared unelaborated in terms of not engaging in a dialogue beyond naming a few markers of failure. A lack of clarity as to what exactly constitutes a treatment failure may explain the clinicians' difficulty in constructing failure and the absence of a clear singular discourse with respect to markers of failure among their narratives. In fact, this seems to be the case in Mike's narrative where he appeared to be uncertain about this concept as he admitted, "I'm not sure about failure" (line 1803). Indeed, this uncertainty is also reflected in the literature on treatment failure. Mash and Hunsley (1993) have commented that, "…clear definitions and precise estimates of the nature and extent of failure in psychotherapy remain elusive and a matter of debate (Bugental, 1988; Lambert, Shapiro, & Bergin, 1986; Mays & Franks, 1985a)" (p. 292). Therefore, it should come as no surprise that the clinicians struggled with this concept of failure and seemed to have unelaborated discourses on this subject matter in their narratives in relation to self-injury.

Another possible explanation for the clinicians' uncertainty and unelaborated discourse in relation to treatment failure in their narratives may reflect the lack or absence of opportunities for clinicians working in the Irish context to engage in discourses about the concept of failure, what it looks like, their experiences of it and

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how they measure or gauge it in their clinical practice with self-injuring patients. Supervision with a colleague and/or peer groups are usually the media through which clinicians engage in case discussions. Perhaps, there is no space to discuss success or failure in these fora because they are usually time limited and most often clinicians bring their most pressing case(s) to these meetings. This is essentially David's point, "Um one tends to be very much caught up with those who are uh acutely presenting" (lines 894-896, part 3).

While no singular clear discourse emerged with respect to markers of failure among the clinicians' narratives, five discursive patterns emerged across the group of clinicians' narratives. These included a discourse of failure in relation to a narrative experience of failure, discourse of remain the same or worse, discourse of disengagement in relation to failure, discourse of partial failure, and discourse of failure in relation to suicide.

Mark was the only clinician who engaged in a discourse of narrative experience of failure. None of the other clinicians shared an experience of treatment failure with a self-injuring client despite my invitation to do so. One explanation may be related to their uncertainty about what constitutes failure, which I discussed in a preceding paragraph. Another interpretation may be located in a discourse articulated in the literature by Stricker (1995), C. R. Rogers (1954), Persons and Mikami (2002) who contended that the issue of treatment failure is rarely discussed in the literature. This may be due to a bias toward only publishing successful outcomes in journals.

Stricker (1995) proposed that clinicians do not tend to proclaim their lack of treatment success. Therefore, an alternative explanation may be as a result of clinicians' disinclination to put forward unsuccessful cases for publication. The

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clinicians' unelaborated discourse about failure may be due to a reluctance to speak of their experiences of treatment failure with self-injuring patients with me. Perhaps, they were concerned that if they opened up a dialogue with me, as a fellow clinician about their experiences of failure that they might lose face, as the sharing of experiences was not reciprocated by me as the interviewee/researcher. Therefore, they may have been avoiding the possibility of constructing themselves as clinicians whose competency may be called into question by such disclosures.

A discourse of no change or symptoms worsening appeared as a marker of failure in five of the eight clinicians' narratives. Curiously, the majority of the clinicians did not elaborate on this indicator beyond naming it. Perhaps, they rarely if ever experienced self-injuring clients as remaining the same or getting worse. Indeed, this was Jack's argument. He contended, "its rare enough for someone to come and say start speaking about cutting themselves and um and then not continue for for a a reasonable period and and and make some sort of progress even if not everything is achieved" (lines 1578-1883).

The subject of disengagement as an indicator of failure emerged in five of the eight clinicians' discourses. What is striking about their discourses in relation to this marker are the different ways that they constructed disengagement as a marker of treatment failure that reflects the diversity among the clinicians. For instance, Sinead proposed, "these are the ones where they may not come back and you're not sure what the not coming back is about" (lines 1423-1425, part 1). Jack offered, "Yeah well I mean failure is where someone simply doesn't you know if they they continue they their uh work hasn't progressed enough so I've failed somehow to uh engage them or you know to allow some kind of a space so that something can be spoken about um

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and they don't turn up again they they stop coming I uh nothing I can do nothing about that" (lines 1568-1574). David described disengagement as a discourse marker "where a person has um for whatever reason uh either fails to engage or having engaged then falls out with you and uh either refuses to return or um just simply vanishes" (lines 1185-1188, part 3). Indeed, the variation in their discourses may reflect their different clinical experiences of disengagement with self-injuring patients. Curiously, none of the clinicians drew on a discourse about how some clients may be difficult to engage in the treatment process and that this may be a contributing factor to treatment failure.

Perhaps, another difficulty for clinicians gauging treatment effectiveness may be related to the multiple and diverse foci of treatment. Indeed, patients have different needs and expectations of the treatment process. For instance, some seek treatment for forms of mental illness, others the amelioration of life's difficulties and challenges, and other clients are seeking to enhance their quality of life and move towards self-fulfilment. Surprisingly, none of the clinicians drew on this discourse about the diverse needs and expectations of self-injuring patients and how difficult it may be to engage some self-injuring clients in the treatment process, and that this difficulty may be a contributing factor to treatment failure. In fact, Barker (2001) noted that De Shazer (1988, 1991) constructed and described three types of psychotherapy patient, the "complainant", the "visitor" and the "consumer". De Shazer (1988, 1991) proposed that, "The *complainant* [sic] recognises that a problem exists, but views this as residing somewhere else, or in someone else. The *visitor* [sic] is referred for therapy by someone else, who recognises that a problem exists. The visitor, on the other hand, does not and may be wholly opposed to therapeutic engagement. The *consumer* [sic], however, is the classic psychotherapy client, and

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actively seeks help for a problem which is she or he recognises as their own (Hawkes *et al.* [sic] 1998)" (Barker, 2001, p. 16). Indeed, Barker (2001) argued that, "…the denomination of the client-as customer, visitor or complainant-is critical for the outcome of therapy" (p. 19).

Remarkably, only one of the eight clinicians Sinead made any reference to partial failure. Otherwise, this was completely absent from the clinicians' narratives. This absence also reflects the treatment literature in which there seems to be no direct reference to partial treatment failure. However, discourses about the impact of empathic failures or ruptures in the therapeutic alliance are well documented in the literature (e.g., Mordecai, 1991; Safran, Muran, Samstag, & Stevens, 2002). For instance, Safran et al. (2002) defined a rupture in the therapeutic alliance "…as a tension or breakdown in the collaborative relationship between patient and therapist" (p. 236). They further added that, "These ruptures vary in intensity from relatively minor tensions, of which both of the participants may be only vaguely aware, to major breakdowns in understanding and communication" (Safran et al., 2002, p. 236). Indeed, Safran et al. cautioned that if major ruptures are not addressed they "…may lead to premature termination or treatment failure" (p. 236). Mordecai (1991) also noted that empathic failures occur regularly in psychotherapy and if not addressed they can cause significant disruption in the treatment process and may eventually lead to failure. Likewise, many authors (e.g., Connors, 2000; Deiter & Pearlman, 1998) have referred to the countertransference difficulties that emerge for clinicians working with self-injuring clients. In fact, Connors (2000) and Deiter and Pearlman (1998) have argued that if the strong feelings and reactions of clinicians are not managed, they can severely hinder the treatment effectiveness. Therefore, these concepts of empathic failures or ruptures in the therapeutic alliance and countertransference

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difficulties could be constructed as partial failures, due to the fact that if clinicians address these issues, then treatment failure may be avoided. Surprisingly, none of the clinicians spoke about the impact of ruptures in the therapeutic relationship or countertransference difficulties in their narratives, considering their impact on the outcome of treatment is a documented discourse in the psychotherapy literature.

So what might explain the clinicians' missing discourses in relation to partial failure in treating self-injuring patients? Perhaps, the clinicians do not recognise or identify with the concept of partial failure. For instance, Eimear made a brief reference to an experience with a self-injuring client that could be constructed as a partial failure. Yet, she did not use this term but referred to this incident as a mistake. Eimear acknowledged, "Certainly when I was starting out I made mistakes of maybe not putting in enough things in place when I was taking annual leave" (lines 1146-1148). She elaborated on the impact of this mistake, "And then the fallout would have been they would have had the kind of feeling of being abandoned that they might have had earlier on in their own lives and" (lines 1150-1152) "would have there would have been an escalation in self-injurious behaviour" (lines 1154-1155). Curiously, Eimear did not seem to equate her admitted mistake with that of a partial failure or disruption in the therapeutic relationship. Maybe, if I had asked the clinicians specific questions about lapses in empathy and ruptures in the therapeutic alliance with self-injuring patients rather than possibly using the unfamiliar term of partial failure, they might have engaged in such a discourse. Likewise, if I had invited the clinicians to speak about their mistakes in their clinical practice with self-injuring clients rather than using the language of failure, this might have opened up an opportunity for them to speak about such experiences without the possibility of constructing themselves in a negative way. Indeed, the clinicians may agree with

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Casement (2002) who argued that making mistakes is part of the analytic process and that they are unavoidable in psychoanalysis and psychotherapy. However, he proposed that in addressing these mistakes, "...it is important that there is always room for a patient to correct the analyst, and for the analyst not only to be able to tolerate being corrected but to be able to make positive use of these corrective efforts by the patient" (Casement, 2002, p. 18). Therefore, making mistakes, if corrected in the treatment process, could be constructed as partial failures, or as successes.

Another interpretation for the absence of a discourse of partial failure may be related to the possibility that the clinicians did not experience counterference difficulties with self-injuring patients. This absence may be due to the fact that they are experienced clinicians and most of them have worked with large numbers of individuals who engage in this behaviour. Indeed, when I asked them about their reactions to those clients who engage in self-injury, they did not appear to have strong reactions to a disclosure of self-injury. For instance, Niamh informed me, "I'm not freaked by scars" (Niamh, line 767) and Ciara told me, "I don't really I see so much of it" (line 983, part 1) "that" (line 983, part 1) "it's not shocking to me any longer" (line 984, part 1) (for full extract of Niamh's and Ciara's transcript, see Appendix J).

Four of the eight clinicians mentioned suicide as a marker of treatment failure with self-injuring patients in their narratives. Curiously, Ciara was the only clinician who engaged in an elaborated discourse, addressing an invisible audience whom she constructed as not understanding the impact of client suicide on psychiatrists. A possible reason for this focus may lie in the fact that Ciara is a psychiatrist and the research literature suggests that her profession has a high rate of encounters with patient suicides (e.g., Alexander, Klein, Gray, Dewar, & Eagles, 2002; Cryan, Kelly

and McCaffrey, 1995; Ruskin, Sakinofsky, Bagby, Dickens, & Sous, 2004). Indeed, Cryan et al. (1995) reported that 82% of Irish psychiatrists in their study had experienced patient suicide. A more recent Irish study by Landers, O'Brien and Phelan (2010) reveals a similar finding of 80%. This figure for Irish psychiatrists is much higher than those reported in North American (57% – O'Reilly, Truant, & Donaldson, 1990) and British (68% – Alexander, et al., 2002) studies. Cryan et al. proposed that the "…higher known to unknown ratio of suicides in Irish practice, since the population is small and less mobile" (p. 6) may account for this differential. This "know to unknown ratio of suicides" is referring to the psychiatrists' knowledge of their patients' suicides. In contrast, North American studies exploring therapists' (23% – Adams & Foster, 2000) and psychologists' (22% – Chemtob, Hamada, Bauer, Kinney, & Torigoe, 1988) experience of client suicide reported much lower rates than those for psychiatrists.

Additional missing discourses in relation to success, failure and partial failure. It is a little surprising to see the level of difficulty that emerged in the clinicians' discourses in relation to markers of progress, considering it is a professional requirement for most, if not all clinicians to keep progress notes of their treatment of patients. Indeed, Chenail, Sommers, and Benjamin (2009) remark that clinicians "…typically record progress notes by articulating client symptoms, diagnoses, functional status, progress, and adherence to treatment plans" (p. 87). Therefore, one would expect clinicians to be familiar with indicators of progress in relation to their treatment effectiveness with self-injuring clients and experience less difficulty and exhibit more clarity in their discourses about success, failure and partial failure. Perhaps, if I had used the term "progress" in place of words like "success, failure and partial failure" in the questions I posed to the clinicians, they might have

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engaged in more elaborate and certain discourses about markers of treatment success and failure. However, it is also possible that if I had spoken of "progress", they might not have engaged in discourses of failure.

Curiously, none of the clinicians drew on a discourse about reflecting on the effectiveness of various interventions and whether they contribute to success, failure and partial failure with self-injuring patients, considering these types of discussions typically occur during supervision sessions and case conferences with other colleagues.

It is also interesting that the majority of the clinicians did not draw on their discourse markers of success on the opposite end of the spectrum as indicators of failure. For instance, they named improved coping skills, decrease or cessation of self-injury, more enriching relationships, changes in discourse and knowledge of themselves, increased functioning and active participation in their lives. Surely, if these are markers of success, no change in these areas or a deterioration in the clients' functioning is perhaps related to treatment failure.

Responsibility for Treatment Outcome

There was a variation among the clinicians' discourses about who is responsible for the treatment outcome with self-injuring patients. These included "it depends" discourse, shifted to the therapist discourse, shifted to the client discourse, shifting discourse of responsibility, and a "mixture" of responsibility in both client and therapist discourse. The varied discursive positions that the clinicians occupied in relation to this question of assigning responsibility for treatment outcome reflects those articulated in the treatment literature. For instance, Mike firmly located the responsibility for treatment outcome with the clinician. Indeed, he argued that

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clinicians tend to blame clients when the treatment is not effective. He contended, "And I think far too often I've heard it being switched back on the client you know that that person isn't psychologically minded enough for therapy and I think it's really interesting how when it doesn't work out sometimes that we blame the client and I think we need to be looking more at ourselves" (lines 2149-2154). This discourse of Mike's, where the clinician appears to blame the patient for a negative treatment outcome, concurs with that of Whiston and Sexton (1993) and Kottler and Carlson (2003).

Likewise Mark's opposing view suggests that he was positioning himself within a shifted to the client discourse, a discourse also uttered in the treatment literature. For example, Bergin and Garfield (1994) and Bohart (1995) placed the responsibility for the treatment outcome with the patient. Indeed, this discursive position is consistent with that articulated in the research findings on outcome and common factors research. The research on psychotherapy common factors argued that, "...outcome is determined to a great degree by the client and outside events—not the therapist" (Asay & Lambert 2001, as cited in Hubble, Duncan, & Miller, 2001, p. 30). It is interesting that none of the clinicians drew on the common factors discourse to support their discursive position in their narratives on assigning responsibility with regard to treatment outcome. Curiously, Niamh and Eimear, two psychologists were the only clinicians who engaged in a "mixture" of responsibility in both client and therapist discourse. Despite the discourse about psychotherapy as a collaborative relationship in the treatment literature, there seems to be an absence of an explicit discourse about patients and their therapists sharing responsibility for the outcome of treatment.

Some of the clinicians' discourses suggest that they were experiencing difficulty with this question of who is responsible for the treatment outcome with self-injuring clients. Indeed, their discourses suggest that they were unclear or not sure about to whom to assign the responsibility. Sinead, Ciara and David all appeared to engage in a shifting discourse with regard to the question of who is responsible for the treatment outcome. For instance, Sinead began by declaring that she saw "therapy as a collaborative effort" (lines 393-393, part 2) and then, she moved to a discourse in which she viewed the client as being responsible for the cessation of self-injury. Upon reaching the end of her narrative on this subject, she returned to the collaborative argument with which she started.

Jack's "it depends" discourse provides a possible explanation for the clinicians' apparent struggle with assigning responsibility for treatment outcome. He proposed, "it depends on which point of view you want to take" (lines 1651-1652). Here, he was referring to whether one locates oneself in the position of the patient or the clinician. He elaborated on this discourse explaining, "from the point of view of the individual the individual doesn't really fail" (lines 1653-1655) and "as an analyst I can fail in lots of way" (lines 1662-1663). However, he also acknowledged that there are times when a client comes for therapy and "they somehow can't find the words to express to to begin um then there's probably not a lot I can do about that" (lines 1668-1670). Thus, Jack's narrative was illustrating that the clinicians' discourse is dependent upon the position she/he locates herself/himself with regard to this question of responsibility.

Considerations of Ireland as a Social Context

The discourses of the clinicians in this research study were co-constructed in the wider context of Irish society. Consequently, there are a number of particular influences that have shaped my interpretations of the clinicians' discourses that are connected to considering Ireland as a social context. Being Irish and having lived in Ireland, I share a sense of humour or Irish "wit" and a pattern of speech with these clinicians that is evident in the extracts from the clinicians' narratives that I have displayed throughout the four findings chapters. In addition, my training within the discipline of psychology as a counselling psychologist has impacted my interpretations, since I have been exposed to particular discourses (e.g., humanistic, psychodynamic, cognitive-behavioural, sensorimotor, systemic, relational and wholistic) in my training and clinical practice within the wider Irish context.

The disciplines of psychiatry, counselling and clinical psychology, psychoanalysis, and psychotherapy are all located within a social context in Ireland. For instance, within Irish society, psychiatrists have a higher professional status than other mental health clinicians. They have higher salaries; they also have a different knowledge because of their medical training, and a different sense of authority because they usually hold more professional responsibility as the head of a multi-disciplinary team with the psychologist, psychotherapist, psychoanalyst and other team members reporting to them.

Counselling psychology is a relatively new profession in Ireland having only been established in 1989, with the first training programme at Trinity College, Dublin (Orlans & Van Scoyoc, 2009). Counselling psychologists tend to receive therapeutic theoretical/training in the major psychotherapeutic traditions of psychoanalytic-

psychodynamic, cognitive behavioural and humanistic-existential modalities of treatment. In contrast, clinical psychology is the older and more established psychology profession and clinical psychologists in the Irish context are predominantly trained as cognitive behavioural therapists. Clinical psychologists tend to work as part of multi-disciplinary teams in mental health settings, while counselling psychologists are more likely to work in educational settings (37%), private practice (26%), voluntary bodies (19%) and the Health Service Executive (15%) (Broderick, 1999). This may account for the dominant and popular discourse of CBT in medical settings. Indeed, one medical professional, Dr. Harry Barry, in his book *Flagging the Therapy: Pathways Out of Depression & Anxiety* has gone as far as declaring:

> Cognitive Behaviour Therapy: In my opinion, no other form of therapy has such potential to 'revolutionise' mental health in Ireland. As part of a holistic package to treat depression, all forms of anxiety, eating disorders and addiction, CBT is unparalleled. (2009, p. 44)

Perhaps, this is the type of comment that Niamh, a counselling psychologist, was reacting to in her discourse community of opposition to a CBT approach which I discussed in Chapter Five.

The psychotherapy profession is a longer established community than psychology in Ireland. The psychological Society of Ireland was formed in 1970, while the Irish Psycho-Analytic Association was founded in 1942 (Carr, 2007). Cognitive behavioural, humanistic, constructivist and family therapy emerged in the 1960s and 1970s. Since then, additional models of psychotherapy have appeared. For instance, Boyne's (1993) edited book *Psychotherapy in Ireland* contains chapters on

different approaches to psychotherapy written by various Irish psychotherapists. These approaches included psychoanalysis, Jungian analysis, psychosynthesis, constructivist psychotherapy, family therapy, cognitive behaviour therapy, Gestalt therapy, client-centred therapy, humanistic therapy and integrative psychotherapy. In the last decade, other therapeutic modalities have emerged such as process oriented psychotherapy, sensorimotory psychotherapy, mindful cognitive behaviour therapy, dialectical behaviour therapy and eye movement desensitisation and reprocessing therapy.

The clinicians' discourses in this study suggest a lack of access to resources and limited opportunities to learn about self-injury and explore other treatment possibilities in the Irish context. Clinicians who work in psychiatric settings mentioned DBT as a treatment programme in Ireland. One clinician, Eimear had received training in this modality. Thus, it seems that only clinicians who work in the psychiatric services in Ireland are given the opportunity to avail of training in DBT. This exclusivity in regard to DBT training within these services has the potential to establish and maintain an "expert" discourse within the psychiatric services, in relation to the conceptualisation and treatment of self-injury. This concentration on a single kind of training may exclude discourses of inquiry among clinicians in these services, where they can engage in a dialogue about other discursive frameworks, and models for understanding and treating self-injuring patients. Thus, there is a great need to create venues, providing opportunities for training and encouraging open discourses of inquiry among all clinicians working in the Irish context in relation to self-injury.

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Limitations of this Research

There are a number of limitations to my research study. First, the use of snowball sampling means that only inferences about this small group of clinicians can be made from the results of this research. Therefore, these results cannot be generalised to individual groups of clinicians represented in this study such as psychiatrists, clinical and counselling psychologists, psychotherapists and psychoanalysts. Neither can the results be generalised to the population of Irish clinicians as a whole. However, the discursive patterns of this small group may be situated in the wider context, and in the clinical and research literature, as I have done in this chapter.

The second limitation relates to interviewer bias. There is no objective position from which to interview. Therefore, no research interview is completely free of bias. Having trained as a psychologist, I bring my own assumptions to each interview regarding the field of knowledge about self-injury and working therapeutically with self-injuring clients. This means that I may have missed something crucial in an interview by not hearing or indeed mishearing what an interviewee said. In addition to the issue of researcher bias, there is also the question relating to the validity and accuracy of the interpretations I made in relation to my analysis of the research data. Taylor (2003) argued, "...*all* [sic] knowledge is considered to be situated, contingent and partial" (p. 319). Therefore, it is not possible to attain truth because reality is not single or static and it is "...influenced and altered by any process through which a researcher attempts to investigate and represent it" (Taylor, 2003, p. 319). Thus, it is not possible to capture completely another individual's reality. However, in my analysis and interpretation of the data, I

have sought to approximate as fully as possible clinicians' discourses of conceptualisation of self-injury and treatment of self-injuring patients. To reduce researcher bias and address this issue of validity, I have also sought readers who challenged my interpretation of my analysis of the research data. These readers were my primary supervisor, my auxiliary supervisor and my research review committee.

A final limitation of my research study pertains to the design or framing of my interview schedule. The way I constructed my interview questions and the language I used shaped the clinicians' discourses profoundly. Indeed, my questions invited particular parameters to the clinicians' discourses, in that I brought the same questions to all of the participants in my interviews with them. This may have had the effect of narrowing the clinicians' discourses and possibly closing down an opportunity to hear a wider range of discourses from them.

Implications of this Study

The findings of my research study have significant potential implications for the education and training of clinicians in Ireland within the professional disciplines of clinical and counselling psychology, psychoanalysis, psychotherapy, and psychiatry. They suggest a need to open up new opportunities for clinicians to use an inquirer's discursive approach to learning about understanding and treating self-injury. Applying a discursive model of inquiry to training, clinicians can engage in a dialogue with their peers and trainers in which they can think, wonder, question and revise their discourses in response to self-injury. Such a training model would provide an opportunity for clinicians to engage in an open and critical dialogue about the many debates and controversies that surround self-injury and its treatment. It would also challenge clinicians to engage in a discourse of interrogation, in which

they could think about and critically reflect on their specific frameworks for understanding self-injury and their particular models of treatment with self-injuring clients and also ask questions about their compatibility and suitability for working with self-injury.

These findings also draw attention to the complexities and difficulties that clinicians encounter with regard to the evaluation of their clinical practice with self-injuring patients. They suggest an absence of a systematic way of thinking or conceptualising progress with regard to self-injury among Irish clinicians. Although, there is an absence of discourse markers of progress in relation to self-injury in the literature, this should not deter clinicians from developing some systematic indicators or markers of progress with respect to self-injury. Therefore, there is a need to create fora that open new opportunities for reflection, discussion and training about these issues among clinicians in the disciplines of counselling, psychoanalysis, psychology and psychiatry. These spaces could facilitate clinicians to come together to engage in dialogue and reflect on their practice with particular reference to developing criteria for marking out progress, considering and naming partial failures, alliance ruptures, empathic failures and mistakes in their treatment of self-injuring clients. There is also a need for clinicians to speak about and reflect on their clinical effectiveness and failures in their work with self-injuring patients, and to consider their own, as well as client variables, in relation to the impact on treatment outcome, with other colleagues who have contrasting views and different orientations to practice.

Future Research and Directions

The findings of my research study highlight the need for additional research to be conducted on the phenomenon and treatment of self-injury within and beyond

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Ireland. The number of studies in Ireland is relatively small and discourses on self-injury in the Irish context are limited to a few unpublished scholarly dissertations.

Certain puzzling features have emerged for me in relation to the findings and point to three areas that warrant further exploration. For instance, a future study is required to further our knowledge about clinicians' difficulty in speaking about success in their clinical practice, as it is not clear why they have trouble engaging in a discourse about their experiences of success with clients in general and also, specifically with self-injuring patients.

In addition, an exploration into the use of theoretical or conceptual frameworks with regard to understanding and treating self-injury by clinicians who write about self-injury and those who don't is also required. It is not known whether those who write about self-injury would actually draw on theoretical or conceptual models in their narratives about their understanding and treatment of self-injuring clients in an interview situation, in constrast to their articulations in the literature in which they write about using frameworks.

Another puzzle to resolve in relation to the findings is the question of the clinicians' training with respect to those who drew on either an inquirer or expert discourse in response to questions about their treatment effectiveness with self-injuring patients. A further study in this area might focus on exploring whether clinicians are open to other discourses of practice that oppose their own with regard to self-injury. Indeed, this could be extended to incorporate other studies investigating this question with respect to other clinical phenomena beyond self-injury.

I would also like to recommend a number of other studies that would go a long way to increasing our clinical knowledge about self-injury and other areas. It would

be useful to extend this study to include the narratives of clients who engage in self-injury, and examine their discourses about the various treatment modalities they have experienced via clinicians working in the Irish context and their relative effectiveness.

This current study could be replicated in other countries such as Canada, the USA and the UK that have long established discourses in self-injury. Indeed, it would be interesting to note whether similar findings emerge. The research questions and methodology employed in my research study could also be used to explore clinicians' conceptualisation and treatment of other clinical phenomena that clients present with, such as anorexia nervosa, bulimia nervosa, depression, anxiety etc. Such studies would help to further our knowledge about whether clinicians have models for considering these clinical phenomena and treatment approaches that are distinct from their primary theoretical orientations to practice.

It would be interesting to replicate this current study with a group of clinicians who began at the same starting as myself, which is with a conceptual framework for understanding and treating self-injury before having worked with their first self-injuring patient. I would be curious to discover if such clinicians engage in similar discursive patterns to the clinicians in my doctoral research study.

There is a lack of established criterion for gauging treatment success and failure in the literature from which clinicians can draw in their clinical practice with self-injuring clients. Indeed, it appears that our discourses of knowledge in this area are limited to the application of outcome measures. The findings of this study point to the need for further research to identify assessment criterion and to develop a systematic, robust, adaptive and clinically useful set of criteria that clinicians could

use in evaluating their current treatment practice effectiveness with their self-injuring patients.

Finally, the interview schedule I developed and used in this study could be adapted and employed as a clinical tool of self-reflection for clinicians with regard to their conceptualisation and treatment of self-injury and other clinical phenomena that they encounter in their clients. This clinical tool could be used by individual or small groups of clinicians to teach and inform each other across the disciplines of psychotherapy, psychoanalysis, psychology and psychiatry.

Summary and Conclusions

In this chapter, I considered the five major findings of my research study in light of the literature. I highlighted the clinicians' discourses that concur, contrast or are newly articulated discourses that have not been previously reported in the literature. I also named the discourses in the literature that are absent from the clinicians' narratives. I offered various interpretations and possible explanations for the findings in relation to the clinicians' discourses that pertain to their understanding of self-injury, their discourses about their treatment models, their perceptions of their clinical effectiveness and failures in their work with self-injuring patients and the sources of knowledge that contribute to their understanding of self-injury.

I concluded with a discussion of the clinicians' discourses within the wider context of Irish society, the limitations of my research study and the potential implications of this study for the education and training of clinicians in Ireland, within the professional disciplines of psychoanalysis, psychology, psychiatry and psychotherapy. I also highlighted areas for future research on the phenomenon and treatment of self-injury.

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Appendices

Appendix A: Self-Injury Illustrative Terms (Ross & McKay, 1979)

1. A little suicide
2. Attempted suicide
3. Attenuated suicide
4. Autoaggression
5. Deliberated disability
6. Deliberated self-harm
7. Deliberated self-injury
8. Demonstrative self-injury
9. Focal suicide
10. Intentional injury
11. Local self-destruction
12. Malingering
13. Masochism
14. Munchausen syndrome
15. Self-abusive behaviour (or conduct
16. Self-aggressive behaviour
17. Self-assaultive behaviour
18. Self-attacking
19. Self-damaging behaviour
20. Self-destructive behaviour
21. Self-harming behaviour
22. Self-hurting behaviour
23. Self injurious behaviour
24. Self-poisoning behaviour
25. Self-punitive behaviour
26. Self-stimulatory behaviour
27. Self-wounding behaviour
28. Self-directed aggression
29. Self-mutilation
30. Small suicide
31. Symbolic wounding
32. Parasuicide
33. Purposive accidents

Appendix B: Selection Criteria for Inclusion in the Research Study

1. Participants must have a professional qualification in at least one of the following that allows them to practice in the Republic of Ireland as a psychiatrist; or a clinical psychologist; or a counselling psychology; or a psychotherapist or a counsellor; or a psychoanalyst.

2. Participants must be full members of the Royal College of Psychiatrists; or a registered member of the Psychological Society of Ireland; or an accredited member of one of the following professional bodies: the Irish Council of Psychotherapy; the Irish Association for Counselling and Psychotherapy; or the Irish Association for Humanistic and Integrative Psychotherapy; or the Irish College of Psychoanalysts.

3. Participants must have a minimum of 2 years clinical experience post qualification in one of the following professions: psychiatry; clinical or counselling psychology; psychotherapy; or counselling; or psychoanalysis.

4. Participants must have worked with at least 3-4 self-injuring clients in the Republic of Ireland for a minimum period of 3-6 months, meeting regularly weekly sessions.

Appendix C: Initial Contact Letter

St. Patrick's College,
Drumcondra,
Dublin 9.

01/08/07

Dear   ,

I am a doctoral research student at St. Patrick's College (a College of Dublin City University). My research supervisors are Prof. Annie G. Rogers (Hampshire College, U.S.A.) and Dr. Catherine Maunsell (St. Patrick's College). The focus of my dissertation is on the topic of self-injury. The purpose of this research study is to explore mental health clinicians' understanding of self-injury and how they work with self-injuring clients/patients in the Irish context. This current research is an extension and continuation of my Master's dissertation on self-injury which I completed a number of years ago.

You are one of a small number of mental health clinicians that have been selected by myself or by one of your colleagues as a result of your experience of working with self-injuring clients/patients. Therefore, I would like to invite you to participate in my study.

Your participation would involve one interview of one and a half to two hours duration with me. The interview will consist of opened ended questions about self-injury and your work with self-injuring clients/patients. You will be asked to complete a biographical data sheet at some point during the interview. You may be asked to participate in a follow-up interview should I need to seek clarification, and/or to follow-up on something you said that I did not fully understand in the initial interview. The follow-up interview if required should take about 30 minutes to one hour with me.

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All interviews will be audio recorded. Each audio file and transcript will be given a pseudonym in order to protect your identity. Therefore, your real name and any identifying information will not be used in any documents related to this research study. In the event that some of the data recorded from your interview contains sensitive clinical information that may be too revealing for you and your clients/patients, I will contact you, ask you to review your transcript and request a follow-up interview to address this issue. Protecting the identity and confidentiality of you and your clients'/ patients' is a primary concern notwithstanding the limits to confidentiality.

Participation in this research study is on a voluntary basis. You can withdraw your consent at any time. You can refuse to answer particular questions should you wish to.

There is no anticipated perceived risk to you as a result of your participation in this research study. It is hoped that participating in this study will provide you with an opportunity to share your knowledge and reflect on your clinical practice.

I will phone you within one week of receiving this letter to enquire about your level of interest in my research study and to answer any questions or queries that you may have in relation to this study.

Thank you for taking the time to read this letter.

Yours sincerely,

_____

Aida Keane
M.Sc., Reg. Psychol., Ps.S.I.

Appendix D: Participant Consent Form

I agree to participate in a research study on self-injury conducted by Aida Keane. This study will become Aida Keane's Ph D dissertation at St. Patrick's College, Dublin City University. The purpose of this study is to explore mental health clinicians' understanding of self-injury and how they work with self-injuring clients/patients in the Irish context.

I understand that my participation involves one interview of one and a half to two hours duration with Aida. The interview will consist of opened ended questions about self-injury and about my work with self-injuring clients/patients. I understand that I will be asked to complete a biographical data sheet at some point during the interview. I am aware I may be asked to participate in a follow-up interview should Aida need to seek clarification, and/or to follow-up on something I said that Aida did not fully understand in the initial interview. A follow-up interview if required should take about 30 minutes to one hour with Aida.

All interviews will be audio recorded. A transcriber employed by Aida who has agreed to protect the confidentiality of research participants will transcribe the audio files. Each audio file and transcript will be given a pseudonym in order to protect the identity of participants. Therefore my real name and any identifying information will not be used in any documents related to this research study. In the event that some of the data recorded from your interview contains sensitive clinical information that may be too revealing for you and your clients/patients, Aida will contact me, ask me to review my transcript and request a follow-up interview to address this issue. Protecting my clients'/patients' identity and confidentiality and my own is a primary concern. I am aware of the limits to confidentiality and accept that this research study is bound by such limits.

All audio files, transcripts and biographical sheets will be stored in a locked filing cabinet in my office at St. Patrick's College. The time frame for the period of data retention will be three to five years or six months after the final submission date of Aida's PhD dissertation, which ever is the shorter period of time. Aida will destroy

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the transcripts, biographical data sheets, and the informed consent forms by confidential shredding. Aida will also erase the audio files of the interviews.

There is no anticipated perceived risk to you as a result of your participation in this research study. It is hoped that participating in this study will provide you with an opportunity to share your knowledge and reflect on your clinical practice.

I understand that I am consenting voluntarily to participate in this research study. I am aware that I can withdraw my consent at any time. I am also aware that I can refuse to answer particular questions should I wish to.

I acknowledge receiving a copy of this participant consent form.

Participant's Name   Date

_____   _____

Participant's Signature   Researcher's Signature

_____   _____

I would like you to send me a summary copy of the results to:

Participant's Name: _____

Address: _____

_____

Appendix E: Participant Background Information Sheet

Q. 1   Please indicate your gender: Male ☐   Female ☐

Q. 2   Please indicate your age range:

20-29 ☐   30-39 ☐   40-49 ☐   50-59 ☐   60-69 ☐

Q. 3   Please indicate your profession:

Psychiatrist ☐   Psychoanalyst ☐

Clinical Psychologist ☐   Psychotherapist ☐

Counsellor ☐   Counselling Psychologist ☐

Q. 4   Please list your professional qualifications?

Q. 5   How long have you been practising as a counsellor/ psychoanalyst/ psychiatrist/ psychologist?

Q. 6   How many self-injuring clients/patients have you worked with?

Males ☐   Females ☐

Q. 7   What is the age range of the self-injuring clients/patients you have worked with?

0-12 ☐   13-19 ☐   20-24 ☐   25-29 ☐   30-34 ☐   35+ ☐

Q. 8   Please name the types of setting(s) in which you have worked with self-injuring clients/patients?

Q. 9   What was the main therapeutic orientation of your training programme in psychiatry/counselling/psychotherapy/psychology?

Q. 10   How would you describe your current therapeutic approach/orientation?

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Appendix F: Interview Schedule

Introductory Questions

Q. 1   Can you tell me about your work generally (your role, setting, clientele, supervision)?

Q. 2   What settings have you worked with self-injuring clients?

Q. 3   What severity of physical damage have your self-injuring clients/patients inflicted on themselves?

Probes
- Level of severity – Mild, Moderate, Severe

- What do these terms mean to you in relation to clients'/patients' level of severity of their self-injury (mostly superficial/more extensive than superficial)?

Q. 4   Can you tell me the level of frequency of self-injury that you clients/patients engage in?

Probes
- In relation to frequency would you say 20-30 episodes per year (Walsh   and Rosen, 1988)?

- In relation to frequency would you say 20-100 over a multiple year period (Walsh and Rosen, 1988)?

- Less than once a month/several times a month/weekly/daily

Confidentiality Reminder to Interviewees

If you are going to introduce particular clients/patients when answering the following questions could you please use their first name initial or make up a pseudonym rather than using their real name as this interview is being audio recorded as agreed.

Main Interview Questions

Q. 1   Can you tell me how you think about self-injury – what it is?

Probes
- What type(s) of behaviour do you categorise as self-injury?

- How do you distinguish between self-injury and suicide?

- What purpose/function does self-injury serve for clients/patients who engage in this behaviour?

- What meaning does self-injury have for clients/patients?

- Why do clients/patients engage in self-injury?

Q. 2   What models/theoretical frameworks help you to understand your self-injuring clients'/patients'?

Q. 3   How do these models/ theoretical frameworks help you understand self-injuring clients/patients?

Q. 4   Where did you get your ideas about self-injury (training, reading, workshops, personal experience, clients/patients, supervisor, peers)?

Q. 5   Can you tell me how you work with clients/patients who self-injure?

Probes
- How do you assess clients'/patients' motivation to stop self-injuring?

- Is this important in your work (i.e. clients'/patients' level of motivation to stop self-injuring) with self-injuring clients/ patients?

- To what extend is your approach directive with self-injuring clients'/patients'?

- How do you assess your clients'/patients' level of self-injury? Are there specific questions you ask? What are they? Do you use self-injury assessment scales? What ones do you use?

- Do you ask to see clients' injuries/scars?

- Do you make contracts with clients about their self-injury?

- Can you tell me how you respond to self-injuring clients/patients in times of crisis?

- Are there any particular strategies/interventions you find helpful when working with self-injuring clients/patients?

- Do you work with self-injuring clients/patients who have a psychiatric history/ diagnosis (relevant for psychologists/ psychotherapists only)?

- How do you deal with holiday periods with self-injuring clients/patients?

- How frequently do you see your self-injuring clients/patients (once per week, twice per week, once every two weeks, once a month?

- What is the trend of your work with self-injuring clients/patients in terms of duration of treatment (short term or long term, average number of sessions over what time frame)?

- How does the issue of self-injury emerge initially? Who raises it? How does that happen or come about?

- Does the setting you work in (either past or present) pose any barriers, restrictions or limitations to your work with self-injuring clients/patients?

- Are there any particular strategies/interventions you find unhelpful when working with self-injuring clients/patients?

Q. 6   What models/ideas guide you in your work with (/treatment of) self-injuring clients/patients?

Probes
- What guides you through risk assessment with self-injuring clients/patients?

- What resources help, support, and sustain you in your work with self-injuring clients/patients?

Q. 7   How do these models/ideas help you in your work with self-injuring clients/patients?

Q. 8   Where did you get your ideas about how to work with self-injuring clients/patients (training, reading, workshops, personal experience, clients/ patients, supervisor, peers)?

Q. 9   Are you aware of any treatment programmes in Ireland for individuals who engage in self-injury? (information question)

Q. 10 What would constitute a treatment success with self-injuring clients/patients?

Q. 11 Can you tell me about your experiences of treatment success with self-injuring clients/patients?

Probes

- What contributed to treatment success?

Q. 12 What led you to conclude treatment was a success?

Q. 13 What would constitute a treatment failure/partial failure?

Q. 14 Can you tell me about your experiences of failures/ partial failures in working with self-injuring clients/patients?

Probes
- What contributed to treatment failures/partial failures?

Q. 15 What led you to conclude treatment was a failure/partial failure?

Q. 16 Who is primarily responsible for the treatment outcome in your view, whether it is positive or negative?

Q. 17 What do you find difficult/challenging about working with clients/patients who engage in self-injury?

Q. 18 What treatment issues do you think are important for clinicians to be mindful of when working with clients/patients who engage in self-injury?

Q. 19 Is there any thing you would like to add that I didn't ask you about?

*Ask interviewee if he/she would like to suggest a colleague(s) whom I should contact with a view to participating in this study who meet the selection criteria for inclusion.

*Thank interviewee.

## Appendix G: Jefferson's (1984) Transcription Notation System

(.5)	The number in brackets indicates a time gap in tenths of a second.
.hh	A dot before an 'h' indicates speaker in-breath; the more 'h's, the longer the out-breath.
hh	An 'h' indicates an out-breath; the more 'h's, the longer the out-breath.
(( ))	A description enclosed in a double bracket indicates a non-verbal activity, for example ((banging sound)).
( )	Empty parentheses indicate the presence of an unclear fragment on the tape.
Under	Underlined fragments indicate speaker emphasis.
[ ]	Square brackets between adjacent lines of concurrent speech indicate the onset and end of a spate of overlapping talk.

Source: Wetherell, Taylor, & Yates, (2003)

Appendix H: Summary Table of Participant's Demographic Data

Interview	Clinician Pseudonym	Gender	Age Range	Profession	Clinical Experience	Training Orientation
Pilot Interview	Niamh	Female	50-59	Counselling Psychologist	17 years	Developmental Psychology
Interview 1	Eimear	Female	50-59	Clinical Psychologist	15 years	DBT
Interview 2	Mike	Male	40-49	Registered Psychologist	14 years	Systemic Family Therapy Narrative Therapy
Interview 3	Jack	Male	50-59	Psychoanalyst	16 years	Freudian/Lacanian Psychoanalysis
Interview 4	Mark	Male	40-49	Psychotherapist	10 years	Psychiatry – 2 year Adult psychiatry Psychotherapy – Body Centred Psychotherapy
Interview 5	David	Male	40-49	Consultant Psychiatrist	11 years as a consultant	Broad based – Pharmacological, Psychodynamic
Interview 6	Sinead	Female	50-59	Psychotherapist	18 years	Constructivist & Systemic
Interview 7	Ciara	Female	30-39	Consultant Psychiatrist	11 years	Biological Psychological Social focus Multidisciplinary Care Approach

Appendix I: Modulation Charts (Odgen & Minton, 2000)
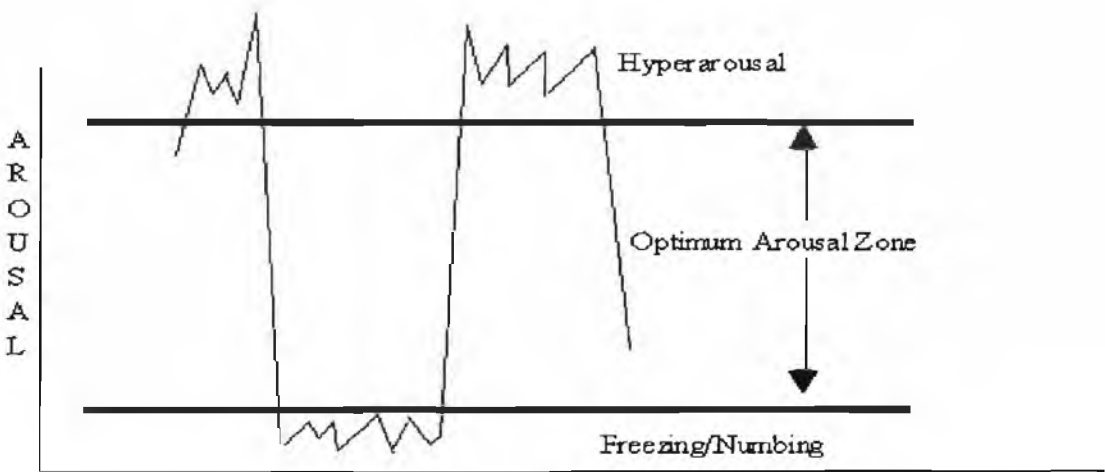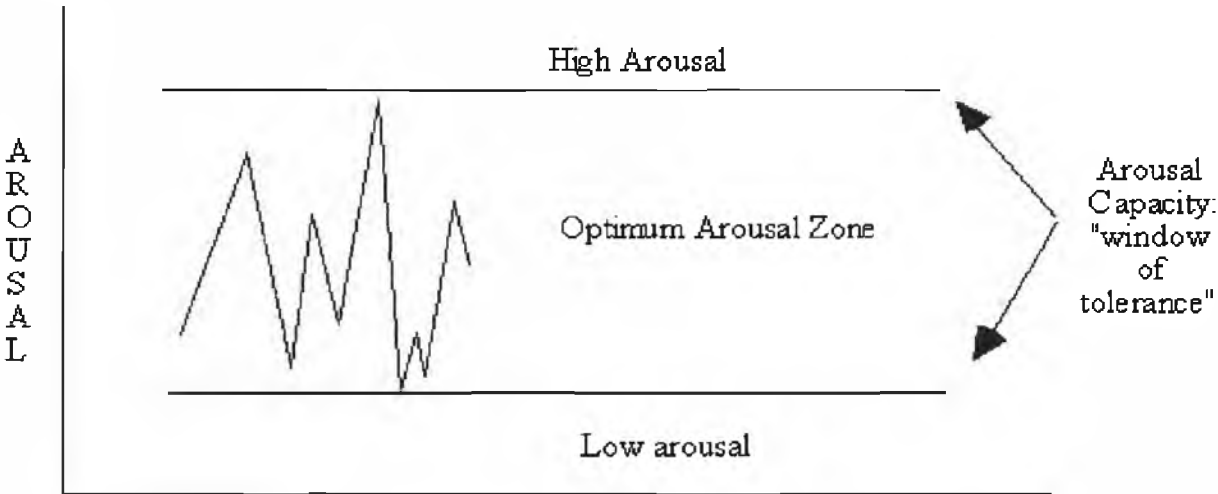
Appendix J: Extracts from the Clinicians' Transcripts

(Referred to in the Discussion Chapter Eight and not included in the Findings Chapters Four, Five, Six, and Seven)

Extract from Niamh's transcript

Lines 748-768   I: Okay and I guess I was wondering how you <u>broach</u> this subject with clients but you, you're saying you don't but they they raise it with you (3) em (2) when they <u>show</u> you their, their scars or their injuries can you me what <u>your</u> internal response is to them when you first see them, their injury or their scar

C: Well just <u>sadness</u> you know

I: Mm-hmm

C: .hh (4) for the inner scar really

I: Okay

C   (2) You know

I: And what's [your]

C: [And] the amount of pain that that represents you know

I: Mm-hmm

C: Externally that's inside

I: Mm-hmm

C: (3) I'm <u>not</u> <u>freaked</u> by scars you know if that's the <u>baseline</u> of the question I d'you know

Extract from Ciara's transcript

Lines 979-984, part 1   I: Okay and when they disclose that they engage in, in self-injury or self-harm .hh do you actually what are your internal responses what's your own reaction when they they say it to you

C: .hh hhhh I don't really I see so much of it really that I I it it it's not <u>shocking</u> to me any longer um