

**GUIDELINES TO SUPPORT ADOLESCENT GIRLS WHO SELF-
MUTILATE**

By

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Dedicated to all parents and adolescents who are growing together.

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SUMMARY

Guidelines to support adolescent girls who self-mutilate

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(Direction: Play Therapy)

This study centered on adolescent self-mutilation as well as possible forms of support and prevention. The information was gathered by assessing the needs of the adolescent girls who self-mutilate by means of semi-structured interviews. In these interviews the adolescent girls expressed their experiences of self-mutilation and their emotional needs. The aim of the study was to explore and describe the needs of adolescent girls who self-mutilate in order to develop guidelines of support so that parents may feel less helpless and overwhelmed. The findings of the study indicated that there are various reasons why an adolescent would engage in self-mutilation, that it serves a function in the adolescents' lives and surfaces at times of emotional crisis. This study found further that a lack of problem-solving skills, coping abilities and social skills could play a role in whether an adolescent chooses to self-mutilate.

Key terms:

Self-mutilation, Self-mutilation behaviour, Self-injury, Suicide, Adolescent, Adolescent development, Qualitative study

This is a dissertation of limited scope and should be evaluated accordingly. I declare that **“Guidelines to support adolescent girls who self-mutilate”** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

Date: 25 November 2008

Name: Veronica Lee Robertson

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Chapter One

OVERVIEW AND RATIONALE OF THE RESEARCH

1.1 INTRODUCTION

Self-mutilating behaviour or SMB is part of a large repertoire of behaviours that involve the sufferer's own body as a means to express distress, at the same time offering the individual a method to deal with the distress (Babiker & Arnold, 1997: 2). More than perhaps any other human action, SMB speaks of distress, torment and pain. The act of harming oneself suggests the existence of something unbearable and unspeakable for that individual, which is communicated in such an act.

SMB refers to the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent, for example cutting, burning, scratching, hitting, biting or pinching (Favazza, 1998: 260). Self-mutilation can be divided into three categories: *major*, *stereotypic* and *moderate/superficial* self-mutilation. Moderate/superficial self-mutilation is the most common type in adolescents and includes cutting, burning, and carving of the skin. Literature (Favazza, 1998: 265; Suyemoto, 1998: 534; Ross & Heath, 2002: 67; Plante, 2006: 189) states that self-mutilation is an increasingly prevalent problem-affecting adolescents. The age of onset is usually in middle to late adolescence (Favazza, 1998: 265; Rosenthal, Rinzler, Wallsh & Klausner, 1972: 48; Suyemoto, 1998: 534; Klonsky, Oltmanns & Turkheimer, 2003: 1503).

Shull, Van Sell and O'Quinn (2008: 20) state that self-mutilation usually begins around the time of puberty. This is a time of changing hormones, emotional peaks and troughs, developing identity, shifting self-esteem and an increased desire to fit in with peers. Babiker and Arnold (1997: 44) confirm that adolescents may be especially vulnerable to SMB. They emphasise the following factors:

- adolescents are still emotionally and financially dependent on parents or caregivers;
- families may be abusive or fail to nurture and support the more complex needs;
- challenges and struggles with issues of sexuality;
- more vulnerable to bullying or abuse from peers due to increased need for acceptance limited experience and lack of mature coping skills;
- relatively less power and control over the circumstances of their lives;
- fewer choices and little money.

This sets SMB in the context of the developmental phase of adolescence, which concerns itself with the challenges and struggles of independence and separation/individuation, which the adolescent must face.

Suyemoto (1998: 44) agrees with Babiker and Arnold (1997: 44), but adds that SMB serves to express and externalize emotion that is intolerable and overwhelming – to the self-mutilator herself and/or to others around her. Externalizing the emotion creates a sense of control. SMB is furthermore an attempt to control pain that is unendurable. In this context, self-mutilation may be compelling as a means of experiencing some sense of control in adolescent lives and of asserting some form of independence and identity (Babiker & Arnold, 1997: 45).

In a review of the literature on self-injury Favazza (1998: 265) and Shull *et al.*, (2008: 20) note that only recently has SMB been recognised as a “morbid form of coping”, and a refuge when suicidal thoughts are overwhelming. Favazza (*ibid.*) notes a long-standing tendency to misrepresent SMB in medical and psychological literature, including trivialisation (delicate cutting of the wrist), misidentification (suicide attempt) and presentation as a symptom of borderline personality disorder. Martinson (2002) concurs, stating that many who self-mutilate are aware of the fine line that they walk. They may therefore resent mental health practitioners who mistake their SMB for suicidal action, failing to recognise its function as a desperate form of coping in desperate circumstances.

Some studies have reported that adolescent females engage in self-mutilation more frequently than do males (Favazza, 1998: 264; Babiker & Arnold, 1997: 37; Shaw, 2002: 193; Turner, 2002: 124), while others have failed to find such differences (Muehlenkamp & Gutierrez, 2004: 15). However, Turner (2002: 2) states that self-mutilation is more identifiable in females than in males. Shull *et al.*, (2008: 20) found that adolescent males were more apt to self-injure, e.g. by hitting a wall with a fist in an attempt to control anger (as opposed to SMB with a sharp object). Yet both forms of behaviour harm the body and both represent an attempt to control anger. Turner (*ibid.*) further states that females more frequently ask for help and seek mental health services such as psychotherapy, which may position this apparent gender difference as a difference in help-seeking, rather than a difference in SMB.

Miller (in Martinson, 2002) posits another explanation for the presumed over-representation of females in self-mutilating populations. Women are not socialized to express violence

externally and instead tend to vent their frustrations upon themselves. Turner (2002: 125) agrees by stating that men tend to express anger by means of physical aggression toward others, whereas women tend to turn angry feelings inward, acting upon themselves. Miller (in Martinson, 2002) claims that men “act out”, while women “act out by acting in”. Furthermore, men may be more socialised to repress emotion. Such men may find it easier to keep turbulent emotions out of awareness when overwhelmed by strong feelings, a dynamic which makes them more likely to externalise anger or pain in a violent act. Male SMB is most often found in confined settings such as juvenile halls, correctional facilities and youth residential treatment centres; or other contexts where this behaviour may be attributed to institutionalisation (Shaw, 2002: 193; Turner, 2002: 2). However, recent research appears to be revealing some new trends. Muehlenkamp and Gutierrez (2004: 15) reported that girls were previously identified as exhibiting a higher incidence of self-mutilation, but current research indicates a rise in SMB among boys. There is much debate surrounding the relative prevalence of self-mutilation in males and females and room for further investigation of this area. It appears, moreover, that an increase in the overall incidence of SMB may be occurring, along with the probable under-diagnosis of males who self-mutilate.

Gilligan (1996: 241) investigates the tensions faced by girls during adolescence and the processes they subsequently go through. She describes how pre-adolescent girls, as they move from childhood into adolescence, become increasingly unsure of themselves and hesitant in voicing their true feelings and desires. In adolescence the forming and maintaining of relationships or acceptance by peers becomes a crucial factor. Gilligan points out an apparent paradox: young girls learn that in order to maintain relationships they need to keep vital parts of themselves out of relationships. Therefore adolescent girls learn how to hide what they feel and know, yet cannot express without harming important relationships.

Leadbeater (in Kohen, 2000: 80) concurs, noting that adolescent girls begin to report internalizing symptoms such as somatic problems, depressed mood, eating disorders and aggression against the self more frequently than adolescent boys. Leadbeater agrees with Geldard and Geldard (2004: 4) that adolescence presents many challenges to both the parents and to the adolescent, as physiological, biological, psychological and social changes are confronted. Although the research picture may be changing, SMB remains more prevalent amongst girls, in the population of adolescents who seek help for SMB. Thus, the gender pronouns “she” and “her” are used throughout this study, whose participants were also

female; but this usage should not be taken to imply that the problem of SMB is only or even predominantly a female problem.

Consistency of terminology is a topic of debate. Throughout literature the terms “deliberate self-harm” (Crouch & Wright, 2004: 185) and “self-injury” (Shaw, 2002: 192) are used synonymously with the term “self-mutilation” or “self mutilating behavior”. The terms “deliberate self-harm” and “self-injury” may provide less stigmatization and sound less negative than “mutilation”. However, these terms overlap with suicidal and parasuicidal acts, which are also deliberate and harmful to the self (Messer & Fremouw, 2008: 164). Accordingly “self-mutilation” remains the most commonly used term (Favazza, 1998: 259; Messer & Fremouw, 2008: 164). Adding the term “behaviour” makes it clear that self-mutilation is something people do, but do not necessarily enjoy or seek out in a perverse sense. Therefore, for the purposes of this study the term “self-mutilating behaviour” (SMB) is used. This term is widely recognized by most readers and it more clearly defines the intention as well as the behaviour at issue.

1.2 PROBLEM AND RATIONALE FOR STUDY

1.2.1 Motivation for choice of research

Fouché and De Vos (2005a: 92) state that contact with the external world and observation of reality is the most evident source of research topics, through personal interest that develops. As motivation for the choice of research topic the researcher cites personal curiosity, observation of a concrete problem in reality, and the pressing need for useful information to guide practice. While working as a student counsellor at a High School in Stellenbosch the researcher encountered several cases of SMB and realised that there is a need for clear information to guide would-be supporters of adolescent girls who self-mutilate. Since the researcher personally experienced this lack of guidelines for practitioners and parents, this study is of personal relevance to the researcher. Fouché and De Vos (2005a: 92) state that curiosity is an equally valuable impetus when searching for a research topic. Thus, according to these authors, a researcher’s personal interests come into play at the very start of a research project. A topic which satisfies the researcher's own curiosity is more likely to be useful, because it addresses questions that arise in practice and also in a context of personal interest.

Turner (2002: 16) also stresses the need for information about SMB in order to raise awareness. In particular it is helpful if supporters can understand SMB as a reflection of complex psychological difficulties within distressed individuals. The author states that because the problem of self-mutilation is not yet well understood, many people - including parents, therapists and other trained professionals - tend to avoid dealing with the issue. Little information is available on younger adolescents who engage in SMB, and the literature offers a limited understanding of why individuals engage in these behaviours, although the availability of this information has a direct bearing on ways to prevent it (Hilt, Kock, Lloyd-Richardson & Prinstein, 2008: 457; Fortune, Sinclair & Hawton, 2008, 96). Amongst numerous studies of adolescent self-mutilation that used a quantitative paradigm, only a few studied the subjective experience (Crouch & Wright, 2004: 187). The authors state that psychological interventions have generally been built on reports gathered from clinicians or carers rather than the adolescents themselves. This situation needs to be redressed; as it is now an accepted principle that consideration must be given to young peoples' own perspective when developing services for them.

1.2.2 Problem formulation

According to Fouché (2005: 116) problem formulation is the point of departure of the research proposal. The research problem must be clearly defined in order for the researcher to understand what the proposed research will include. This problem is the foundation of the research study. In this study, the research problem is centred on adolescent self-mutilation, with particular attention to the emotional needs of the adolescent self-mutilator as well as possible forms of support and prevention.

A key observation contributing to the above formulation is that 'adolescents who self-mutilate do so generally because of an internal dynamic, and not in order to annoy, anger or irritate others' (Focus adolescent services..., 2000). Their self-mutilation is a behavioural response to an emotional state and moreover, is an indication of extremely difficult and distressing life experiences. Babiker and Arnold (1997: 57) postulate that self-mutilation is behaviour that originates as an adaptive response to a person's situation and it fulfils specific and complex functions. However, it tends to trigger horror and disgust in a social context where attitudes toward the body and its care are ambivalent.

Other authorities (Favazza, 1998: 262; McDonald, 2006: 194; Turner, 2002: 15) have also viewed the adolescent who self-mutilates as attempting to preserve herself rather than wanting to destroy herself. These authors state that self-mutilation helps the adolescent to stay 'together' in order to struggle for survival. Deiter, Nicholls and Pearlman (2000: 1187) confirm that most self-mutilation is a survival technique. They view it as a reaction to unendurable circumstances or internal experiences; a reaction that allows the individual to endure and to carry on.

Suyemoto (1998: 550) links SMB to the developmental tasks of adolescence, contending that some may use self-mutilation as a way to negotiate a difficult adolescence. The author states that the self-mutilation models presented in her article relate quite clearly to adolescent developmental tasks. They include the following: separation/individuation issues; learning to modulate emotions as physiological changes create intense experiences that are new and can be overwhelming; dealing with emerging sexuality; struggling with the need to control the environment, as this is directly related to the task of developing autonomy, independence and ego mastery as well as creating a stable identity. Suyemoto (*ibid.*) adds that adolescent self-mutilators may have fewer resources or may lack early preparing experiences that enable them to meet these life tasks in a productive manner.

Kaplan (2000: 553) states that the self becomes more differentiated in adolescence. During middle adolescence, individuals experience new conflict in their self-concerning authenticity. They experience themselves and others acting "phony" and tend to wonder if their friends are authentic. Gilligan (1996: 247) argues that adolescent girls experience conflict between their desire to voice their true opinions and feelings and the felt need to conform to society's view of what is "feminine". The author argues that, to adolescent girls, it seems easier to hide their feelings and experience, than to risk being labelled a 'loud mouth' or a 'troublemaker', since girls who remain outspoken often get into trouble and become known as 'troublemakers' or as 'loud mouthed girls'. The author further postulates that adolescent girls' desire for relationships and the political consequences of speaking out combine to create both internal and external pressure on girls to become more silent and hidden. Self-mutilation may serve not only to validate the internal experience, but also to express the depth of this feeling to others, as self-mutilators often have difficulty with verbal expression (Suyemoto, 1998: 45).

Herman (in Babiker & Arnold, 1997: 1) describes the conflict between speaking and not speaking as the conflict between the will to deny horrible events and the will to proclaim them out loud. Individuals who have traumatising stories to tell sometimes reflect this conflict by speaking in a way that undermines their credibility. The author further states that in these terms self-mutilation will serve both to tell the unspeakable secret, while detracting attention from it. The author therefore considers self-mutilation a *paradoxical* tool for communication as it is used at once to speak and not to speak.

Babiker and Arnold (1997: 34) state that individuals in distress draw on the full repertoire of human behavior in their search for ways of relieving and resolving their difficulties. The authors maintain that some of the functions that self-mutilation fulfils are precisely those that an adolescent in mental pain would seek: namely healing, the restoration of order, familiarity and safety, social acceptance, community and harmony, a means of expressing loss and grief, release from guilt and a sense of power and control.

Hilt *et al.*, (2008: 457) agree that self-mutilation serves a multiplicity of functions for the adolescent. The four types of functions they propose are not mutually exclusive since SMB serves multiple functions for adolescents. The authors state that the automatic or emotion-regulation functions of self-mutilation have received a great deal of attention in the literature. In their studies with psychiatric inpatients, Nock and Prinstein (2004: 886) found that many adolescents reported engaging in self-mutilation for automatic positive (“*to feel something even if it was pain*”) and negative (“*to stop bad feelings*”) reinforcement. Taking a social-learning perspective, their work supports the view that adolescents engage in self-mutilation for social positive reinforcement (“*to get attention*”) and negative reinforcement (“*to avoid punishment from others*”). In summary, several authors have noted that self-mutilation serves important functions for the adolescent be it relief from emotions, validation of emotions, getting attention or avoiding punishment from others.

As Babiker and Arnold noted (1997: 20), SMB provokes very strong reactions amongst family members and friends towards those who harm themselves, as well as within society at large. Infliction of intentional damage to the body seems to be an extremely difficult form of expression for society to process. Research indicates that those involved with someone who self-mutilates are often left feeling a combination of helplessness, horrified, guilty, furious, betrayed, disgusted and sad (Babiker & Arnold, 1997: 15). There is certainly a considerable

amount of stigma and shame associated with self-mutilation and the problems underlying it (Babiker & Arnold, 1997: 11).

Self-mutilation is normally carried out in private and in secrecy; nevertheless it reveals itself upon the body in the form of scarring and tissue damage (Burns, Outterson, Sharff, & Timofeyev, 2002). The individual will not be able to avoid the scarring which later on, may act as a barrier to forming relationships with peers. This in turn can lead to social isolation, feelings of loneliness, alienation and despair.

Peer relations are postulated as being of vital importance to adolescents in that they serve socialization and educational functions, readying the adolescent for participation in society (Louw, Van Ede, & Louw, 1999: 449). However, as noted above, SMB may inhibit the formation of friendships. Louw *et al.*, state that adolescents have an intense desire to belong and their social development is therefore characterized by an increasing investment in 'belonging' with the chosen peer group. The alienated adolescent may suffer from social ostracism and in desperation may attempt suicide. Although SMB is not suicidal in intent, according to Martinson (2002) it can easily promote suicidal ideation or enactment. However, Herpertz (in Martinson, 2002) notes that self-mutilators themselves distinguish between acts of self-mutilation and suicidal ones. It is also true to say that SMB is not only distinct from the suicidal gesture or attempt – it may serve as a viable alternative to suicide.

Babiker and Arnold (1997: 45) assert that isolation and lack of support are common features in the histories of people who self-mutilate; and that these factors may affect adolescents more than is recognized. The authors explain that peer relationships are important to adolescents, but these relationships tend to be more transitory and limited than those of older people with established partners and families. From the authors' experience of working with adolescents it emerged that adolescents often find it difficult to obtain support from adults who may view their feelings and difficulties as trivial. Whilst working as a student counsellor the researcher experienced similar complaints. The adolescents commonly felt that their parents did not take them seriously or listen to them. It is the researcher's conclusion that the adolescents experienced little (or ineffective) support from their parents and other adults.

From the above discussion it seems that the parents of adolescents who self-mutilate, lack awareness of the disorder. Negative reactions can be strong, reflecting feelings that range

from shock, fright, anger, incomprehension and repulsion. These reactions add to the adolescents' own feelings of shame and guilt. Clinical impressions and literature thus support the premise that there is a lack of family and social support for adolescents who self-mutilate. There is therefore a need to develop supportive guidelines for those who are responsible to help adolescents with SMB. For the purpose of this study the problem can be formulated as follows: the presence of SMB does not only impact on the lives of those who mutilate themselves, but also on parents, caregivers, and others. As much as it is important for mental health practitioners to support adolescent girls who self-mutilate with relevant understanding, there is also a need for guidelines that not only support parents so that the problem is not made worse, but also aid parents to join more constructively with helping efforts. However, not enough is known about adolescent girls' subjective experience of SMB, in the face of this apparently growing problem. This study addresses both the general lack of guidelines, and the inadequate representation of the young peoples' voices.

1.3 RESEARCH QUESTION

Mouton (2006: 7) defines the research question as the problem or the issue that is being addressed by the research. Strydom and Delpont (2005a: 321) suggest that in order to avoid threats to objectivity and validity, vague thoughts must be organized as specific questions pertaining to the subject. According to Mouton (2006: 106) the research question must be clarified before a study can be designed and implemented that will ensure optimal results.

The research question that informs the present study can be formulated in two parts:

- a) *What are the expressed feelings, perceived needs, reported experiences and practical suggestions of adolescent girls who self mutilate?*
- b) *Based on the above, what guidelines can be suggested for parents to act as a more effective means of support for adolescent girls who self-mutilate?*

1.4 AIM AND OBJECTIVES OF THE RESEARCH

The aim of the research is defined as “*the end toward which effort or ambition is directed*” (Fouché & De Vos, 2005b: 104). Mouton (2006: 101) states that the research objective indicates what researchers wish to achieve in the research. Elaborately stated the aim is the “dream”, while the objectives are the steps that one has to take in order to attain the dream

(Fouché & De Vos, 2005b: 104). The aim of this research study was to develop guidelines for parents of adolescent girls who self-mutilate in order for parents to offer more effective support to their daughters.

In order to achieve this aim, the following objectives were established:

- To review related and pertinent literature regarding self-mutilation and adolescent development in order to have a better understanding of the concepts on which the interview schedules should be based;
- To complete semi-structured interviews with adolescent girls who self-mutilate as well as with psychologists working with these girls in order to explore and describe the support needed by such adolescents;
- To analyze the data and to compare the findings with existing literature (literature control) in order to suggest guidelines of support for parents of adolescent girls who self-mutilate;
- To draw conclusions in order to develop guidelines for parents to support and assist adolescent girls who self-mutilate. These conclusions should be practical, promoting awareness and understanding so that parents can feel less helpless, overwhelmed or infuriated by the SMB.

1.5 RESEARCH APPROACH

In this study a qualitative and exploratory approach was applied. This is an interpretive approach that “*aims mainly to understand social life and the meaning that people attach to everyday life*” (McRoy in Fouché & Delport, 2005: 74). It produces descriptive information often in the participants' own spoken words, thereby arriving at a genuine understanding of their reality. The goal of qualitative research according to Babbie and Mouton (2007: 53) is defined as “describing and understanding” rather than the “explanation and prediction” of human behaviour. Fouché and Delport (2005: 74) report that a qualitative study is concerned with non-statistical methods and small samples that are often purposively selected. This study, which fits all these foregoing descriptions, set out to explore, describe and understand the feelings, needs, experiences and ideas of a selected group of adolescent girls who self-mutilate, in order to enhance the quality of parental support that may be available to them in future.

1.6 TYPE OF RESEARCH

Fouché and De Vos (2005b: 105) state that “applied research” is aimed at solving specific problems in practice. The present study is clearly applied research, as it is concerned with the practical application of the research findings to a specific problem in the real world, i.e. what constitutes appropriate and effective parental support for adolescent girls who self-mutilate.

The type of research that was undertaken was of an exploratory and descriptive nature. Fouché and De Vos (2005b: 106) explain that exploratory research is conducted to gain insight into a situation, phenomena or individual. Babbie and Mouton (2007: 80) state that exploratory research is done to expand the researcher's understanding of a given subject, as well as to develop new hypotheses about existing phenomena and to determine future research priorities. Mouton (2006: 72) states that exploratory research breaks new ground and seeks to answer a ‘what’ question. The ‘what’ questions explored in this study include the feelings, needs, experiences and ideas of the adolescents elicited via semi-structured interviewing; and the ways in which these may translate into guidelines for parents. These reasons relate to the study at hand and serve as motivation for exploratory research.

Descriptive research, while similar to exploratory research, seeks to present a detailed picture of the situation and focuses on “how” and “why” questions (Neuman in Fouché & De Vos, 2005b: 106). A function of descriptive research is to describe situations and events (Babbie & Mouton, 2007: 81). The authors add that this descriptive function will serve to help fill out the shortcomings of exploratory research by facilitating a more intensive description of the phenomenon. A richer description of the subjective experience of adolescent girls who self-mutilate is made available, so that guidelines for parents may more helpfully indicate how these girls can be supported, and why this support will be more effective.

1.7 RESEARCH DESIGN

According to Fouché (2005: 268) the research design is the way in which the researcher will go about collecting the data. The author states that qualitative research differs inherently from quantitative research in that it does not usually provide the researcher with a step-by-step plan or fixed recipe to follow. In qualitative research the researcher's choices and actions

determine the design or strategy. Qualitative studies have a number of design strategies to choose from. For the purpose of this study the research strategy to explore the phenomenon of self-mutilation was the instrumental case study.

Fouché (2005: 272) states that the case study consists of detailed and in-depth data collection methods such as interviews, observations and documents from multiple sources of information that are rich in contextual information. This information is used to elaborate on a theory or to gain a better understanding of a social issue (Fouché, 2005: 272). Creswell (in Fouché, 2005: 272) further describes the case study as an exploration or in-depth analysis of a system bounded by time and/or place. The product of such research is an in-depth description of a case or cases. Babbie and Mouton (2007) situate the case study within its larger social context taking into account numerous viewpoints and the influence that society has on the research participants. The result of the empirical process was a detailed description of the case study.

Fouché (2005: 272) states that the exploration and description of the case takes place through detailed, in-depth data collection methods, involving multiple sources of information. In this study data was collected by semi-structured interviews from a selected group of seven adolescent girls as well as from two psychologists. The detailed description that resulted reflects the contexts experienced by the participants regarding their sense of the history of the problem in their lives and the impact their SMB had on their relationships with self and with others.

1.8 RESEARCH METHODOLOGY

1.8.1 Literature

The place of a literature review in the study is an important one as literature guides the research process (Fouché & Delpont, 2005: 83). According to Mouton (2006: 119) a review of existing research helps the researcher to see how others have investigated the problem and it provides a guideline for the design of one's own project. The purpose of a literature review is to become familiarized with the current state of knowledge regarding the research problem and to learn how others have dealt with similar problems (Delpont & Fouché, 2005: 263). Theory can be used to guide the study in an explanatory way or used towards the end of the study to compare and contrast it.

A first literature review was conducted to gain information on the subject matter, as well as to learn from other studies. The literature review focused on the concepts of self-mutilation and the developmental phase of adolescence. The fields of study that were incorporated in the literature review were those of abnormal psychology, abnormal child psychology and developmental psychology. Different sources of literature were used, namely books, journals, articles and the Internet. The use of references older than 10 years was kept to a minimum and used only when the information was pertinent to the study. The literature review served to enhance the researcher's knowledge base and provide guidelines for the interview schedule. Mouton (2006: 120) states that a literature review is of vast importance as one "*can learn a great deal by studying related fields and from the designs and methods used*". The author adds, "*a survey of the literature is an essential component of any study as it is the main access point or gateway to the relevant body of knowledge*". A second literature study in the form of a literature control was conducted upon completion of the empirical study to compare the findings from the data with that of existing literature.

1.8.2 Paradigm of researcher

A paradigm according to Babbie (2001: 42) is the fundamental model or frame of reference one uses to organize ones observations and reasoning. A paradigm is the researcher's point of view, or frame of reference for understanding life.

The researcher's paradigm is that of a critical thinking middle class, English speaking, white South African female. The researcher has an inherent faith in the good of people and that through knowledge and genuine understanding we may better serve one another. The researcher has a background in education and educational psychology and therefore believes in the power of knowledge and education as a tool towards empowerment. The researcher believes that learning and growth is a continuous process that takes place throughout ones entire lifetime. The researcher is a nurturer by nature and believes in helping people to better help themselves.

The researcher has a particular interest in children and in helping them to reach their full potential. The researcher believes that although children are resilient and adaptable they are vulnerable and in need of nurturance, protection and advocacy too. The researcher believes that childhood is a period of accommodation, acceptance, learning, rebellion and observation

where children try to make sense of the rules by which adults live. The researcher believes that the more children are nurtured, protected, guided and respected, the better adjusted they will be as adults. Therefore the researcher views herself as an advocate for children, adolescents and families alike.

The researcher's educational psychology training provided a client centered and systems-theory approach. The researcher's more current training has provided her with knowledge of Gestalt Theory. Gestalt Theory is a phenomenological-existential theory, which means that Gestalt theory is about existing in the present, awareness of self and accepting responsibility for self (Yontef, 1993: 1). The Gestalt view is that the whole is greater than the sum of its parts, echoing a holistic approach. The Gestalt paradigm of holism matches the researchers worldview of holism and humanitarism. The researcher is also of the opinion that ones context plays an integral role in shaping who a person becomes and therefore environment can never be ignored. The researcher comes from a nuclear family and was privileged to grow up on a farm surrounded by extended family. The researcher believes in the importance of family and family values. The researcher and the researcher's family of origin is liberal minded, accepting and has a positive outlook on life. Therefore the researcher is solution orientated, determined and curious by nature. The researcher draws strength and motivation from her natural surroundings as well as through careful observation and engagement with her social world. The researcher views the topic of adolescent self-mutilation as an urgent and important matter that is not adequately addressed nor understood and that knowledge, understanding and empowerment of all who are involved parents and adolescents alike is key to addressing the situation.

1.8.3 Universe, Population, Sample and Sampling Technique

Arkava and Lane (in Strydom, 2005a: 193) draw a distinction between the term universe and population. The authors state that the term universe refers to all potential subjects who possess the attributes that the researcher is interested in, while the term population sets boundaries on the units of study. The universe of this study included all adolescent girls who self-mutilate in the Western Cape province of South Africa, as well as Psychologists who work with self-mutilation. The population of this study was comprised of all adolescent girls who self-mutilate from High School's in Stellenbosch and Somerset West, Western Cape, as well as psychologists in the Cape Town area who work with self-mutilation.

Sampling according to Kerlinger (in Strydom, 2005a: 192) means to take any portion of a population or universe as representative of that population or universe. He states further that the sample taken is not representative, rather it is considered to be representative. In this study adolescent girls were chosen according to the following characteristics:

- English speaking girls;
- Attending two specific High School's in Stellenbosch and Somerset West;
- Adolescents of a specific age group (between 14 and 19);
- Voluntary participation;
- No discrimination in terms of race;
- Adolescent participants had a history of self-mutilation on more than one occasion.

The decision to include adolescent self-mutilators in this study was based on the use of a definition by Favazza (1998: 260) whereby self-mutilation is considered to be any incident where an adolescent attempted to deliberately alter or destroy body tissue without suicidal intent, for example cutting, burning, scratching, hitting, biting, pinching. Based on these criteria, adolescent girls who reported taking drugs, mentally hurting themselves, for example putting themselves down or engaging in other risky behaviours, were excluded from the study.

The criteria for the Psychologists were:

- English speaking;
- Working in Stellenbosch, Somerset West or Cape Town area;
- Voluntary participation;
- No discrimination in terms of race or gender;
- History of at least five years of experience working with self-mutilation or specialising in treatment of adolescents.

A qualitative study with an exploratory and descriptive nature is suited to the use of non-probability sampling, namely that of purposive sampling (Strydom & Delpont, 2005b: 328). The authors state that purposeful sampling requires that the researcher critically describes the parameters of the population and then choose the population accordingly. In order to rule out the possibility of failure and to reach saturation point a minimum of five adolescent participants were used as the sample size. As a student counselor at one of the schools, several

adolescent girls who self-mutilate came to the researcher's attention. Teachers referred all adolescent girls for counseling due to emotional and behavioral problems. Further girls have been sourced from one specific High School in Somerset West; the school counselor identified these girls.

The researcher interviewed seven adolescent girls who self-mutilate or were once active self-mutilators on more than two occasions. Saturation was obtained after seven adolescent participants were interviewed. The adolescent girls were asked whether a parent or other adult caregiver might be interested in being interviewed to offer his or her perspectives on adolescent self-mutilation. However, only two expressed a willingness to have their families contacted for an interview and since this was such a small number no parents were contacted for interviews. The adolescent girls indicated that their parents were not accessible i.e. worked full time or lived a distance away, would not be interested in research or that they did not want to remind their parents of unpleasant memories which would be uncovered through the interview.

Interviews were also conducted with two psychologists, in order to better understand the dynamics of adolescent self-mutilation as well as the response(s) and role(s) of parents with daughters who self-mutilate. The inclusion also strengthened the trustworthiness of the study as it served as triangulation for the data received from the adolescent girls and provided information on behalf of the parents. By consulting psychologists the researcher sought to better reflect both sides of the story.

It was a great challenge to source psychologists who were willing to participate in the study. The researcher approached three clinics, one of which was a private clinic, the others were government clinics as well as four psychologists and two psychiatrists in private practice and only two favourable responses were obtained. The reason given for the lack of willingness to participate in the study was a lack of available free time although all were in favour of the research. The researcher was able to secure only two interviews with, the head of the adolescent unit at Kenilworth Clinic and with a psychologist who has a doctorate in psychology who runs a private practice.

1.8.4 Expert Experience

The researcher approached two experts in order to find out if the study was viable. The first expert was Sharon Steyn, an educational psychologist currently working as a counsellor and guidance counsellor for a high School in Somerset West. Mrs Steyn is in contact with adolescents on a daily basis in the capacity as teacher as well as counsellor. She is of the opinion that self-mutilation is on the rise as she is confronted with self-mutilation cases on a monthly and at times weekly basis. She felt that this study was of importance and that the topic was viable.

The second expert was Lezaan Lennox, a social worker in private practice specialising in child abuse cases. Mrs Lennox felt that the study was viable due to her experience with self-mutilation cases. The study would be valuable in providing knowledge about a relatively unknown population, namely the adolescent girls who self-mutilate, as well as helpful to parents. The contexts of the semi-structured interviews are discussed below.

1.8.5 Data Collection

The researcher obtained written consent from the principals (see addendum E) to conduct this study after which written consent was obtained from the adolescent girls and their parents (see addendum A, B & C). Due to the researcher's initial involvement with several of the adolescent girls through counseling, the researcher intended to approach the girls from this known relationship. This initial therapy was terminated in light of the surfacing problem and the cases were referred. The school counselor from the other school was approached for additional adolescent girls, these girls were known to the school counselor. The researcher approached the girls individually during school hours and explained the nature and intent of the research in order to obtain their participation and consent. Thereafter the researcher telephonically contacted the parents in order to explain the research before sending them the letters of informed consent (see addendum A). Thus the parents were informed both verbally and in writing. The parents were fully informed about the research in order to obtain their permission (see addendum B).

As the researcher aimed to develop guidelines to support and assist parents of adolescent girls who self-mutilate, the main information collection method was face-to-face interviews, namely semi-structured interviews. Kvale (in Greeff, 2005: 287) defines qualitative interviews as *“attempts to understand the world from the participant's point of view, to*

unfold the meaning of people's experiences, [and] to uncover their lived world prior to scientific explanations”.

Semi-structured interviews are further defined as being organized around areas of particular interest, while still allowing for considerable flexibility in scope and context (May in Greeff, 2005: 292). The author states that semi-structured interviews are specifically suited when one is interested in complexity or process or where an issue is controversial or personal, as in this study of self-mutilation. The author adds further that semi-structured interviews are a flexible vehicle for describing and understanding the world from the participants' point of view. The interviewer is guided by a set of predetermined questions on an interview schedule, rather than dictated by it and the participant may introduce an issue not on the interview schedule. Greeff (2005: 296) states that in light of this relationship, the participant can be perceived as the expert on the subject and give meaning to her experience.

As mentioned the researcher conducted face-to-face semi-structured interviews. Data-recording strategies, namely recording memos, limited note taking and the use of a tape recorder were employed in order not to interfere with the interview process. The interviews with the adolescent girls took place in the counseling room of the specific high schools, which are comfortable and private rooms separate from the school in order to ensure privacy and confidentiality while the interviews with the psychologists took place in their counseling offices. All manner of recordings occurred only after obtaining written consent from the participants and their parents.

The semi-structured interview schedule contained open-ended questions that assisted in raising the topic of study while affording the adolescent girls and psychologists an opportunity to share their feelings, perceptions and opinions. The questions were formulated on the basis of the theoretical chapter, thus the literature was used as the basis for question generation. The interview schedule focused on self-mutilation. The adolescent girls were asked to elaborate on what they knew about self-mutilation, in what way it helped them and what their needs were in life. In addition, adolescent participants were questioned on possible forms of support, for example what in their opinion would help them to stop the self-mutilation or what practical things they could think of to do instead of self-mutilating. This information could be useful to parents in order to offer support to their daughters.

Further semi-structured interviews with two professional psychologists were conducted (see addendum D). The researcher is of the opinion that valuable knowledge and insight was gained from these professionals who deal with adolescents who self-mutilate. The psychologists were asked to elaborate on their experience with self-mutilation amongst adolescent girls as well as the dynamics of adolescent self-mutilation, and the ways in which parents react to it. Their suggestions as to what the parents could do to assist their daughters in stopping the behaviour, as well as their view on how the parents exacerbate the problem of self-mutilation was explored. It is from these semi-structured interviews that data analysis followed.

1.8.6 Data Analysis

Data analysis as defined by De Vos (2005: 333) is the “*process of bringing order, structure and meaning to the mass of collected data*”. Marshall & Rossman (in De Vos, 2005: 333) state that qualitative data analysis does not proceed in a linear fashion, it is instead a time consuming and messy process, that yields general statements about relationships among categories of data. Creswell (in De Vos, 2005: 334) refers to the process of data analysis by way of a spiral image and indicates that the analysis of data does not proceed in linear fashion, but is a process instead. The steps to be followed in data analysis as identified by Creswell (in De Vos, 2005: 334) are proposed as guidelines and will not be followed rigidly by the researcher.

De Vos (2005: 334) states that the researcher should plan for the recording of data in a systematic manner that does not intrude upon the information gathering process. For the purpose of this study the researcher made use of a tape recorder to record all interviews in order not to interfere with the interview process.

De Vos (2005: 335) further states that a qualitative study involves an inseparable relationship between data collection and data analysis. The author adds that data analysis necessitates making revisions in the data collection process as each analysis serves to fine tune the collection process. Greeff (2005: 299) states that it is poor practice to “*stack*” interviews and then attempt to transcribe the tapes. Instead the author cautions that the researcher should transcribe and analyze the data while it is still fresh. For the purpose of this study the researcher made use of preliminary coding in order to effectively manage the data.

De Vos (2005: 336) states that organizing data is the first step in data analysis away from the field. The author adds that the transition between fieldwork and analysis, between collection and analysis, begins in earnest when the researcher begins to transcribe the interviews. In this study the researcher intends to transcribe the interviews by typing up the information in full and in this way become immersed in the information.

By identifying categories, themes and patterns throughout the research the data was organized and managed. De Vos (2005: 338) describes identifying themes, recurring ideas and patterns of belief as *“the most intellectually challenging phase of data analysis and one that can integrate the entire endeavour”*. The author states that category generation is a process that involves taking note of regularities in the setting or participants chosen for study. The author states *“as categories of meaning emerge, the researcher searches for those that have internal convergence and external divergence”*. According to Creswell (in De Vos, 2005: 338) the researcher will take the qualitative information apart by identifying categories, themes or dimensions of information to be written in the final report. The use of semi-structured interviews provided the researcher with selected themes that ensured a degree of standardization (comparability) and the ability to answer the research question in order to develop guidelines for parents to support and assist adolescent girls who self-mutilate (cf. De Vos, 2005: 347).

The next step for the researcher was to code the data. This according to De Vos (2005: 338) involves applying a coding scheme to the generated categories and themes by way of abbreviation of key words or numbers that clearly marks passages in the data. The different themes were coded by marking the data that was collected on the same theme and thus narrowed the theme down into a number of sub-themes (see addendum F).

Marshall and Rossman (in De Vos, 2005: 338) state that next the researcher begins the process of evaluating the plausibility of the generated themes and exploring them through the data. The researcher has the task of determining how useful the information is in bearing light on the research question and how central is the knowledge to the phenomena being studied (De Vos, 2005: 339). In this study the researcher verified the findings of the study with a literature control. Before the final step of writing the research report, De Vos (2005: 339) states that the researcher should critically challenge the categories and patterns present in the data. The author adds that other plausible explanations always exist and it is the researcher's

duty to search for, identify and describe them and to demonstrate why the offered explanation is most plausible. The researcher will submit this dissertation of limited scope in order to obtain the Degree of Master of Diaconiology (Play Therapy) and will allow participants and parents full access to the report.

1.9 ETHICAL ASPECTS

Strydom (2005b: 57) defines ethics as a set of moral principles, which are widely accepted and which offer rules and behavioural expectations about the most appropriate behaviour towards participants. Anyone involved in research should be aware of general, ethical expectations serving as guidelines for acceptable scientific research (Babbie & Mouton, 2001: 47). Strydom (2005b: 57) further adds that ethical guidelines serve as standards and as a basis upon which a researcher ought to evaluate his behaviour. Ethical principles applicable to the present research include autonomy, anonymity, confidentiality, privacy and the avoidance of harm and deception of others. These principles are discussed briefly below.

- Avoidance of harm

Strydom (2005b: 58) cautions that the responsibility to protect participants against harm reaches further than mere efforts to repair or attempt to minimize such harm afterwards. The author adds that participants should be thoroughly informed beforehand about the potential impact of the research. The author states that such information offers participants the opportunity to withdraw from the research if they so wish. For purposes of this study the researcher informed all participants beforehand about the intent of the research and its potential impact. Assurance was given that they might withdraw at any stage should they wish to do so.

- Informed consent

Strydom (2005b: 59) states that “informed consent” implies that participants are informed of the goal of the research, the procedures to be followed, the possible advantages, disadvantages and dangers to which participants may be exposed, as well as the credibility of the researcher. For the purpose of this study informed consent was obtained from the principal, all adolescent girls and their parents before the study was undertaken. Letters confirming informed consent were signed by both the adolescent girls and their parents (see addendum B & C). A letter of consent was signed by the psychologists (see addendum D). The researcher stated to all

participants that they might at any time ask questions concerning the study. Participation in the study was entirely voluntary with no element of coercion.

- Deception of subjects and or participants

Loewenberg and Dolgoff (in Strydom, 2005b: 60) describe deception of subjects as *“deliberately misrepresenting facts in order to make another person believe what is not true, violating the respect to which every person is entitled”*. In the course of this study, no information was withheld and care was taken to ensure that correct information was given to participants, thus no participant allowed herself to be included on the basis of false assumptions or expectations.

- Violation of privacy/anonymity/confidentiality

Sieber (in Strydom, 2005b: 61) defines privacy as *“that which normally is not intended for others to observe or analyze”*. “Privacy” implies the element of personal privacy, while “confidentiality” indicates the handling of information in a discreet and respectful manner (Strydom, 2005b: 61). These principles can be violated in a variety of ways and it is imperative for the researcher to be aware of the importance of *“safeguarding the privacy and identity of participants and to act with the necessary sensitivity when the privacy of subjects is relevant”* (Yegidis & Weinbach in Strydom, 2005b: 61). In order to ensure the privacy of young participants the interviews took place after school hours so that other students or for that matter staff, were not aware of their involvement in the process. Their anonymity was further protected in the transcripts by using symbols to identify each participant. Regarding the information gained from the semi-structured interviews only the researcher and study leader had access to any information.

- Actions and competence of researcher

Strydom (2005b: 63) states that researchers are ethically bound to ensure that they are competent and adequately skilled to undertake the proposed research. The study involved a sensitive investigation. Therefore, the researcher was constantly aware of her ethical responsibility *“from the composition of the research population, the sampling procedure, the methodology utilized and the processing of the data, to the writing of the research report”* (Strydom, 2005b: 63). The study has been completed with the guidance and co-operation of a supervisor.

- Release of findings

Strydom (2005b: 65) states that research findings must be made available to the reading public and researchers should compile the report as accurately and objectively as possible. The author adds that the researcher is ethically required to ensure that the research is conducted correctly and that the results are not in any way deceptive. Rather, the final report should be accurate and objective; it should contain all relevant information and should not include any form of bias. In particular, the researcher sought to avoid plagiarism at all costs and endeavoured to acknowledge all resources in the appropriate manner. Submitting this dissertation of limited scope to the University will make the findings available to interested readers and to researchers involved with similar topics.

- Debriefing of participants

“Debriefing sessions during which subjects get the opportunity, after the study, to work through their experience and its aftermath, are one possible way in which the researcher can assist participants and minimize harm” (Judd, Smith & Kidder in Strydom, 2005b: 66). For the purpose of this study, debriefing sessions followed immediately after the interview session. This allowed the adolescent participants to discuss their feelings about the interview; and also allowed the researcher to rectify any misperceptions that may have arisen in their minds (cf. Salkind in Strydom, 2005b: 66). Strydom (2005b: 65) states that participation in a research project should be a learning experience for all concerned. The author adds that making the research report available in simpler language is another way to round off the project ethically, so that participants know exactly what has happened to the information. In conformity with this recommendation, a simplified research report will be made available to the adolescent participants and to their families. Further counselling has been made available at the school by the researcher, but should the participants choose to be referred to another counsellor/ therapist this will be arranged.

1.10 DEFINITIONS OF MAIN CONCEPTS

For the purpose of this study the following concepts are defined:

1.10.1 Self-mutilation

Favazza (1998: 260) defines self-mutilation as any incident where an adolescent has attempted to deliberately alter or destroy body tissue without suicidal intent, for example

cutting, burning, scratching, hitting, biting, and pinching. The definition of self-mutilation that best fits this study is that self-mutilation is a direct, socially unacceptable, repetitive behaviour that causes minor to moderate physical injury (Favazza, 1998: 260; Rosenthal *et al.*, 1972: 47; Suyemoto, 1998: 532). Suyemoto (1998: 532) adds that when self-mutilating the adolescent is in a psychologically disturbed state, but is not attempting suicide or responding to a need for self-stimulation, nor is he or she displaying a stereotypic behaviour, as observed in some people with mental disabilities.

The classification that is now most widely accepted divides pathological self-mutilation into three observable categories based on the degree of tissue damage, the rate and pattern of behaviour (Favazza, 1998: 263). The categories are major, stereotypic and superficial/moderate. For the purpose of this study self-mutilation is housed within the superficial/moderate category. Burns *et al.*, (2002) describe superficial self-mutilation as any act performed by an adolescent by cutting and burning themselves, excoriating wounds and otherwise hurting their bodies as a means of experiencing relief from psychological crisis and stress and often the damage is inflicted in the absence of pain. The author adds that the intent of superficial self-mutilation is not to commit suicide, as most of the wounds are superficial and non-lethal. The superficial/moderate category has three subtypes: compulsive, episodic and repetitive.

The most common form of self-mutilation and the topic of this study will be superficial or moderate self-mutilation (Martinson, 2002). For the purpose of this study self-mutilation will be seen as cutting, burning, skin picking, hitting and interference with wound healing.

1.10.2 Adolescence

According to Papalia, Olds and Feldman (2006: 412) adolescence is generally considered to begin with puberty. It begins at about age 12 and concludes in the late teens or early twenties, but neither its beginning nor end is plainly marked. Gullotta, Adams and Markstrom (2000: 17) add that adolescence is a period of transition that differs in length for each individual; a growing up process that includes making decisions and making mistakes. Geldard and Geldard (2004: 3) consider adolescence to be the period of human development during which a young person must grow from dependency to independence, autonomy and maturity. Adolescence is characterized by biological, cognitive, psychological and social changes in the young person's life.

For the purpose of this study adolescence is viewed as the developmental phase between childhood and adulthood that is characterized by major physical, cognitive and psychosocial changes. Participants were between the ages of 14 and 19 years of age, so they are understood to be negotiating this adolescent developmental phase.

1.11 OUTLINE OF RESEARCH REPORT

The research report is presented in five chapters as follows:

Chapter one

Overview and rationale of the research

This chapter includes a brief description of self-mutilation and the study to be conducted, motivation for choosing this research topic, problem formulation, aim and objectives, research question, research methodology, ethical aspects and definitions of the main concepts.

Chapter two

Self-mutilation and the dynamics of the adolescent developmental phase

This chapter reviews the literature that focuses on the phenomena of self-mutilation and the adolescent developmental phase. A theoretical and empirical overview of the topic is presented, and this provides background information as well as a basis for the semi-structured interview schedule. A more in-depth literature review in the form of a literature control is carried out in chapter four.

Chapter three

Research report: Methods and findings

This chapter contains the description of the data collection procedure, clearly explaining the context and purpose of the data collection and describing the participants, the research design, the sampling plan and steps followed in the data collection procedure. The process, analysis and interpretation of the data collected are also included in this chapter.

Chapter four

Adolescent girls who self-mutilate – Literature control

Chapter four contains a second more in-depth literature review as a control to evaluate the findings of the empirical research and compare the findings to that of existing literature.

Chapter five

Conclusion, limitations and recommendations for future research

The final chapter contains the conclusions based on the findings of the empirical research as well as the recommended guidelines for support of adolescent girls who self-mutilate. It contains limitations to the study and recommendations for future research on this topic.

1.12 CONCLUSION

This chapter introduced the research problem, the research questions, and motivation for this study. The chapter also served to justify the research approach, strategy and methodology. The procedure that was followed and the sampling techniques as well as important ethical aspects were discussed. Definitions of the main concepts of self-mutilation (SMB) and adolescence were included. The following chapter further explores the phenomena of self-mutilation and the adolescent developmental phase. The available literature suggests possible reasons why an adolescent girl might be at risk of SMB.

Chapter Two
SELF-MUTILATION AND THE DYNAMICS OF THE ADOLESCENT
DEVELOPMENTAL PHASE

2.1 INTRODUCTION

Chapter One identified that self-mutilation is an increasingly prevalent problem affecting adolescents. Literature (Favazza, 1998: 265; Suyemoto, 1998: 534; Ross & Heath, 2002: 67; Plante, 2006: 189) confirms that adolescents may be more vulnerable to self-mutilate for a number of developmental reasons including: identity development, autonomy and independence and separation from parents. As a developmental period, adolescence presents its own unique demands and specific tasks to be accomplished for both the adolescent and the family. Suyemoto (1998: 550) raises the possibility that some adolescents use self-mutilation as a way to *overcome a difficult adolescence*. According to Plante (2006: 189) herein lies a key or central struggle for the adolescent self-mutilator. The adolescent must overcome a classic developmental impasse: the need to stay dependent at an unsteady time of life, yet simultaneously to seize autonomy and independence from parental figures. Nowinski (2007: ix) agrees and adds that as adolescents negotiate this stage of development they become harder to reach and are more at risk to self-mutilate. Yet there are healthy strivings underlying the seemingly pointless act of self-mutilation, and untangling them becomes imperative in order to understand and intervene in the developmental struggle. Therefore, in order to help these adolescents, parents need to understand what is behind their daughter's problems.

The aim of this chapter is to describe the phenomenon of self-mutilation and to explore the factors that place an adolescent at risk of SMB. Specific reference is made to the adolescent and the dynamics of the adolescent developmental phase which link strongly to aspects of development that may motivate an adolescent to self-mutilate.

2.2 THE PHENOMENA OF SELF-MUTILATION

Research literature has previously given relatively little attention to the problem of self-mutilation in adolescence, and yet SMB has become an increasing problem in the adolescent population (Plante, 2006: 189; McDonald: 2006: 193; Turner, 2002: 21). Literature testifies to a rising prevalence of self-mutilation (such as the cutting and burning of the skin) among

adolescents (Favazza, 1998: 265; Suyemoto, 1998: 534; Ross & Heath, 2002: 67; Plante, 2006: 189). It seems that much can be learned from adolescents themselves about SMB, as it is during adolescence that this behaviour typically begins. The following section serves to explain and define the term “self-mutilating behaviour” as it applies to the present research, including historical and present day perspectives around the aetiology of this behaviour and its relationship to the question of suicide risk.

2.2.1 Self-mutilation: a description

As stated in Chapter One, Favazza (1996: 225) defines self-mutilation as the “direct, deliberate destruction or alteration of one’s body tissue without conscious suicidal intent”. However, the reality of self-mutilation is more complex. McDonald (2006: 193) states that acts of self-mutilation include, but are not limited to, cutting, burning, carving, hair pulling, inserting objects under the skin or in body orifices, and skin picking or scratching. She adds that common sites of self-mutilation include the arms, wrists, ankles and lower legs; less common and more discreet areas include the armpit, abdomen, inner thighs, under the breasts and the genitals. Scars on these areas can number from a few to more than one hundred (Derouin & Bravender, 2004: 14; Favazza, 1996: 230).

Historically, SMB has been viewed as a diagnostic criterion of borderline personality disorder (BPD). However, other psycho-social conditions such as depression, anxiety, ineffective coping skills, alcohol or drug abuse, eating disorders, poor impulse control and adjustment disorders may also be linked with adolescent self-mutilation (McDonald, 2006: 194; Derouin & Bravener, 2004: 14; Favazza, 1998: 261). Currently, the increased incidence of self-mutilation among adolescents has led scholars to push for a diagnosis of self-mutilation as a separate disorder in the Diagnostic and Statistical Manual of Mental Health Disorders, 4th Edition-Text Revision (McDonald, 2006: 194; Turner, 2002: 58).

2.2.2 Self-mutilation and suicide

The occasionally 'savage' nature of adolescent SMB can lead to confusion about the relationship between self-mutilation and attempted suicide. However, there is a distinction between self-mutilation and a suicide attempt (McDonald, 2006: 194). The author cites that those who engage in self-mutilation are theorized to be doing so to manage stress and to feel a sense of relief, whereas suicide is an attempt to end one’s life. Self-mutilators do not have a

preoccupation with death, nor do they want to end their lives (McDonald, 2006: 194; Favazza, 1998: 262). They are seeking to feel better.

Favazza (1998: 262) states definitively that self-mutilation is distinct from suicide. *“Major reviews have upheld this distinction. A basic understanding is that a person who truly attempts suicide seeks to end all feelings whereas a person who self-mutilates seeks to feel better.”* This does not mean that suicide should not be a concern. Although the self-mutilator may not be driven by suicidal intent, she is actively travelling down a very self-destructive path (Lieberman, 2004: 16). Plante (2007: 10) warns that although the current trend of SMB among adolescents is predominantly a strategy geared towards alleviating, communicating and advertising distress, the associated risk of suicide is not to be taken lightly.

Many adolescents who self-mutilate do so at a time of crisis when their coping skills are poor. They reach a particularly dangerous turning point when their negative thoughts evolve into harmful behaviour (Lieberman, 2004: 16). Furthermore, adolescents who self-mutilate often suffer from social ostracism and this promotes desperation (Favazza, 1998: 262). Thus, although self-mutilation is not suicidal in intent, it can easily lead to suicidal ideation. Even without suicidal intent, if self-mutilator goes too far, death may ensue. Prior self-mutilation may have occurred in many adolescents who do eventually commit suicide, however, these statistics do not address the vast number of adolescents who self-mutilate, but never contemplate suicide. For the purpose of this study the focus falls on this rapidly growing number of self-mutilating, but non-suicidal adolescents and their specific needs for support.

2.2.3 Categories of Self-Mutilation

Favazza (1996: 126) identified two categories of self-mutilation, namely culturally sanctioned self-mutilation and pathological self-mutilation. Culturally sanctioned self-mutilation includes rituals, traditions and practices that reflect beliefs and symbolism of a society. These acts are repeated over several generations and seek to promote healing, spirituality and social order (Favazza, 1998: 280). The authors state that examples of culturally sanctioned self-mutilation include the initiation of sickness, body dismemberment, self-punishment to achieve redemption and body modifications as rites of passage for adolescent initiation into adulthood. Plante (2007: 6) agrees with the comparisons that are drawn by Favazza between shamanic healing, religious mortification, adolescent rites of passage and today’s current forms of self-mutilation. Both authors focus on the visual significance of scar tissue as a representation of

healing and survival and a record of one's personal struggles. However, McDonald (2006: 195) states that culturally sanctioned self-mutilation is rarely seen in the school setting.

Pathological self-mutilation, the deliberate, deviant destruction of the body without intent to end one's life, is divided into three categories, namely "major", "stereotypic" and "superficial to moderate" self-mutilation (Favazza, 1996: 126). *Major* self-mutilation involves infrequent and rare acts of self-mutilation that are frequently the product of a serious mental illness or neurological illness. Examples include castration, limb amputation and removal of one's own eyes. *Stereotypic* self-mutilation involves monotonous, repetitive, and rhythmic patterns that are most commonly associated with neurological illness or developmental disabilities, such as head banging of mentally retarded or autistic persons. Moderate/superficial self-mutilation is a complex group of behaviours resulting in the self-destruction of body tissue, including skin picking, hair pulling, burning, carving and most frequently, cutting (McDonald, 2002: 194). These acts of self-mutilation can be done with razor blades, knives, glass, needles, pins or scissors. Moderate/superficial self-mutilation, especially cutting, is the type most commonly seen in the adolescent population and is the focus of this study.

2.2.4 Moderate/Superficial Self-Mutilation

Moderate/superficial self-mutilation, according to Favazza (1998: 263) can in turn be divided into three types, namely, "compulsive", "episodic", and "repetitive" self-mutilation. The author states that *compulsive* self-mutilation differs in character from the other two types and is more closely associated with obsessive-compulsive disorder. Martinson (2002) explains that compulsive self-mutilation comprises hair pulling (trichotillomania), skin picking and excoriation of wounds when it is done to remove perceived faults or blemishes in the skin.

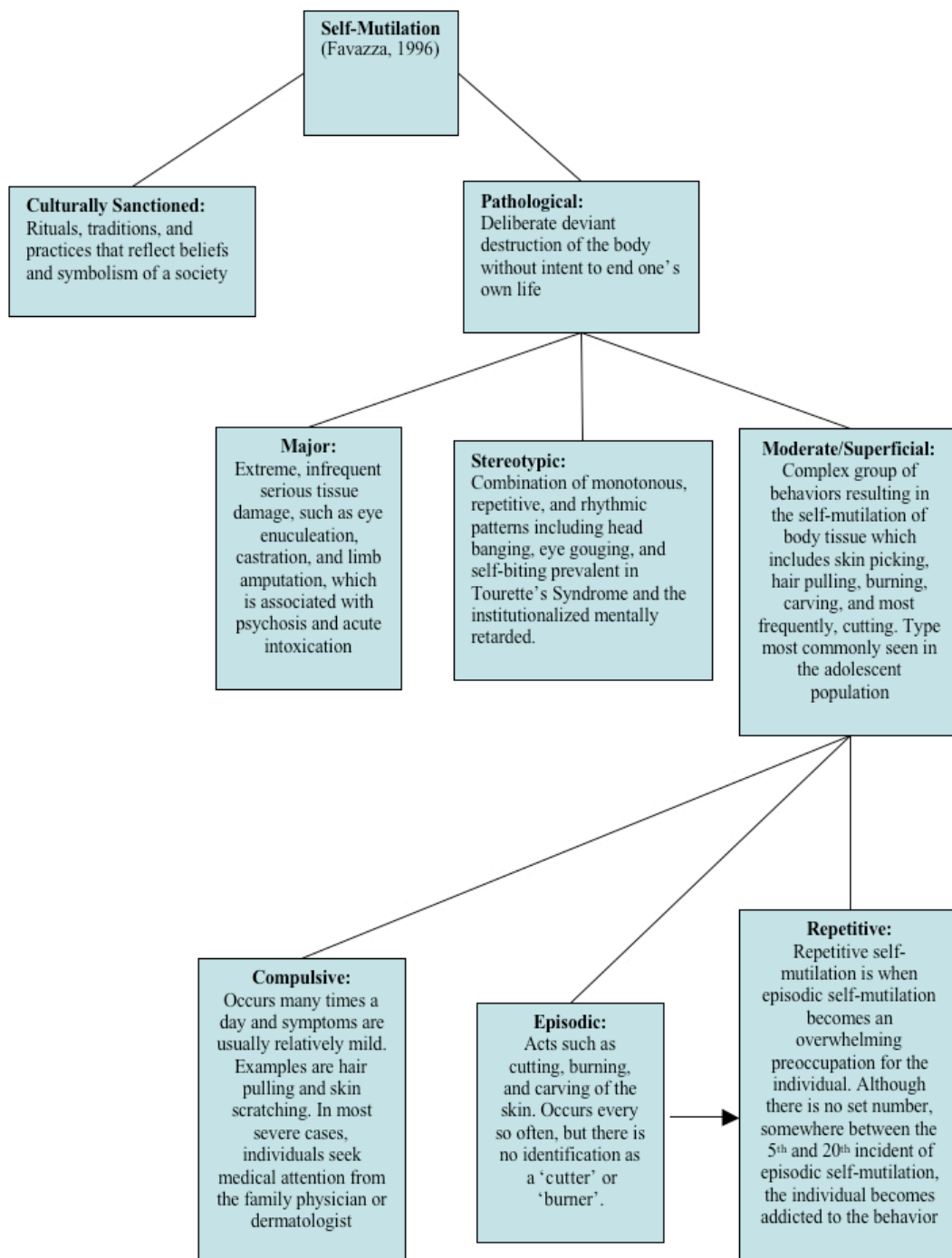
Episodic and repetitive forms of moderate self-mutilation are seen as including a range of non-lethal behaviours such as cutting, burning, needle sticking, skin scratching, interference with wound healing, hitting and hair pulling (Andover, Pepper & Gibb, 2007: 238). Favazza (1998: 264) describes both episodic and repetitive self-mutilation as impulsive acts and views the difference between the two types to be a matter of degree. The author explains that episodic self-mutilation is self-mutilating behaviour engaged in every so often by adolescents who do not think about it obsessively and do not see themselves as self-mutilators. McDonald (2006: 194) states that episodic self-mutilation usually is associated with mental disorders such as borderline personality disorder (BPD), anxiety or depression and can be related to

releasing tension, establishing control and expressing anger. The author states that the episodes are a temporary relief from mounting tension, anxiety and distress.

Repetitive self-mutilation develops when episodic self-mutilation becomes an overwhelming preoccupation for the adolescent and an *identity as a self-mutilator* is adopted (Favazza, 1998: 264; McDonald, 2006: 195). Although there is no set number, it is thought that somewhere between the 5th and 20th incident of episodic self-mutilation, the adolescent becomes “addicted” to the behaviour (Favazza, 1998: 264). Episodic self-mutilation becomes repetitive when what was formerly a symptom becomes a disease in itself; the expression “addicted” is often used by people who self-mutilate to describe their experience of repetitive SMB. The authors state that some consider repetitive self-mutilation to be a disorder of impulse control that often becomes a reflex response to any sort of stress whether positive or negative. This “repetitive self-mutilation syndrome” is theorized to start in early adolescence and may persist for years (McDonald, 2006: 195). The author adds that it may also coexist with other impulsive behaviours, such as eating disorders and alcohol abuse.

The figure below outlines the categories of self-mutilation.

Figure 1: Categories of self-mutilation



2.2.5 Behavioural and individual characteristics

The typical (modal) self-mutilator has been described as female, adolescent or young adult, single, intelligent and from a middle to upper-middle class socioeconomic background who cuts on her wrists and arms (Favazza, 1998: 265). Earlier studies found a higher frequency of self-mutilation amongst females (Ross & Heath, 2002: 67). However, more recent studies

have shown similar rates of self-mutilation in males and in females (Muehlenkamp & Gutierrez, 2004: 15).

Ross and Heath (2002: 67) found that in community samples of adolescents self-cutting was found to be the most common method of self-mutilation, followed by self-hitting, pinching, scratching and biting. The typical age for starting self-mutilation is fourteen years of age, or early adolescence (Favazza 1998: 260). The author states that the number of incidents of SMB ranges from once to hundreds of times.

2.2.6 Self-Mutilation and the Adolescent

Literature (McDonald 2006: 193; Turner, 2002: 116; Lieberman, 2004: 15; Favazza, 1998: 260) states that self-mutilating behaviors typically have an onset in early adolescence and can last up to 10 to 15 years. Rates of self-mutilation are at their highest in adolescent populations. Lieberman (2004: 17) notes that the onset can be triggered by a specific stressful event or simply by the extremely challenging nature of adolescence. Dramatic hormonal changes, intense social dynamics and the stress of establishing an identity while maintaining group connectedness can exacerbate or trigger self-mutilation in an adolescent.

Dibrino (1999: 5077) has identified specific factors that predispose an adolescent to self-mutilate, namely a traumatic history of sexual or physical abuse or neglect, anger in the family, the inability to express feelings in the family, the unavailability of affect in the family, social isolation and alexithymia, which is a difficulty in experiencing, expressing and describing emotional responses. McDonald (2006: 195) mentions presumed risk factors for self-mutilation as including sexual or physical abuse, parental alcoholism or depression, a history of chronic illness with childhood hospitalization, lack of coping skills associated with stress, depression, and even curiosity or peer pressure.

Plante (2007: 2) highlights two categories of adolescents who are most at risk for developing repetitive SMB. First, adolescent girls have typically been more likely to engage in moderate/superficial SMB than adolescent boys. This seems to be consistent with patterns indicating that boys tend to utilize more lethal methods than girls in a range of self-mutilating acts (Plante, 2007: 2; Turner, 2002: 1; Favazza, 1998: 265). Secondly, the authors state that adolescents with depression, eating disorders, adjustment disorders, social difficulties, sexual

conflicts and often simply normative problems related to adolescent development can all seek an outlet, control and communication through the act of self-mutilation.

McDonald (2006: 195) confirms that the reasons why adolescents engage in self-mutilation are varied and difficult to attribute to any one theme. However, the author adds that their *coping abilities* are a major area of concern, because the cognitive and emotional ability to cope is not fully developed in adolescents. Underdeveloped and ineffective coping strategies may manifest in adolescent self-mutilation. Frustration, tension release, expression of anger, self-punishment, uncontrolled impulses and anguish have been reported as feelings and reasons associated with adolescent acts of self-mutilation (Favazza, 1998: 267; Derouin & Bravender, 2004: 16). Self-mutilators do not report pain when self-mutilating but rather a sense of relief. The authors state that the urge to seek relief in this manner is sometimes overwhelming or even irresistible and that it eventually can become addictive for some. According to Turner (2002: 23) self-mutilation causes a release of chemicals in the brain that are similar to addictive opiates - therefore making it very difficult for the adolescent to stop once she becomes 'hooked' on this form of behavior.

According to Suyemoto (1998: 533) and Favazza (1998: 260) there is surprising agreement in the phenomenological accounts of self-mutilation. The authors state that often the precipitating event is the perception of an *interpersonal loss*, such as an argument or rejection from another. Furthermore the self-mutilator reports feeling extremely tense, anxious, angry or fearful prior to self-mutilating. Isolation from others almost always precedes the act of self-mutilation. The SMB is usually quite controlled. Suyemoto (1998: 533) states that razor blades are the favoured implement, and wrists and forearms are the most common target areas.

The majority of mutilators report the absence of pain during the act. The anger, tension or dissociation typically is ended by the self-mutilating behaviour. Adolescents occasionally report feeling guilty or disgusted after self-mutilating, but the response of relief, release, calm or satisfaction is far more common. In other words, self-mutilation may be a preferred coping mechanism because it quickly and dramatically calms the body, even though adolescents who self-mutilate may have very negative feelings after an episode (Martinson, 2000). The author states that the self-mutilator feels bad in other ways, but the overwhelming anger and tension is gone.

Plante (2007: 2) maintains that most commonly adolescents will inflict non life-threatening cuts or burns to their arms or legs in an attempt to alleviate intense distress. Furthermore the discovery of an adolescent who self-mutilates raises horrified alarm in parents, friends and teachers and often requires immediate intervention. Cavanaugh (2002: 97) states that self-mutilation is usually a symptom of underlying stress or anxiety and it serves the purpose of relieving inner tension and turmoil. The author warns that those caring for adolescents who self-mutilate must be aware that it is an external marker for unresolved inner conflict.

Self-mutilation not only raises the overall risk of suicide, but can also result in infection, permanent scarring, social alienation and an intractable pattern of self-mutilation (Plante, 2007: 3). The author adds that reliance on self-mutilation can inhibit healthy development, interfering with the young person's engagement in normative developmental challenges. A further danger of adolescent self-mutilation is that it can escalate over time in both frequency and intensity, undermining her ability to control impulses and behaviour when emotional (Favazza, 1998: 266). If not treated, self-mutilation can develop into a dangerous and chronic behaviour that continues in adulthood. The next section will further elaborate on and explain why an adolescent chooses to engage in self-mutilation.

2.2.7 Possible reasons why adolescents are at risk of self-mutilation

Plante (2007: 3) states that the destructive act of self-mutilation falls under the common adolescent theme of *“doing all the wrong things for all the right reasons.”* Adolescents engage in SMB as the 'wrong' way to cope with the 'right' strivings related to the developmental tasks of independence, intimacy and identity formation (Martinson, 2002; Plante, 2007: 3; Ross & Heath, 2002: 69; Suyemoto, 1998: 544). The authors agree that despite the apparent perversity, many adolescents utilize SMB as a coping mechanism to overcome distress related to normative conflicts. Their objectives for the behaviour include alleviating painful emotions, securing the help of others, rejecting negative parts of oneself or striving toward greater control, autonomy and independence.

Although SMB is clearly a destructive means of achieving such goals, the positive nature of the goals themselves should not be overlooked. Suyemoto (1998: 531) states that while much literature hypothesises the function(s) self-mutilation may serve, little attempts have been made to integrate or differentiate between the different functions. The author adds that part of

the difficulty in understanding the reasons behind self-mutilation lies in the likelihood that it serves more than one function simultaneously, making it the behaviour of choice for a disturbed adolescent.

One of the most commonly cited goals of adolescent self-mutilation is the alleviation or regulation of anxiety and distress (Babiker & Arnold, 1997: 74; Plante, 2006: 192). The authors report that its effectiveness in reducing distress renders many adolescents reluctant to discontinue the behaviour. Plante (2006: 192) states that the adolescent who is overwhelmed by longing, sadness, anger, hurt, self-loathing, or anxiety commonly resorts to SMB as a means of refocusing the emotional pain onto a physical act over which she has control. Many adolescents report that cutting helps them feel numb, calm, in control, relieved or otherwise less distressed. Babiker and Arnold (1997: 75) add that what comes across is the relative manageability and perceived benign nature of self-mutilation in comparison to the enormity of the distress and tension experienced by the adolescent.

A second goal of adolescent self-mutilation can be the conscious or unconscious wish to communicate emotional distress to others (Babiker & Arnold, 1997: 83; Plante, 2006: 192). The authors state that the sight of scars is a direct signal of distress to parents, friends and teachers, who are inevitably alarmed by these disturbing signs. Plante (2006: 193) points out that often the adolescent is in conflict over the desire to be independent, while still reliant on her family for support. The scars are displayed for 'accidental' discovery as opposed to a direct plea for help. The author explains that although SMB spells out the adolescent's desire for help, she is often resistant or even defiant to intervention. Self-mutilation then may become the ground upon which the dependence-independence battle is fought within the adolescent, as well as between herself and others.

A third goal of adolescent SMB can be to cleanse, punish or reject hated aspects of the adolescent self (Plante, 2006: 193). Poor body image and low self-esteem create intense rage and misery that demands action. The SMB serves to provide a sense of cleansing and relief that helps the adolescent return to equilibrium and a temporary sense of redemption. Babiker and Arnold (1997: 80) add that self-mutilation can operate as a punishment or atonement: in that painful situation the adolescent feels as though she deserves the pain. Her wounds are the tangible evidence of her shame because she is so bad and worthless. The authors state that following the 'punishment' the adolescent can forgive herself and feel absolved of some of

her supposed badness. Plante (2006: 193) adds further that self-mutilation may be associated with the same “magical thinking” that drives the anorexic adolescent to starve or the bulimic adolescent to purge. The adolescent reasons that by ridding herself of the hated feeling, the self-mutilation serves to restore a sense of greater peace and acceptance.

Babiker and Arnold (1997: 77), as well as Plante (2006: 194), identify the fourth goal of adolescent self-mutilation as that of declaring *autonomy and independence*. The authors state that self-mutilation provides the adolescent with a sense of having control, of exercising autonomy and being in charge of her own life. Plante (2006: 195) claims that an adolescent who self-mutilates wields a terrible power. As parents campaign to make the adolescent stop the destructive behaviour, a dynamic develops where the adolescent discovers a source of tremendous power over adults. Parents and others may plead, demand, panic, threaten and otherwise attempt to help the adolescent to stop, however the adolescent holds the power to self-mutilate or not. The author states that this sense of control over others can be a misdirected means of expressing her independence to others. The author maintains that self-mutilation can serve as a means of asserting that the adolescent is demanding more freedom and autonomy, while displaying inner strength and resolve.

A fifth goal of adolescent self-mutilation is that of the adolescent attempting to express her changing *identity* through the act of self-mutilation (Plante, 2006: 194). Since time immemorial people have engaged in body art, adornment, scarring and other symbolic rituals that visibly mark the skin. Plante (2006: 204) adds that in most cultures tattoos and piercing are used much like clothes or hairstyles to signify affiliations with subgroups or peer cultures while rejecting mainstream norms. Self-mutilation can be a truly private act, however it is always possible that the evident scarring conveys significant meaning within some specific cultural context (for example: being “friends with the emo kids”, see 3.5.1.6. below, concerning feelings of alienation). This possibility raises justifiable concerns about the effects of peer influence and social contagion or an “epidemic” of SMB among young people.

Suyemoto (1999: 549) confirms that self-mutilation may become a means of conveying an adolescent’s affiliation with a peer group, thus serving to produce an identity. It also confirms boundaries by helping to create a separate and unique sense of self. Others often view these adolescents in terms of their self-mutilating behaviour: being known as “cutters” they have acquired an identity by means of this symptom. Plante (2006: 204) further adds that the

adolescent displays to friends and others the painful and intriguing nature of her budding maturity. Scars garner a curiosity and added mystery that appeals to the adolescent in her search to declare herself no longer a child, but a unique and complex person. As the adolescent struggles with the distress of conflicts regarding autonomy, sexuality and establishing a sense of identity her self-mutilating behaviour represents “*the relinquishing of childhood’s innocence and dependency and the advent of full-blown adolescence.*”

It is becoming apparent that social contagion does indeed account for some of the increased prevalence of self-mutilation (Plante, 2006: 191). The author elaborates by stating that adolescents have a compelling need to identify with peers and try out all sorts of strange activities. This aspect readily explains the reportedly spreading use of self-mutilation as a means of coping with and expressing pain. Observation of peers engaging in self-mutilation can result in contagion through modelling of these behaviours as an appropriate coping device. Much like the social contagion of overt suicide attempts and eating disorders, increased awareness of self-mutilation amongst peers can and does provoke engagement in such acts.

Self-mutilation is therefore much more than simply the expression of pain or a cry for help. While it may be tempting for some to dismiss this disturbing behaviour as the hostile and manipulative action of an exasperating adolescent, it is imperative that parents and clinicians understand the primary motives as being rooted in otherwise healthy developmental challenges (Plante, 2006: 195). Adolescents are at a developmental stage where the safety net of childhood naiveté has been removed, yet the perspective of adult cognitive reasoning is still years away (Nowinski, 2007: 203). The journey through adolescence is littered with opportunities to make unhealthy choices and without the benefit of a firmly established identity in place; adolescents are at risk of making potentially dangerous choices.

Next a description is given of what adolescent development entails, along with a basic explanation of the dynamics of this developmental phase that centres on the themes of identity formation, independence and intimacy and sexuality.

2.3 THE DYNAMICS OF THE ADOLESCENT DEVELOPMENTAL PHASE

Geldard and Geldard (2004: 3) consider adolescence to be the period of human development during which a young person must grow from dependency to independence and towards autonomy and maturity. Plante (2007: 27) agrees, explaining that adolescence is first and foremost a cataclysmic transition. The drive toward adulthood competes with the pull of childhood dependency and innocence, creating an ambivalence that can be confusing for both adolescents and parents. The almost universal challenges of adolescence can be summed up as centering around three central themes, namely identity formation, independence and intimacy (Plante, 2007: 27). Sexuality forms a significant aspect in each of these developmental themes. In order to support healthy adolescent development there needs to be an understanding of the nature of adolescence and the processes that are involved. The challenges that must be overcome in order for the adolescent to develop and mature towards the next developmental phase will be discussed in the following section.

2.3.1 Biological changes in adolescence

Adolescence begins with the maturation event known as puberty. Geldard and Geldard (2004: 4) refer to puberty as the biological events that surround the first menstruation in girls or the first ejaculation in boys. These events signal the beginning of a process of all-round change in physiological, sexual and emotional aspects. The authors state that this process may cause difficulties for the adolescent especially when the adolescent is precocious in puberty or when puberty is significantly delayed. Either situation can leave the adolescent feeling awkward and low in confidence.

2.3.1.1 Physiological changes

The first outward sign of puberty is the rapid gain in height, weight and strength. Girls develop breasts, body hair grows and changes occur in sexual organs (Berk, 2002: 528). According to Geldard and Geldard (2004: 5) physiological changes take place over a period of time, at different ages and rates for different adolescents. Consequently adolescents may feel self-conscious, awkward and out of step with peers who develop at a different rate. The authors state that significant and important increases in the production of sexual hormones occur during puberty. These changes are likely to cause discomfort for the adolescent because as sexual drive rises, the adolescent is confronted with issues of personal sexuality and sexual identity. They add that during this time some adolescents will become involved in sexual experimentation while others manage their sexual feelings through fantasy and masturbation.

According to Berk (2002: 637) gender intensification occurs in early adolescence, as physical and cognitive changes prompt the adolescent to view herself in gender-linked ways, while gender-typed pressures increase from parents and peers. Plante (2007: 28) affirms that puberty is the pivotal point at which major transition in psychological and social development commences. Berk (2002: 533) agrees and adds that girls often abhor the rapid changes in their bodies, experiencing unwelcome weight gain, struggles to cope with menarche or menstrual cycles, and feelings of vulnerability as their bodies become visibly sexualized.

Berk (2002: 618) explains that puberty magnifies gender differences in appearance, causing adolescents to think about themselves in more restrictive gender-linked ways. When the adolescents start to date they often become more gender stereotyped as a way of increasing their attractiveness to the opposite sex. Parents, especially those with traditional gender-role beliefs, may encourage “gender appropriate” activities and behaviour to a greater extent during this stage in development. Thus early maturing adolescent girls feel less free to experiment with “other gender” activities and behaviour. Berk (2002: 618) adds that overall the androgynous adolescent tends to be psychologically healthier, more self-confident, more willing to speak her mind, more popular, and more comfortable with her identity.

Literature (Berk, 2002: 538; Kaplan, 2000: 470; Plante, 2007: 28; Papalia *et al.*, 2006: 417) consistently states that girls who mature earlier than their peers are at an increased risk for a variety of difficulties such as depression, eating disorders and low self-esteem. The authors add that these girls are also more likely to interact with older peers, thus becoming more susceptible to e.g. high-risk sexual contact, drug and alcohol abuse or delinquency.

Early-maturing girls tend to diet more and to hold more negative views about their bodies (Berk, 2002: 540; Kaplan, 2000:474; Plante, 2007: 29; Papalia *et al.*, 2006: 422). These girls frequently have a disturbed body image and low self-esteem, along with problematic eating habits and sometimes frank eating disorders. Such adolescent girls often resort to alcohol or other drugs in an effort to relieve anxiety or reduce stress. This behaviour may place them at risk for serious harm. These at-risk girls may pursue intimate relationships and engage in sexual activity as a source of comfort or as a means of coping with their emotions. This behaviour puts them at further risk for becoming pregnant or acquiring sexually transmitted diseases. Thus, the authors contend that early maturation in girls represents a risk factor for a number of emotional and behavioural problems, including SMB.

2.3.1.2 Emotional changes

Literature (Berk, 2002: 536; Kaplan, 2000: 464; Papalia *et al.*, 2006: 413) states that the rise in sex hormones may influence the adolescent's emotional state and social behaviour. Higher hormone levels are related to mood swings, as well as problematic anger and depression in girls (Berk, 2002: 536). However, according to the author hormones act in conjunction with other major changes impacting on the adolescent namely changes in social relationships, beliefs and attitudes and in self-perception. Furthermore compared with the moods of adults, adolescents' feelings are in any case less stable, often varying from cheerful to sad and back again. Berk (2002: 536) adds that adolescents also move from one situation to another more often, and their mood swings can be strongly related to these changes. Thus, situational factors combine with hormonal influences to affect adolescents' moodiness.

According to Williams and Bydalek (2007: 22) emotional aspects such as moodiness, poor self-esteem, poor impulse control, sadness or tearfulness, anger, anxiety, disappointment in oneself and an inability to identify positive aspects in ones life can also be risk factors for adolescent self-mutilation.

Cavanaugh (2002: 98) notes that differentiating from attention-seeking behaviour is important as it is often felt that adolescents self-mutilate in order to be noticed. Not all adolescents want their SMB to be noticed, or use it to gain attention; many self-mutilating adolescents try to hide their injuries from others for fear of being discovered or reprimanded (see Chapter Three for more on this).

2.3.2 Cognitive changes in adolescence

The adolescent develops a capacity for abstract thinking, discovers how to think about relationship issues, discerns new ways of processing information and learns to think creatively and critically (Kaplan, 2000: 484).

2.3.2.1 Development of abstract thought

According to Piaget (1966: 136), during early adolescence there is a shift from concrete operations to the formal operations stage. The adolescent moves beyond the limitations of concrete thinking and shows a new capacity to work with ideas, concepts and abstract

theories. The development of abstract thought results in dramatic revisions in the way that adolescents view themselves, others and the world.

Berk (2002: 569) states that just as adolescents are awkward in the use of their developing bodies, so are they clumsy in the use of abstract thought. The author identifies typical reactions of adolescents as those of argumentativeness, self-concern, sensitivity to public criticism, idealism, criticism and indecisiveness. Geldard and Geldard (2004: 10) add that the adolescent developmental stage is characterized by emotional reactivity and a high intensity of emotional response. This factor makes it difficult for adolescents to control and modulate behavioural responses that at times may be inappropriately extreme.

Plante (2007: 33) states that as the adolescent transitions to adulthood, she is expected to become increasingly capable of responsible and independent functioning and accordingly, parents are required to relinquish control and tolerate the diminished closeness they can enjoy with their child. This process is a seesaw of emotional peril and exhilaration for both the adolescent and her parents. The adolescent mind is rife with conflicts and contradictions, so the proclamations and behaviours of young people can seem utterly irrational to anyone else. The author states that adolescents' actions may seem directly opposed to their attitudes. The act of self-mutilation seems to be a direct cry for help, and once it has been discovered by parents, friends and teachers it cannot be ignored. However, very often the adolescent wishes to keep it secret or refuses to be helped. Thus the ritual of self-mutilation seems to demand the impossible from caregivers: *"I want you to understand me"* and *"Stay out of my business"* (Plante, 2007: 33).

2.3.2.2 Egocentric thinking

Adolescents are self-conscious: they believe that others see and judge them just as they see themselves. Kaplan (2000: 485) states that adolescents often look at themselves in the mirror and imagine what others will think of them. This is known as adolescent egocentrism and is defined as the adolescent's failure to differentiate between their own thoughts and the considerations of others. This failure leads to two phenomena, known as the 'imaginary audience' and the 'personal fable'. The 'imaginary audience' is the person or group from whom the adolescent perceives attention and evaluation. Her relationship with this 'audience' promotes self-consciousness and a constant preoccupation with privacy. The 'personal fable' is the adolescent's belief that what she is thinking and experiencing is original, new and special

(Kaplan 2000: 505). Adolescents who believe they are unique may also believe that they are invulnerable to harm resulting in dangerous risk-taking (Kaplan, 2000: 486).

2.3.2.3 Idealism and criticism

The dramatic physical and cognitive changes of adolescence lead the adolescent to see herself and her surroundings from new vantage points (Berk, 2002: 524). During adolescence psychological distancing between parent and child takes place, followed by a renegotiation of the relationship between parents and adolescent. Conflict may escalate due to the adolescent failing to appreciate her parents' efforts to protect her from such risks as substance abuse, motor vehicle accidents and early sex, and the parents' failure to appreciate how crucial her social life is to her; or to give her a chance to develop autonomy.

Berk (2002: 571) notes that the idealism of adolescents leads them to construct grand visions of a perfect world. However their visions do not leave room for the shortcomings of life and so they become faultfinding critics. Adults have a more realistic view of the world. The author states that the disparity between adults' and adolescents' worldviews is often called the "generation gap", and it creates tension between parent and child.

2.3.3 Psychological challenges in adolescence

McDonald (2006: 193) views psychological health as an essential aspect of the overall health status of an adolescent. The author defines psychological health of an adolescent as the achievement of expected developmental milestones, the growth of secure attachments and satisfying social relationships, and an improvement in effective coping skills. Psychological health problems have a negative impact on adolescents, which is reflected in social functioning, family relationships and academic achievement.

2.3.3.1 Identity formation during adolescence

Plante (2006: 191) states that identity formation is the ultimate development of an acceptable and realistic sense of who one is, how one relates to others and what activities and interests form the structure of one's life. Erikson (1968: 128) defined the central developmental task of adolescence as the establishment and development of industry, identity and intimacy. According to him, identity formation is the key personality achievement of adolescence. The adolescent who successfully resolves the psychological conflict of identity versus identity confusion constructs a solid self-definition consisting of self-chosen values and goals.

Plante (2006: 191) in contrast, suggests that identity is rarely solidified in the adolescent years and instead may evolve over the course of a person's life. However, a consistent sense of self that helps guide decision-making becomes more clearly integrated during the course of adolescence (Plante, 2007: 30). The author states that identity confusion can result in the appearance of troubling symptoms such as depression, anxiety, hostility, anger, school failure and self-doubt. Increased complexity of choices presented to the adolescent understandably creates confusion and conflict. These conflicts can prove overwhelming, resulting in unmanageable emotions and problematic behaviours such as self-mutilation.

Erikson (1968: 131) viewed the formation of a personal identity as the positive outcome of adolescence. Role confusion and failure to answer fundamental questions of identity, is the negative outcome of the stage (Kaplan, 2000: 553). Identity formation involves exploration and commitment for the adolescent, in order to achieve a vocational and ideological identity. The author states that identity achievement and 'moratorium' are viewed as psychologically healthy routes to a mature definition of self, whereas foreclosure and identity diffusion are seen as maladaptive. Berk (2002: 640) explains that foreclosure occurs when an individual has accepted ready made values and goals that were chosen by others for them; identity diffusion occurs when an individual does not have firm commitments to values and goals and is not actively trying to reach them. Both identity foreclosure and diffusion are associated with adjustment difficulties in adolescents. Berk (2002: 604) states that "foreclosed" adolescents tend to be dogmatic, inflexible and intolerant. Some use their commitments in a defensive way, regarding any difference of opinion as a threat. The author adds that most are afraid of rejection by people whom they depend on for affection and self-esteem. Long-term diffused adolescents are the least mature in identity development, typically entrusting themselves to luck or fate. They may adopt an "I don't care" attitude and tend to go along with whatever their peers are doing. As a result, such an adolescent is likely to experience academic difficulties, is at risk for substance abuse, and often feels a sense of hopelessness about the future (Berk, 2002: 604).

Kaplan (2000: 553) explains that emotional autonomy involves a shifting away from emotional dependency on parents, and forming new relationships. Most adolescents achieve emotional autonomy while remaining connected with families; they have a good relationship with their parents and despite some inevitable conflict, their adolescence is not a time of

continual storm and stress. Geldard and Geldard (2004: 31) state that adolescents may not be aware that their actions in relation to their parental figures can vary from intimacy to isolation. Yet the struggle for autonomy is a natural process that is necessary for the development of the individual adolescent. Adolescents are both aware and unaware of their struggle to break from childhood ties and establish an identity separate from their parents. According to Plante (2006: 4) it is these underlying and often unconscious conflicts in the lives of adolescents that drive destructive SMB but also hold the key to overcoming it.

2.3.3.2 The adolescents' search for independence through freedom and responsibility

According to Kaplan (2000: 553) behavioural autonomy involves being able to manage behaviour successfully when on one's own. Adolescents gradually achieve autonomy and independence in between maintaining critical parental attachments and a sense of competent independent functioning (Plante, 2006: 191). The author states that adolescents become less dependent on parents for both intimacy and decision-making assistance as they simultaneously begin more earnest friendships, sexual relationships and autonomous pursuits outside of the home.

McConville (2001: 31) points out that this phase of development is anything but linear and orderly for adolescents. While an increasing responsibility and freedom is granted, for example driving a car, other avenues are being closed off: for example, turning to their parents to solve social problems like bullying by peers. Berk (2002: 524) adds that adolescence is both an exhilarating and an apprehensive phase as the adolescent is expected to give up childish ways in favour of greater responsibility. In their fledgling social and emotional state, adolescents may find the responsibilities that come with freedom to be a great challenge. According to Freud (in McConville, 2003: 32) the psychological shift away from parents results in psychological distress for adolescents. Sociological influences require that adolescents dissociate from parental dependence, turning instead to peers for emotional satisfaction. McConville (2001: 39) postulates that where once the child felt fully immersed in the family and comfortably available to parental influence, the adolescent now begins to stand apart and turns to peers instead, thereby creating a separating boundary between self and family. The author explains that these new life space privileges are unfamiliar and vaguely determined and in many instances serve to confuse adolescents. Adults may be held at arms length and adolescents may hold back information about personal feelings and thoughts,

heightening the boundary between family and self through concern for privacy (McConville, 2001: 39).

2.3.3.3. Intimacy and sexuality and the adolescent

Although intimacy and sexuality are lifelong themes, according to Plante (2006: 191) adolescents are especially challenged when maintaining a healthy romantic relationship as a result of pubertal changes. Berk (2002: 626) states that sexual interest is affected by the hormonal changes of puberty and the beginning of dating is regulated by cultural expectations. The author adds that Western societies tolerate and even encourage romantic involvements between adolescents. Literature (Berk, 2002: 626; Erikson, 1968: 137; Kaplan, 2000: 516; Plante, 2006: 192; Papalia *et al.*, 2006: 481) states that during adolescence an imperative developmental goal is the ability to form intimate and rewarding relationships with others. The authors emphasize that adolescents may be caught in the new experience of intense sexual desires, the need for acceptance and affiliation and the challenging task of defining their sexual orientation and identity. Plante (2006: 192) adds that facing these challenges during a time of decreased parental guidance and increased freedom make for a hazardous and stressful period of development. Berk (2002: 626) adds that early dating in mid-adolescence does not foster social maturity. Instead it is related to drug use, delinquency and poor academic achievement. Furthermore early-dating adolescent boys gain status among their same-sex peers, while early-dating adolescent girls often experience more conflicts due to competition and jealousy from other girls.

Gilligan (1996: 27) argues that it is also important to note that much of the inner conflict that girls experience during the adolescent developmental phase is influenced by social expectations regarding gender roles and female sexuality, specifically within patriarchal societies. The expectations deliver mixed and confusing messages to young girls. Kohen (2000: 83) states that gender role socialization has been put forward as a partial explanation for why adolescent girls are at a greater risk for internalizing disorders such as depression, eating disorders and low self-esteem. Berk (2002: 629) agrees that stressful life events and gender-typed coping styles account for girls' higher rates of depression. The author views passivity and dependency as maladaptive gender-typed coping responses to the many challenges that an adolescent girl must face in her complex society.

2.3.4 Social challenges in adolescence

A major challenge for adolescents is their need to find a place in society and experience a sense of belonging in that place. Geldard and Geldard (2004: 11) describe this process of socialization as the adolescents' integration into society. Furthermore, the socialization process and the search for a personal identity are interrelated and interdependent. The authors state that socialization enhances the sense of identity achievement while development of a personal identity better equips the adolescent to deal with society's expectations. The combined expectations of society, parents and peers combined with psychological and cognitive changes, challenge the adolescent to make changes in her social behaviour.

2.3.4.1 Society's expectations

Geldard and Geldard (2004: 11) claim that adolescents can only construct a personal identity in the context of relationships with others. Having relationships with others involves respecting and responding appropriately to their expectations. However, society's expectations about how adolescents should behave often conflicts with the adolescents' own expectations. The authors agree that adolescents who are unable to cope with the demands of society may experience problems ranging from addiction to violence.

Messer and Fremouw (2008: 173) state that social contingencies may also play a role in perpetuating some self-mutilating behaviour. The authors agree with Plante (2006: 97) that observation of peers engaging in self-mutilation can result in contagion through modelling of these behaviours as an appropriate coping strategy.

2.3.4.2 Parental expectations

Geldard and Geldard (2004: 12) maintain that most parents do not know what is normal and realistic with regard to their expectations of their adolescent children. As their children grow through adolescence many parents become distressed by behaviours that are normal for adolescents.

Berk (2002: 619) states that adolescent development involves striving for independence and autonomy. Adolescents seek to establish themselves as separate, self-governing individuals. This means relying more on themselves and less on parents for direction and guidance. The author asserts that adolescents attain greater self-directedness by shifting away from their parents to their peers. Parent-adolescent conflict escalates along with parents' efforts to protect adolescents from harm. The authors argue that the parents' response may

inadvertently create negative feelings and catapult the adolescent into anti-social behaviour. In Plante's perspective the adolescent's development is inextricably linked to her parents, and they must each adapt to the sudden developmental changes facing them (Plante, 2006: 200).

While adolescents struggle with their developmental issues, parents must face a loss of control, a loss of intimacy and a new set of behaviours and emotions governing their previously predictable child. Geldard and Geldard (2004: 13) state that these challenges often result in parents disengaging from adolescents at the very time when they need continuing guidance and support. An important challenge, therefore, for adolescents is to maintain a positive relationship with their parents while achieving their developmental goals - one of which is paradoxically to separate from their parents.

2.3.4.3 Adolescent expectations

Adolescents believe that their major challenges revolve around relationships with family and peers, and performance issues within society or school (Geldard & Geldard, 2004: 13). The authors note that along with forming close relationships and friendships, most adolescents are interested in belonging to a group whose members share common attitudes and interests. Within these groups adolescents have strong expectations of their friends to be trustworthy and loyal to them.

For some adolescents, developmental challenges prove so painful or overwhelming as to compel them to self-mutilate. Along with drug abuse, school failure, and promiscuity, self-mutilation is increasingly becoming a mode of coping with overwhelming distress that the adolescent is otherwise unable to contain (Plante, 2006: 192).

Plante (2006: 205) states that the meaning and message contained in self-mutilation can only be deciphered in the context of each adolescent's peer, family and cultural milieus. This is precisely why the author contends that intervention often requires more than focusing on the adolescent's pathology and instead to also focus on aspects of her environment that can be used as resources, or addressed as detrimental.

2.3.4.4 The adolescent's coping style

According to Lench (2007: 61) *coping* is an attempt to either alter the environment to make it less stressful or to increase personal resources to deal with the stressor. The author defines

good coping skills by their effects, namely, those that create positive emotions by changing the situation or changing how one perceives the situation are considered healthy and effective. Plante (2006: 202) adds that adolescents need to develop a new set of coping skills now that the childhood options of running to one's parents or throwing a tantrum no longer seem age-appropriate.

According to Geldard and Geldard (2004: 43) there are remarkable differences in the abilities of adolescents to cope with the challenges that confront them. Some adolescents have great difficulty in dealing with problems that for others seem to be trivial. Adolescents who are unable to cope with stress in an adaptive manner may develop problems such as self-mutilation. The authors state that adolescent coping styles are influenced by cultural factors, gender, socio-economic status and current environmental factors.

Geldard and Geldard (2004: 43) observe that coping styles that are counter productive tend to be passive. These are described as *non-productive coping styles, which* include worrying, seeking to belong, wishful thinking, ignoring the problem, keeping to oneself and self-blame. Lench (2007: 61) states that ineffective coping styles fail to make the adolescent feel better and may actually increase the negative emotions, as the situation is not resolved. Coping styles that are productive involve an active process as opposed to a passive process and are described as *seeking to solve the problem* by seeking social support, focusing on finding a solution, investing in friends, seeking a relaxing diversion, working hard, and being positive. Turning to peers or professionals for social and spiritual support is also an effective coping strategy (Geldard & Geldard, 2004: 43). Lench (2007: 61) adds that coping strategies that are likely to resolve many situations effectively include problem solving, framing the situation into an opportunity for positive outcomes, and giving positive meaning to events.

2.4 CONCLUSION

This chapter focused on the increasing prevalence of self-mutilating behaviour among adolescents and emphasised that particular attention and sensitive understanding are needed in order to address the issue. Increasingly, self-mutilation is becoming a mode of coping with overwhelming distress that the adolescent is unable to contain. The self-mutilation needs to be viewed as the complex issue that it is, and not merely as the weird manipulative behaviour of

a wayward adolescent. Critical to any effective intervention or support, is an understanding of the adolescent in the context of her developmental phase.

It is inherent in the definition of adolescent development that change takes place over a significant period of a person's life (Geldard & Geldard, 2004: 4). The authors add that as a formative period in the life course, changes take place in adolescence both in the individual herself, with regard to cognition, emotions, values and behaviour and in her interactions with her social and psychological environments. Furthermore, there are few reasons to believe that development in one domain occurs in isolation from other aspects of the growing adolescent. It is only by looking at the adolescent as a whole person and in context that one may come to a full understanding of the individual and her problems.

The purpose of the literature review was to act as background for the completion of the empirical section of the research. Although there might be similarities between the literature study and the empirical data in the next chapter, the strength of this study lies in the fact that the data is the direct experience and view of the adolescent self-mutilator and her description of her emotional needs as well as the purpose self-mutilation serves in her life. The following chapter provides a description of the empirical research process. The empirical research will be documented by providing the interview schedule, transcriptions of the interviews as well as findings made. Findings will be supported by a second literature study, which will serve as a control for the information that is collected.

Chapter Three

RESEARCH REPORT: METHODS AND FINDINGS

3.1 INTRODUCTION

From the literature study in chapter two it is clear that SMB is a problem amongst adolescents. Self-mutilating behaviour is often misunderstood and information is scarce. Few people know what self-mutilation is or can explain it in common sense terms. The literature study served as a theoretical framework for the semi-structured interviews that formed the basis of the empirical study discussed in this chapter.

The present research study is directed at a better understanding of the underlying variables and dynamics in adolescent girls who self-mutilate. The research further aimed to refine the available knowledge of the problem, including the underlying dynamics of SMB in adolescent girls, in order to initiate a set of guidelines for parents that might enable them to support adolescent girls who self-mutilate.

In this chapter, the data collection procedure is comprehensively described. A description is given of the participants, the research strategy, and the sampling plan as well as the steps that were followed in the analysis and interpretation of the data.

3.2 DATA COLLECTION PROCEDURE

The research interviews conducted with the adolescent participants and psychologists contained a wealth of information that will be reflected as comprehensively as possible within the scope of this chapter. In this study adolescents had the opportunity to share their feelings and experiences. The need for and effect of self-mutilation became quite clear through the verbal responses given by the participants. Discussions focused on themes around the purpose that self-mutilation fulfils in the adolescents' lives, their unfulfilled emotional needs, and their suggestions of practical things to do instead of self-mutilating.

3.2.1 Sampling plan

3.2.1.1 The universe and population

The universe in this study was adolescent girls in the Western Cape Province in South Africa who have self-mutilated on more than one occasion, as well as Psychologists in Somerset West and Cape Town who work with self-mutilation amongst adolescents. The population in this study was adolescent girls from High Schools in Stellenbosch and Somerset West in the Western Cape who self-mutilate and Psychologists in Somerset West and Cape Town who work with self-mutilation amongst adolescents.

3.2.1.2 Demarcation of the sample

The sample was originally set to come from adolescent girls who self-mutilate and who attend a specific High School, in Stellenbosch. However, due to a lack of adolescent participants, the sample could not be drawn exclusively from the school. Instead, the sample included a second High School in Somerset West. The school counsellor referred participants willing to partake in the study to the researcher.

3.2.1.3 Sampling technique

The research study used non-probability, purposive sampling. The participants were chosen due to the significance of the research topic and their ability to provide the information needed. Strydom and Delport (2005b: 328) state that purposeful sampling requires that the researcher critically describes the parameters of the population and then choose the population accordingly. The researcher selected the participants due to specific criteria with attention given to the specific content of each case.

The sample included adolescent girls from High Schools who self-mutilate in Stellenbosch and Somerset West, Western Cape, South Africa and two Psychologists. The adolescents were all English speaking girls, between the ages of fourteen and nineteen, who were referred for counselling due to emotional or behavioural problems and during counselling the self-mutilation was disclosed. Participation in the study was entirely voluntary and no discrimination was made in terms of race of the participants.

3.2.2 Participant information

Details of the criteria for inclusion have been given above. The adolescent participants are referenced by letters A – G, to ensure their anonymity. The psychologists are referenced with numerals 1 and 2.

As part of the data collection process the adolescent participants were asked specific biographical questions that provided some background on their family structure and interaction, medication and their current self-mutilation status. These biographical questions provided qualitative information and were not asked separately, as opportunities to ask the questions arose naturally during the course of the interviews. In the table below, the adolescent participants' ages are noted first, followed in brackets by the age when they first engaged in self-mutilation and the age at which they stopped if not still engaging regularly in SMB. The + sign denotes that the adolescent was actively self-mutilating when the interview was conducted. The responses are summarized below.

- **Age of participants**

All adolescent participants were between the ages of fourteen and nineteen. One adolescent was fourteen years old, two of the adolescents were seventeen years old, one adolescent was eighteen years old and three were nineteen years old.

- **Status of self-mutilation**

Participant A: no longer self-mutilating

Participant B: no longer self-mutilating

Participant C: actively self-mutilating

Participant D: no longer self-mutilating

Participant E: actively self-mutilating

Participant F: actively self-mutilating

Participant G: actively self-mutilating

- **Position of adolescent in the family**

One of the adolescents was the only child in the family, two of the adolescents were the eldest, and one was the second child with no younger siblings. Two were the youngest of three children and one was the third child in a family with four children.

- **Marital status of parents**

One participant had divorced parents, the others all reported married parents. However, two of the adolescents' fathers are deceased and one adolescent's mother is deceased.

- **Use of medication**

Two participants (B and C) used medication that was prescribed by a psychiatrist for reasons other than the self-mutilation. The participants were unable to name the type of medication but the prescription was given to them for depression from doctors.

Table 1: Summary of adolescent participants interviewed

Participant/ Age at onset of self- mutilation	Status of self- mutilation (SM)	History of self- harm	Position of child	Marital status of parents	Attempted suicide by means other than SM	Other identified psychological stressors
A. 19 y.o (14 – 18)	Inactive	4 years	3/3	Divorced	Never by any means	Family discord
B. 19 y.o (16 – 18)	Inactive	2 years	3/3	Married (Father deceased)	Yes	Family financial difficulty, bereavement
C. 18 y.o (14 -)	Active	4 years+	3/4	Married	Never by any means	Family discord
D. 19 y.o (16 – 17)	Inactive	1 year	2/2	Married	Never by any means	None
E. 17 y.o (15 -)	Active	2 years+	1/3	Married (Mother deceased)	Yes	Family financial difficulty, witness to mother's murder
F. 14 y.o (13 -)	Active	2 years+	Only child	Married (Father deceased)	Yes	Bullied at school, suicide within family (father)
G. 17 y.o (15 -)	Active	2 years+	1/2	Married	Yes	Bullied at school

Psychologist 1 (see 3.2.2) was the Head of The Adolescent and Young Adults Unit at Kenilworth Clinic (KAYA) who spoke on behalf of the team of clinicians that make up the unit at Kenilworth Clinic. The multi-disciplinary team at KAYA comprises psychologists, senior professional nurses, occupational and art therapists and addiction counsellors. A consultant psychiatrist and dietician are also available at all times.

KAYA routinely treats adolescents and young adults who are not coping with:

- anxiety and depression
- behavioural problems at school and at home

- anti-social behaviour
- eating disorders
- self-mutilation
- sexual abuse
- substance abuse
- suicidal behaviour
- and other high risk behaviour

Psychologist 2 wished to remain anonymous; therefore no details will be given.

3.2.3 Research strategy

As described in chapter one, the instrumental case study served as strategy for this study. The researcher interviewed seven adolescent girls who self-mutilate or were once involved in self-mutilation in order to gain knowledge of the emotional needs of these girls and to set guidelines for their parents that could possibly empower them to support their daughters. As previously described the adolescent girls were asked whether a parent or other adult caregiver might be interested in being interviewed to offer his or her perspectives on adolescent self-mutilation. However, only two expressed a willingness to have their families contacted and since this was such a small number, no parents were contacted for interviews. 62

The researcher interviewed the two psychologists in order to better understand the dynamics of adolescent self-mutilation as well as the response(s) and role(s) of parents with daughters who self-mutilate. This input is particularly valuable, given the absence of information concerning parents and lack of access to interview parents. The contexts of the semi-structured interviews are discussed below.

3.2.4 Semi-structured interviews

Greeff (2005: 287) states that interviewing is the predominant mode of data or information collection in qualitative research. The researcher conducted semi-structured interviews with seven adolescent girls who self-mutilate as well as with the psychologists. Semi-structured interviews are defined as interviews that are organized around areas of particular interest, while still allowing for flexibility in scope and context (May in Greeff, 2005: 292).

Semi-structured interviews were more applicable, as the questions on the interview schedules focused on the emotional and developmental needs of the adolescent girls. The areas of interest that were covered in the interviews were: participant's knowledge of self-mutilation, in what way it helps them and what their needs are in life. In addition, participants were questioned on possible forms of support, for example what in their opinion would help them to stop the self-mutilation or what practical things they could think of doing instead of self-mutilating. The aim of the semi-structured interviews was to explore the emotions of the participants and to describe the support needed by adolescent girls who self-mutilate in order to put forth guidelines for parents to support such girls.

The questions were formulated on the basis of the literature described in the second chapter. This literature explored the phenomenon of self-mutilation and focused on reasons why an adolescent would self-mutilate. Hence the questions on the semi-structured interview schedule explored the adolescent's knowledge of self-mutilation as well as the ways in which this behaviour helps. The dynamics of the adolescent developmental phase were described in the literature with special focus on the psychological and social developmental needs of adolescents. Thus questions regarding their emotional needs were explored during the semi-structured interviews. Furthermore the literature showed that self-mutilating behaviour was a prevalent problem-affecting adolescents, and that parents were at a loss as to how to respond to the crisis of self-mutilation. Yet there was a lack of information concerning the impact of SMB upon families. Hence the questions on the semi-structured interview schedule for the psychologists explored the prevalence of the problem their experiences of self-mutilation amongst adolescent girls, as well as the dynamics of SMB and the ways in which parents react to it. Their suggestions as to what parents could do to assist their daughters in stopping the behaviour and their views on how parents sometimes exacerbate the problem of self-mutilation were explored.

The interviewer was guided by the sets of predetermined questions on the interview schedules, rather than dictated by it and the participants were allowed to introduce issues that were not on the interview schedule. Allowing there to be flexibility in the interview enabled the inclusion of other areas that participants wished to discuss, such as the experience of inadequacy and worthlessness. The semi-structured interviews with the adolescent girls were conducted over a period of six weeks. The interviews were conducted during school hours and took place within the guidance counsellor's office where there is privacy.

For the purpose of transcribing the data, a voice recorder was used. The parents completed consent forms (see addendum B) prior to the adolescent interviews and the participants were informed and verbally agreed to the recording of the interview. The psychologists completed a consent form (see addendum C) prior to the interview. Data was collected and saturation was reached. The time spent per interview varied between forty and sixty minutes per participant. This did not include the fifteen-minute orientation to the interview, which explained the reasons for the research, the aims, purpose and scope of the study, and how the information would be used. The researcher made assurances regarding the confidentiality and anonymity of responses by reading through the consent form with each adolescent and explaining the concepts of anonymity and confidentiality to her before the interview began. At the end of each interview orientation the adolescent participant was reminded that she could stop the interview at any time if she felt uncomfortable. Following the interview, a debriefing session took place. The debriefing session varied between thirty and sixty minutes. Participants were thanked for their contribution and informed once more of the subsequent stages of analysis.

3.2.5 Interview schedules

The questions of the interview schedules were used as a guide only and where applicable, the researcher raised clarifying questions related to the responses of the participants. The interview schedule for the adolescent girls comprised the following questions:

- What do you know about self-mutilation?
- In what way does self-mutilation help you?
- Tell me about your needs in life?
- Tell me about your needs in order to stop self-mutilating?
- Tell me about possible practical things to do instead of self-mutilating?

The question schedule for the psychologists was compiled with the following questions:

- Please tell me about your experience with self-mutilation amongst adolescent girls and the way in which their parents react to it?
- Have you seen an increase in self-mutilation? If yes, to what would you attribute this?
- According to you, what are the dynamics behind adolescent self-mutilation?

- From your experience what do the parents do to exacerbate the problem?
- What can the parents do to help the situation?

3.3 TRUSTWORTHINESS OF STUDY

The authors Marshall and Rossman state that all research must respond to canons that stand as criteria against which trustworthiness of the study can be evaluated. In order to allow for trustworthiness, certain constructs of credibility, transferability, dependability and conformability must be adhered to (Grinnell & Unrau, 2005: 426). These constructs of trustworthiness are discussed below.

3.3.1 Credibility

Credibility, according to Lincoln and Guba (in De Vos, 2005: 346) is a “qualitative” alternative to internal validity. In their view, a credible research study is conducted in such a manner as to ensure that the subject is *accurately described and identified*. The authors state that a qualitative study that aims to explore a problem or describe a setting, a process, a social group or a pattern of interaction will be perceived as “valid” if the process is credible. An in-depth description of the variables and interactions will be so embedded with data derived from the setting that - within the parameters of the research setting, population and theoretical framework - it will inevitably be seen as valid (De Vos, 2005: 346). The researcher has stated the parameters of the study, by stating the criteria for participant selection; thereby placing boundaries around the study in order to ensure credibility.

3.3.2 Transferability

Transferability is proposed as the alternative to external validity, in which the task of demonstrating the applicability of one set of findings to another context rests more with the researcher who would make the transfer than with the original investigator (Lincoln & Guba in De Vos, 2005: 346). A qualitative study’s transferability to other settings is seen by traditional canons as problematic. De Vos (2005: 346) proposes that to counter challenges, the researcher can refer back to the original framework to show how concepts and models guided the data collection and analysis. By doing so, the researcher states the theoretical parameters of the research and those who design research studies within those same parameters can then determine whether or not the cases described can be generalized for new research policy or transferred to other settings. The author further states that an additional strategic choice can

enhance a research study, namely that of *triangulation* of multiple sources of data. Data from different sources can be used to corroborate or elaborate the research in question. The researcher sought to design a study in which multiple cases, and multiple informants were used, namely psychologists working with adolescent girls who self-mutilate and adolescent girls who self-mutilate, in order to strengthen the study's usefulness for other settings. The findings, however, could not be generalized to cases or populations that stand outside the stated parameters, e.g. adolescent males with SMB.

3.3.3 Dependability

Dependability according to De Vos (2005: 346) is the alternative to reliability, in which the researcher attempts to account for changing conditions in the chosen field of study as well as changes in the research design due to refined knowledge of the setting. In order to be reasonably sure that the findings would be replicated if the study were conducted with the same participants in the same context the researcher made sure to follow specific criteria during the data collection process, namely that of suspension of personal prejudices and biases, systematic and accurate recording of the observations, establishment of trust and rapport with the interviewees and optimal conditions in terms of location for the collection of data.

3.3.4 Confirmability

The final construct is *confirmability*, which captures the traditional concept of objectivity. Lincoln and Guba (in De Vos, 2005: 347) stress the importance of asking whether another could confirm the findings of the study. By doing so, the authors remove evaluation from some inherent characteristic of the researcher (objectivity) and place it squarely on the data. In order to avoid threats to confirmability and credibility, the researcher based the interview questions on literature, did not make use of biased sampling, continued with interviews until saturation was reached and did not make use of conclusions that are not supported or grounded in the evidence. Furthermore, no use was made of unfounded questions, or leading questions and participation in the research was entirely voluntary. During the empirical study, the researcher fulfilled the role and requirements of researcher, and not that of a practitioner. The researcher did however support the adolescent girls with a thorough debriefing session after the interviews were conducted and follow up sessions with the guidance counsellors.

3.4 DATA ANALYSIS

According to De Vos (2005: 333) data analysis is the process of bringing order, structure and meaning to the mass of collected data. Qualitative data analysis is a search for general statements about relationships among categories or information, and it builds grounded theory (Marshall & Rossman in De Vos, 2005: 333). Following these authors, the data was analyzed by identifying patterns and themes in the data and drawing conclusions from them. De Vos (2005: 334 – 339) described five steps that can be taken in the process of data analysis: managing of data, reading and writing memos, generating main categories and themes, coding of data and testing emergent understandings. The last step also includes the important task of furnishing “alternative explanations” (*ibid*).

3.4.1 Managing of data

All consent forms were filed in a ring binder prior to the start of the interviews. The hand written field notes made during the interview process were filed with the consent forms for each individual participant on completion of every interview. On completion of each interview, the interview was then transcribed. The interview information captured on audio files was then converted into texts, which is known as transcription. Transcribing interviews offers a point of transition between data collection and analysis, as part of data management and preparation (De Vos, 2005: 336). The researcher completed all interview transcriptions, which provided the necessary opportunity to become immersed in the data and generate emergent insights. The transition between data collection and analysis allowed for continuous fine-tuning in the collection method, namely by revising the data collection procedures. The data was thereafter marked and separated into three files, namely consent forms, handwritten data collected during the interviews and the transcribed interviews.

3.4.2 Reading and writing memos

The preliminary data analysis began by repeatedly reading through all the field notes and transcripts. Marshall and Rossman (in De Vos, 2005: 337) state that “*reading, reading and reading once more through the data forces the researcher to become familiar with the data in intimate ways.*” The authors state that during the reading process the researcher can list the data available on note cards, perform the minor editing necessary to make field notes retrievable, and organize further data. This process of reading and reading through the transcripts and field notes provided the researcher with an overview of what was collected and notes were made in the margins of the transcripts to identify preliminary themes.

3.4.3 Generating main categories and themes

Generating categories, themes and patterns in the data is the most difficult phase of the data analysis (De Vos, 2005: 337). This is an analytic process, whereby the researcher makes comparisons, looks for categories and identifies themes. During this phase the researcher continued to read and re-read through the transcripts, which allowed for identification of main themes, recurring ideas and language. Annotations were made in the margin of the transcripts identifying keywords to the themes that were emerging. The researcher also used different colors to mark the data related to the different main themes. Table 2 below illustrates the development of provisional themes. In this case, an extract from a transcript is presented on the left hand column and the themes identified are presented in the right hand column.

Table 2: Development of provisional themes

<p>Participant C</p> <p>I mostly cut myself when I was angry, irate angry or blind angry. Also frustrated or sad but most of the times anger. It helped me. It was like instantaneous the feeling of calmness that I would feel and people would say go for a run, ride your bicycle, punch a bag but its just nothing compares to that. It was like a drug, it calmed me down, I could see clearly again. I was rational again, it made me feel better.</p>	<p>Feelings of anger, frustration and sadness – Anger.</p> <p>Served function: provided relief/calm – helped me.</p> <p>Others didn't understand.</p> <p>First choice of coping mech - like a drug - addiction</p> <p>Irrational - lacking coping mechs</p>
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3.4.4 Coding of data

The different themes were then further coded by marking the data that was collected on each theme in order to extract a number of sub-themes. Therefore after completing the above stage of analysis for each transcript, the researcher examined the different themes and key words for evidence of convergence across the differing transcripts in order to identify an overarching theme and set of sub themes that was relevant for all the participants: for example, the main shared theme that self-mutilation serves a function, which was identified as being important in all the transcripts.

3.4.5 Testing emergent understandings and alternative explanations

The researcher began this process by evaluating the developing themes and exploring them throughout and across the gathered data. The researcher had to determine how useful the data was in illuminating the questions being explored and how central it was to the unfolding story of the social phenomenon of adolescent self-mutilation (cf. De Vos, 2005: 339). As the researcher discovered patterns and themes in the data, the researcher had to engage in critical challenge of the very themes that seemed so apparent. This was followed by questioning whether the data provided could be linked to any other explanation or motive outside of the research parameters. Marshall and Rossman (in De Vos, 2005: 339) state that since alternative explanations always exist, the researcher must search for, identify and describe them and then demonstrate why his/her own conclusions are more plausible or preferable.

3.5 RESEARCH FINDINGS

The research report is structured by first listing all the main themes and sub-themes that were identified during the analysis. The data that is found to be relevant to the various main themes and sub-themes is then provided in transcribed form. To facilitate easy reading during the description of the empirical data, reference to “the adolescent” is made only when referring to the “adolescent who self-mutilates”. The themes are discussed below, in no particular order of importance or priority.

3.5.1 Self-mutilation serves a function in the adolescents’ lives

The adolescents all explained that self-mutilation serves a function(s) in their lives. All the adolescents felt that self-mutilation helped them to cope. From this theme, the following sub-themes were identified:

3.5.1.1 Self-mutilation provides relief from overwhelming feelings

Although it is a self-destructive behaviour, the adolescents all reported feeling relief from overwhelming emotional pain in their lives after self-mutilating. All described self-mutilation as a means to calm themselves when they felt overwhelmed by feelings of anger, sadness, frustration, rejection and despair. **A** felt that “*it’s a stinging pain that just clarifies things. Calm, it really calmed me. It just calmed me.*” **B** noted that after self-mutilating, “*I would feel like I can breathe again, like I am not choking anymore.*” **C**’s experience mentioned that “*it was instantaneous the feeling of calmness that I would feel. It was like a drug, it calmed*

me down, I could see clearly again, it made me feel better.” **D** felt “there is now an outlet for all those feelings you have been feeling and suddenly you just feel ok. It’s like a sense of relief.” Self-mutilation provided relief for all when intense feelings built up. The adolescents described that they felt overwhelmed and unable to cope. However, by self-mutilating they were able to reduce the level of emotional and physiological arousal to a bearable one. **G** describes this process for her as “you stay in a void of no feeling for awhile, afterwards the bad feelings do return but by then you are ok.” **E** felt that she could not adequately describe the many ways self-mutilation helped her and said plainly after many attempts “it just helps me cope.” **F** felt “it makes me feel better...it just releases stress...I really feel much better and calmer.”

Psychologist 1 felt that self-mutilation is a prevalent problem amongst adolescents and that they use it as a form of coping with their problems. She said, “I have been working here for six years. When I first arrived, I had come from treating mostly adults and I didn’t see it much in the adult world. It was a big shock to me to see just how many children self-mutilate. So I experience that there is a very high degree of self-mutilation; it’s a very common way of coping with problems amongst teenagers these days. The most common reason given by these adolescents is that it’s a relief, they sit with feelings, they can’t express those feelings and it’s a way of letting those feelings out, by feeling the pain and by seeing making it visible, making it real, that is how they explain it to me.”

Psychologist 2 felt that self-mutilation is definitely increasing in rate. She said, “in practice I definitely have seen an increase of self-mutilation.” She felt that self-mutilation is a common problem, and not only for youth and adolescents. “I have noticed that younger children (primary school level) are also tending to fall into this self destructive pattern as well.” She said further that the children or adolescents describe self-mutilation as “often being the only thing that reminds them that they are alive or can feel something or it brings relief from tension and this gives them satisfaction in a way.”

3.5.1.1.1 Self-mutilation as a means of venting anger

All the adolescents felt that they have enormous amounts of anger within. They all felt that it was impossible to express outwardly and so they expressed it inwardly by self-mutilating. The self-mutilation serves as a way of venting those feelings of anger. **A** felt that for her “it [self-mutilation] had a lot to do with self-control and being angry with myself and just being

angry.” **B** would self-mutilate when she felt angry or frustrated “*every time I would be angry or frustrated or it was hard to handle a feeling then I would take a razor blade and just start cutting myself.*” **C** felt “*I mostly cut myself when I am angry also frustrated or sad but most of the times I am angry.*” She recalls the first time she self-mutilated was because of an argument that she had had with her little sister “*over something stupid like a magazine and I got so angry. I just wanted to hurt her but instead I hurt myself.*” **D** had a similar experience as the first time she self-mutilated was because of feeling angry toward someone, “*I was just very very angry, I was just very very angry with someone . . . Instantly it felt better, it felt better than sitting there with all that anger.*” **E** felt that although “*I had other ways of expressing emotional pain, cutting was more of a way for me to express myself, to express anger, rejection and depression...*” **C** and **E** felt unable to control their anger. **C** described her anger as “*an anger that you can’t conquer*” while **E** described herself as a “*suicide bomber, press the little red button, just press it once and I blow up.*” **F** felt that self-mutilation helps her to cope with her angry feelings, as “*I don’t feel so angry anymore.*” The target of the adolescents’ anger is just as likely to be herself, as any other person. However self-mutilation is used to deal with both forms of anger.

3.5.1.2 Self-mutilation as a means of expressing emotional pain

All the adolescents felt that self-mutilation allowed them to express emotional pain in a way that no amount of words could do. The participants described their emotional pain as “*inner pain and rage*”, “*ball of tension*”, “*blind fury*” and “*depression.*” They all felt that these feelings or tensions were too much for them to bear, resulting in the majority of adolescents (5) self-mutilating at school. Although the adolescents were unable to pinpoint the source of their emotional pain, they all felt that self-mutilation created a physical pain for the emotional pain they were feeling. **A** associated her SMB with a social predicament: “*when you are an emotional introvert and there is so much going on inside but no one to talk to*”. The only way she was able to cope was by self-mutilating as this act allowed her to feel a sense of control and release over her emotional pain. **G** felt similarly “*there are too many things affecting you and it [self-mutilating] is a way of releasing them. There is too much within you for your body to hold [emotions] so you want to let it out.*” **B** felt “*I was feeling pain inside me like in my heart and I just wanted to feel physical pain instead of that emotional pain.*” **D** described her self-mutilation as “*a short term solution to a problem of emotional issues.*” She felt that the self-mutilation provided her with an outlet “*there is now an outlet for all those feelings you*

have been feeling and suddenly you feel ok, you feel fine.” E told the researcher, “it feels like when I cut that I can release just a bit of the emotional pain.”

Apparently, all the adolescents felt that it was easier to handle the physical pain of self-mutilation than to deal with the overwhelming emotions that they felt. **B** felt *“its easier to handle physical pain than emotional pain. It was so much better feeling that pain, than some weird feeling that you didn’t understand.”* **E** felt similar and said that *“I would rather feel the physical pain, cause the physical feels better to me than the emotional pain as the physical lasts for only awhile while the emotional pain feels like it can last for decades of your life.”* **D** described how the self-mutilation *“felt better than sitting there with all that anger.”*

Psychologist 1 said *“my experience of self-mutilation is that it’s a way of getting rid of the feelings without them being able to identify the feelings. They don’t really understand why they feel the feelings they feel. When you ask them, ‘but why would you need to cut?’ They say, ‘well I need to get rid of feelings’ and you ask ‘why do you have the feelings?’ They can’t say why, they are just stuck they can only say, ‘I feel’. They can only say that it’s a relief so our job is to help them understand when the feelings first started and to help them to talk about them and that’s why we have so many family sessions because after that they have to be able to tell their parents.”* She felt strongly that even though the adolescents with whom she works are often unable to identify their feelings or understand why they self-mutilate *“there are always concrete reasons for why a child is cutting herself.”*

3.5.1.3 Self-mutilation as a means to communicate inner pain to others

The majority of the adolescents (5) felt that by expressing their inner pain through physical means, that others would understand the depth of their emotional pain. **B** felt *“people don’t understand when you say that you have emotional pain, they are like what? But they understand physical pain.”* **D** felt that she could not talk to her mother about the hurt and anger she was feeling and stated that *“now your heart is broken but you can’t really show this to your mother, it’s not real [visible]. It’s an emotion but once you cut yourself its real, there is pain. There is an actual pain, it’s not just that my heart was broken.”*

All the adolescents felt that they did not have the words to describe the depth of emotional pain and/or rage that they felt. Furthermore for all the adolescents this was the first time that they *“thought”* about why they self-mutilated. The adolescents were often unable to identify

their feelings or the events leading up to their feelings, and when they could identify these aspects they were still unable to stop self-mutilating. **C** felt that she could give no verbal explanation of the reasons why she self-mutilated – not even to herself. She felt *“there are reasons that need to be voiced that cannot be said in words.”* **A** felt that self-mutilation *“was tangible as an expression of your emotion that you could see this wound in comparison to talking about how depressed or angry you were and you are not sure how to express yourself verbally for fear of judgment as people might not understand you.”* Thus, self-mutilation for the adolescents can be viewed as a means of communicating inner pain to other people, when the adolescents felt that there were no other ways available for this.

3.5.1.4 Self-mutilation as a means to communicate a need for support

All the adolescents felt that they had communication problems with their parents and that verbal communication of their emotional needs was difficult. The adolescents expressed a need to be able to talk to someone who would accept them without judgment. They felt that it was impossible to talk to their parents for various reasons namely, that their parents do not understand them or take them seriously; for fear of disappointing them; fear of angering them; a need to protect them; lack of time; or a lack of trust. Trust, it seemed, had been undermined by conflict or criticism, as well as the adolescent's inability to articulate their emotional problems. **A** felt as if her parents did not notice her. She said, *“I would like to be noticed and not criticised or judged so much.”* She felt that she really needed to be able to talk to her parents *“because when you can't then things just fester.”* She further felt that *“you want someone who is able to give advice, someone who is able to talk with you and not at you. You would like to be taken seriously and most of all you want someone to be on your team.”* She also felt that if she had someone to talk to it would have helped her to stop self-mutilating. **B** described needing warmth, love and support. She said, *“When I am struggling to do something or get out of a problem I need to know that someone cares. It's that I know there is someone to run to, someone who cares.”* She felt that this person can be a teacher, a friend but above all *“especially a parent.”* **C** however, felt that her teachers and high school peers were not concerned for her *“I felt like they did not care, that it was not sincere.”* She did feel that it is important to *“talk to your family about how you feel, even though it is hard, it makes it better getting out of it [self-mutilation].”* **D** felt *“I think it would have helped if I felt like I could go to my parents, if I felt like I could have talked to someone”.* She felt further that her friends were not able to provide sufficient emotional support or helpful advice. **E** felt plainly *“my need is to be accepted by my family instead of rejected, you know [for them to] try and*

understand me. Maybe if people listened to me at home and if there was less favouritism.” (She is the eldest child and often has to take care of her younger sisters). **F** felt that her mother did not understand her at all. She also felt that she needed to be listened to and said, *“my needs in life are to be noticed, to be listened to and to have support.”* She also felt angry when her mother teased her about her self-mutilating behaviour or choice of clothing or hairstyle. She said, *“my mom calls me her little emo kid or worse, now I get it at school and at home. Sometimes she says it as a joke in front of other people, cause I dyed my hair black and I have piercing.”* **G** felt that her parents make a joke of her self-mutilation, *“my mother makes a joke of it and my dad makes a joke of it. Every time my mother picks up a knife she says like ‘here you should use this one its sharper and you can cut yourself’.”* She felt that this situation *“is impossible to laugh off”* and that *“the whole point of telling them was to get help and all they are doing is creating worse effects.”* She felt further that she had no way of talking to her parents about how she felt, *“I have never been able to talk to them. I realised that I was alone and I had to deal with it”*.

In answer to the question of how parents exacerbate the problem of self-mutilation, Psychologist 1 felt partly that it is *“when a child is not taken seriously or when they are neglected, particularly emotionally neglected. When they sit with problems and nobody hears them or notices or sees and their behaviour is clearly showing there is a problem and the parents do not see it. I think a lot of the parents really don’t know what to do. They are not bad parents they just don’t know. And what parents really need to do is to be able to listen, to be able to know how to listen, that is not judgmentally, not giving advice, no trying to fix it just being able to hear.”*

3.5.1.5 Self-mutilation as a means of expressing and coping with feelings of alienation

The adolescents expressed a keen need for acceptance and belonging. Every adolescent felt misunderstood, believing that she was rejected or did not belong or fit in at school. **A** felt *“I didn’t fit in, for my first two years of high school I would take a book and go read during breaks. When I did make friends we were the outsider group. We were like rejects.”* **C** said, *“I have always felt like a social outcast.”* She described how that feeling of not belonging *“makes you feel like you are not good enough...feeling like I don’t fit in here [school] there has to be some major flaw in me.”* Even though **D** *“was part of the cool crowd”* she felt *“as though I was an irrelevant member of the group, like I never quite fitted in.”* **E** felt *“I feel like I don’t belong I cut just to know that I am still bleeding and then maybe I do belong as*

everyone bleeds.” **F** felt that she does not fit in at school “*I don’t fit in at all.*” She said that she is “*friends with the emo kids at school. Emo is emotional, they like listen to bad music, they wear black skinny jeans and they cut themselves and they wear hardcore punk tops and have black hair and they are always depressed and they hardly ever talk or smile.*” She and her friends are teased and bullied at school. She felt that “*if there was not so much trouble at school, like people teasing, you know those emo names and all*” that it would help her to stop self-mutilating. According to **G**, “*I am the class freak, at least my class thinks so. I feel alienated and I spend my entire life trying to be invisible.*” She spoke of having friends “*who are at war with one another*” and constantly expecting her to choose sides, which leaves her feeling more isolated.

Psychologist 1 felt that self-mutilation appears more in adolescents who feel alone, misunderstood and isolated. She remarked: “*to a certain degree it’s quite popular, it’s almost like a bond, and often this is with teenagers who feel quite alone and misunderstood and it’s a kind of connection with their friend.*”

Psychologist 2 felt similar, that “*self-mutilation has become the ‘in thing’ to do and when one starts doing it, cutting, then others often follow.*”

3.5.1.6 Self-mutilation as a means to validate emotional pain

Some of the adolescents (4) felt that the scars served as evidence that their feelings of emotional pain were real. **A** felt “*it’s also the healing process, to know exactly how you felt when you made that cut and then to watch it fade or heal is like having something tangible as an expression of your emotion.*” **B** agrees with this and she describes how it relieved her to know that she had managed to “*survive those feelings*” and “*I would constantly be looking at those scars. I would look at them the entire time and I would feel like I could breathe again.*” **D** felt “*it [self-mutilation] made it [emotional pain] a physical feeling. It wasn’t real, it was only an emotion and once you cut yourself its real, there is pain.*” **E** said when she feels as if she does not belong, “*I cut just to know that I am bleeding still and then maybe I do belong as everyone bleeds.*”

3.5.1.7 Self-mutilation as a means of punishment

The adolescents felt very unworthy and depressed. The majority of the adolescents (6) described how self-mutilation was an attempt to punish themselves. **A** said that she was

always *“angry with myself. I always felt like I wasn’t good enough and it was sort of a punishment.”* C felt *“I was angry at myself and I thought that I needed to be punished for being a bad person for having these thoughts.”* D felt that the whole point of cutting was to hurt herself *“that’s kind of the point.”* E said *“I cut when I am feeling like I never did enough, not being able to make other people proud, not being able to help other people, feeling like you are just worthless, feeling like you just can’t do anything right.”* F felt that she self-mutilated in order to *“to give myself pain.”* G felt as if she *“wasn’t even part of the plan. My parents only married because I was born but they planned for my brother. They wanted my brother.”* She felt she was of little consequence to her parents. When she felt these painful feelings of unworthiness then she would self-mutilate.

Regarding the dynamics of self-mutilation amongst adolescents, Psychologist 1 reported that sexual abuse plays a huge role. *“In sexual abuse these young girls’ boundaries have been crossed from an early age and they think they are bad, they feel dirty, they feel guilty and they want to punish themselves. They don’t like their bodies, they hate their bodies and they hurt themselves.* She felt that sexual abuse is one dynamic of self-mutilation, and *“another dynamic is the issue of worthiness and low self-esteem. This is the reason with victims of eating disorders, in both cases the feelings of unworthiness are there.”*

Psychologist 1 felt that children are under a lot of pressure, which results in them feeling stressed or anxious. There is often chaos in the home and the child usually has to act like an adult, *“they have often had to become an adult early on and they don’t have parents that they can talk to.”* She experienced that self-mutilation is also due to *“the personality disordered type with intense mood swings, feelings of emptiness, feeling as if their needs are never met.”* She felt that personality disorders are one dynamic. Other dynamics of adolescent self-mutilation are the chaotic and conflict filled home, then the “adult child” who feels an intense sadness, and the “silenced” child. She reported the latter as emerging *“when there is a very strict right and wrong moral code and these children are just silenced. There is almost any reason for why they would cut because they can’t express their feelings. And these feelings are for many different reasons.”* Her experience was that *“there are other reasons to, there are always concrete reasons for why a child is cutting herself.”*

3.5.1.8 Self-mutilation as a means of exerting control over ones self

Three adolescents described self-mutilation as a way of empowering themselves. They felt strong and in control as they endured the pain that they inflicted on themselves. **A** felt *“cutting myself would be a test of my self-control.”* Self-mutilation gave her a sense of self-control as she would have to control the knife, how deep she cut herself and *“for me self-mutilation was gaining back control over what I was feeling.”* **G** felt similarly as self-mutilation gave her a sense of control over her emotional pain as she controlled how much she cut and how much it hurt. According to her she *“used to use a blunt knife because it takes longer to make a cut. Now I use a really sharp instrument and as soon as you have cut you hold it closed for a few seconds just to allow the blood to clot, then you won’t feel as much pain.”* For **B** self-mutilation allowed her to control her feelings of mounting anxiety, *“when I felt like I couldn’t breathe then I would go for the blade.”* After she cut herself, she was able to focus on another sort of pain, *“you do feel the pain of cutting, I felt the pain.”*

3.5.1.9 Self-mutilation as a means of exerting control over and punishment of others

C said that at times she self-mutilated in order to punish others. *“When my dad tells me no, you are not going to, we don’t want you to. Then I get angry and I think sometimes that cutting myself is my way of punishing him.”* **F** self-mutilates *“because of problems at home, my mom and everything.”* She has a conflict-ridden relationship with her mother and discipline is a problem. *“My mom and me fight constantly and she just doesn’t understand me. . . on week-ends when I want to go out with my friends, she tells me no because you don’t listen. . . she doesn’t like me to have a lot of freedom but I don’t care I still take my freedom. My mom doesn’t let me go to parties but I still go to parties.”*

Psychologist 1 felt that *“there is also a lot of power or manipulation involved in cutting. When mom becomes so scared that daughter will hurt herself if she is sad or angry in any way and then they [parents] give in which is wrong. The child is able to use the self-mutilation as ammunition.”*

3.5.1.10 Self-mutilation as a means to prevent suicide

All the adolescents explained that self-mutilation was never an attempt to commit suicide. **A** felt that *“when you are in the action of doing it, you stop and think that I am not going to be silly about this [self-mutilation] it would be stupid to die from cutting.”* **C** said *“I didn’t ever have the intention of killing myself by cutting.”* However, she described a fear of losing control. *“There were times when I just carried on and on [cutting] and I didn’t want to stop*

but I knew I have to because I don't know where this is going to go [suicide]." F also expressed this fear of losing control in her response to the question of when to stop cutting during an episode of self-mutilation? She said, *"I don't. I just go on and on until there is blood everywhere and then I know when to stop."* Although she did not use self-mutilation as a means to commit suicide she has been to a clinic *"for cutting and trying to commit suicide."* E explained that by self-mutilating her intentions were never to kill herself but rather *"it is almost as if you are trying to make yourself feel better."* She felt that *"I am very careful when I cut. I usually cut on the outside of my body as there are no main veins or anything there that is possible to kill me."* She said *"I didn't use self-mutilation to commit suicide but I used another form, tablets, until I got involved with a counsellor."* She felt that *"self-mutilation is caused via the depression and via your circumstances and that from that it could seriously go suicidal."* G also described that she had attempted to commit suicide although suicide was never her aim when self-mutilating, *"usually you cut above your main arteries just to see it bleed."* Her response to the question of had she ever intended to commit suicide while self-mutilating was *"no, not then but I have tried a lot of times before."* There can be no doubt that these adolescents pose a suicide risk and are in need of intervention on that basis.

Psychologist 1 felt *"surprised at how parents seem to not completely freak out"* when they find that their daughter is self-mutilating. She experienced that most parents were apathetic towards the self-mutilation, *"they [parents] say that my child cuts and I don't understand and it's strange but they don't really react. I find that the parents don't even remove sharp objects from their child, they still allow the child to spend a lot of time alone or don't get the child immediate help. These children are often cutting for a long time before the parents get help. And they certainly don't understand it."* Her reasoning for the parents' lack of reaction was *"a lot of the parents don't know, the parents don't know about the self-mutilation until they arrive here and often maybe the calmness is because they know they are getting help."* She also felt that many parents don't know about the self-mutilation: *"I don't think that this is an attention seeking thing because if it was then the parents would know about the cutting."*

3.5.1.11 Self-mutilation as a means to end a dissociative episode

Four of the adolescents said that at times they felt *"emotionally dead"*, *"switched off"* or were suspended in a *"void of no feeling."* They further described a fascination with the blood that their cuts produced and said that they no longer felt pain when self-mutilating. C answered that while she was self-mutilating it did not hurt her. She said, *"not at all, I would*

only feel it the next day. It was a little bit of a sting but it wasn't pain.” E said, *“when I cut I am emotionally dead, completely dead, not just emotionally dead completely dead. I am not there.”* F said that when she first began to mutilate she did feel the pain however she feels no pain when cutting herself now. She said *“the first time it was sore but now when I cut myself I don't feel the cuts anymore. It's like my body has done something because when I cut I don't feel pain anymore.”* G mentioned that the self-mutilation *“didn't really hurt.”* She felt that it was due to her knowledge of how to apply pressure to a wound that made this so. She said further that when she self-mutilates she remains in *“a void of no feeling.”* She described this void as feeling *“spaced out”*. She enjoys feeling spaced out as it gives her a *“moment of peace”* from her emotions. She said that only after remaining for some time in this *“spaced out void”*, would her feelings return to normal *“but by then you are ok.”*

B described the time her parents discovered her after a particularly bad episode of self-mutilation. *“I was really out of it and I started cutting myself at home. And my mom and dad had taken my sister somewhere but when they came home I was unconscious or something, I don't know, I was really out of it. They found me lying in the blood and they took me to the doctor.”* She described feeling *“really out of it”* and recalls that she has no memory of the incident.

Psychologist 2 felt that often a child or adolescent self-mutilates because of *“feelings of emptiness and wanting to stop feeling that way. After the self-mutilation the child or adolescent no longer feels those feelings.”*

3.5.1.12 Self-mutilation can become addictive

The majority of the adolescents (6) have cut a minimum of twenty times and they all felt that it was their preferred form of coping with overwhelming feelings. **A** described how the longing to self-mutilate would build up inside her like a volcano. *“The feeling would start and then it would reach a level where you had to go and cut. It would reach cut off time, like a volcano exploding.”* **B** said, *“I did think about it [self-mutilation]. I would just want to do it. It was like a normal thought to me and I would think about doing it, even at school sometimes. I would cut myself in the bathrooms if I was feeling pressured.”* **C** felt that it helped her immediately and that it was her first choice of coping with her feelings, *“it was instantaneous the feeling of calmness that I would feel and people would say go for a run, ride your bicycle, punch a bag but that is nothing compared to the calm it [self-mutilation] brings. It was like a*

drug, it calmed me down.” The prospect of giving it up seems unthinkable to **E** “*when I feel this small and hurt you can forget about talking to me as I know I am going to get those blades.*” She further said that “*it used to hurt in the beginning but it doesn’t anymore.*” Both **C** and **E** expressed fear at the thought of no longer being able to self-mutilate as a way of coping. Adolescent **F** describes her relationship with self-mutilation in compulsive terms: “*I don’t think there is anything that can stop me. It’s like an addiction. If I don’t cut then I get these urges to cut myself, its weird.*”

Psychologist 2 felt that the relief, which the SMB provides often, makes it difficult for the child or adolescent to stop the behaviour. She said, “*the more they want to avoid doing it the more they feel the urge to do it as it is the short term solution to dealing with their distress.*”

3.5.1.13 Self-mutilation as a means of gaining attention

The majority of adolescents (6) described their self-mutilation as “*private*” and not as a means to gain attention. **A** felt that “*it was never about the attention for me, I was never wanting people to look at me and feel sorry for me, it was a private thing. I never talked to anyone about it.*” **D** did not want anyone to find out about her self-mutilation and mentioned “*when I started doing it on my hands it got too hard to hide. I would start on my arms again but it was ridiculous because it was boiling outside and I was always wearing a jersey.*” She felt it was like trying to hide a “*hickie.*” **E** said, “*I don’t cut for attention. If I cut for attention then I would wear string tops every day of my life showing off every cut on my body.*” Instead she wears long sleeves and long pants throughout the year. **F** felt that talking about her self-mutilation was “*really embarrassing*” as she does not talk about it with others “*this feels really embarrassing talking about it cause I don’t usually talk about the cutting with people, I don’t even do it with my friends.*” **G** explained that people who self-mutilate cut themselves on parts of their body that are easily hidden and usually wear long sleeves and do not wear shorts. She described that when self-mutilating “*technically you want to get ride of the evidence. You have to hide it at home as you don’t want to be discovered.*”

B felt differently to the others, claiming that she did not mind the attention and in fact almost courted it. “*After I cut I would wear long sleeves, I would just leave the blood and roll down the sleeves. If blood was running down then I would wipe it but if there were little stains I would leave it.*” She also explained how she would look at the scars the entire time [during school] as confirmation of her feelings. She would also self-mutilate during school and she

said “*people noticed that I was always wearing long sleeved tops when it was hot, they noticed.*” She felt that at times it was really difficult hiding the self-mutilation and she would invent the weirdest stories to explain the scars. She said, “*there came a time when everyone found out I was cutting, it all just clicked.*” She felt that the school was sympathetic to her needs and allowed her to leave her classes if she felt overwhelmed and she enjoyed this freedom.

Furthermore four adolescents mentioned that there were many others who self-mutilated in their schools and that they saw it as a real problem with “*everyone’s doing it*”. Some of the adolescents expressed feeling a sense of disgust at those who would self-mutilate for attention while another adolescent felt concern for a friend who had begun to self-mutilate. **G** felt that “*people have no idea how many people cut themselves.*” **E** described how “*you get those who are willing to cut to copy you and I know some of those. She was trying to be all Goth until I told her, ‘excuse me but its actually emo to cut’. But she would cut in places for everyone to see and I would tell her, ‘but you are seeking attention’.*” **E** felt disgust towards this particular girl as she viewed her self-mutilation behaviour as attention seeking. During the debriefing session **F** mentioned how she was concerned about a friend of hers who had begun to cut. She said, “*and I told her that it was wrong, that she does not want to get into this because it does not make things better.*” **F** then sought advice from the researcher on how to dissuade her friend from self-mutilation.

3.5.1.14 Summary

Self-mutilation is clearly a sign of a troubled individual. A common misperception, however is that adolescents who self-mutilate are cutting themselves in an attempt to commit suicide. From the interviews in this study, the opposite appears to be true: the adolescents are self-mutilating in an attempt to provide relief from overwhelming feelings as well as to vent intense feelings of anger and to express emotional pain. While the suicidal adolescent seeks to end her life and her painful feelings, the adolescent self-mutilator is attempting to feel better and cope with her painful feelings. The wounds are typically not life threatening, for example on the upper forearms, inner forearms and inner thighs or torso as opposed to fully slitting their wrists. However, this does not mean that suicide is not a concern as at some point the majority of adolescents in this study have contemplated suicide or tried to harm themselves more seriously or may still do so in the future, and besides, the SMB is dangerous. Clearly, for all of the adolescents SMB serves a function in their lives at times of emotional crisis

when their coping skills are poor; but despite undeniably serving to protect the psyche against intolerable pain, it is not a reliable safeguard against suicidal feelings or gestures.

Self-mutilation thus seems to be a maladaptive coping behaviour that fulfils a multitude of needs in the adolescents' lives. From this study it seems as if the adolescents are unable to *regulate or control their emotions*. They experience intense emotions and are then driven to find relief from these overwhelming emotions. Self-mutilation can serve as a means to relieve intolerable emotional pain, to express anger, to express emotional pain, to communicate inner pain to others, to communicate a need for support, to cope with feelings of alienation, to validate emotional pain, as a form of self punishment, to exert control over oneself and over others, as a means to prevent suicide and to end a dissociative episode. The adolescents are not attempting to manipulate others around them or obtain attention through their behaviour; instead they are trying to express what they cannot put into words through the self-mutilation. Furthermore the adolescents are unable to identify their feelings or why they feel this way and often explained that they self-mutilate because it helps them cope or feel better. The younger adolescents were unable to link the events preceding the act of self-mutilation to the actual self-mutilation, so it seems that they do not think in a logical manner. SMB helps the adolescents to regain a sense of control over their feelings; however, they are clearly not in control. Rather, the behaviour seems to be controlling them. The adolescents are unable to stop on their own and professional help is needed to address the behaviour and underlying cause.

3.5.2 The adolescents feel a deep sense of shame and guilt

The adolescents all experience shame, social stigma and guilt regarding their self-mutilation. Every one of the adolescents felt the need to hide any evidence of their self-mutilation as well as the scars; even **B**, who had an impulse to show off her scars, displayed ambivalence about this. The majority of the adolescents (6) explained that they did not self-mutilate in order to gain attention; instead they described the self-mutilation as something that they did in private, as a secret behaviour. The majority (6) of the adolescents described the behaviour as wrong, stupid and horrible. **A** experienced her self-mutilating as *“now that you think about it, it does sound like a stupid thing to do, cutting yourself”*. **D** felt that *“you know you shouldn't be doing it, you know it helps but its horrible”*. **F** described how the self-mutilation *“actually makes me feel ashamed when I talk about it and I do need help”*.

All the adolescents had feared that their self-mutilation would be discovered. The shame and social stigma are further illustrated by their reported need to hide not only the behaviour but the scars as well. All of them felt that it was necessary to hide their self-mutilation from friends and family alike. **A** said *“I always wore my blazer to school to hide the scars.”* **E** spoke of how her father would kill her if he found out she was hurting herself in this way *“If he knew he would kill me so I wear long sleeves and long pants twenty-four seven throughout the year.”* Her father was, in fact, aware of the self-mutilation but **E** still felt it necessary to hide the scars from him, in a reversal of the “imaginary audience” phenomenon. She does not want him to see the extent of her self-mutilation and imagines that he is unaware. **E** concluded this thought by saying *“I know that what I am doing is not the smartest thing on the planet.”* **G**, more straightforwardly, felt that *“you have to hide the scars as you don’t want anyone to know what a stupid irresponsible thing it is that you did”*.

The majority of the adolescents (5) would make up excuses for the scars or cuts on their bodies. **A**: *“I would make up absolutely ridiculous stories that she [mother] would believe, like I was mountain biking and fell.”* **B** did the same. She said *“I would come up with the weirdest of stories, like a dog bit me. I don’t know if they [teachers, friends and mother] believed me.”* **D**'s approach was similar: *“one of my teachers once saw the marks and I made up a story that my kitten had scratched my hand. I know she knew, she knew. She chose not to say anything and if she did maybe it would have gotten worse or better.”* All the adolescents felt that it was difficult to talk about the self-mutilation to anyone, friends and family alike.

3.5.2.1 Summary

There is a sense of shame, social stigma and guilt associated with SMB. All the adolescents who participated in this study attempted to hide the scars, blood or other evidence of their self-mutilation. The adolescents described wearing long sleeved tops, jerseys or jackets even in the heat of summer in order to hide their scars. They made up excuses for wearing these clothes, and if the scars or cuts were discovered, they invented ingenious excuses for these as well. Most of the adolescents felt that the behaviour was wrong and stupid but they did not know how to stop. The adolescents all felt that it was difficult talking about their self-mutilation and the majority (5) said that they had never before spoken openly about their behaviour to anyone, not even to family or friends.

3.5.3 The adolescents have low self-esteem

All the adolescents experience low self-esteem and a low sense of self-worth, amounting at times to active self-loathing. **A** felt that often her self-mutilation was brought on by a chronic feeling of inadequacy and anger *“it was usually brought on by that feeling of not being good enough.”* **C** spoke of having a love hate relationship with herself, saying, *“I have a problem with confidence and self-esteem and I just want to accept myself for who I am.”* She said, *“I don’t want to strive to be a person, um I don’t want to feel like I need that validation from another person. I want that to come from inside of me, that’s what I feel truthfully.”* **D** felt *“I am never the pretty one or the one worth dating. I feel very insecure.”* She felt that these feelings got in the way of her socializing and enjoying life. Both **C** and **D** spoke of their bad choices in romantic partners, the need to feel loved, but they did not expect to feel valued, and this had lead them into *“awful psychopathic”* and *“hurtful”* relationships with men. **E** felt that the emotions she needed to express by self-mutilating were anger, rejection and *“feeling like I am just worthless, like I can’t do anything right.”* **F** felt *“I just wish I could live a normal life...and I had to get all of the opposites, you know bad at schoolwork, not good in sport, my life in front of psychologists.”* **G** felt that her mother rejected her and she tended to blame her self-mutilation on rejection: *“My mother doesn’t show much affection or emotion. A daughter not only needs her mother but she is her biggest role model in life and if a girls mother rejects her daughter then her daughter is liable to do things.”* She felt that *“the way she [mother] treats me is as if she couldn’t care less.”* Consequently **G** felt that she was of little importance or value to the family.

3.5.3.1 Summary

Self-esteem is the value we place upon ourselves. It is our assessment of our worth as a human being, based on our approval or disapproval of our behaviour and selves. Self-esteem is not a single quality or aspect; rather, it is the basis upon which we build our lives. Since we do not live in isolation from others, the way we feel about ourselves affects how we relate to people around us and to every other aspect of our lives. If self-esteem is the assessment of people’s worth as human beings based on their approval or disapproval of their behaviour and themselves, it is clear from the responses that the adolescents do not place much value upon themselves.

3.5.4 The adolescents experience their home life as conflict filled, neglectful and rejecting

All the adolescents felt that they had conflict problems with their parents and that communication of their needs was difficult. Many of the adolescents also described feeling

neglected and rejected by their parents. Four of the adolescents described 'average' to 'normal' conflict problems and disagreements concerning curfews and parties, choice of friends and romantic partners, clothing or academic achievement. However, three adolescents described extreme forms of conflict including "*shouting*" and "*hitting*."

A felt that "*I was a constant disappointment to my parents. Always saying that I was an underachiever.*" They argued over her status as an under-achiever, her sexual orientation, and the parties she attended with under age drinking. She said, "*I would like to be noticed and not criticised or judged so much.*" She felt that she needed to be accepted, listened to and supported. **B** felt that "*there was conflict when I was at school. When I was there every single day, when we are constantly in each others faces that's when conflict arises.*" She argued with her mother about issues regarding food and disagreements between her sisters. Her needs were to be loved, listened to, as well as supported by her family and friends as well as safety. **D** felt "*there was a massive lack of communication with my parents. It was not caused by the cutting as there were other things going on.*" She was lying to her parents about her boyfriend and about parties that she was attending. She felt that she could not openly discuss her problems with her mother, as "*my mother is not a very emotional person so she doesn't really talk about stuff.*" Her needs were to accept herself, to be noticed, to be able to talk to her parents or "*someone who could help*" and to be taken seriously. She concluded by saying "*if I had a better support system maybe I would have thought a little bit more about myself.*"

C's relationship with her parents differs to the others as although she felt "my family makes me angry a lot" she also felt that "*my family knows me and they have never once told me to be any different to the way I am.*" Her needs were to feel accepted, particularly by herself and society. She said "*I just want to accept myself for who I am...so that acceptance thing is not only from the outside world but also from the inside world as well.*" She also felt that she needed to learn to love herself and begin to take proactive steps towards her own recovery.

E's home life is characterized by extreme conflict between herself and her father: "*there are always problems in the household, over religion and money. There is much conflict in the house...if my father would stop blaming me and thinking bad of me, just say something nice, you know to uplift you.*" At times the conflict escalates to physical blows, which she would not describe as abuse "*my sisters can answer back but if I do it he wants to klap me.*" **F** declared, "*we fight a lot...we fight almost every night...one time I pushed her and she hit me*

so I hit her back and it gets really violent.” However she felt that if there was less conflict at home, if her mother understood her better, if she could achieve better grades and if there was less teasing at school then *“I would not do it [self-mutilate] at all.”* G felt that *“there has been war since my brother was born.”* She feels as if her parents have always favoured her brother as he has special needs and her parents have had to lavish attention on him at her expense. She said that her parents used to spend time looking for professional assistance with her brother, *“and during that time I was often just left at home, you know just left.”* She felt that her needs were to belong, to be accepted and to be loved by her parents.

Psychologist 1 felt that often the parents of adolescents who self mutilate are completely without boundaries. She felt that parents need to learn that adult stuff is adult stuff, *“you do not talk to your child about how dad came home drunk. That is adult business and should not be discussed with a child.”* She felt that it is dangerous when the child has to carry so much. She advised *“it’s this crossing of boundaries, not being able to say no to their child, or treating their children as confidants and friends. Parents need to no longer be scared of their children not liking them or hurting themselves. Parents need to set reasonable boundaries and be able to listen.”*

Psychologist 1 felt that parents help the situation of adolescent self-mutilation by listening. She said *“to listen, to listen. To speak with one voice and to be the parents by setting the boundaries for their child but there is a fine line between being too rigid and 'laissez faire'.* *There is often a lot of trauma that happens in the home and you can’t blame the parents. It’s just how it has played out. When parents work against one another then the child gains the power. So we help the parents to take back the power and to speak with one voice and it allows the child to feel safe. Often we find that when the parents take back the power then their child is calmer.”* Another thing that parents can do is to spend time together and do fun things together. She felt that family meals are important, *“there must be at least two sit down meals in the week. Over weekends there must be some family fun time in which they do something together as a family, for instance go play putt putt or go for a walk together, as a family or just mom and daughter or dad and daughter. There is not enough family time together, spending time together.”* She concluded by saying *“parents need to set reasonable boundaries and be able to listen. Parents have to prioritize their children and their roles as parents.”*

Psychologist 2 said *“the parents often get a big fright when they become aware of such behaviour and they do not know how to react.”* She felt that there are many reasons why a child or adolescent would self-mutilate, *“the reason for this behaviour is often a lack of close relationships with significant others, especially the mother figure, the busy lifestyle, high divorce rate, and materialistic attitude are only some of the factors that contribute to such behaviour.”* She said, *“the main focus of attention in treatment is to restore broken relationships and to build a sense of self value. The child or adolescent often feels no sense of belonging and unfortunately that has often started since an early age.”* She felt that parents can prevent and improve the situation by *“taking an interest in their children, spending time with them; do things together to show them that they care and so on.”* She said further *“there is no point to work only on the symptom when one needs to look at the underlying dynamics. One can consider the possibility of medication usually an anti depressant such as SSRI'S (PROZAC) types; in that case referral to a Psychiatrist is necessary. However, each situation is individual and needs an approached tailored to the situation.”*

3.5.4.1 Summary

The adolescents all described having conflict problems with their parents which were further compounded by a difficulty in communicating their needs. They asserted that their needs were to be loved and accepted by their parents and family, to be listened to and understood, to feel a sense of belonging, to have positive quality time with their parents, for there to be less conflict between themselves and their parents, for there to be less bullying at school and to feel a sense of safety.

3.5.5 The adolescents' practical suggestions of what to do instead of self-mutilating

All the adolescents were able to give practical suggestions of what to do instead of self-mutilating. **A** proposed *“journaling, writing about how you feel helped me even if it is dark.”* She also said that listening to music and going for runs or walks helped her, it was even better if she could walk in beautiful surroundings, like in the mountains or in open spaces. She said further that finding something that you can be good at doing, like singing in a choir, playing an instrument helped her to feel better about herself, it gave her a feeling of accomplishment. **B** felt that getting help for herself was important. She said that, *“therapy helped me, it helped me realize I had to stop.”* She felt that the medication she was given helped her as it helped her with her depression. She also felt that it was important to look after herself, to be good to herself instead of disliking herself. She also said that one must, *“try to think nice things about*

yourself.” She felt that it was also important to do good things for herself, like following a healthy eating plan, exercising and to have fun with her friends, like watching a movie or having coffee together. C said that going for a run, riding her bicycle or punching a punching bag did not help her as much as the self-mutilation did. However, she felt that *“having family and friends”* to support her has helped. She also felt that she needed to be better equipped with coping skills, so that she could learn to cope with her feelings. D felt *“I think it would have helped if I felt like I could go to my parents, if I felt like I could have talked to someone.”* She said *“when I am angry or hurt now I cry most of the time. I think about what I am going to do now and then I try to make a decision about what I need to do. I often need to talk about it to.”* She felt that *“it would help if there was someone who could help you make decisions, teach you to make decisions.”* She also felt that *“shouting or running helps, listening to music helps, or playing with my cat or petting her helped me feel better.”* E felt that she was able to mention many practical things to do instead of self-mutilating. She said *“I can think of many, drawing, writing poetry, playing tug of war, karate, getting out of the house, that is probably the best one, removing yourself from your cutting tools, keeping your mind busy, reading also.”* F felt that going to get help from professionals like an educational psychologist or psychologist was helpful, it would help more if her mother addressed the problem *“she doesn’t listen. She doesn’t work it out.”* Her practical suggestions were *“smoking cigarettes, listening to music, chatting with friends, going to a friends house, walking around town with her friends, and petting her dogs.”* G suggested *“reading to take your mind off unpleasant things, going for a walk or going outside to cool off before you blow your top, and being active.”* She felt further that it helped to have a cultural activity or hobby if *“you are not any good at sports.”* She mentioned that *“I am a leader in Scouts and I am learning about how to become a medic.”* She felt that it was *“funny”* because when someone at Scouts has a problem they *“always come and talk to me about it.”* However she has no one to confide in or turn to for advice. The situation appears ironic because she does not feel in control of her own life, and yet she is attempting to lead and to support others.

3.5.5.1 Summary

The adolescents gave the following practical alternatives to self-mutilating: getting out of the house; doing a physical activity either alone or in a group, like walking, jogging, dancing or playing a sport; listening to music and singing or shouting; drawing or writing in a journal; removing yourself from situations that cause you to feel upset; doing something relaxing like petting the family dog or cat or taking a bath; doing something fun with your friends, like

going for coffee or watching a movie; reading to distract your mind; phoning a friend or talking to parents; “getting help like, going for therapy”; shouting into a pillow; punching a pillow or punching bag; smoking a cigarette; crying and learning to cope with overwhelming emotions.

3.6 CONCLUSION

This chapter describes the data collection procedure by explaining the research design and sampling plan, and describing the research participants and semi-structured interviews. The chapter highlights the practicalities that had to be in place in order to conduct the semi-structured interviews as well as the difficulties, which were involved in gathering the data. The chapter further describes the data analysis process by explaining the steps involved in data analysis. The analysis and the interpretation of the data are included in this chapter.

In the following chapter, a literature control is conducted in order to compare the findings reported in this chapter with those found by other researchers in the field.

Chapter Four

ADOLESCENT GIRLS WHO SELF-MUTILATE – LITERATURE CONTROL

4.1 INTRODUCTION

In this chapter the literature control is used in order to compare and contrast the findings set out in Chapter Three with already existing studies (Delpont & Fouché, 2005b: 263). This allows the research question to be refined and rendered more meaningful by setting it in the context of other studies involving similar populations. A table (Table 3) is provided at the end of this chapter to show the key findings of other relevant research, and how these line up with the findings of the present study.

In this research study, the adolescents gave voice to their perceptions and experiences of self-mutilation as well as their needs in life. By exploring and describing their subjective experiences, this study sought to suggest guidelines of support for parents to help their adolescent daughters who self-mutilate. In giving space to the adolescents' voices, a better understanding of self-mutilating behaviour is achieved, which hopefully will be of service to those tasked with supporting or treating adolescents in distress. This is particularly important in the light of the suspicion that there are many adolescents who self-mutilate to at least some extent but without ever receiving any help for their problems.

The literature control strategy closely follows the themes previously defined in Chapter Three, namely, (1) self-mutilation serves a function in the adolescents' lives, (2) the adolescents feel a deep sense of shame and guilt, (3) the adolescents have low self-esteem, (4) the adolescents experience their home lives as conflict filled, neglectful and rejecting and (5) the adolescents own practical suggestions for alternatives to SMB. These themes, and sub-themes, are discussed below.

4.2 SELF-MUTILATION SERVES A FUNCTION IN THE ADOLESCENTS' LIVES

In this study, the adolescent girls all agreed that self-mutilation served a function in their lives, and at times it served a multitude of functions, namely to relieve intolerable emotional pain, to express anger, to express emotional pain, to communicate inner pain to others, to communicate a need for support and perceived lack of needs being met, to cope with feelings

of alienation, to validate emotional pain; as a form of self punishment or punishment of others, to exert control over oneself and over others, as a means to prevent suicide and to end (or sometimes to induce) a dissociative episode.

Adler and Adler (2007: 538) conducted 80 in-depth, unstructured interviews with college students and adult “self-injurers”. Despite increased awareness and attention on self-mutilation, an integration of terminology, definitions, explanations and treatments is lacking (Messer & Fremouw, 2008: 162) so it may be that this sample does not engage in the same SMB as the present sample. However, Adler and Adler's participants overwhelmingly agreed with the adolescent participants in the present study, that although it can be morbid and often maladaptive, SMB represents an attempt at self-help (See Table 3). The older participants reported immediate but short-term release from anxiety, depersonalization, racing thoughts and rapidly fluctuating emotions. Some also reported less tension and feeling more grounded (i.e. cessation of depersonalisation), and not infrequently euphoria after self-mutilating. Improved sexual feelings, fading of anger, satisfaction of self-punishment urges, security, uniqueness, manipulation of others and relief from feelings of depression, loneliness, loss and alienation were also reported by this sample of older self-mutilators. For them, SMB provided a sense of control, reconfirmed the presence of one's body, dulled feelings and converted unbearable emotional pain into manageable physical pain (Adler & Adler, 2007: 540).

Clinical researchers (Favazza, 1998: 259; Suyemoto, 1998: 531; Cavanaugh, 2002: 97; Ross & Heath, 2002: 69; Crouch & Wright, 2004: 185) have theorised about the psychological and emotional functions of self-mutilation. These authors have suggested that self-mutilation serves a range of functions for individuals and may even serve several functions simultaneously. This study found that SMB serves different functions simultaneously in the adolescent girls' lives.

The dominant clinical belief (Favazza, 1998: 259; Suyemoto, 1998: 531) is that self-mutilation is an internalised response to family, sexual or other traumas that allows survivors to organise their feelings and express their suffering (Abrams & Gordon, 2003: 430). However, not all those who self-mutilate are trauma survivors, so self-mutilation may serve other functions entirely. The present study confirms that SMB has multiple functions according to the South African adolescents.

4.2.1 Self-mutilation provides relief from overwhelming feelings

A study of self-harm narratives of urban and suburban young women by Abrams and Gordon (2003: 437) found that the suburban participants all linked their cutting, carving or burning acts to general feelings of depression, emotional turmoil and at times suicide ideation. It was found that all the suburban participants connected their self-mutilation histories with general emotional distress and depression. Furthermore the study found that the common underlying theme was that self-mutilation generated a feeling of intense release or an outlet for general emotional turmoil. For all the suburban participants, self-mutilation helped to provide relief from their overarching pain and distress. The urban participants reported gaining a similar sense of relief, although for them, it was relief from their overwhelming anger. In one participant's case, "*carving on her skin helped her to calm down when she was mad as it provided her with a sense of calm and a release like crying*".

Shapiro (2008: 126) states that self-mutilation is a coping strategy while McDonald (2006: 196) views it as an effective method of relieving stress and emotional tension. The author states that when used as an emotional regulator, SMB offers the individual a way to deal with negative feelings toward the self. The phenomenon of relief can be understood via the *affect regulation model* which views self-mutilation as a method for reducing and controlling arousal (Messer & Fremouw, 2008: 176). Several emotional states have been found to precede acts of self-mutilation, including increased tension and anxiety, despondency and anger at oneself or others and feelings of not being real or lacking an identity (Abrams & Gordon, 2003: 437-438; Crouch & Wright, 2004: 197). Allen (in Shephard, DeHay & Hersh, 2006: 306) found that self-mutilation serves to manage negative moods. The study reported that most adolescents feel intensely angry or distressed immediately preceding the self-mutilation. The subsequent mutilation serves as a form of self-medication in that the behaviour releases tension.

Crouch and Wright (2004: 192), in a study of in-patients, found that participants also frequently mentioned the idea of a need to achieve some sort of release through the act of habitual self-mutilation. It appeared that self-mutilation led to a feeling of calm and avoidance of facing painful emotional states. The participants saw their self-mutilation as a way of coping; amongst them, it was an accepted fact that people would self-mutilate in order to cope emotionally.

In the present study, it was found that the adolescents described SMB as serving primarily to help them cope with painful emotions, which they cannot express. This function was most frequently mentioned by all the adolescent girls, as they described how SMB provided them with a sense of relief, release or calm. This study found that the act of self-mutilation helped to calm the adolescents when they felt overwhelmed by emotions. The two psychologists consulted also agreed that self-mutilation is a common way of coping with problems amongst adolescents of today. However, it is not clear to what extent the adolescents themselves accept the SMB, with the possible exception of those for whom it has become a sub-cultural marker of belonging (see 4.2.5. below).

4.2.1.1 Self-mutilation as a means of expressing anger

Turner (2002: 229) states that anger management is specifically a problem for those who engage in self-mutilation, as self-mutilation is often an outward expression of suppressed, unacceptable internal feelings. Self-mutilators typically lash out at themselves, sometimes exclusively. Abrams and Gordon (2003: 437) found that the urban adolescents overwhelmingly linked their self-mutilation to being “*angry*” or “*mad*.” These participants described hurting themselves as a way to release anger at family members or boyfriends. The study found that the urban participants talked about getting “*mad*” as a trigger to self-mutilation. Similarly, Crouch and Wright (2004: 192) found the adolescent participants described feeling upset, anxious or angry before the act of self-mutilation took place.

Ross and Heath’s (2002: 71) study attempted to determine which affective state most characterized acts of self-mutilation between hostility and anxiety. They reported higher levels of both intro-punitive and extra-punitive hostility for the adolescents who self-mutilated compared to controls. The authors concluded that the study evinced greater support for the hostility model of self-mutilation due to a component of hostility found in almost all cases of self-mutilation.

The adolescents in this study felt that they had enormous amounts of anger within themselves and that they were unable to manage this anger or release it appropriately. One participant clearly expressed her struggle with self-control: “*it had a lot to do with self-control and being angry with myself and just being angry*”. Another described her first experience of SMB: “*over something stupid...I got so angry. I just wanted to hurt her but instead I hurt myself*”. The powerful image of the “*suicide bomber, press the little red button, just press it once and I*

blow up” expresses the centrality of anger to these adolescent's experience of SMB and confirms the findings of the overseas studies as relevant to South Africa.

4.2.2 Self-mutilation as a means of expressing and validating emotional pain

Adams, Rodham and Gavin (2005: 1293) state that a function of self-mutilation is to validate emotional suffering by creating a physical manifestation of inner pain. Babiker and Arnold (1997: 34) point out that the origins of emotional pain might be unclear and difficult to control, but the act of deliberate self-mutilation converts it into a physical tangible pain, which can be controlled and attended to by physical means. Abrams and Gordon (2003: 438) found that for some participants, the flowing blood became a powerful representation of the emotional pain that they believed was releasing itself. For these individuals, *“the emotional catharsis [was] to be located in the actual physical injury, such as the scars, burns or blood pouring from the skin” (ibid).*

One of the psychologist participant in the present study viewed self-mutilation as a way for the adolescents to *“get rid of feelings without ever being able to identify the feelings”*.

The present study found that SMB allowed the adolescent girls to express their emotional pain through conversion to a physical pain. Furthermore the adolescents found that it was easier to handle the pain associated with the physical act of self-mutilation, than to deal with the emotional pain. The adolescents were seldom able to identify the source of their feelings or the feelings themselves, but the SMB made the feelings more “real” to them. As one adolescent participant described: *“it's real, there is pain...it's not just that my heart was broken”*. As the wounds began to heal and form visible scars, one participant felt contained emotionally by the process: *“...to know exactly how you felt when you made that cut and then to watch it fade or heal is like having something tangible as an expression of your emotion”*. Another said, *“I would constantly be looking at those scars. I would look at them the entire time and I would feel like I could breathe again”*.

4.2.3 Self-mutilation as a means to communicate inner pain to self and others

The struggle to communicate inner pain to others through any available means (including SMB) may be understood as part of adolescent development. Adolescents face the challenges of identity formation, separation and independence from parents and sexual intimacy (Geldard & Geldard, 2004: 4). Berk (2002: 524) remarks on the development of psychological

distancing from parents and the need for this important relationship to be renegotiated, something that challenges both parents and adolescents. Plante (2006: 193) depicts the dilemma of the adolescent who desires to be independent, yet remains reliant on her family for support. According to this author, scars may be displayed for ‘accidental’ discovery as opposed to a direct plea for help. A goal of self-mutilation can be the conscious or unconscious wish to communicate emotional distress to others (Babiker & Arnold, 1997: 83; Plante, 2006: 192). The authors state that the sight of scars is a direct signal of distress to parents, friends and teachers, who are inevitably alarmed by these disturbing signs.

Abrams and Gordon (2003: 438) reported that two of the three urban adolescents described an additional function of their self-mutilation as “*specifically, that family members finally noticed how angry or distressed they felt at that time.*” One participant described that cutting her wrists got her parents attention and eventually helped her to get into therapy.

Crockwell and Burford (1995: 9) summarised the struggles of participants as the need to be helped against feeling they did not need a helper, the struggle of independence and dependence, and a need to disclose against a need to be private. Participants expressed a fear of rejection but a desire to be understood. The authors linked these conflicts with extreme forms of the conflicts involved in normal adolescent development. According to their study, participants expressed and acknowledged ambivalent feelings about themselves and contradictory expectations about what they needed from others.

In this study it was found that the majority of adolescents expressed their emotional pain through the act of self-mutilation. It was found that the adolescents believed that a physical manifestation of their emotional pain could serve as an explanation of their pain to self and others. However, in this study the adolescents were able to clearly express their needs as well as what they needed from others. Moreover, they did not seem to expect that their SMB would improve communication; and according to at least two of them, it did not because the parents simply ignored it or even tried to joke about it. As one participant said, “*I realised that I was alone and that I had to deal with it*”. However, the South African participants expressed struggles that are close to those described by Crockwell and Burford (1995: 9), with the added element that their fear of rejection appears, sadly, to have been well founded.

4.2.4 Self-mutilation as a means to communicate a need for support

Adler and Adler (2007: 543) considered the larger picture concerning adolescents in distress, and found that apart from clinical populations, street youth or prisoners, there was a largely unserved population suffering significant adolescent stress. Although the psychological literature suggests that self-mutilators come from backgrounds of abuse and neglect, many of the participants in their study had unremarkable childhoods. The study reported that sometime small events felt overwhelming to individuals going through adolescence. The researchers found that participants from ordinary family backgrounds turned to self-mutilation because of school stress, over-commitment in extracurricular activities and a driving sense of perfectionism. The study describes how a 21 year old college student decided to self-mutilate while still in high school: *“...it was a rough time for me. I got miserable. I just didn’t feel like confiding in my parents. They probably would have been a great resource of help, come to think of it, but I was at that age where I wasn’t comfortable talking to my parents about that sort of thing and I felt no one understood. So my friend told me about her newfound techniques and I tried it as something that may unleash some of my stress. And it was, which reinforced it.”*

In a study by Draucker (2005: 959) which sought to describe common interaction patterns between adolescents who are depressed and the important adults in their lives found that all participants discussed how both adolescents and adults ignore, hide or minimize the adolescents’ distress by putting up a façade. The façade could be broken down, when adolescents had a meaningful connection with an adult who was vigilant to the adolescents’ distress, receptive to disclosure and determined that the adolescent get help. This is consistent with research indicating that the quality of the relationship between adolescents and their parents, especially perceived support and warmth, contributes to the affective well being of adolescents. However, it is clear that this support is not obtained by SMB, but by talking about it to someone, confiding in someone.

Psychologist 1 in the present study took the view that parents exacerbate the problem of self-mutilation when they do not take the adolescent seriously or when they neglect the adolescent, particularly emotionally. She highlighted the problems that arise when behaviour is clearly showing that the young person is in trouble, *“but the parents don't see”*. Kindly, she attributed this to ignorance and in particular, lack of listening skills on the part of parents.

In the present study, it was found that the adolescents experienced communication problems with their parents and that verbal communication of their emotional needs was difficult. It was found that the adolescents felt it was difficult to talk to their parents due to various reasons namely, that they feel that their parents do not understand them or take them seriously, for fear of disappointing them, fear of angering them, a need to protect them, lack of time or a lack of a trusting relationship due to conflict or criticism from parent(s) and an inability to clearly express their emotional problems. Yet for all this, there was a longing to express feelings directly to parents and a sense that parents ought to be the ones who care the most: *“talk to your family about how you feel, even though it is hard, it makes it better”*. The adolescents need *“someone to run to, someone who cares”*, and especially they need the love and support of their parents. However, if the South African sample's experience is any guide, SMB in itself is quite likely to fail as a means of obtaining much-needed family support and may have the opposite effect due to the tendency pointed out by Draucker to minimise. However, there is no evidence from this sample that the adolescents themselves either minimise the suffering behind SMB, or attempt to put up a façade of any kind. Instead, participants react sensitively and angrily to any attempt to *“laugh it off”*.

4.2.5 Self-mutilation as a means of expressing and coping with feelings of alienation

A behavioural/environmental model of SMB focuses on environmental factors that both initiate and maintain the behaviour (Messer & Fremouw 2008: 176). According to this model, cutting or other acts of self-mutilation may be reinforced through external gain from the environment, or through internal relief. Other studies (Crouch & Wright, 2004: 197; Favazza, 1998: 262, Plante, 2007: 4) emphasis social learning attributable to positive attention, inclusion in a group and contagion.

Adler and Adler (2007: 544) found that some self-mutilators rooted their unhappiness in peer social situations that elicited feelings of rejection, be it in the form of a break-up or fight. Other participants however turned to self-mutilation because they felt they had no friends, describing themselves as loners. In either situation, the study found that feelings of rejection and alienation turned the participants inwards, to self-mutilate.

That finding was not unexpected, but Adler and Adler also identified a number of self-mutilators who self-consciously belonged to alternative youth subcultures. Some of the participants in their study reported that they hung out with the 'wrong crowd' such as

“Goths”. Worryingly, there were some participants for whom this was very much the 'right crowd'. These cited joining self-destructive peer groups as a mode of adolescent rebellion, fully intending to shock their parents or community. For this subgroup, SMB may be viewed as a “*province of young, trendy youths who did it to be 'cool'.*”

There is growing evidence for the contagion factor in ‘normal’ adolescents in the school setting. Plante (2007: 4) identifies social contagion as a reason why adolescents engage in self-mutilation at such alarming rates. Social contagion has been recognised as a significant influence in the spreading epidemic of self-mutilation amongst adolescents. Derouin and Bravender (2004: 17) state that self-mutilation is frequently passed among social groups in schools when an adolescent engages in the behaviour and reports to peers about the relief it provides. Plante (2007: 4) explains that adolescents have a compelling need to identify with peers, to feel accepted and try out all sorts of activities, a fact that readily explains the spreading use of self-mutilation as a means of coping with and expressing pain.

The two psychologists interviewed for the present study thought that self-mutilation is more likely in adolescents who feel misunderstood, alone and isolated. They also stated that self-mutilation is a ‘popular thing’ among adolescents, creating a connection with others who do it. In this view, for the lonely or isolated adolescent SMB may create a *sense of belonging or group identity*.

Crouch and Wright (2004: 193) also found that issues of group identity began to emerge when discussing self-mutilating behaviour in context. The authors state that adolescent groups seem to develop from a mutual preference for characteristics and activities. Confident of the understanding and acceptance of the chosen group, an adolescent is likely to become critical of other groups. These in-group/out-group perceptions serve to strengthen and affirm identity choices. Furthermore being popular is important in adolescence; so not fitting into any group is personally difficult. This research suggests that groups are important in influencing SMB, especially in school and residential settings.

This present study found similarly that SMB provides a way for an adolescent to identify or belong to a group, but unlike the young people surveyed by Adler and Adler (ibid), the South African adolescents did not express a motivation to shock their parents or community. Quite the reverse – they wanted to be accepted, but instead they felt misunderstood, suffered from

feelings of rejection, and also described a sense of loneliness and isolation. One adolescent in this study described how she felt that she did not fit in at school and consequently has found friends with the group at school who listen to bad music, wear skinny jeans and cut themselves. Thus it is clear that the sense of belonging and acceptance, which was found by this participant within a group of other self-mutilating girls, reinforced her SMB.

Therefore, there are indications from both adolescent participants and the psychologists interviewed, that at least some South African adolescents are identifying with a self-mutilating peer group: for example, the emergence of the “emo” as a category of identity. On the basis of the present findings, it can be hypothesised that adolescents whose peers engage in self-mutilation are at a greater risk for trying these behaviors. The adolescents in this study cited curiosity, knowledge about the relief self-mutilation provided and the need to inflict pain on something due to anger as reasons for making a first attempt at self-mutilation. It is also worth noting that the majority of adolescents in this study knew someone who had previously self-mutilated, or was currently self-mutilating. They were also themselves dismissive of the social contagion effect: for instance, tending to regard those who copied them as inauthentic: “*She was trying to be all Goth but then I told her, excuse me, but it's actually Emo to cut*”.

4.2.6 Self-mutilation as a means of punishment or control

Allen (in Shephard *et al.*, 2006: 306) found that adolescents who engage in self-mutilation report that it is a way of dealing with a sense of internal badness and anger at other individuals. The study found that self-mutilation serves as a way to inflict punishment on oneself for having inadequacies as well as to channel aggression toward others back to the self.

The majority of the adolescents in the present study described SMB as an attempt to punish themselves, and yet three also spoke of empowering themselves and feeling in control through SMB. They felt in control by *enduring the pain that they inflicted upon themselves* as well as by managing their mounting or overwhelming emotions. Despite this aspect, adolescents felt unworthy, depressed, angry or disgusted with themselves – especially when they are aware of using self-mutilation as a means of self-punishment. One participant mentioned attempting to increase the suffering by using a blunt blade so that the cutting would take longer. Another reported: “*I cut when I am feeling like I never did enough, not being able to make other people proud, not being able to help other people, feeling like you are just worthless, feeling*

like you just can't do anything right." Yet another seemed to feel so unwanted by her parents that she should be punished for merely existing.

This study also found that self-mutilation was used as a means to punish others, and two participants mentioned that self-mutilation was used to control others. In such situations, when parents told their adolescent daughters "no", or thwarted their attempts to gain independence and freedom, the adolescents would self-mutilate. This would release the feelings of frustration and anger, but also supposedly punish the parent in the spirit of "*look what you've made me do*". As one adolescent said, "*I think sometimes that cutting myself is my way of punishing him [my dad]*". It seems likely that, at least in the mind of the adolescent, the parent is part of the "imaginary audience" (Kaplan, 2000: 505) and therefore involved in/accountable for the SMB in some or other way.

4.2.7 Self-mutilation as a means to prevent suicide

There has been considerable debate over the past thirty years surrounding the relationship between suicide and self-mutilation (Anderson, Standen & Noon, 2005: 318). The authors refer to a suicide spectrum, devised by Hill in 1995, and argue that the motives behind adolescents who over-dose or self-mutilate are wide-ranging. The suicide spectrum is composed of the range of actions that carry connotations of suicide. At one end of the spectrum is self-mutilation and at the other end is suicidal behaviour, which is a clear desire to end one's life. In between and active within this spectrum are the behaviours of adolescents who take overdoses or self-harm in other ways. The adolescent's intent to die increases across this spectrum.

However, some clinicians and researchers have distinguished SMB from other forms of deliberate self-harm that may be suicidal (Fortune, 2006: 408). Self-mutilation is defined by Favazza (1998: 260) as "*the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent*". Cavanaugh (2002: 98) discusses how in most instances adolescents who self-mutilate are not actively suicidal, as their injuries might suggest. Favazza (1998: 267) has argued that "*self-mutilation has come to be understood as a morbid form of self-help that is antithetical to suicide*" - and yet repetitive self-mutilators have a higher risk of medication overdose. A recent study (Rodhams, Hawton & Evans, 2004: 87) examined intent and methods of deliberate self-harm by means of a community based study of adolescents. They found that those who took overdoses more often said that they wanted to

die, whereas those who cut themselves more often reported self-punishment and escape from a terrible state of mind as motives for their deliberate self-harm.

Muehlenkamp and Gutierrez (2004: 15) found that self-mutilators are more at risk for suicide attempts and thoughts. Stanley, Gameroff, Michalsen and Mann (in Messer & Fremouw, 2008: 163) consistently found that suicide attempts by those who self-mutilate involve a different method than the preferred method of self-mutilation, e.g. a 'cutter' overdosing on tablets. These studies suggest that self-mutilation behaviour among adolescents is not suicidal behaviour; but adolescents who engage in self-mutilation are more at risk for suicide attempts and thoughts.

Messer and Fremouw (2008: 163) assert that while using *intent* as the sole distinction between suicidal and SMB seems the simplest solution, ambiguity still exists. This presents problems for clinicians who may wish to assess an individual's lethality, motivation and pattern of behaviour in terms of a safety plan or contract. The occasional clinical failure to distinguish between suicide attempts and self-mutilation with no intent to die is of particular concern to these authors: "Differentiating between these two groups is important when examining functions or explanations of the behaviour in order to properly identify, successfully treat and accurately conceptualize either behaviour" (*ibid*).

A German study by Kirkcaldy, Eysenck and Siefen (2004: 314) sought to understand several factors associated with suicidal ideation and self-destructive behaviour in adolescence. The final contribution of the study was to clarify those factors associated with suicidal ideation and those associated with self-mutilation. The most general predictor of both suicidal ideation and self-mutilation was anxiety/depression. There is strong evidence that anxiety and depression are closely related negative affective states and it seems highly probable that both suicide ideation and self-mutilation reflect strongly negative emotional states. These researchers found that many of the adolescent participants had been suffering from depression while some were currently medicated with anti-depressants. Furthermore the Kirkcaldy *et al.*, study found that many of those who deal with adolescents on a regular basis, namely teachers and paediatricians, substantially underestimate the percentage of adolescents who experience either suicidal ideation or self-mutilation. It would seem, then, that before we become too concerned as clinicians with the different risk factors, we would have to make sure that we are

able to recognise the signs and symptoms of anxiety or depression amongst adolescent populations.

Moreover, it also emerges that even if the two conditions (suicide and repetitive SMB) are clinically distinct, there is a very strong tendency towards co-morbidity. A study by Fortune (2006: 414) revealed that nearly all the adolescents engaging in deliberate self-harm reported suicide ideation at some point prior to the episode of deliberate self-harm, including all the self-mutilators. Self-mutilation and overdosing were the most common methods of “deliberate self-harm” among the adolescents in Fortune’s (2006: 414) study, and self-mutilators were unfortunately not distinguishable as a subgroup. However, the self-mutilators were more likely to report a history of suicide ideation even in the absence of previous self-mutilation. These findings suggest that they may have been grappling with thoughts of suicide over an extended period of time.

Fortune (*ibid.*) concludes that distinguishing self-mutilation as a less serious behaviour can have negative consequences for adolescents. In any case, adolescents who engage in repetitive, ongoing SMB may or may not die as a result, but are likely to have their maturation process and adult lives impaired by experiencing ongoing psychological distress and by relying on poor coping strategies.

In the present study it was found that participants did not view an episode of self-mutilation as a suicide attempt although four of the adolescents had attempted to commit suicide by other means. These findings are therefore similar to the findings of Fortune (2006: 414), as the majority of adolescents in the South African sample had also attempted to commit suicide by means other than self-mutilation. However, when self-mutilating, they took care not to inflict lethal injuries. As one participant said, “. . . *when you are in the action of doing it, you stop and think...it would be stupid to die from cutting*”. And yet, the same adolescent also reported that at times she had lost this ability to 'stop and think': “. . . *I just carried on and on and I didn't want to stop but I knew I have to*”. The adolescents also seem to have a dangerous lack of specificity in terms of deciding when to stop: “*I just go on and on until there is blood everywhere and then I know when to stop*”, said one participant, who had in fact been hospitalised because her severe cutting was interpreted as a suicide attempt.

Therefore the present study confirms the concept of suicide and SMB as separate conditions, but also notes the close relationship between them and – more importantly – the need to recognise that SMB carries serious consequences of its own, as well as placing self-mutilators at higher risk of suicidal ideation. The findings also strongly suggest (though evidence given by participants and by one of the psychologists consulted) that some parents are not taking SMB seriously, since they do not even trouble to remove sharp implements despite knowing that their daughter is cutting herself. The loneliness and distress reported by the adolescents is also evidence of inadequate concern when young people appear obviously anxious or depressed, and this is in line with the findings of Kirkcaldy *et al.*, (2004: 314).

4.2.8 Self-mutilation as a means to end or induce a dissociative episode

Sutton (2004: 24) states that it is increasingly recognised that dissociative processes, particularly dissociative amnesia, depersonalisation and derealisation, can underpin self-mutilation. According to this author, dissociation is a psychological mechanism that allows the body or mind to split off, in order to compartmentalise traumatic memories or disquieting thoughts, isolating these from normal consciousness. The author explains that those who experience depersonalisation have disconcerting feelings of being detached from their bodies and mental processes. Indeed many self-mutilators report feeling ‘emotionally numb’, ‘detached from themselves’ or ‘dead inside’ prior to the act; feel little or no physical pain during the act; and feel more alive, more real and more grounded following the act.

An explanation of the relationship between dissociation and self-mutilation is clarified by Mazelis (in Sutton, 2004: 26). Mazelis notes that whereas self-mutilation is used as a coping mechanism to manage overwhelming emotional states, *“it can also serve to alter feelings of profound numbness or deadness. Self-mutilation seems to be an effective tool for managing dissociation in both directions – to facilitate it when emotions are overwhelming, as well as to diminish it when one feels too disconnected from oneself and the world.”* Sutton (2004: 260) states that in this context self-mutilation can serve as an extreme grounding technique to bring oneself back to the here-and-now.

The depersonalization model according to Suyemoto and MacDonald (in Messer & Fremouw, 2008: 171) focuses on the psychological state of *depersonalization* reportedly experienced by individuals who self-mutilate. In order to regain a sense of self or re-establish one’s identity, individuals engage in self-mutilation to end the dissociative experience. The scars left from

self-mutilation may serve as visual reminders to the individual that they do exist and have an identity.

Shephard *et al.*, (2006: 307) state that there is a surprising degree of agreement among researchers regarding the phenomenological aspects of self-mutilation. The authors state that personal accounts by individuals who engage in self-mutilation often include descriptions of powerful and overwhelming feelings of anger, tension or anxiety immediately prior to the self-mutilation, little or no pain during an episode, and a sense of relief and invigoration after engaging in cutting. In this way, SMB serves to relieve emotional distress and regulate the stress level of the individual, but it does so through a process of dissociation: as one participant in the present study said, “*you stay in a void of no feeling for a while*”. When awareness of the pain does return, there is a stronger sense of reality, but also an increased risk that the next time there is overwhelming emotional pressure leading to dissociation, the individual will once again self-mutilate.

In this study, it was found that self-mutilation could serve to end a dissociative episode for some of the adolescents as well as to induce an episode. Sometimes the adolescents self-mutilated when they felt emotionally dead, switched off or totally “*out of it*”; but one adolescent felt suspended in a void of no feeling *after* self-mutilating. Thus the self-mutilation served to return the adolescents to a normal state of arousal but for some individuals might serve to induce a dissociative state: being fascinated with the blood but at an emotional level feeling “*completely dead. . . not there*”. It was also found that most of the adolescents felt no pain while self-mutilating. One participant said “*It's like my body has done something because when I cut I don't feel pain anymore*” - a clear description of automatic depersonalisation. Afterwards, they would feel the pain, especially the next day, but this would validate not only their feelings (see 4.2.2 above) but also their existence. Looking at the scars, as one participant said she constantly does, serves as a physical reminder that helps her to stay grounded in her body and her feelings – until the next time she feels driven to desperation or begins to dissociate.

4.2.9 Self-mutilation can become addictive

Research examining the biological effects of self-mutilation suggests that SMB often triggers the release of neurotransmitters that are associated with decreased stress and increased pleasure. In particular, endogenous opiates may be implicated in the development of repeated

self-mutilation (Sandman & Touchette in Shepard *et al.*, 2006: 307). Endogenous opiates are released within the body when injury or physical trauma occurs and serve to reduce pain. Their release also results in an 'opiate high' where the adolescent experiences a euphoria-like state. This physiological change is reinforcing in itself, but as the adolescent engages more in SMB to experience the release of endogenous opiates, her system will develop a tolerance for the chemical and will require a higher dosage of endogenous opiates to produce a euphoric state. Consequently, the adolescent will engage in more frequent and severe self-mutilation in order to receive the opiate high (Sandman & Touchette in Shepard *et al.*, 2006: 307).

As with other addictions, there may be an underlying physiological or psychological vulnerability. Messer and Fremouw (2008: 174) suggest a biological vulnerability for engaging in such behavior, either due to a dysfunctional neurotransmitter system or an abnormal psycho-physiological response to self-mutilation that produces tension reduction.

There is also a cognitive dimension to this. Favazza (1998: 264) states that episodic self-mutilation becomes repetitive when the SMB becomes an overwhelming preoccupation. The repetitive self-mutilator may adopt an identity as a “cutter” and describe herself as addicted to her self-mutilation. The author states that although there is no set number, the switch from episodic to repetitive SMB is fluid; somewhere between the 5th and 20th incident of episodic self-mutilation, the individual becomes 'addicted' to the behaviour.

When well established, SMB can be associated with the kind of minimisation and denial that is heard from habitual substance abusers. According to Adler and Adler's (2007: 549) study a group of long-term chronic users of self-mutilation were identified, who had been self-injuring for at least a decade. The long-term chronic users described their self-mutilation as a “*coping strategy*”, as a “*coping mechanism gone wrong*” or as a “*life long tool*” and saw no reason for stopping the behaviour. The researchers found that a few people had abated their use after many years, either through therapy or with the help of online peer support or education. This dimension is important to understand, especially in the case of older self-mutilators, as it explains their reluctance to seek help. The understanding that the behaviour can become addictive in a physical and psychological sense should add to the sense of urgency in trying to treat or prevent its development amongst adolescents. One of the local psychologists reflected that “*the more they want to avoid doing it the more they feel the*

urge”, a predicament which in her view makes it difficult for a repetitive self-mutilator to stop the behaviour.

The present study demonstrates that the pattern of “addiction” as reported by the adolescents broadly conforms to Favazza's predictions (1998: 264). Six out of seven adolescents in this study have self-mutilated over twenty times and they felt that it was their preferred form of coping mechanism. The adolescents described how the feelings of wanting to self-mutilate would build up inside of them and that these feelings were so strong that they could often not resist them. They also expressed doubt that any other coping mechanism would work as well as SMB, even though they had negative attitudes towards the SMB and towards themselves for relying on it. One participant mentioned thinking constantly about cutting, another stated that self-mutilation “*was like a drug, it calmed me down*”, and a third echoed the older participants in the study by Adler and Adler (2007: 549): “*I don't think there is anything that can stop me. It's like an addiction*”. However, it is noted that in this small sample of seven adolescents, three claimed that they no longer self-mutilated – which if true, must surely be cause for hope.

4.2.10 Self-mutilation as a means of gaining attention

Allen (in Shepard et al., 2006:307) found that in the eyes of family members and friends of adolescents who engage in self-mutilation, the behavior is seen as a frequent cry for help or as a means to gain attention. However, it is by no means clear from the literature that this is always or even predominantly the case when an adolescent is self-mutilating.

Adler and Adler (2007: 537) view SMB as carried out secretly for the most part; as long as the wounds are superficial and easily self-treated, even young people can successfully hide them. Crouch and Wright (2004: 193) in their hospital-based study of adolescents who self-mutilate, also found that self-mutilation was usually a private act, which was carried out in secrecy even though these acts would soon become public knowledge in the unit. It appears, however, that “*attention seeking*” is a major taboo amongst adolescents who self-mutilate. The authors found that “*in talking about their view that self-mutilation should take place in secret, some of the participants expressed anger that they felt toward the attention seeking self-mutilators, seeming to view them as somewhat pathetic*”. The idea that adolescents might self-mutilate for attention was a difficult one to accept for the non-attention seeking participants. This theme shows the emergence of group identity as an important issue in

understanding self-mutilation as it moves the understanding of self-mutilation from a cause and effect model to a more social phenomenon (Crouch & Wright, 2004: 193). Within the context of this social group, the behaviour was defined as private if not secret and anyone seen as “*attention seeking*” might be shunned.

This finding was replicated in the present study, as the majority of adolescents (six out of seven) felt strongly that their self-mutilation was a private behaviour and not a means to gain attention. Like the participants in Crouch and Wright's (2004: 193) study, some expressed contempt and disgust towards those that would self-mutilate for attention or in imitation of themselves. Only one adolescent expressed concern for a friend who had begun to self-mutilate. They reported defending the privacy of their SMB by never talking about it, by not seeking sympathy, and by hiding the marks with clothes no matter how unsuited to the weather the clothing might be. One participant also commented on how “*embarrassing*” it was for her to be talking about the SMB to the researcher. The adolescent who claimed that she did not mind attention still apparently tried to hide the cuts, although she would allow bloodstains to be visible. This participant seems to have found it a strain to keep making up cover stories: “*there came a time when everyone found out I was cutting, it all just clicked*”. Since after that, the school would allow her to leave her classes if she felt overwhelmed, it clearly was to her advantage to be open in this way. In general, though, the adolescents interviewed disapproved of those who would cut for attention, while at the same time claiming, “*everyone's doing it*” or “*people have no idea how many people cut themselves*”. It seems that the adolescents want to claim special knowledge of SMB, but are ambivalent about sharing their status with “*everyone*” - an indication that SMB forms part of the self-mutilator's sense of identity.

4.3 THE ADOLESCENTS FEEL A DEEP SENSE OF SHAME AND GUILT

Shame and guilt are strong motivations for the impulse to be secretive about the SMB. A study by Adler and Adler (2007: 555) found that many participants regarded their self-mutilation negatively and were often torn between their desire to do it and their feelings condemning it. Those who did think about it sometimes “*had thoughts of remorse or regret but when they needed it, they were grateful it was there*”. However, the study also found that there were those who had embraced their self-mutilation. This group of participants represented an informal Pro-Self-mutilation movement, which viewed self-mutilation as a

lifestyle choice and not a medical or deviant issue. Similar groups have emerged in recent years around issues such as eating disorders, so perhaps it is not surprising if some people with SMB are taking collective action to assert their right to self-mutilate. Adler and Adler's study featured older participants, so perhaps for them that is debatable, but when it comes to young adolescents the argument is not likely to find widespread acceptance.

In this study the adolescents clearly displayed feelings of shame and guilt around their SMB. They attempted to hide any evidence of their self-mutilation by self-mutilating in private as well as by wearing long sleeved tops or jerseys in order to hide the scars. This study also found that the adolescents felt that the behaviour was wrong and stupid but they did not know how to stop. They described SMB as “*a stupid thing to do*”, “*horrible*”, “*irresponsible*”, or “*makes me feel ashamed*”. Even the participant, who doubted if she would ever stop, told the researcher that her SMB “*actually makes me feel ashamed when I talk about it and I do need help*”. The adolescents feared discovery of the SMB and would make up “*ridiculous stories*” which it seems their parents were willing to believe or at least pretend to believe. This was partly to conceal the self-mutilation, and partly to avoid having to talk about it.

4.4 THE ADOLESCENTS HAVE LOW SELF-ESTEEM

A healthy self-esteem gives a person 'armor' against the challenges of the world. Research confirms that for children or adolescents who have low self-esteem, challenges can become major sources of anxiety and frustration. Adolescents who think poorly of themselves have a hard time finding solutions to problems. If they are plagued by self-critical thoughts, namely “*We were the rejects*” or “*I needed to be punished*” they may become passive, withdrawn or depressed. Hawton, Rodham, Evans and Weatherall (2002: 1211) found that low self-esteem is significantly associated with self-mutilation as negative self-regard was found to be a risk factor for self-mutilation amongst adolescents.

In a British study investigating the perception of self among self-mutilators between the ages of sixteen and twenty-six, many of the participants expressed a sense of inadequacy about themselves, implying that they lacked more qualities than they possessed (Adams *et al.*, 2005: 1301). In addition to this, there was evidence to suggest that participants felt deserving of the quality of life they led, that being such a “*worthless*” individual predisposed them towards this role. In conclusion the study found that its participants revealed a fundamental desire to

be considered legitimate people of worth, but their experience of a life of self-mutilation undermines their hope of achieving this and their ability to view themselves that way.

In this study, the adolescent participants described themselves in negative terms. All seven adolescent participants who took part in the study identified that they had either a low self-esteem or problems with their self-esteem. They felt worthless and inadequate. The adolescents reported that these feelings of worthlessness and inadequacy interfered with their lives and caused them emotional pain. Their self-descriptions included words like “*not being good enough*”, “*insecure*”, “*never the pretty one or the one worth dating*”, “*worthless...can't do anything right*”. Some felt rejected by parents, of little value to their family; and two of them mentioned making bad choices of romantic partners. Yet like the participants in the study by Adams *et al*, the adolescents expressed a need to feel loved, accepted and to have worth in their own eyes and in the eyes of others.

4.5 THE ADOLESCENTS EXPERIENCE THEIR HOME LIFE AS CONFLICT FILLED, NEGLECTFUL AND REJECTING

Messer and Fremouw (2008: 173) combine the systemic model with the interpersonal model as both models involve the role of other individual's in the adolescent's self-mutilating behavior. The systemic model emphasises self-mutilation as being symptomatic of family or environmental dysfunction. An adolescent is thought to self-mutilate in an attempt to deflect from this dysfunction or gain attention. The system involved may be the family but also could be a residential home or hospital environment, which sometimes replicate the dynamics of family life. The environment may be unknowingly supporting or reinforcing the behavior, as this problem or behaviour serves to detract from other problems (Suyemoto, 1998: 539). The systems approach assumes that when something is wrong with any part of the system, the entire system seeks equilibrium, and that this may be achieved through one part of the system (family member) displaying a symptom or distress while others react differently to the same circumstance.

A small, in-depth study by Abrams and Gordon (2003: 435) found that although specific traumas were unique to each case, all six participants identified family problems as a source of pain, including parental death, drug use, divorce, affairs, violence, family fighting and family financial instability.

In a British study concerning suicidal behavior as experienced by nurses and doctors working in pediatric medicine it was found that suicide behavior is a powerful form of communication not unlike that of self-mutilation (Anderson *et al.*, 2005: 324). It was found that professionals often recognised that young people who engaged in suicidal behavior as individuals were living in a family where *incongruent* situations occur. Incongruence is usually experienced in a family through communications that are poor, relationships that are discordant, messages that are confusing or mixed, and inconsistency.

Trepal, Wester and MacDonald (2006: 343) state that little is known about the reactions of family when adolescent members self-mutilate. The majority of the research that has been conducted on families of adolescents who self-mutilate examined the family system, but did not focus on the reactions of and impact on family members themselves. The authors state that research by Suyemoto (1998: 539) that examined family dynamics, found that self-mutilating adolescents are more likely to come from physically abusive or neglectful homes, have experienced physical or sexual abuse or come from a violent or high-conflict family. Furthermore, parental divorce or loss within a family has been linked to self-mutilation. Thus, self-mutilation may be a result of a problem in family functioning, not just a symptom of the individual.

This study found that the adolescents experienced their home lives as characterized by conflict, neglect and rejection. In this sample, loss of parents through death (three participants) and divorce (one participant) was also a significant factor. The adolescents described conflict filled interaction patterns with both their parents as well as with siblings. The majority (five out of seven) experienced their parents' attitudes towards them as neglectful and rejecting. As a result, the adolescent participants have continued to self-mutilate for months or even years without ever receiving treatment even when parents apparently know or suspect that something is badly wrong. However, it is also clear from this study, and from the comments of the local psychologist, that many parents do not know what to do. They do not have access to services, which could provide them with knowledge and help. The psychologist stated that this lack of understanding or knowledge does not make them "*bad parents*". However, in the community or the hospital setting, 'best practice' will require that dysfunctional family relationships are addressed, and any attempt to treat the young person without also working with the family is likely to meet with limited success.

4.6 THE ADOLESCENTS' PRACTICAL SUGGESTIONS OF WHAT TO DO INSTEAD OF SELF-MUTILATING

Crouch and Wright (2004: 198) found that the adolescents in their study all seemed to think about how they could be helped to stop self-mutilating. It was found however that to do this required the acceptance of help, and therefore attention. This presented a problem, if receiving attention was in conflict with the group identity, because adolescents could become trapped in a vicious cycle.

A British study (Fortune, *et al.*, 2008: 96) concentrating on adolescents' views on preventing self-harm found that adolescents who harm do not readily seek help and therefore *community based prevention strategies* are important. However little is known about adolescents' views on prevention of self-harm. Fortune, *et al.*, (2008: 97) identified ways of to prevent self-harm at the community level, "*including the primacy of informal social networks over professional organisations, the importance of confiding stable relationships, the need for structured group activities and the key role that schools play*" in the lives of adolescents. Furthermore their study revealed that concerns about stigma acted as a barrier to seeking help for some adolescents, "*while bullying and serious problems at home were highlighted as psychological stressors that needed to be addressed.*" The study concluded that the adolescents considered family, friends and the school as the main sources of support in preventing suicidal behavior and/or self-harm namely, self-mutilation. The adolescents in the study found these forms of support more pertinent than external helping agencies.

McDonald (2006: 199) states that providing emotional support to adolescents both at home or at school can be a deterrent to stress and self-mutilation. The author notes further that prevention of self-mutilation should include interacting with adolescents to promote positive coping skills, formulating decision-making strategies, encouraging healthy relationships and building self-esteem. Shephard *et al.*, (2006: 313) state that the adolescent should be taught to replace the self-mutilation behaviour with alternative coping behaviours that are engaging. There are different categories of coping skills, which are differentially effective for different negative emotions.

Abrams and Gordon (2003: 440) found that participants also spoke about their positive coping methods, such as writing and creative expression. Writing, art and creative expressions constituted the strongest coping themes in all of the participants. The participants also cited prayer, spirituality and contacting others as forms of coping, as well as attending counselling or group therapy sessions. *“All these young women described a range of strategies for coping with distress, fear and anger and were clearly struggling to use their positive outlets rather than their self-destructive ones, for expression”* (ibid). The findings in the Abrams and Gordon study confirm the findings in this study as the adolescent girls were able to describe positive coping strategies; however the South African adolescents were sceptical and fearful of the effectiveness of such strategies over the effectiveness of self-mutilation. This is understandable, given the lack of guidance or counselling resources these girls had previously experienced.

Nonetheless, in this study the adolescents proposed many practical suggestions of what to do instead of self-mutilating. The suggestions included physical activities like jogging or playing a group sport. Other activities include journaling and poetry writing, listening to music, engaging in activities that provided a sense of value or accomplishment, spending time with supportive individuals such as a friend or family member, talking to a trusted confidant, getting out of the house, and keeping away from sharp objects. Other suggestions included going for therapy, learning better coping skills and ways to deal with anger, learning to make wise decisions and working on improving self-esteem.

All of these have the potential to overcome the barriers raised by stigma and fear. In the terms laid down by Fortune *et al.*, (2008: 109) the best options for adolescents trapped in the lonely cycles of self-mutilation, involve bringing the sources of help closer to their everyday lives so that there is, as one participant put it, *“someone to run to, someone who cares”*, or as another said *“someone to be on your team”*.

Although authors are right to highlight the limitations of local helping responses and to promote more holistic community based responses, in our South African setting this is a less than practical prescription – and even in well resourced countries it would be difficult to evaluate the success of such measures. The findings of this research study suggest that we need a both/and approach. Community based prevention initiatives are important, but so is recognition of the skills, abilities and knowledge’s that the adolescents themselves have, as

we seek for ways to bring the help they need within their reach through peer groups, schools, community organisations and parent education.

4.7 SIMILARITIES AND DIFFERENCES BETWEEN PRESENT RESEARCH FINDINGS AND FINDINGS FROM LITERATURE

Table 3 summarizes the main points from the literature, the conformity or non-conformity of the findings from the present study (in the columns marked 'Similar' and 'Different') and where relevant, records observations concerning these similarities or differences.

Table 3: Similarities and differences between present research findings and findings from literature search

FINDING	SIMILAR	DIFFERENT	OBSERVATIONS
SMB represents a misguided but conscious attempt at self help: Adler & Adler, 2007	<input type="checkbox"/>		Participants viewed SMB as an attempt to alleviate stress or painful emotions.
SMB serves a range of different functions: Favazza, 1998; Suyemoto, 1998; Cavanaugh, 2002; Ross & Heath, 2002; Crouch & Wright, 2004	<input type="checkbox"/>		Dominant view has held that SMB is an internalized response to trauma: Abrams & Gordon, 2003
SMB generates a feeling of intense emotional release: Abrams & Gordon, 2003; Allen, 2006; McDonald, 2006; Shapiro, 2008; Crouch & Wright, 2004	<input type="checkbox"/>		Participants viewed this as the primary function and most of them mentioned a feeling of calm or relief after self-mutilating
SMB serves as an outward expression of unmanageable feelings of anger: Turner, 2002; Ross & Heath, 2002; Abrams & Gordon, 2003; Crouch & Wright, 2004	<input type="checkbox"/>	Crouch & Wright also note that feelings of being upset and/or anxious may trigger SMB	Participants experienced their anger as overpowering and inappropriate
SMB validates emotional suffering by converting emotional pain into physical pain: Adams et al, 2005; Babiker & Arnold, 1997	<input type="checkbox"/>		Participants also experienced the sight of healing wounds as scars as validating their past pain

Blood, healing and scars symbolize emotional containment and/or release: Abrams and Gordon, 2003	<input type="checkbox"/>		
SMB is an ambivalent way to communicate emotional distress: Babiker & Arnold, 1997; Plante, 2006; Abrams & Gordon, 2003; Crockwell & Burford, 1995		<input type="checkbox"/>	Participants saw it as expression of inner pain but did not believe that SMB would be understood as anything but physical hurt. They mostly tried to hide their wounds and scars from others

FINDING	SIMILAR	DIFFERENT	OBSERVATIONS
There is a tendency to ignore, hide or minimize the distress behind SMB: Draucker, 2005; local psychologist, 2008.		<input type="checkbox"/>	Participants did not tend to minimize their distress but parents sometimes did so. This left them feeling alone in the world. No evidence that participants put up a façade
SMB both relieves and affirms feelings of alienation, and can create a sense of belonging to an alternative youth subculture: Local psychologists, 2008; Adler & Adler, 2007; Crouch & Wright, 2004; Plante, 2007; Derouin & Bravender, 2004	<input type="checkbox"/>		No evidence that participants set out to shock their parents or community but some are motivated by the need to belong, to join a peer group where others self-mutilate
SMB is experienced as a way to control and to punish, both self and others: Allen, 2006	<input type="checkbox"/>		Reports of feeling more in control through <i>enduring the pain</i> appear to be new in the literature, though making intuitive sense
SMB is a morbid form of self help that is antithetical to suicide: Favazza, 1998		<input type="checkbox"/>	Most participants had made suicide attempts or had thoughts of suicide despite frequent SMB
Self-mutilators are more at risk for suicide and should be seen as part of a “suicide spectrum”: Muehlenkamp & Gutierrez, 2004; Anderson et al, 2005	<input type="checkbox"/>		Failure to take SMB seriously may be due in part to perceptions that it's “not suicide”. Local psychologist and participants mentioned <i>situations where parents fail to remove sharp objects</i> despite being aware that their daughter self-mutilates
Self-mutilation is distinct from suicide: Rodhams <i>et al</i> , 2004;			

FINDING	SIMILAR	DIFFERENT	OBSERVATIONS
Favazza, 1998; Fortune, 2006; Cavanaugh, 2002; Stanley <i>et al.</i> , 2008;	<input type="checkbox"/>		

FINDING	SIMILAR	DIFFERENT	OBSERVATIONS
Teachers and doctors underestimate the percentage of adolescents experiencing suicidal ideation and self-mutilation: Kirkcaldy et al, 2004.	<input type="checkbox"/>		Participants including the psychologist indicate that some parents similarly underestimate the dangers or perhaps are in denial about them
Self-mutilation is used as a coping mechanism to manage overwhelming emotional states: Mazelis in Sutton, 2004; Messer & Fremouw, 2008	<input type="checkbox"/>		Words such as numbness, deadness, emptiness and 'not feeling' capture the subjective experience of dissociation
For physiological and psychological reasons, SMB can become “addictive”: Favazza, 1998; Sandman & Touchette, 2002; Messer & Fremouw, 2008; Adler & Adler, 2007; local psychologist, 2008	<input type="checkbox"/>	<input type="checkbox"/>	Findings support the idea that SMB can become compulsive or even 'addictive' at a fairly early stage, and yet 3/7 participants claimed that they had stopped their SMB
SMB is a “cry for help” and a means to gain attention: Allen in Shephard et al, 2006		<input type="checkbox"/>	Participants denied seeking attention and emphasized privacy or even secrecy. However they tend to believe that others are doing it for attention and disapprove, a reaction noted by other researchers e.g. Adler & Adler, 2007 and Crouch & Wright, 2004
People who self-mutilate are torn between shame about it and gratitude for it: Adler & Adler, 2007		<input type="checkbox"/>	Participants were unreservedly ashamed of the behavior and conscious not only of guilt and shame, but also of social stigma

FINDING	SIMILAR	DIFFERENT	OBSERVATIONS
Adolescents who self-mutilate have low self esteem: Hawton et al, 2002, Adams et al, 2005	<input type="checkbox"/>		If anything the adolescents seemed to have a more fragile self esteem than the participants in the cited studies, which probably reflects the intense

FINDING	SIMILAR	DIFFERENT	OBSERVATIONS
			vulnerability of adolescence
SMB may be the result of problems in family functioning and not just a symptom of the individual: Trepal <i>et al</i> , 2006	<input type="checkbox"/>		More research is needed both in this country and overseas to support family therapy approaches and parent education
Adolescents themselves have ideas about what helps them to stop SMB and/or to manage without it: Crouch & Wright, 2004; Abrams & Gordon, 2003	<input type="checkbox"/>		
Adolescents with SMB do not readily seek help so it is better to promote community based prevention strategies: Fortune et al, 2008		<input type="checkbox"/>	In the South African context there is limited capacity but as the authors suggest, informal social networks should be used. Participants did not seem averse to seeking help, just unaware of what help was available or unable to access it

4.8 CONCLUSION

This chapter compared the literature on self-mutilation and adolescence with the data findings presented in chapter three. The findings of the present study are for the most part in line with studies reported in the literature, despite the fact that these are not based in South Africa. This in itself is reassuring, as it suggests that studies done elsewhere in the world do have relevance for at least some populations in South Africa. There are some findings in Chapter Three, which are neither confirmed nor denied by the literature due to a lack of information available, and some findings challenge the assumptions made by authors in the past or in other settings. Table 3 summarizes the main points from the literature, the conformity or non-conformity of the findings from the present study (in the columns marked 'Similar' and 'Different'), and, where relevant, records observations concerning these similarities or differences. The following chapter will discuss the overall findings of this study and the implications that these findings have for future research as well as the limitations to the study.

Chapter Five
CONCLUSION, LIMITATIONS AND RECOMMENDATIONS FOR FUTURE
RESEARCH

5.1 INTRODUCTION

In this chapter the relevance of the study's aims and objectives are discussed along with an assessment of the extent to which these have been attained. Conclusions are drawn regarding the information elicited from the interviews and the literature reviews. The chapter sets out a research-based guideline to parents concerned about their daughters who may be self-mutilating. Finally, the limitations of this study are explored and recommendations for future research are presented.

5.2 AIM AND OBJECTIVES

There was one main aim and four main objectives for the present study

5.2.1 Aim

As stated in chapter one, the aim of the research was to develop guidelines for parents to support adolescent girls who self-mutilate, so that they can help their daughters more effectively. The assessment of the adolescent girls' needs was conducted by means of semi-structured interviews and set out in detail in Chapter Three. The needs assessment offers parents a glance into the lives of developing adolescents and the conflicts they face. The aim was reached by focusing on the various objectives.

5.2.2 Objectives

The researcher used the objectives in order to gain a better understanding of the terms “self-mutilation” and “adolescent development”. There is little literature available offering South African perspectives on the problem, but some recent research is available from overseas which provides a starting point for understanding the problem, and (along with advice from local experts) to assist in the structuring of interviews. The data then needs to be compared against findings from other studies, to discern similarities and differences, although in an exploratory, descriptive study it is not possible to assess the significance of these or

relationship between the various factors that are described. Nonetheless, it is possible to draw conclusions that have relevance for parents, counsellors and other researchers.

These objectives and the way they were reached are briefly discussed below.

Objective one:

To review related and pertinent literature regarding the subject of self-mutilation and adolescent development in order to have a better understanding of the concepts.

A literature review (Chapter Two) was carried out, and this acted as a conceptual framework for the terms “self-mutilating behaviour” (or “self-mutilation”), and “adolescent development”. The researcher found much literature on the phenomenon of self-mutilation and its prevalence in both clinical and community samples, but there was limited information available on SMB amongst younger adolescents, and there was also a lack of practical applications suggested in the literature. Despite numerous clinical studies of adolescent self-mutilation using a quantitative approach, only a few studied the subjective experience of young people who self-mutilate. Psychological interventions have mainly relied on evidence gathered from clinicians or carers (“clinical lore”), rather than the adolescents' own views. This situation needs to be redressed, and more consideration given to the adolescents' perspective as consumers of services and/or participants in prevention programs.

Objective two:

To complete semi-structured interviews with adolescent girls who self-mutilate as well as with professionals in the field of adolescence or self-mutilation in order to explore and describe the support needed by such adolescents.

The researcher conducted semi-structured interviews with seven adolescent girls who were or had been involved with self-mutilation, as well as two semi-structured interviews with psychologists working in the field of adolescent self-mutilation. Through the semi-structured interviews and the transcription process the researcher was able to gain an understanding of the emotional needs and experiences of a purposive sample of South African/Western Cape adolescent girls who self-mutilate (Chapter Three).

Objective three:

To analyse the data and to verify the data against existing literature in order to suggest guidelines to support adolescent girls who self-mutilate so that parents, through awareness and understanding, may feel less helpless, overwhelmed and infuriated.

The researcher analysed the data contained in each semi-structured interview transcription by way of identifying themes and sub themes in the data. The interviews yielded five main themes (Chapter Three). The researcher compared these themes and sub themes with those reported by other authors, in order to set the findings of the present study in the context of recent research literature. The findings were summarised and these findings describe the emotional needs and experiences of adolescent girls who self-mutilate (Chapter Four). Most findings were similar to those made in other research studies but there were also a few interesting differences which are relevant to controversial issues in the field, e.g. the question of whether adolescents self-mutilate in order to seek attention, the role played by previous trauma, the significance of 'alternative' youth subcultures, and the relationship of SMB to suicidal ideation and/or suicide risk.

Objective four:

To draw conclusions in order to suggest guidelines for parents to support and assist adolescent girls who self-mutilate.

Recommendations for information and guidelines that can be given to parents, in support of adolescent girls who self-mutilate, are set out below in section 5.5. The role of SMB in the population appears to be changing. Although this perception of change is as yet unsupported by definitive research it is attested by both the adolescent and professional participants in the present study; as one adolescent said, *“everybody's doing it”*. Moreover, at least one research study found that 'ordinary' teenagers doing 'ordinary' things (working for exams, keeping up with extra-mural lessons, trying to please their parents and teachers etc) can also become stressed enough to begin self-mutilating; and there is plenty of research evidence, including from the present study, to suggest that SMB can easily become a habit on which the adolescent relies, both for the *“opiate high”* it induces and for the instant, short-term feeling of being in control and able to cope. In the light of these recent discoveries concerning SMB, it is imperative that parents and caregivers have access to the latest and most reliable information about the behaviour, in order to help them understand it and deal with it both sensitively and constructively. Parents whose adolescent children may not (yet) be cutting but

are showing signs of emotional distress can also benefit from being more aware of the “danger signs” that their daughter might be vulnerable to SMB, especially if she is in contact with other adolescents who self-mutilate.

5.3 SUMMARY OF RESEARCH

A brief summary of the major findings of the study as a whole provides an important context for defining the kinds of support that would be needed by an adolescent who self-mutilates. These findings are based primarily on the adolescents' perspectives but also incorporate the perspective of the psychologists that were interviewed.

Interviews with the adolescents generated five main themes pertaining to self-mutilation. These themes were: (1) self-mutilation serves a function in the adolescents' lives, (2) the adolescents feel a deep sense of shame and guilt, (3) the adolescents have low self-esteem, (4) the adolescents experience their home lives as conflict filled, neglectful and rejecting and (5) the adolescents are able to offer practical suggestions regarding alternatives to self-mutilating behaviour (SMB). .

Self-mutilation serves a function in the adolescents' lives, surfacing at times of emotional crisis when their coping skills are overwhelmed. There are various reasons why an adolescent would engage in self-mutilation. Prior research has suggested that adolescents self-mutilate in order to cope with problems in relationships, or to deal with past childhood traumas. However, childhood trauma is not the only cause of self-mutilation in adolescents. This study has found that problem-solving skills, coping abilities and social skills can play a role in whether an adolescent chooses to self-mutilate. It was also found that the adolescent girls lack the ability to identify and verbally express their emotional distress, which renders them unsuccessful at communicating their distress to others or understanding it for themselves.

Adolescent participants report a lack of distress tolerance and emotional regulation, the need to relieve intolerable emotional pain, struggling to express anger, struggling to express emotional pain, and struggling to communicate inner pain to others. Self-mutilation may also communicate a need for support, help the individual to cope with feelings of alienation, validate emotional pain, or serve as a form of self-punishment. Furthermore, adolescents self-mutilate to achieve a sense of control over themselves and over others, as an alternative to

suicide, to end or induce a dissociative episode and (once the practice becomes habitual), as a form of general coping. This finding is worth emphasizing as the cognitive development of an adolescent's logical and reasoning capacity is still developing, and thus by virtue of their cognitive development and age adolescents are at higher risk for self-mutilation. Adolescents are in need of guidance and intervention at this level in order to identify and express their distressing emotions in a healthier manner, but the study found that for these participants and their parents, this guidance and support is badly lacking.

A common misperception is that adolescents who self-mutilate, especially those who cut, are doing so in an attempt to commit suicide. According to the data presented here, the opposite appears to be true: participants view self-mutilation as an attempt to provide relief from overwhelming feelings as well as to vent intense feelings of anger and to express emotional pain. They do not intend to kill themselves and sometimes take great care not to inflict life-threatening harm. However, this does not mean that suicide is not a concern as at some point the majority of adolescents have contemplated suicide or tried to harm themselves more seriously. Moreover, the mental state in which self-mutilation takes place is not always conducive to good judgment, a point illustrated by the participant who bled so excessively that she collapsed and was admitted to hospital. Although self-mutilation seems to be a form of coping for an adolescent, it can have serious negative outcomes including physical marks from scars, infections from interfering with wound healing or using contaminated blades, or social rejection because of multiple scars or marks on the body. Given that self-mutilation is only a temporary, immediate release of the emotion or solution to the problem, this may lead to further frustration or intense feelings and so to an increase in frequency or severity of self-mutilation. The adolescent may soon find herself relying solely on this behaviour as a form of coping, as was found in this study.

Although it is often thought that adolescents self-mutilate in order to attract attention, this was not supported by the participants in the present study. The adolescents feel guilty or shameful for continuing to engage in SMB and are afraid of the behaviour being discovered. They are secretive about the cutting, tend to isolate themselves because they feel embarrassed about cutting or burning their skin, and seldom talk openly about their behaviour to anyone. The adolescents overdress for events or seasons in order to hide the scars and have excuses - sometimes, outlandish excuses - for such behaviour. There seems to be conflict and

ambivalence in the adolescent's views about their self-mutilation as they describe the behaviour as wrong and stupid, yet they do not know how to stop.

Concerning the adolescents' self-esteem and overall assessment of their own self worth, they did not place much value upon themselves. Since adolescents do not live in isolation from others, the way they feel about themselves affects relationships and every aspect of their lives, so for many their low self-esteem was a significant problem. Due to feelings of worthlessness the adolescents frequently felt inadequate and angry with themselves; they felt isolated and did not enjoy socialising as much as their peers. The adolescents described a need to accept and love themselves more and they longed to feel more worthy of love and respect, although in some cases they seemed to be giving up on the possibility of ever feeling loved or accepted by their parents and other significant people and two of them mentioned entering into destructive romantic relationships, seeking love but instead finding more pain.

The adolescents all reported conflict at home and communication problems with parents, compounded by difficulty in identifying and expressing their needs. Some of the adolescents described 'normal' adolescent/parent issues: curfews, poor grades, choice in hairstyle or clothing, and friends. However, some described more extreme forms of conflict at home including physical violence. The adolescents also experienced their parents as controlling. They especially appeared to resent (and actively, to resist) parental attempts to control their social behaviour. The adolescents felt that their needs were to be loved and accepted by parents and family, to be listened to and understood, to belong, for positive quality time with parents, for less conflict with parents, and to feel a sense of safety. The psychologist thought that parents should set reasonable boundaries, be available and (very importantly), listen to their children. According to her, parents should prioritise their children and their roles as parents, especially when the young person's behaviour clearly shows that something is wrong in her life.

Other researchers have suggested that self-mutilating adolescents are resistant to help and have instead suggested that the focus be on community based prevention programs. However, in this study the adolescents were all able to discuss practical suggestions of what to do instead of self-mutilating, and they all wanted help regarding their behaviour. They expressed a desire to stop self-mutilating yet they could not do it on their own; they were fearful of giving it up which would leave them without a way to cope with overwhelming emotional

pain. Their practical suggestions included physical activities, calming activities, activities that lent them social support, activities that allowed for healthy emotional expression and activities that provided a sense of accomplishment. Most importantly the adolescents felt that equipping themselves with better coping skills, constructive ways to deal with and express anger, making wiser decisions and improving their self-esteem would be helpful to stop their SMB.

For the researcher the value in this work lies in the adolescents' perceptions and experiences being given voice. Considering that the age of onset of SMB is usually in adolescence, and that services are aimed at adolescents, their needs and experiences are invaluable in promoting a better understanding of the behaviour. This richer understanding is essential when planning any program or service for the prevention and treatment of self-mutilation in the future. The information contained in this study should therefore prove useful and valuable not only for concerned parents, but also for those working with adolescent girls who self-mutilate or planning services for adolescents e.g. High School counselling services or youth drop-in centres.

5.4 LIMITATIONS AND RECOMMENDATIONS

5.4.1 Limitations of the study

This study has a number of associated limitations that warrant discussion. It would have been ideal to be able to interview more adolescents who self-mutilate as well as more psychologists who work in this field. With only seven adolescent participants and two psychologists, and with non-random sampling, it is certain that these findings cannot be generalized to a larger population. Although qualitative research is typically not intended to be generalized, a sample size of seven adolescent girls and two psychologists, selected by the researcher purposively for their richness in detail, cannot be said to represent even the larger population from which the data was drawn. For instance, it is not known (and cannot be known), whether the high incidence of parental loss in the sample has influenced aspects such as self-esteem, the adolescents' need to belong, or features of emotional dyscontrol. However, the fact that many of the present findings are replicated by research conducted elsewhere with larger samples (see Table 3) inspires a certain amount of confidence that despite the limitations of the sample, the results are 'transferable' and 'dependable' (De Vos, 2005: 346). Although the sample was small, the seven adolescents outperformed all prior expectations for the responses

they gave. Any credibility that this study may derive is, therefore, due in no small part to their willingness to share private and painful experiences so honestly and in so much detail.

Participant validation could have been used to check how the participants viewed the interpretation of their conversations in the semi-structured interviews. However this was thought to be too difficult, as five of the adolescent participants had begun to write final school year and university examinations by the time the transcripts were analysed, while the psychologists were hard pressed to find available time for the interview, let alone detailed feedback sessions.

When working with adolescents who are as distressed as those in this study, it was obviously important to have their therapeutic needs in mind as well as gathering information. There were a number of procedures not discussed at length in this research report, that were used by the researcher to ensure the emotional and physical welfare of the participants. For instance, the researcher made follow up phone calls to the adolescent girls, as well as arrangements for counselling to take place at school with a counselling psychologist working at the first school and an educational psychologist working at the second school.

Furthermore, a major limitation of the study is the limited data that the researcher could obtain concerning the needs, beliefs and attitudes of parents whose adolescent children are self-mutilating. Because separation from parents is a normal developmental task for adolescents or young adults, the researcher respected the adolescents' reluctance to involve their parents; and yet, it is also very clear that the adolescents sampled experienced serious conflict with parents, which means that they might not be in a good position to articulate an objective point of view. With more time and/or resources available to the research, parents of adolescents who self-mutilate could be located directly by adaptive sampling, rather than using the adolescent participants as gatekeepers to their parents' involvement as had initially been hoped by the researcher. However, as well as being able to provide a relevant South African perspective which was lacking in the literature, the interviews with psychologists also helped to mitigate the lack of parental involvement. As therapists working with young people and their families, and as adults themselves, the psychologists were able to present a more objective viewpoint on the feelings and responses of parents whose adolescent children are self-mutilating.

5.4.2 Recommendations for future research

As an exploratory, preliminary study the present research offers multiple angles, any of which could usefully be researched with a larger more comprehensive sample.

For example research could be undertaken into the process of defining, diagnosing and classifying “self-mutilation” in order to create a more effective and efficient treatment process. This increased knowledge and understanding of self-mutilation will enable parents and experts alike to deal efficiently with the problem instead of shying away from such behaviour and ignoring a growing problem. A useful step has been taken in terms of separating the concept of SMB from that of suicidal behaviour, on the one hand, and Borderline Personality Disorder on the other, and hopefully this re-classification will be reflected in future editions of textbooks and manuals published to guide the professions.

The findings of this study point to several more areas that warrant future research. It should be noted that the participants in this study were exclusively female. However, this is not to imply that males do not self-mutilate. There is much debate surrounding the relative prevalence of self-mutilation in males and females, and room for further investigation of this area.

The meaning of different methods of self-mutilation and the contribution of these factors to self-image and aspects such as suicidal ideation or behaviour among adolescents requires further investigation.

There are still some issues attracting controversy in the field and these too merit research, especially in the South African context where not much research has yet been done. For instance, participants in this study refuted the notion that they self-mutilated in order to seek attention, and yet they tended – with strong disapproval - to suspect others of attention-seeking if they found out that others were self-mutilating. One even reprimanded a fellow learner for trying to be “all Goth” when “it's actually emo to cut”. Could this negative attitude, perhaps, be due to denial of exhibitionistic wishes and consequent projection of these onto other people? Is attention seeking a covert aspect of SMB and if so, what does this mean? Services providers should strive to question the notion that adolescents self-mutilate for attention, and if this description is used, deconstruct what it means – especially, if this idea is being used to devalue or minimise the emotional distress of young people who self-mutilate,

or as an excuse for doing nothing to help them despite the well-supported fact that SMB is very dangerous.

As this “Goth/Emo” example from the research data indicates, the question of social construction of meanings and identities around SMB arises and this is best dealt with from the perspective of the social constructivist paradigm, which shows increasing popularity in social research. The issue of contagion, which is the process of spreading of self-mutilation, warrants further investigation as well.

This study supports the view that adolescents who self-mutilate are a high-risk group. What do helping professionals assume about self-mutilation cases in their assessment and treatment strategies? Can we build a more dynamic understanding of why adolescents choose self-mutilation above other coping strategies, and of what it is like for a young person to end her relationship with cutting or other methods of mutilation? These questions, along with the findings presented here, can serve as a basis for further inquiry into this apparently growing problem among South African adolescents.

5.5 RECOMMENDED GUIDELINES FOR SUPPORT OF ADOLESCENT GIRLS WHO SELF-MUTILATE

The following section sets out the background information, which the researcher considers relevant and important to communicate to parents or caregivers of adolescents who are actively self-mutilating or at risk of SMB.

Self-mutilation is described in the psychiatric literature as the deliberate and direct destruction of body tissue without a conscious intent of suicide, for example cutting, burning, scratching, hitting, biting or pinching. Self-mutilation can be divided into three categories, namely, major, stereotypic and moderate/superficial self-mutilation.

This type of behaviour tends to begin in adolescence. Adolescence is a time of changing hormones, emotional fluctuations, developing identity, developing self-esteem and a desire to fit in with peers. Adolescents may be more vulnerable to self-mutilate for a number of reasons. They are still dependent upon families who may be abusive or who provide insufficient nurture and support; adolescents may be struggling with issues of forming an

identity, dealing with an emerging sexuality and separation from parents, experiencing bullying from peers; adolescents also have limited experience and lack mature coping skills; adolescents have relatively less power and control over the circumstances of their lives, they have fewer choices and little money.

Adolescents, who self-mutilate do so generally because of internal distress and not in order to annoy, anger or irritate others. Their self-mutilation is a behavioural response to an emotional state and is an indication of extremely difficult and distressing life experiences. Self-mutilation allows the adolescents to cope with overwhelming emotional distress and as such serves a function or functions in the adolescents' life by providing relief as it serves as an outlet for the emotional pain. However, self-mutilation is a short-term solution, which ultimately does not solve the adolescents' emotional problems, and can become a maladaptive coping mechanism that they turn to when faced with an emotional crisis.

There are distinctions between self-mutilation and suicidal behaviour. Typically self-mutilation is of low lethality and the physical damage may be superficial to moderate. A second distinction is that self-mutilation tends to be repetitive compared to suicide attempts. The adolescent who self-mutilates is doing so to manage stress and feel a sense of relief while suicide is an attempt to end one's life. However, this does not mean that suicide is not a concern as the adolescent is travelling a dangerous road and the risk of suicide should not be taken lightly.

When it comes to helping an adolescent who repeatedly cuts or burns herself on purpose her parents, schoolteachers, friends and counsellors and she herself are often at a loss. Treatment that includes therapy and medication may be a difficult and lengthy process. The adolescent who self-mutilates may find the home and school environment difficult during treatment. This is why teachers and parents must seek education about adolescent self-mutilation in order to care for those who engage in this behaviour.

Those who care for adolescents - parents, teachers and other professionals alike - must be aware that self-mutilation is an external symptom for internal mental health problems. An understanding of adolescent development and potential mental health issues is imperative when dealing with adolescent self-mutilation. Building a trusting relationship is the first step towards helping an adolescent who self-mutilates. Key to this relationship is providing an

environment that is safe, one in which the adolescent will feel cared for, listened to and not judged. When interacting with an adolescent who self-mutilates one should take an interest in and demonstrate concern for the adolescent and reserve judgment or criticism.

A parent's best hope of identifying the problem and intervening if their daughter is self-mutilating, is to arm himself or herself with knowledge. A parent's knowledge of risk factors for self-mutilation coupled with observed behavioural clues can aid in identification. Behavioural clues may include a tendency to dress in long sleeves and pants even in warm weather, wearing wrist bands or bulky bracelets, avoidance of activities, particularly where adolescents are required to change clothes and expose their skin, signs of anger, sadness and anxiety expressed through acts of defiance or withdrawal and low self-esteem. In addition to daily observation of the adolescent in the home or at school, suspicious markings on an adolescent should alert attention to the possibility of self-mutilation. All sharp objects should be removed from the adolescents. One of the key aspects of helping adolescents who engage in self-mutilation behaviour must be to get closer to factors that mean something to the individual adolescent, and this can only be done by really listening and paying attention to her.

The adolescent may ask for help, but more than likely will try to conceal the injury. Therefore a parent should be watchful for signs of self-mutilation. Once self-mutilation is suspected, the parent should approach the adolescent with a calm and non-judgemental manner. This manner is recommended as it conveys to the adolescent that her thoughts and feelings are acknowledged without judgement. The discussion can become emotionally charged and a calm demeanour will help remove volatility from an already emotionally charged situation. In addition a calm approach will not reinforce the behaviour and the parent and adolescent can avoid manipulative and unproductive power struggles.

Risk factors for self-mutilation:

- Age: the onset of self-mutilation usually begins in adolescence;
- Childhood history of illness or surgery;
- Children with a history of abuse, especially sexual abuse;
- Children with emotional disturbances;
- Family history of drug abuse, alcohol abuse or other self-destructive behaviours puts children at risk for developing negative coping strategies, among them self-mutilation;

- Other mental health problems such as anorexia, anxiety, depression, obsessive-compulsive disorder, borderline personality disorder and other major psychiatric disorders;
- Social modelling may play an important role in self-mutilation;
- Any life event that leads to the inability to develop healthy, adaptive coping strategies can result in self-mutilation behaviour.

What are the symptoms of self-mutilation to look out for? The following are symptoms or signs of self-mutilation in adolescents:

- Pulling out one's hair;
- Hitting oneself;
- Carving one's skin;
- Burning one's skin;
- Tattooing self;
- Scraping skin to draw blood;
- Using an eraser on one's skin to draw blood;
- Picking on skin to draw blood;
- Inserting objects under skin;
- Picking at wounds.

What are the signs of Self-mutilation?

In order for parents to help their child then the parents should be educated about the signs of self-mutilating behaviour and encouraged to increase supervision of their child. Detecting adolescents who self-mutilate is difficult because of the secretive nature of their behaviour. Adults can look for certain signs. However, these may also indicate other risk factors such as depression or abuse:

- Frequent or unexplained scars, cuts, bruises or burns (often on the arms, thighs and abdomen);
- Consistent, inappropriate use of clothing designed to cover scars;
- Secretive behaviour, spending unusual amounts of time in the bathroom or other isolated areas;
- General signs of depression (lack of appetite or extreme appetite: weight gain or loss, disturbed sleeping patterns: trouble falling asleep or always feeling fatigued, suicidal ideation and suicidal planning);
- Social and emotional isolation and disconnectedness;

- Substance abuse;
- Possession of sharp implements (razor blades, knives, thumb tacks);
- Indications of extreme anger, sadness or pain or images of physical harm in class work, creative work etc;
- Extreme risk taking behaviour that could result in injuries.

Treatment

Treatment for an adolescent who self-mutilates should be active and include immediate intervention with the adolescent and her family. Active support of the adolescent should be composed of some form of professional intervention, such as counselling or referral for medical evaluation. Professional help is advisable, so that the adolescent can learn more adaptive forms of coping, how to regulate emotions, and explore ways to feel connected to others as well as more comfortable in her own skin.

For the family, an intervention should include education, training and support so that each member can contribute to the well being and progress of the adolescent. Understanding the difference between suicide and self-mutilation is important. Families also need to focus on their patterns and habits of communication, which may be creating more distance or isolation between parents and adolescents or children. Learning how to decrease or avoid problematic communication will serve to minimize conflict and also provide support to an adolescent who is trying to practice more effective and positive coping skills. Furthermore, although the adolescent's feelings and personal boundaries should be treated with respect, it helps if the self-mutilation does not remain hidden as a shameful secret of the family. If the adolescent feels that she can talk opening with family members about her experiences of self-mutilation, that will be both supporting and empowering for her and good for family relationships.

Coping skills

The adolescent should be taught to replace the SMB with alternative coping behaviours that are helpful and specifically suited for the adolescent. There are different categories of coping skills, which are differentially effective for different negative emotions. For angry or irritable feelings, coping strategies that expand energy, e.g. running, biking or playing outside can be highly effective. For worried or anxious feelings, coping strategies that induce relaxation such as deep breathing or a bubble bath can be useful. Doing something to distract one's thinking: reading a book, surfing the web (appropriately!) or playing a game is often helpful with many

different negative emotions. The adolescent should also be informed that different coping skills may work at different times, so it may be necessary to try a couple of coping strategies and not to give up if a single effort fails to decrease the powerful urge to self-mutilate. The researcher further recommends that parents organise enjoyable activities for the adolescent and parent to participate in together. If the parent can show interest and create quality time together with the adolescent that will go a long way to strengthen the relationship. Furthermore the extra attention coupled with the interactive activities could serve to facilitate the adolescent's coping mechanisms.

Problem solving

Problem solving focuses on actions the adolescent can take to change situations, which typically lead to the urge to self-mutilate. A few examples of problems that have been found to lead to self-mutilation in adolescents are fighting with siblings or parents, poor grades, family violence, parental substance abuse and teasing by peers. It is important to emphasize that problem solving is only an option when the situation is one in which the adolescent has some control (peer teasing). For instance, the adolescent has no control over parental substance abuse. Problem solving can be taught concisely to adolescents in a five-step process:

- Identify the problem. What happened that provoked thoughts of self-mutilation;
- Determine the goal. What does the adolescent want to happen;
- Brainstorm plans. It is important to come up with at least five plans so the adolescent can try a different plan if one does not work. Plans can include coping skills;
- Guess the pros and cons of each plan and pick the best one(s). In this stage the adolescent, guided by the professional or parent, picks the best plan after estimating the pros and cons of each. Plans may be combined too;
- Praise yourself. The adolescent should be encouraged for attempting to manage the situation without self-mutilation, even if the plan does not work out. A successful problem solver is one who attempts to come up with a solution to a problem, even if the plans that are tried do not work.

A few suggestions for general problem-solving plans:

1. Journaling. Journaling is a cathartic process, which helps to release negative emotions. If an adolescent is stuck it may help to structure the activity by giving them prompts:

write down five things you are grateful for, write two good and two bad things that happened today etc.

2. Increasing extracurricular activities. Minimising the time the adolescent has to engage in self-mutilation would be helpful.
3. Drawing. Like journaling, artistic expression is a way of coping and releasing emotion.
4. Listening to music. This is a distracting and enjoyable activity and very developmentally appropriate for adolescents.
5. Exercise. As previously mentioned, exercise may be especially helpful for self-mutilators. Aerobic activity releases endorphins, which are natural mood enhancers. Adolescents may enjoy spending time outside in nature with friends, walking or biking, dancing or playing a sport. They may partake in organized exercise classes i.e. yoga or dancing.

Key points to remember

- Self-mutilating behaviour (SMB) is defined as the direct, deliberate and repetitive destruction or alteration of body tissue, which results in minor to moderate injury, without conscious suicidal intent;
- Self-mutilating behaviour is not the same as a suicide attempt, but some adolescents who engage in an act of self-mutilation subsequently attempt or commit suicide, often by other means;
- Self-mutilation behaviour is most often classified into three broad categories of stereotypic, major and moderate/superficial self-mutilation;
- The functions of self-mutilation behaviour for adolescents are most often to manage negative moods, as a response to negative beliefs and to manage their social interactions;
- Self-mutilation behaviour is believed to have a neuro-chemical basis and is thought to produce euphoria, relieve tension or reduce feelings of numbness;
- Psychopathologies commonly associated with self-mutilation are depression, eating disorders, substance abuse and personality disorders;
- Self-mutilation is found to spread via social exposure, known as the contagion effect;
- Treatment strategies that have shown promise in improving the symptoms of self-mutilation are: cognitive and behavioural therapies, problem-solving therapy and psychopharmacological interventions.

5.6 CONCLUSION

Based on a thorough search of the literature, and interviews with a sample of adolescents, South African adolescent girls who self-mutilate are in desperate need of emotional support in order to help stop their self-mutilating behavior. The adolescents who participated in this study were given the opportunity to express their needs and to share their experiences of self-mutilation. They experience intense feelings of anger, upset and perceived interpersonal conflict. In their world (internal and external), the act of self-mutilation serves many functions. However, its major function seems to be that of providing a *temporary relief from overwhelming feelings and conflicts*. There seems to be conflict and ambivalence in the adolescents' ideas about self-mutilation, since they view the behaviour as appalling, stupid and shameful and yet remain captive to its appeal as a "quick-fix" coping strategy. The adolescents discussed many experiences of self-mutilation as well as their emotional needs. Many of the adolescents' emotional needs concerned experiencing a sense of love, support, acceptance and belonging from family and friends. The adolescents did not experience their needs as being met. They experienced a sense of shame and isolation, unworthiness and communication and they reported conflict with parents and families, which on many occasions they initiated themselves.

The most striking feature of their stories and the feature of greatest concern to the researcher, was the deep isolation of the adolescents within their life of self-mutilation, resulting in feelings of loneliness and low self-worth. The adolescents reported that one way these feelings could be addressed, from within the emotional space allowed by their reliance on SMB, was in seeking support from other adolescents who self-mutilate. This support was not, however, support to stop mutilating and to deal with one's problems. Instead, it was couched in the form of a requirement for the sense of self or identity that is so important to adolescents, to be structured around anger, depression, social alienation and self-mutilation. The reward for assuming this negative identity would be the right to belong to a subculture of similar adolescents and to be accepted by them.

The findings of this and other relevant studies offer hope to adolescents and to their caregivers that this situation need not prevail. An improved understanding of the conditions which promote SMB, the emotional processes associated with it, and the needs of adolescents who self-mutilate or are tempting to start self-mutilating, can serve to prevent the SMB becoming a

lifestyle choice or a lifelong burden to the sufferer. At the same time, the general public and institutions including clinics and schools should be more aware of the prevalence of the problem and of its dangers to the mental and physical health of young people. Dismissing SMB as attention seeking or manipulative self-drama is no longer an option, in the face of research that explores its complexity and the ways in which adolescents and especially girls are placed at risk.

In terms of its aim therefore, this study has achieved what it set out to do. It has assessed the emotional needs of adolescents who self-mutilate in order to provide parents and families with information and guidelines that can help them to stop this behaviour and to prevent its recurrence.

It is hoped that the information provided in this study will also be of help to teachers, counsellors, nurses and researchers who are dealing with the problem of adolescent self-mutilation, and most of all that it will be of help, ultimately, to young people who deserve so much more from life.

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ADDENDUM A: Letter to parents

PO Box 2231
Dennesig
7601

Dear Parents

I am currently a student of The University of South Africa (UNISA) completing my Masters degree in Play Therapy (MDIAC in Play Therapy). For the purpose of my studies I am undertaking research concerning the development of guidelines for parents to support adolescent girls who self-mutilate and am conducting the research at your daughters school. In order to complete my research I am requesting your permission to conduct an interview with your child as well as to tape record the interview. During the interview discussions will centre around your child's experience of self-mutilation as well as to explore and describe the support needed by adolescent girls who self-mutilate in order to develop guidelines of support for parents.

Your child is under no obligation to participate in the research and may withdraw from the interview at any time if she wishes to. As researcher I intend to inform your child beforehand about the intent of the research, what the potential impact can be as well as the fact that she may withdraw at any stage if she wishes to.

I undertake the following:

- To ensure protection and confidentiality of your child's identity at all costs. Any references in the research report will be handled anonymously.
- To ensure all information of a personal nature will be managed confidentially.
- To ensure that only the researcher and study leader will have access to any information. Findings regarding support strategies will be made available in the dissertation.
- To ensure that the information will not be used for any other purposes other than the research.
- To ensure that debriefing sessions will follow immediately after the interview so that your child may discuss her feelings about the interview and to rectify any misperceptions that may have arisen in the mind of your child.

- To ensure the compilation of simplified guidelines that will be made available to you as parent in order to know exactly what has happened to the information.

I conclude that participation in a research project should be a learning experience for all concerned. Should you have any queries in this regard please do not hesitate to contact me at 082 567 6359.

Yours sincerely

Veronica Robertson

ADDENDUM B: Consent form for parents

I _____ Parent/Guardian of
_____ hereby give permission to
Veronica Robertson to conduct an interview with my child.

I acknowledge the following:

- That protection and confidentiality of my child’s identity will take place at all costs. Any references in the research report will be handled anonymously.
- That all information of a personal nature will be managed confidentially.
- That only the researcher and study leader will have access to any information. Findings regarding support strategies will be made available in the dissertation.
- That the information will not be used for any other purposes other than the research.
- That debriefing sessions will follow immediately after the interview so that my child may discuss her feelings about the interview and to rectify any misperceptions that may have arisen in the mind of my child.
- That participation is voluntary and that my child may withdraw at any time during the interview.
- That simplified guidelines of support will be made available to me as the parent in order to know exactly what has happened to the information.

.....
Signature: Parent/Guardian

.....
Date

ADDENDUM C: Consent form for adolescent

I _____ hereby give permission to Veronica Robertson to conduct an interview with myself.

I acknowledge the following:

- That protection and confidentiality of my identity will take place at all costs. Any references in the research report will be handled anonymously.
- That all information of a personal nature will be managed confidentially.
- That only the researcher and study leader will have access to any information. Findings regarding support strategies will be made available in the dissertation.
- That the information will not be used for any other purposes other than the research.
- That debriefing sessions will follow immediately after the interview so that I may discuss my feelings about the interview and to rectify any misperceptions that may have arisen in my mind.
- That participation is voluntary and I may withdraw at any time during the interview.
- That the dissertation will be made available to me in order to know exactly what has happened to the information.

.....

Signature: Adolescent

.....

Date

ADDENDUM D: Consent form for psychologist

I _____ hereby give permission to Veronica Robertson to conduct an interview with myself.

I acknowledge the following:

- That protection and confidentiality of my identity will take place at all costs. Any references in the research report will be handled anonymously.
- That all information of a personal nature will be managed confidentially.
- That only the researcher and study leader will have access to any information. Findings regarding support strategies will be made available in the dissertation.
- That the information will not be used for any other purposes other than the research.
- That debriefing sessions will follow immediately after the interview so that I may discuss my feelings about the interview and to rectify any misperceptions that may have arisen in my mind.
- That participation is voluntary and I may withdraw at any time during the interview.
- That the dissertation will be made available to me in order to know exactly what has happened to the information.

.....

Signature: Psychologist

.....

Date

ADDENDUM E: Consent form for principal

PO Box 2231
Dennesig
7601

Dear Principal

I am currently a student of The University of South Africa (UNISA) completing my Masters degree in Play Therapy (MDIAC in Play Therapy). For the purpose of my studies I am undertaking research concerning the development of guidelines for parents to support adolescent girls who self-mutilate and am requesting permission to conduct the research at your school. No manner of reference will be made to your school and all information regarding the school will be treated as strictly confidential. I intend to work through the guidance counsellor of your school and all correspondence will be conducted through the guidance counsellor who is fully aware of the needs for my study and has agreed to offer her full assistance.

I conclude that participation in a research project should be a learning experience for all concerned. Should you have any queries in this regard please do not hesitate to contact me at 0825676359.

Yours sincerely

Veronica Robertson

I _____ hereby give permission to Veronica Robertson to conduct research within my school.

.....

Signature: Principal

.....

Date

Key

Left hand
Key words
Future research

Right hand
margin

ADDENDAM F: Coded transcript

Researcher: What do you know about self-mutilation?

Adolescent C: *(The Adolescent C is nervous, holding on firmly to her coffee cup and sitting squarely in her seat, almost rigidly. She is timid and soft spoken yet eager to please.)* That's a very broad question, what do I know. I know that it is a definite sign of distress and I also just recently found out that there are, they say that there is a self-mutilation that you do that is very private, that you do just for you to deal with your feelings and there is also a very public one, where you hurt yourself and you deliberately do it where people can see. Either because you want to make it known how much you are struggling. And then also that, I keep forgetting.

distress

private
deliberate
hurt

Future research:

Issue of attention

Researcher: Where did you find this information?

Adolescent C: I was reading a book about personality disorders and how it gets to self-harm. *(She speaks with little emotion, deadpan voice it seems that it takes much energy from her little reserve to speak of these things)*. It was very interesting and that self-harm is not something that is very apparent, cutting yourself could also be drinking or binge eating or stuff like that.

Researcher: So there are other ways of harming yourself other than cutting?

Adolescent C: Yes.

Researcher: Can you tell me more?

Adolescent C: Well, I suppose there is just so many ways so many things you could use, I mean burning was also something that I did but not as much as cutting.

burning
cutting

Researcher: So you mostly cut?

arms

Adolescent C: Yes. My arms mostly.

Theme 1: Served a function

Theme 2: Shame and guilt

Theme 3: Low self-esteem

Theme 4: Conflict

Theme 5: practical suggestions or other

in bedroom
at school

Researcher: Did you have a special place that you would cut?

get it
out

Adolescent C: Um, ya. Like pretty much in my own bedroom but there were times that I did it at school in the bathroom when I just had to get it out. *(The Adolescent C is very eager to please but she just has no energy to engage with, it seems that even talking is an effort).*

Researcher: In what ways does self-mutilation help you?

Angry
Sad
frustrated
calm

Adolescent C: *(long pause)* I mostly cut myself when I was angry, irate angry or blind angry. Also frustrated or sad but most of the times anger. It helped me, it was like instantaneous the feeling of calmness that I would feel it and people would say go for a run, ride your bicycle, punch a bag but its just nothing compares to that. It was like a drug, it calmed me down, I could see clearly again. I was rational again, it made me feel better.

• provide relief from angry feelings + sadness
• calmed

Researcher: Did it hurt when you did it?

Adolescent C: Not at all, I would only feel it the next day. It was a little bit of a sting but it wasn't pain. It was, it is difficult to explain because people say oh you cut yourself how can it not hurt? But it was more like a pleasurable feeling than pain.

Researcher: How would you know when to stop?

calm

Adolescent C: That's a good question. You just, when you are in the process of doing it and you are starting to calm down, you kind of get to a stage where you say this is enough now. But there were times when I just carried on and on and I didn't want to stop but I have to because I don't know where this is going to go. I didn't ever have the intention of killing myself by cutting.

killing myself

Future research: suicide +

Self-mutilation

Researcher: Ok, can I go back to when you said that you would do it when you were angry or sad, are there specific examples or times that you can remember what made you feel angry?

Adolescent C: Ya, um. My family makes me angry a lot. This sounds very childish but getting my own way or not getting my own way makes me really irate. You know, it just wanted to make me scream or shout or throw a tantrum but I didn't I went and hurt myself.

↓ Turns anger at others against Self

Researcher: So you were frustrated?

punished bad person

Adolescent C: Yes, pretty much. Or me, ya and sometimes I was angry with myself and I thought that I needed to be punished for being a bad person for having these thoughts.

angry with Self

↓ self-punishment ↓ low self-esteem

Researcher: So you used this as a method to punish yourself?

no rational thinking

Adolescent C: Yes, I thought I deserved it. My rational thinking was not at its best in those times *(There is the hint of humor in her voice and a smile in her words).*

↳ lacking coping abilities or problem solving

Researcher: Can you tell me when you first started?

Adolescent C: I first started? I had just turned 14. It was before I started grade 9 and after grade 8 those December holidays. It was over something stupid with my little sister over a magazine and I got so angry, I just wanted to hurt her but instead I hurt myself.

Future research: issue of contagion

Adolescent C: And how did you get the idea to hurt yourself?

Adolescent C: A friend of mine, she had done it and I heard about it through other people who had done it.

Researcher: Did she explain that it had made her feel better?

overwhelming inflict pain on self

Adolescent C: I wondered, I just had this overwhelming desire to inflict pain on something and that something that someone was me. I have a big bad temper. I don't get angry often but when I get angry its blind anger, I literally can't see. My mom says my dad was like that and his dad was like that, so I don't know if it's genetic?

↓
first choice for coping = inflict pain on self

Researcher: Tell me about when you stopped?

medication
alleviates
angry feelings

Adolescent C: I had stopped for about 6 months and then it started again. It was after awhile after I stopped taking the medication. But its not as often as it was before. It still alleviates the angry feeling.

Researcher: You say you don't get angry like that often?

Adolescent C: No, not often. I try to stay calm. I am usually a person who goes with the flow and does not like to let things get to me. There are just some things...it's an anger that you can't conquer.

Researcher: Could you give me an example?

Angry
Lacks
control?

Adolescent C: If I want to go out for a drink but then something happens and its not really anyone's fault but somebody had plans before or there is no way of getting around or you know. I want to go out! (*The Adolescent Cs voice has energy for the first time; she is talking in animated gestures and stirs in her seat*). And its no ones fault but I just get so angry! And then its also when my dad pretty much tells me no, like we are not going to, you are not going to, we don't want you to. Then I get angry and I think sometimes that cutting myself is my way of punishing him.

Researcher: Did you hear that often in your family?

Adolescent C: No.

Researcher: So your parents did not frustrate your freedom?

parents

Adolescent C: I am not being so clear here. It's when ~~my parents. I feel like they are trying to suppress me where as they have been the most liberal~~ parents around and then if my dad says something like you are not going out or I don't want you to date someone of a different race (*emotion has entered her voice, she sounds angry*) I feel

like it's a personal attack, like I am being told no. I don't really think about the reasons why he is saying those things.

Researcher: And that makes you feel frustrated?

Adolescent C: Yes!

Researcher: Can you tell me about some of your needs in life?

noticed

cared
about

accepted

social
outcast

Adolescent C: *(The Adolescent C takes a deep breath before answering, there is a long pause before she begins to speak again).* I feel like I need to be taken notice of, I feel like I need to be cared about in a different way, like in a romantic way. I think the big need in me is to feel accepted. I have always felt a bit like a social outcast. And that I think my biggest driving force, the need to be seen or accepted.

Researcher: Accepted for who you are?

Validation

self-
acceptance

Adolescent C: Yes, for who I am, definitely. I try not to, I don't want to strive to be a person, um I don't want to feel like I need that validation from another person. I want that to come from inside of me, that's what I feel truthfully.

Researcher: There is a need to be cared for romantically is there a need to be cared for in other ways?

acceptance

Adolescent C: All of that, to be accepted for who I am for all of my faults. All of that.

Researcher: You mentioned that you felt like an outsider in school could you elaborate on that?

hated
school

Adolescent C: Yes, I hated school so much *(You can see the dislike shining out of her eyes).*

Researcher: Yes, I can see that.

never
fitted
into
school

Adolescent C: *The Adolescent C answers laughingly*, I was never one of the cool people; I was never one of the overly smart people. I don't deny my own intelligence but I just never fit into that group at school. I felt a kind of a niche in making friends with people who were also not really accepted anywhere else. And that was what we had in common and it was really cool.

Researcher: So as a group you were accepting towards one another?

Adolescent C: Yes, and I know that my friends felt the same as I did that they also didn't belong anywhere else.

Researcher: That feeling of 'not' belonging. How would you describe it?

feeling
not good
enough
flaw

Adolescent C: It makes you feel like you are not good enough. I kind of got a complex about that, feeling like I don't fit in here, there has to be some major flaw in me, what's wrong with me?

Researcher: It is not like that at all.

Smaller
self-esteem

Adolescent C: Deep down inside you know it is not like that but you can't help the way it makes you feel. And then that part of you that knows kind of gets smaller and smaller and smaller. I felt like they did not care, that it was not sincere.

Researcher: Acceptance, is it the social sphere you are in, is it your family, friends and society.

Adolescent C: *(Big sigh)* Pretty much society. My family they know me and they have never once told me to be any different to the way I am. They have learned to accept it and my friends are still the friends that I have had from the beginning of high school. It's always with new people that don't know me that it is a mission with.

Researcher: Explain this to me?

misjudge

Adolescent C: They misjudge you, it takes years to get to know someone and then after a couple of hours they know you and what you are all about and its not like that at all.

Researcher: Ok, thank-you. If you would like to add anything on to that you can. The last question is this: what do you think you need in order to stop self-mutilating.

Adolescent C: I think that I need to really get to know myself, and deal with a part of me that has problems.

Researcher: Help me to understand, are you saying that there is a part of you that is hurting and you need to help that part.

confidence
Self-
esteem
accept
myself
learn
recovery
love myself

Adolescent C: Yes, and I have a problem with confidence and self-esteem and I just want to accept myself, um, for who I am. I mean I fight with myself all the time, so that acceptance thing is not only from the outside world but also from the inside world as well. And I think that, that is the biggest thing I need to learn is to accept myself as well as learn to love myself and actually take the steps to recovery. And it would be easier if I put my all into it, I mean cause I would care about myself more.

Researcher: So you think that it needs to come from within? Can you think of any outside resources that could help you?

friends
+
family
as
support

Adolescent C: I don't know, I know I have friends and family they always make me feel good about myself its just that I have a hard time believing those good things they say. I think that it really has to come from inside me.

Researcher: It is good that you have that support?

come from
within →

Adolescent C: Yes, I mean it does help. If I didn't have that I wouldn't have anything so that is still something but most important for me is that it will still come from the inside and that is then going to help me as a person through life. I need to grow up (Adolescent C begins to laugh softly).

Researcher: *(Laughing to)* Well we all do.

Researcher: Can I ask also, when you first expressed that people say to you go for a run and you said that none of that worked? Do you think that sometimes if you had other ways of dealing with your frustrations it could have helped?

thought
about
after
learn
coping mechanisms.
emotions

Adolescent C: *(the Adolescent C interrupts me eagerly)* Yes, that's a big thing I have thought about that often. And I thought that if I had learnt at an earlier age how to really deal with these things then I might not have such a big problem now. I mean I really do think that my coping mechanisms are not good, especially emotionally.

Researcher: You think that this would help you, if you had better coping skills?

lack of
attention
conflict
in
household

Adolescent C: Yes, I think that it needs to come at an earlier age. My parents were very focused on their business but it was from home so they were home all the time but they never really paid attention or taught us, um. My mom acts like an invalid, she is always complaining about her health. It's as if she thinks that complaining will get her attention, she acts just like a baby and my dad when he gets angry, then we argue.

Adolescent C went on to explain how she feels that her mother never stands up for her that she acts like a baby and can't make any decisions and relies solely on her father who is not a mean man but he does not get to make all the decisions, she thinks that decisions should be made as a family. The researcher helped to calm her down by moving along to the debriefing session and asked her to vent these angry feelings in order for her to leave the interview in a calmer space.

Researcher: If you can think of anything else to add then please do. Otherwise we are finished with the interview and we can start with the debriefing. Thank-you for your willingness to share, your thoughts and feelings and for talking with me about this.

Debriefing: further thoughts from the adolescent

talking
family
support

Adolescent C: Talking to your family about how you feel, even though it is hard, it makes it better getting it out.

Adolescent C: **There are reasons/feelings that need to be voiced that cannot be said with words**