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Abstract

Self-injury research has been located primarily in the disciplines of psychiatry and psychology however it is gaining increasing recognition as an interdisciplinary field, ripe with potential for sociological and psychosocial analysis. In this article, I revisit Goffman's theory to explore retrospectively the dynamic nature of stigma and identity for people affected by self-injury in the socio-political context of Northern Ireland. Drawing on 30 in-depth interviews with people reporting a history of self-injury and practitioners in community roles who provide support to people that self-injure, I sought to understand their perspectives on the moral career of people who self-injure. This article provides insight into participants' experiences of three intersecting phases in the lives of those who self-injure: engaging in self-injury; help-seeking interactions; and, recovery. I propose that developing critical understanding of social theory is paramount for self-injury interventions in practice, research and policy.

Key words: self-injury, stigma, qualitative, Grounded Theory

Introduction

In this article, I employ the term self-injury to refer to the range of actions that involve intentional damage to the body, usually on skin tissue, including cutting, burning or scratching. I set out to demonstrate the importance of understanding social context in self-injury research and practice. Specifically, I locate the research in Northern Ireland (NI), to provide critical insights into self-injury in a social context characterised by political violence. Moreover, I argue that the internalisation of many hegemonic "clinical" discourses of self-injury contributes towards self-stigma and social stigma.

Literature Review

Self-injury

Self-injury is a specific form of self-inflicted damage to the body, usually enacted on skin tissue through self-cutting or self-burning. In contrast to the more generic term self-harm,

which includes self-poisoning or overdose, acts of self-injury are often conducted without suicidal intent (Klonksy, May and Glen 2013). Increasingly the distinction between self-harm and self-injury has been subject to conceptual scrutiny although definitional inconsistencies remain, particularly regarding the extent to which suicidal intent can be determined (Hawton, Harriss and Rodham 2010). Self-injury is understood to be distinct from self-poisoning because the functions of self-injury are to recover rather than end feeling (Simpson 2006), to transfer psychological distress into a visible and physical reality (Babiker and Arnold 1997) and to enact the communication of emotional distress through the body, whereby self-injury represents "the voice on the skin" (McLane, 1996: 107).

Historically, the clinical focus of self-injury research has created critical ramifications for the understanding and treatment of self-injury including: the questionable correlation between self-injury and borderline personality disorder (BDP) (Proctor 2007); the conflation of self-injury and suicide (Warner and Spandler 2012); pejorative accusations of manipulation and attention-seeking (Pembroke 1996) and the misconception that self-injury is a female phenomenon (Chandler, Myers and Platt 2011; Shaw 2002). It is argued that the construction of self-injury in the clinical literature has caused a legacy of misunderstanding, which has shaped prejudicial attitudes and concomitantly informed approaches to intervention and treatment (Chandler et al. 2011; Shaw 2002; Warner and Spandler 2012).

There is a growing body of research that conceptualises self-injury from a sociological perspective. Studies have focused on the perspectives of adults who self-injure (Adler and Adler 2004, 2007, 2011; Chandler 2012, 2013; Hodgson 2004; Inckle 2010a) and on healthcare practitioners (Chandler, King, Burton and Platt 2016; Redley 2010). Self-injury has been depicted as a deviant behaviour (Adler and Adler 2011; Hodgson 2004) and embodied emotion work (Chandler 2012). Chandler (2012) applied Hochschild's (1979) concept of emotion work to self-injury, which theorised on the sociocultural aspects of

emotions, whereby people use emotion management techniques to either suppress or express their emotions, to abide by feeling rules in different social contexts. Thus Chandler (2012) suggested that self-injury is an embodied way of managing emotions. Hodgson (2004) presented the ways that people who self-injure manage a deviant identity, using Goffman's (1963) framework of stigma management. While Adler and Adler (2004, 2007, 2011) argued that since the mid-1990s there has been a social transformation of the meaning and enactment of self-injury from a pathological condition among clinical psychiatric populations to an act of deviance among subcultures. Chandler et al. (2011) questioned whether the extent of self-injury in the general population in the past could be accurately determined to provide a longitudinal comparison. Chandler et al. (2011) also recognised that some of the participants in Adler and Adler's (2004, 2007) research did not seem to concur with the authors' label of deviance. More recently, Brossard (2014) suggested self-injury serves a normative function by enabling people to continue to function in society rather than mobilise against dominant ideology.

Psychiatric survivor and feminist discourse relates that self-injury facilitates expression of agency through the body in social conditions of silencing, trauma, and oppression (McLane 1996; Pembroke 1996; Shaw 2002). In patriarchal society, self-injury is a rational response to structural level subjugation and control (Harrison 1997). The psychiatric survivor movement has been instrumental in critiquing the cultural hegemony of clinical discourse and its reductionist conceptualisation of self-injury as either pathology or suicide (Cresswell 2005). The term survivor relates to service users' survival of the double violation of the psychiatric system, which legitimised and re-enacted gender-based abuse. Essentially the self-advocacy of the psychiatric survivor movement inspired a new wave to challenge the hegemonic clinical discourse (Foucault 1965) on those who self-injure. The aspiration was to engender a bottom-up approach to understanding and working with self-

injury, informed by service-users rather than imposed by the establishment (Cresswell 2005). Evidence indicates that this aspiration has still to be realised, with a prevailing disconnect between the needs of service-users and the outcome-based approach to clinical practice lauded by policy-makers (Warner and Spandler 2012).

Stigma and Identity

Goffman (1963) identified three types of identity: social identity relates to how we are perceived in social interactions; personal identity relates to how we present ourselves to society; and ego identity relates to our subjective sense of who we are and how we exist in the world. It is through social identity that stigma occurs. Goffman defined stigma as, "an attribute that is deeply discrediting" (Goffman 1963: 13), which is based on assumptions and shaped in social intercourse. These ideas were developed by incorporating Foucault (1986) and Bourdieu (1977), who situated power as central to configurations involving a demarcation between 'us' and 'them', those who 'have' and those who 'have not'. In these terms stigma unfolds on the basis of social identity, which becomes defined as and articulated by an acceptance of differences in status in addition to those of body, character, and tribe (Scambler 2009). Not only do people who self-injure experience a double stigma of body and character, but diminished status and power at structural levels (Long 2018).

According to Goffman (1963), the target of stigma adopts information control strategies to manage the effects of stigma and thus shape their personal identity. The person's approach to information control depends upon their ego identity, how they feel about their social identity and the experience of stigmatisation. Information control strategies include "passing" and "cover stories", identified among people who self-injure in managing a deviant identity (Hodgson 2004). Modified labelling theory (Link 1989; Link and Phelan 2001) provided further insights on the impact of stigma and labelling on the person, including shame, self-blame and secrecy. In contemporary sociological terms, stigma is a component

of the tapestry of labelling, stereotype, prejudice and discrimination, consequences of social and individual differences, which unfold at institutional levels in structural stigma, between people in social stigma, and an intrapersonal level, in self-stigma.

Goffman's work has been critiqued for his apolitical approach to conceptualising social processes of stigma and identity, whereby he sought to identify how stigma was enacted rather than why (Tyler 2018). As Scambler (2018) asserts, in understanding stigma, we ought to look up, to consider the structures that create stigma. Indeed in failing to acknowledge the political in stigma, we contribute to the structural discourse that renders stereotype, prejudice and discrimination possible (Tyler 2018). Further, Scambler (2018) has argued that through neoliberal discourse, stigma has been weaponised to locate both cause and cure for mental health problems within the person.

While the psychiatric survivor movement mobilised service-user narratives to expose experiences of healthcare harm in the psychiatric system, these narratives have been hijacked by apparently philanthropic movements, with the explicit purpose of overcoming the stigma of mental illness (Tyler and Slater 2018). When we consider that such movements are sponsored by corporate elites, we can deconstruct explicit from implicit purposes, whereby breaking stigma by speaking out about one's mental health concerns unfolds in tandem with a neoliberal ideology, which posits that those on the margins of society are there by their own hand, and not by the hands of the structures that marginalise them (Scambler 2018; Tyler and Slater 2018). Stigma and deviance are misused to apportion shame and blame upon the targets thereof rather than on the structures that generate normative ideologies and create the context for stigma and deviance (Scambler 2018).

As Tyler and Slater (2018) acknowledge there are significant discrepancies between the consequences of a person of royalty, wealth or fame speaking out about mental health difficulties and people from marginalised social groups. In the case of self-injury, we have

witnessed celebrity disclosures, from Princess Diana in the 1990s to Lady Gaga more recently, which contrasts starkly with case study research on self-injury, for instance one of the women in Walker's (2009) study who recounts changing her method of self-injury to avoid scrutiny by social services and protect her role as mother. In a world of celebrity disclosure, self-injury might be less stigmatised, but for those on the fringes of society, such disclosure represents a real threat to their life chances and identity.

The Northern Ireland Context

Northern Ireland (NI) is a region of the United Kingdom that endured more than 40 years of political conflict, euphemistically termed the 'Troubles', which was recognised in 2004 to be the most intensive and violent conflict to unfold in Europe (Muldoon 2004). NI society transitioned to peace in 1998, with the signing of the Good Friday Agreement (GFA), designed to ensure that the two main communities in NI; Nationalists from predominantly Catholic backgrounds, and Unionists from predominantly Protestant backgrounds, could live together without segregation, discrimination and violence. Despite the peace process and concomitant equality legislation, NI is still considered to be a segregated society confounded by the segregation of both the education system and political institutions.

The traditional socio-religious divides foreground a heteronormative, patriarchal social context typified through policy and law, whereby NI remains the only region of the United Kingdom (UK) where same-sex marriage is illegal and women are denied reproductive rights (Bloomer and Fegan 2014; Schubotz and O'Hara 2011). Prejudiced attitudes towards groups including women, same-sex attracted people, young people, black and ethnic minorities and other marginalised groups has been recognised in NI-based research (Bloomer and Fegan 2014; Horgan 2011; Muldoon 2004; Schubotz and O'Hara 2011). The consequences are most severe among communities exposed to the most intensive

violence of the political conflict, where poverty, segregation and violence persist and rates of suicide are highest (Tomlinson 2012).

In 2018 it was revealed that more people had died by suicide in NI in the 20 years since the GFA, than in the violence of the conflict (Northern Ireland Statistics and Research Agency, 2018). Both population prevalence of mental health problems and population suicide rate are higher in NI than other regions of the UK and Western Europe (Bunting et al. 2013; O'Connor, Hawton and Rasmussen 2014; O'Neill et al. 2014; Tomlinson 2012). Moreover, self-harm hospital presentations and admissions are higher in NI than in the rest of the UK (O'Connor et al. 2014). Despite elevated rates of suicide, the most recent Suicide Prevention Strategy has not been implemented and funding for mental health services has diminished because there is currently no government operating in NI, which has created serious repercussions for publicly funded services across the region.

Large-scale psychological research on suicide, mental health and childhood adversity in NI, suggests evidence of a transgenerational transmission of trauma, whereby younger generations who were not exposed or were exposed minimally, to the political violence in NI, are impacted by the ripple effects in the aftermath of the trauma (O'Neill et al. 2014; O'Neill et al. 2015; McLafferty et al. 2018). Concepts derived from psychosocial studies shed light on the processes of projection, whereby trauma is transmitted from one generation to the next through societal silencing and avoidance, a "conspiracy of silence" (Danieli 1998) whereby "hauntings" of trauma are carried by subsequent generations who never witnessed the original trauma (Woodward 2015). Further, Danieli, Brom and Sills (2005) identified the notion of "fixity", whereby freedom of movement across identities becomes restricted in societies characterized by trauma and terror. Becoming entombed in a single identity has damaging repercussions for the mental health of the population, which from a Goffmanian lens is suggestive of greater reliance on information control strategies that carry a heavy

psychological burden (Pachankis 2007). Moreover, shame and blame directed against those who do not conform to dominant views (Scambler 2018) embeds a culture of prejudice and discrimination. In NI, the consequences of silencing and fixity are manifest in the high rates of suicide, self-harm, and mental health problems more generally.

Little is known about self-injury in the wider community in NI. There are no statistics available about self-injury in the general population in NI, however figures on self-harm more generally help to provide some context on the issue. The NI Registry of Self-harm (Public Health Agency 2016) captured the tip of the iceberg with reported figures based on self-harm hospital presentations and admissions over a limited period of time (2012/13-2014-15). There is a small body of NI-based statistical research on self-harm among young people (O'Connor et al. 2014; Schubotz 2009), with many results comparable to other regions of the UK. However, in NI, for young people who identified as "same-sex attracted", the lifetime prevalence of self-injury was 37%, comparing starkly with the 8% lifetime prevalence of self-injury among young people who identified as "opposite-sex attracted" (Schubotz and O'Hara 2011: 498). These figures convey the challenges of life in NI for people from marginalised groups. Moreover, it has been postulated that young people in NI might have inherited a culture of silencing, from previous generations who grew up during the conflict, which compounded by a sense of isolation and marginalisation, might mean they are less willing to disclose personal information than their counterparts across the UK (Muldoon 2004; O'Connor et al. 2014). Thus, experts hypothesise that rates of self-injury are much higher in NI than reported statistics suggest (O'Connor et al. 2014). Having some insight into the scope of the issue in young people, and with elevated rates of self-harm hospital presentations and admissions, and suicide more broadly, it seems imperative to address the lacuna of self-injury research among adults in the NI community.

Rationale

From the dual perspectives of people with a history of self-injury and practitioners, I sought to understand stigma and identity at three intersecting phases in the lives of people who self-injure: engaging in hidden self-injury; help seeking; and, recovery, when they no longer engage in self-injury. Existing research has shown how people who self-injure manage the effects of a deviant identity. Moreover, in seeking to understand experiences of identity in those who self-injure, by looking up, at the structural systems that create the context for self-injury and its stigmatisation, I sought to explore how we understand self-injury in the unique socio-political context of NI. Thus, this paper makes an original contribution to understanding of self-injury in a social context characterised by political violence.

Methodology

This qualitative study draws upon research methods, processes and principles from grounded theory (Corbin and Strauss 2008).

Sampling and Recruitment

The sample included a range of key stakeholders who could provide understanding about self-injury. There were 30 participants in total, comprising 10 people with a history of self-injury and 20 practitioners. I employed a combined purposive and snowballing sampling strategy, which involved advertising in community organisations and third level education throughout NI. Additionally, some participants were recruited though word-of-mouth. Participants with a history of self-injury included eight women and two men, aged between 19 and 42 years. Persons with intellectual and developmental disabilities were not included in this study. Participants who worked with self-injury came from a range of roles, including those who work in front line intervention roles and those who work in therapeutic roles on a long-term basis. Participants in frontline intervention roles included youth workers,

community workers, crisis response workers, helpline supervisors, members of the clergy and one participant was the partner of a person who self-injures. Practitioners who worked in therapeutic roles on a longer-term basis comprised counsellors working in the third sector in NI.

The limited body of research that has explored self-injury from a socio-cultural perspective has focused on community populations (Adler and Adler 2004, 2007, 2011; Chandler 2012; Hodgson 2004) or practitioners (Redley 2010). Where this study differs is that participants included both people with a history of self-injury and community level practitioners who have experience of working with self-injury. Thus I employed a dual recruitment strategy in seeking to understand experiences of "the own"; the stigmatised group, and "the wise"; those who work with the stigmatised group (Goffman 1963). The diversity of the practitioner sample aimed to generate diversity of perspectives from people working in different roles, to add to the richness of the data.

The research was deliberately situated at a community level to create a more nuanced understanding of self-injury, help seeking and movement away from self-injury than has been captured by research located in clinical settings. In studies involving participant recruitment through attendance at formal statutory services (Hume and Platt 2007; Redley 2010), participation in the research might have been perceived as a condition of treatment or at least affecting the standard of care. Moreover, carrying out research in a setting where the person attends for treatment might colour the social desirability of responses. By contrast, I hoped to facilitate an interview setting that was clearly delineated from any services with which participants had been in contact. Moreover, by taking time to build rapport and clarify any questions about the research, including my own interest in the area, I aimed to create an atmosphere that was conducive to in-depth exploration of participants' reflections on their

experiences. This strategy fostered the participants' capacity to elaborate on their stories, particularly in relation to service use.

Practitioner participants were deliberately recruited from community level roles because I thought practitioners in these settings would have more heterogeneous experience of self-injury. The rationale for this decision was derived from the iceberg model of suicide and self-harm (McMahon et al. 2014), which proposes that the tip of the iceberg represents the visible though infrequent occurrence of death by suicide, just below the surface and less visible is reported incidence of self-harm captured by self-harm attendances at statutory services, and well below this level at the base is the very common, unreported, episodes of hidden self-injury. The difference in prevalence across the levels of the iceberg model is evident in statistics among young people in the Republic of Ireland, where rates of suicide were 10/100,00, hospital treated self-harm was 344/100,00 and self-injury in the community was 5,551/100,000 (McMahon, et al. 2014). Thus, since the majority of people who self-injure never present to formal statutory services (McMahon et al. 2014), I thought that the perspectives of people working in statutory services might be limited to more acute cases and repeat emergency department attenders, which would not necessarily be applicable to the hidden self-injuring population. To develop understanding of the broad range of self-injury and people who engage therein, I thought that the community level practitioners would provide a wider range of experiences. Clearly, there are limitations to this approach, since many people who self-injure will never present to community services either, however some do, as the practitioners were able to share a plethora of experiences.

Data Collection

I conducted one interview with each participant using a face-to-face, in-depth interview. Interviewing participants face-to-face helped to illuminate the data and added layers of richness that might well have been lost in telephone (Hodgson 2004) or online (Adler and

Adler 2011) data collection methods that could amplify barriers between participants and the researcher. While non-clinical, community populations of people who self-injure are generally a difficult to access group, I thought it was important to seek face-to-face contact, to gain a sense of the participants' lived realities and experiences during the interview, privileging researcher-participant relationship as paramount. Most of the interviews were carried out in rooms on one of the four campuses of the university, which are located in different areas throughout NI. Participants were invited to choose a location convenient to them. Many chose to attend the campus closest to their home and some practitioners opted for interviews in their place of work.

I carried out all of the interviews and recorded them with a digital audio-recording device. After each interview, I personally transcribed the data and began the process of open coding before proceeding to the next interview. Where participants identified a concept or theme that was not included in the interview guide, I updated the guide accordingly and asked subsequent participants about that particular idea, a technique central to grounded theory (Corbin and Strauss 2008). This ensured that concepts were generated in a bottom-up way from the participants rather than solely imposed by the researcher. The initial interview guide posed a range of open-ended questions exploring experiences of self-injury, experiences of moving away from self-injury and help seeking among clients and experiences of working with self-injury and responding to self-injury disclosures among practitioners. The duration of the interviews ranged from 27 minutes to 93 minutes.

Data Analysis

I employed a Grounded analysis, which entailed a constant comparative technique to identify relationships between concepts and themes across the interview data (Corbin and Strauss 2008). The analysis was an iterative process, whereby each interview was transcribed and open coding commenced before proceeding with subsequent interviews. Following

transcription, I began the process of open coding by reading, highlighting and annotating the hard copy of transcripts. I used Qualitative Research Data Analysis Software (QSR) NVivo 9 (Richards 2015) to help with the analysis process. Following annotation on the hard copy of a transcript, I uploaded to NVivo, to extend the process of open coding. I found NVivo particularly valuable for organising the data and 'holding' my thinking (Corbin and Strauss 2008), with the range of useful tools including memos, enabling me to provisionally organise and label data in the throes of the early stages of analysis. I identified concepts, by breaking the data down into small units of analysis, which would later be reconnected to create the storyline, a narrative of relationships between concepts and categories.

Ethics

Ethical approval was obtained from the University's Research and Ethics Committee prior to data collection. The research topic is sensitive and thus every stage of the research was managed with appropriate regard for ethical research practice with marginalised groups (Holland, Williams and Forrester 2014). Pseudonyms have been used to protect the anonymity of participants.

Findings and Discussion

Participants shared their stories of self-injury, which included retrospective accounts of engaging in self-injury and overcoming self-injury from participants with a history of self-injury, and of responding to and working with people who self-injure from practitioner participants. I discuss these processes in detail below in the key themes identified from the analysis: Self-injuring self - hidden outsiders; Reaching out – removing the mask; and, life without self-injury – moving forward and looking back. Data extracts from practitioners have been coded with (PR) beside each pseudonym to differentiate practitioners from participants with a history of self-injury.

Self-injuring Self: Hidden Outsiders

Most participants who reflected on personal experiences of self-injuring recounted a time of isolation and hiding, whereby their self-injury formed a component of their personal identity that they endeavoured to conceal from others. There were findings that implied engaging in self-injury is a form of emotion work (Chandler 2012; Hochschild 1979), the purpose of which Ruth described as "to take the pain out of my head and put it somewhere else." For Rosie, the physicality of the injury facilitated the management of intolerable feelings of shame for feeling "so abnormal" (Rosie), with shame leading subsequently to a compulsion to hide (Erikson 1963; Link 1989).

One participant, Anne described her initial self-injuring as "attention-seeking", or interpersonal influence as depicted in clinical literature (Klonsky and Muehlenkamp 2007).

> Anne: Initially I think it was attention-seeking behaviour, em, it quickly became, just something that made me feel better and I would go to a lot of pains to hide it, em, but people were aware.

Anne recounts a childhood and adolescence replete with traumatic experiences of emotional, physical and sexual abuse, wherein self-injury became the panacea for her emotional distress. It could be interpreted that Anne's self-injury was an act of deviance, particularly when she discusses her relationship with a friend who self-injured:

> Anne: it's a strange thing to relate to someone about but it was also nice because there wasn't anybody else to relate to from the same perspective.

Moreover, understanding the traumatic legacy of Anne's past suggested agency, in an interaction between Anne's efforts to tolerate her distress, relate to another person and ultimately endure. Anne's experiences of abuse were compounded by her status as a child and as a girl, subjected to gender-based violence by her father. Her use of cutting led to a referral to psychiatric services whereby she became subject to re-victimisation by the patriarchal system of psychiatry (Creswell 2005; Harrison 1997; Shaw 2002). Women's

over-representation in psychiatric populations has been connected with their experiences of gender-based violence, which are often silenced through the systems of gender inequality that create the conditions for them to unfold in the first instance (Kelly and Radford 1990). As feminist discourse suggests self-injury represents women's efforts to speak out against gender-based abuse, yet it ultimately serves to reinforce the representation of women as irrational and unstable, thus locating blame within the victim (Harrison 1997; Shaw 2002).

One of the practitioner participants demonstrated his perspective on a client he worked with, who had a history of rape. The participant interpreted that she had used self-injury as a means of protecting herself from subsequent acts of sexual violence:

> Phil (PR): All of the reasons have a significant positive intent behind them, all of them, you know, so, I mean for one client it was to, on the surface of it, to create a certain level of disfigurement, as a response to series of abuse and rape throughout her life, so the idea was if she disfigured her face a little bit or somewhat she wouldn't be vulnerable, however the disfigurement wasn't the real reason, the real reason was safety. And I think that's what was important, to chunk back to that level.

Phil presents to us an example from his clinical work, of a woman who has harmed her body, which he interpreted as a mechanism to protect her from any potential act of sexual violence. This narrative recounts experiences of oppression and exploitation, with self-injury serving a role of resistance, in a system where a woman cannot navigate an alternative path. The therapist recognises the client's need for safety but does not challenge the legitimacy of a world where a woman needs to create safety in this way. Moreover, the therapist presumes to know the client's "real reason" for her self-injury, which could indicate complicity in a top-down approach to clinical practice. An approach that jars with Warner and Spandler's (2012) principles for practice and research with people who self-injure, which are framed in an ethos of recognition that emotional distress originates in social context.

Self-injury manifests in marginalised groups of people, for instance men from working class communities that were impacted most significantly by the political conflict in NI. Kate a counsellor working in Belfast, explains the nature of her work with men who lived under threat from paramilitaries in their communities:

> Kate (PR): so I was working quite a bit with quite a few young men who had been put out of Belfast because of the Troubles, and who had come back but were still living under quite a lot of threat . . . And I think a lot of that comes from "big boys don't cry", they don't know how to express their emotions, they don't know how to talk through things, it's almost like they're imploding on themselves with this self-injuring.

Tomlinson (2012) suggested that men who grew up during the worst years of the Troubles were the demographic contributing most to the upward trend in suicide in NI since the GFA in 1998. Practitioners like Kate, worked a one-to-one basis with legacy issues including a range of mental health problems, in those areas that were impacted in the most severe ways by the political conflict. Kate's narrative depicts a context of anomie (Durkheim 1897), whereby insufficient integration unfolded during times of peace, with a loss of purpose and identity for those men who had fought for a cause in which they were raised to believe during the conflict. However, Durkheim's theory of integration is not sufficient to explain the complexities of suicide and mental health outcomes in conflict societies (Tomlinson 2012). Further, the "imploding on themselves" that Kate describes goes some way to portray the complex weave of psychological processes and social structures contributing to self-injury in NI.

Rosie demonstrates how the political context contributed directly to her sense of alienation, damaging family and community relationships, when she was growing up. Rosie recounts that during her teenage years, she began to self-injury as an outlet to cope with

living in a neighbourhood as a target of sectarian abuse. Self-injury became an enactment of the social control infringed upon minority groups, an opiate facilitating this young woman's capacity to accept her marginalised status as a religious minority in the area she grew up within, as a catholic family living with sectarian abuse in a protestant neighbourhood (Muldoon 2004; Trew 2004):

> Rosie: we lived in an area where, we had a lovely house and lovely neighbours on either side of us, but it was a bad area in general and there was a lot of sectarian abuse going on for us as a catholic family living in a protestant area, and there was a huge problem with local youths and our family were targeted, so because I couldn't go out and defend my family for fear of getting arrested or getting into trouble, em I took it out on myself basically, just to get the anger out of me.

Both Kate and Rosie's accounts indicate evidence of self-injury serving the function of maintaining social order (Brossard 2014).

Based on these findings, I suggest that engaging in self-injury is an isolating experience among people already marginalised through the social conditions in which they live. The shame and blame of being stigmatised and deviant, stems both from the self-injury and the social conditions that lead to self-injury. Further, I propose the need to understand social context in creating the conditions for self-injury is vital for practitioners and researchers in this field.

Reaching Out: Removing the Mask

Participants who self-injured relayed their experiences of revealing their self-injury to others through direct or inadvertent disclosures. Practitioners reflected on responding to self-injury disclosures. I found insights into the process of stigmatisation of self-injury, which occurs through social identity perceived by others in social interactions.

Through accessing services, participants perceived alternative perspectives on their self-injury, for instance Ruth, who said that she only began to view her self-injury as unhealthy when pointed out to her by a counsellor. Prior to that interaction, Ruth related that she viewed her self-injury as an adaptive coping mechanism that enabled her to live with traumatic memories of rape. Only when the self-injury was described as "wrong", did Ruth consider adapting her behaviours accordingly, at this stage embarking on a journey towards the cessation of self-injury. If self-injury was perceived as a transgression of social norms about protecting and enhancing the body, the counsellor's assertion served to maintain moral order (Foucault 1965).

> Ruth: I don't know that for the self-injury, I always saw it as a natural sort of thing, it was only when counsellors suggested that it was a bit, em, eh, verging on the unhealthy side that I realised I did need help, but I needed somebody else to point it out for me cos I just thought it was my coping mechanism . . . I suppose probably when it was getting really bad and I mean now looking back on it I was out of control, so it might've been an unconscious cry for help too, telling the counsellor and then for her to say, "this is wrong", so I needed somebody else to tell me, I couldn't kinda work it out for myself.

Although Ruth stated that she did not consider her self-injury to be wrong, it is interesting to note she still kept it hidden, and talked about making up stories to explain her cuts and bruises, before she ever attended counselling:

> Ruth: I had the greatest stories for what I was doing to myself, I was the most accident-prone person ever but nobody ever seemed to put two and two together so as long as I could remember what story I'd told for what happened then that was ok.

John's story involved institutionalisation in psychiatric care and incarceration in the prison system. He reflected that his criminal behaviour represented a form of self-injury that evoked

similar feelings during and subsequent to its enactment. John observed that his criminal record was in many respects an attempt to seek help for the mental health concerns with which he had lived since psychiatric hospitalisation at the age of 15. John portrayed a microcosm of layered stigma (Reidpath and Chan 2005) in self-injury, whereby he experienced stigma on the basis of the social conditions that led to mental distress, and the consequences thereof such as self-injury and criminal behaviour, and subsequently stigma and prejudice in the institutions tasked with protecting him:

> John: I guess unconsciously I seen people getting help within the justice system and that was where my criminal record came from, that was just to get some sorta help and well, in the end I think that probably is what helped me, in the end but initially it didn't it just made myself feel worse. Every time I was arrested and woke up in the police cell, it's almost, it was as if, it was the way I woulda felt if I'da harmed myself the previous night, you know that's just what it felt like, me getting into trouble was like a form of me harming myself without actually cutting myself or harming myself physically against myself.

Two participants with a history of self-injury discussed their fears about disclosure, conveying apprehensions about the potential repercussions of disclosing self-injury, for future career plans:

> Rosie: I was thinking about my career as well ... and I thought any, if I blot my copy book with this mental illness, I'll never be for anything, I'll never ... achieve my goal, my dream. So that was the apprehension, there was really apprehension and those were the anxieties.

Practitioners in support roles betrayed understanding about the inhibitions of people disclosing their self-injury and the level of exposure that might involve. In availing of support, practitioners suggested that people might be compelled to unveil more personal

information than they would choose, which could create long-lasting ripple effects on their lives.

> Fiona (PR): I would say it's fear of people finding out, and I suppose maybe fear of more people finding out and everybody knowing, and even fear of having to deal with the issues that come with it, I suppose, cos obviously you can't just deal with the cutting without dealing with the reasons why.

Despite a generally sympathetic approach towards self-injury, even the most compassionate practitioners communicated in a language of "othering" (Foucault 1965), which objectified people who self-injure, representing them as irrational:

> Pat (PR): I mean I guess some people realise that it's hard to explain it and therefore why would I, that's embarrassing then because you can see the part of your brain that it's not rational to have done, to be cutting yourself and so how do you explain that. But then there's a part of you that know that because it's your coping mechanism you don't want help so you don't seek more help than, you don't seek enough help to actually be helpful.

Practitioners discussed the different ways that clients might present in counselling, perhaps disclosing self-injury very openly, whereby the self-injury is a component of the mask, which the person uses to hide other facets of their identity. Two practitioners related this presentation in terms of trust, explained by Kevin:

> Kevin (PR): Just cos someone is able to talk about it straight away, doesn't mean that they trust you; that could be a histrionic presentation. So, on one level you might think "oh yeah the person's telling me straight away" but they might well run about telling everyone, it could be part of their repertoire, part of the actual problem, that they're too exposed, that they're too open, and they haven't got any self-regulation.

This finding connects with Erikson's (1963) theory of psychosocial development, which posits that developing a healthy degree of both trust and mistrust in infancy, creates the foundations for identity formation. Shaw (2002) draws on Erikson's theory to conceptualise the common onset of self-injury in adolescence, the stage of identity formation, and proffers the need for practitioners to explore the developmental histories of people who self-injure in looking beyond the behaviour. Further, this practitioner's views seem at odds with the current movements urging people to speak out about their mental health problems (Tyler and Slater 2018), which suggest that speaking is sufficient to alleviate distress. Here Kevin intimates the important points raised by mental health activists about the potential impact on people of publicising personal stories of mental distress (Tyler and Slater 2018).

The process of making choices between privacy and disclosure is influenced by the interaction of ego identity, personal identity, and social identity (Goffman 1963), yet importantly configured on the basis of power. The findings inferred the existence of power differentials between clients and counsellors, implicit in Phil's narrative, with clients asking their counsellor whether to tell others about their self-injury. In this finding I consider whether decisions about future disclosure could be based on this type of interaction with a professional, which could serve to maintain the interaction order:

> Phil (PR): I also believe that people have a right to keep it secret, you know. And again clients of mine that are coming to the end of work, particularly at the end and they'll be asking, things about scarring for instance and they'll be asking me things like, you know maybe they're ready to get involved with somebody, have a relationship with somebody, become intimate with somebody and they're saying "oh do I tell them what I did?" Well, that's entirely up to you, you can make up anything you want if you think that's ok, I mean yeah, cos not everybody needs to know

everything about everybody . . . I think it's bad that we *have to* keep things a secret, but I think we can choose privacy.

The findings in this theme implied that for some participants who self-injured, seeking help was recounted as an experience where they risked exposure, not only of their self-injury but of other discreditable features of their identity, with potentially longer term consequences for other aspects of their lives. Practitioners recognised the challenges for people in managing the demands of decisions between privacy and disclosure, both in seeking help and in disclosing their self-injury in future relationships.

Life without Self-injury: Moving Forward and Looking Back

Participants reflected on their lives since they stopped engaging in self-injury. They relayed how they managed their identity, some suggesting that the relinquishment of self-injury led to a more open approach to self-representation. Yet, participants demonstrated their ambivalence in being more open about their experiences. Rosie and Hannah conceded that there were situations where impression management persists in relation to their history of self-injury. These findings suggested tensions prevail between the past self that engaged in self-injury and the present self that no longer self-injures and seeks to be transparent. These findings supported the work of Pachankis (2007) about the heavy psychological burden of concealing a stigma, which could become a lifelong endeavour. Hannah's excerpt below suggests ongoing shame about her past experiences of self-injury, particularly in relation to her profession:

Hannah: I have a career and stuff, did even then so I would've lost that if people in my professional life knew anything about the stuff I was getting up to. And it's great in theory to be able to say we should be honest about things, I wish the world was like that, I do, because there's so much stigma and judgment out there, it's just not possible.

Some client participants framed their experiences of self-injury as a mechanism for survival or a catalyst for personal and social growth. I consider salutogenic theory (Antonovsky 1979, 1987) to be of relevance to these findings, which explains the ways that people enhance their own health through their perceptions of life. Integral to salutogenesis is a "sense of coherence", which relates to the extent that people perceive stressful life events to be comprehensible, manageable and meaningful, and thus enables people to maintain their health and indeed thrive in debilitating social contexts. Applying salutogenic concepts to recovery means focusing on factors and resources that contribute to good health rather than deficits and disorders (Parkin 2016). For many of the participants, reflecting on their lives in relation to self-injury potentially involved a reframing of the act of self-injury as enabling them to maintain their mental health albeit in a time-limited way while living in demanding and often traumatising conditions. I suggest that the participants' retrospective reflections on these experiences could infer the role of self-injury in developing a sense of coherence:

> Bret: it's something that helped make me stronger, if it never happened I probably wouldn't be the person I am today therefore I think I'm happy that it happened because I like who I am today, so I want to keep it that way.

Two related salutogenic concepts are resilience (Ungar 2008, 2013) and posttraumatic growth (Tedeschi and Calhoun 2004). Resilience encapsulates the capacity for adaptation in the face of significant adversity. Sociologically, both the genesis of adversity and resilience are interpreted as social constructs created in social structures (Vanderplaat 2016). Through participation in this research, participants reflected on traumatic experiences that contributed to the onset of self-injury. These experiences unfolded in contexts of political conflict, family breakdown, gender-based violence, impacting upon people from social groups subject to inequality on the basis of socio-economic status, gender, age, and, religion. The participants'

navigation of the help-seeking process and access to services was similarly shaped by these factors. Self-injury presented as a symptom of illness that requires a cure, yet for many it represented survival against the psychological symptoms of social injustice. Thus, self-injury could be understood as a statement of resilience and agency in the face of oppression.

Rosie provides insight into an aspect of resilience, whereby her scar is a visible reminder of survival, "I can look at my scar and say that I'm proud that I got through it, that I survived" (Rosie). This approach to conceptualising recovery is also presented in psychiatric survivor literature, as Harrison articulates, "I no longer hurt myself. I refuse to target blame on my body. Although I am proud that my scars mark out each battle I have fought and survived" (Harrison 1997: 439). For Rosie, it seems the scar provides an increased sense of recognition of her own personal strength and ability to overcome adversity. This narrative of agency comes with the caveat that "there's still a lie there to cover up, you know just for them . . . that's a burden they don't need", in relation to the need to continue to hide her past self-injury from her parents, out of a duty to protect them from what she perceives to be a burden, suggesting persistent internalised stigma (Pachankis 2007).

Furthermore, I suggest there is evidence of posttraumatic growth (Tedeschi and Calhoun 2004), defined as the positive changes evoked by trauma. For instance Megan has pursued a career working with young people, where she supports those who self-injure:

> Megan: we have youth groups ... where I'm in charge and like we've young people between like eight and 22 that come through our doors nightly ... so the roles have completely changed, it's so, like I had a conversation with a young person a couple of weeks ago who was struggling and it's so strange because it's like, "no, that was me," now it's kinda the other side of the coin, where I'm supporting them.

By eventually finding support that was helpful, Megan was able to transform her experiences of self-injury and the conditions that led to it, into a role that involves supporting young

people struggling with similar issues. I argue here that the domains of posttraumatic growth are inherently social, in this example finding a career supporting others with similar issues, is dependent on the social conditions that facilitate that process and the integration of experiences into a meaningful sense of self. A vibrant community sector emerged in NI as a grassroots response to inadequate statutory services over the decades of conflict (Cochrane and Dunn 2002). Growth enhancing opportunities are evident in the community sector, a bittersweet outcome of conflict and compromised infrastructure. A testament to the activism of the community sector is exemplified in Inckle's (2017) case study of Zest, a community sector organisation located in Derry in the North-West of NI, which has supported people who self-injure in a range of ways for more than 20 years, in the challenging context of the social inequalities existent in NI.

Louise discusses attending university as a mature student, which she was not in a position to avail of in her teenage years due to the emotional problems she was experiencing at that time,

> Louise: the fact that I'm sitting in university, I'm in my third year ... I'm three months away from graduating ... proves that academically I can do this but it was just socially, emotionally at the time I couldn't.

This finding supports Inckle's assertion that for people who self-injure, "the potential for self-development in formal education via its promotion of conceptual and articulation skills certainly merits further attention" (2010b: 164). Indeed, many of the client participants were university-educated, which was in part attributed to the recruitment methods. However, it was not only participants recruited from higher education that were educated to university level. Self-injury is recognized to cut across social strata, yet the extent to which growth ensues in recovery from self-injury is also socially determined in terms of access to resources including appropriate, helpful interventions, education and hobbies. Social capital to navigate systems

is salient for overcoming self-injury and the associated emotional challenges. For instance, Hannah, who paid to attend counselling on a private basis rather than access statutory services. This point raises important questions for self-injury researchers, in terms of our understanding of self-injury, which has in the main been derived from more highly educated groups, with McDermott and Roen (2016) a notable exception focusing on social class and queer youth accounts of suicide and self-injury. I would suggest there is a need for a more creative and targeted approach to recruitment that engages people from a diversity of backgrounds across the social strata to develop research in the field.

Limitations

This research was carried out in NI, a region with a distinctive social context, still defined by socio-religious segregation as a legacy of the political conflict. Prejudicial attitudes towards people perceived to have mental illness, such as those who self-injure, might constitute another group to face social exclusion and disadvantage in NI. Moreover, in this social backdrop, people from and living in NI might be more sensitised to perceptions of stigmatisation. Nonetheless, the findings of the study extend existing research to provide important insights to the experiences of persons who self-injure beyond the unique context of NI. The imbalance in the sample, with more practitioners than people with a history of self-injury is a notable limitation. The process of recruitment was lengthy and a range of efforts was employed to recruit participants with a history of self-injury, within the confines of the inclusion and exclusion criteria stipulated by the ethics committee. For future research, recruitment methods will be developed based on experiences of the challenges of field research in this study.

Conclusion

In this article, I raise important political points about the contexts in which self-injury flourishes and stigma is created. I propose that developing a coherent understanding of social

context in creating the conditions both for self-injury and recovery is paramount in the transdisciplinary field of self-injury research and practice. This article makes an original contribution to understanding of self-injury in a social context characterised by political violence, drawn from but not unique to the case of NI. Furthermore, I argue that hegemonic "clinical" discourses of self-injury have been internalised by many practitioners and clients, which contribute towards self-stigma and societal stigma. Self-injury is often presented as a symptom of illness that requires a cure, yet for many participants in this study, it represented survival against the psychological symptoms of social injustice. Based on this research, I propose that viewing self-injury as essentially salutogenic could foster a more empathically attuned approach among practitioners working with people who self-injure. Recognising the health enhancing functions rather than focusing on pathologies could help to overcome the pervasive self and social stigma so noxious in the lives of people that self-injure. Thus, self-injury could be understood as a statement of resilience and agency in the face of oppression.

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