EXPLORING EXPERIENCES AND MEANINGS OF SELF HARM IN SOUTH ASIAN WOMEN IN THE UK

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others

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ABSTRACT

Epidemiological studies have reported significantly higher rates of self harm in South Asian women than South Asian men or White British women, particularly within the 16-24 age group (Cooper et al., 2006). Furthermore, findings of qualitative studies indicate that South Asian women do not feel able to access mainstream support services (Chew-Graham, Bashir, Chantler, Burman, & Batsleer, 2002). As a result researchers have emphasised the importance of developing services which are appropriate to South Asian women's needs and that achieving this will require understanding of self harm from the women's own frame of reference (Husain, Waheed, & Husain, 2006).

The present study aimed to explore the experiences and meanings of South Asian women who self harm; and their experiences and perceptions of support services. Semi-structured interviews were conducted with six women of South Asian ethnicity who have experience of self harm, five of which were analysed using Interpretative Phenomenological Analysis. Individual and group level analyses were conducted and three superordinate themes of *control*, *identity* and *communication* emerged, although the interrelations between them were also important in understanding the women's experiences and meanings of self harm.

The meanings of self harm offered by the women in this study are similar to those described in other studies with South Asian women (Bhardwaj, 2001; Chantler, Burman, Batsleer, & Bashir, 2001; Marshall & Yazdani, 1999) and white western women (Babiker & Arnold, 1997); however, the participants' ambivalence regarding their self harm was more apparent. Qualitative methodology allowed exploration of the complexities and ambiguities in the women's experiences and meanings, including how they both endorsed and rejected concepts such as 'culture clash' and self harm as 'attention seeking'.

Participants simultaneously described both positive and negative experiences and perceptions of support services, including valuing a confidential forum within which to talk and feel understood. Themes which emerged included *service responses inadvertently exacerbating distress; fear of judgment* and the *impact of ethnicity*.

These findings are discussed in relation to the wider research and the extent to which the women's accounts speak to psychological models of self harm is also considered.

Strengths and limitations of the study, clinical recommendations and further research possibilities are outlined.

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CHAPTER 1: LITERATURE REVIEW

Introduction

It is over twenty years since Merrill and Owens (1986) first reported that rates of self harm are significantly higher in South Asian born women than in South Asian men or white British women. Since then this finding has been replicated by various studies and UK born South Asian women have also been shown to be at elevated risk (Bhui, McKenzie, & Rasul, 2007). For example, Neeleman, Jones, Van Os, and Murray (1996) found rates of self harm in UK born Indian females to be 7.8 times those of UK born white females; and Bhungra, Desai and Balwin (1999) reported that the rates of self harm in Asian women were 1.6 times those in white women. Subsequent research has reported that young South Asian women between the ages of 16-24 years have the highest rates of self harm (Cooper et al., 2006). This is made more concerning in view of the known link between self harm and suicide (Owens, Horrocks, & House, 2002); indeed, women from South Asian communities have also been found to be at increased risk of completed suicide (Soni Raleigh & Balarajan, 1992). Not all research has corroborated this higher rate of self harm in South Asian women (Cooper et al., 2010); furthermore, there are limitations of estimating incidence from these epidemiological studies.

Irrespective of the rate of self harm, qualitative studies have reported that South Asian women do not feel able to access mainstream services (Chew-Graham et al., 2002); and systemic failures have been purported to result in the functional neglect of South Asian women's needs (Burman, Chantler, & Batsleer, 2002). Thus researchers have emphasised the importance of developing services which are appropriate to South Asian women, and that achieving this will require understanding of self harm from the women's own frame of reference (Husain et al., 2006).

Outline of literature review

The first section of this review will consider current understandings of self harm, beginning with a discussion of the term 'self harm' and of the psychological models which have been proposed to explain its functions. Before considering self harm in South Asian women specifically, the broader socio-political context will be discussed, including ethnic and gender disparities in mental health. The relationship between gender and self harm will be outlined before focusing on the factors which have been implicated in self harm by South Asian women, including epidemiological and qualitative research findings. The second section of the review will consider issues related to the accessibility of current service provision for South Asian women, including perceptions of mental health services and systemic issues.

Understandings of self harm

Defining self harm

Self harm is an indeterminate concept. There is a lack of unanimity in the literature regarding the terms used to describe the behaviour, resulting in various terms being employed (e.g. self injury, self mutilation, deliberate self harm, parasuicide). This has led to confusion regarding what constitutes self harm and difficulties in establishing its incidence (Sutton, 2007). Self harm has been defined as the intentional and direct injuring of one's body without suicidal intent (Klonsky, 2007). However, the question of intentionality is complex and there is debate as to whether self harm and attempted suicide are distinguishable concepts. Thus Hawton et al. (2007) define self harm as intentional self-poisoning or self-injury, irrespective of motivation. In their multi-centre study of self harm epidemiology, the authors found self-poisoning to be the most common form of self harm in hospital populations, comprising approximately 80% of presentations. However, self harm covers a wide range of behaviours including cutting, burning, scratching, banging or hitting body parts, interfering with wound healing, trichotillomania and the ingestion of objects. The National Clinical Practice Guidelines for self harm (2004) define self harm as *'self-poisoning or self-injury, irrespective of the apparent purpose of the act'*. Harm resulting from culturally accepted behaviours such as smoking, drug and alcohol use, and excessive eating or dieting is excluded.

As well as differences in methods, there are differences in individuals' patterns of self harm, so that self harm may be a one off response to crisis or a repeated behaviour. It is probable that the experiences, meanings and motivations for self harm vary according to the method and pattern of self harm, and for the particular individual across time (Horrocks & House, 2010).

Psychological models of self harm

In considering the literature on self harm, it is important to remain aware of what is observation and what is conjecture. Indeed, despite increased research on self harm in recent years (Skegg, 2005) there is limited understanding of the function it serves. Various theoretical models have been proposed, for example, from reviewing the literature on self injury, Suyemoto (1998) outlined Affect regulation, Drive, Boundaries, Dissociation and Environmental models. However, the difficulty of differentiating functions of a highly complex and contextually embedded behaviour is recognised and it is acknowledged that self harm may serve multiple functions simultaneously. Indeed, Suyemoto's models (outlined below) focus on

repetitive self injury, as opposed to all self harm, although it is suggested that they can also explain other self harming behaviour (Horrocks & House, 2010):

- The Affect regulation model proposes that self harm allows the individual to manage intolerable and overwhelming emotions, either by externalising the emotion or through avoidance. Thus the behaviour serves as a means of expressing emotions which cannot be verbally communicated either to others or oneself. Self harm is also purported to allow a sense of control over emotions.
- The Drive models originate from psychodynamic developmental theory and explain self harm as expressions of life, death and sexual drives:
    - The Anti-suicide model sees self harm as a compromise between life and death drives. Self harm is conceptualised as a coping mechanism, allowing the individual to channel self-destructive impulses and therefore avoid suicide.
    - The Sexual model views self harm as stemming from conflicts over sexuality, menarche and menstruation. The Freudian theory underlying this model, that young women develop 'penis envy' and thus feel inferior and internalise their aggression, has been criticised widely for being sexist (e.g. Horney, 1967). However, the concept of internalised aggression has been influential in theories of psychopathology. Indeed, self harm has been conceptualised as an expression of anger towards the self (Klonsky, 2007).
- The Boundaries model originates from object-relations theory and views self harm as an attempt to distinguish self from others. It is proposed that an individual's poorly defined boundaries mean that perceived abandonment by others is experienced as loss of identity or self. Thus, as the skin represents the boundary between self and other, self harm serves to redefine this distinction and protect against fear of being engulfed or loss of identity.
- The Dissociation model also focuses on self harm as a means of maintaining a sense of self or identity, suggesting that self harm serves to end dissociation which results from the intensity of emotions experienced. It has also been suggested that self harm causes dissociation and thus allows the individual to escape from distress.
- The Environmental model highlights the interaction between the individual and their environment, suggesting that, on one hand, self harm results in environmental responses which reinforce the behaviour, for example, secondary gains of care or attention. At the same time, self harm serves the needs of the environment, by deflecting attention from systemic (e.g. familial or social) dysfunction, thus enabling the homeostasis to be maintained.

The evidence for the above explanatory models of self harm is variable, ranging from single case studies to empirical studies, reflecting the diversity of their theoretical bases (Messer & Fremouw, 2008). In reviewing the evidence for the functions of self harm, Klonksy (2007) notes the difficulty in comparing results across studies due to the different functions examined and variability in the conceptualisation of functions. The author concludes that the Affect regulation model receives most support, as does the idea of self harm as punishment, functioning as an expression of anger toward towards oneself. Messer and Fremouw (2008) conclude that aspects of several models probably contribute to the understanding of self harm, as the strongest empirical support was found for a behavioural/environmental model which comprised an integration of the affect regulation, interpersonal/systemic and depersonalisation ideas. This highlights how self harm can be understood on various levels, from intrapersonal to interpersonal and systemic explanations.

Ethnic or cultural differences in participants were not considered when evaluating the above functions of self harm, thus it is not known whether these models apply cross culturally. Thompson and Bhugra (2000) have proposed a conceptual model of the aetiological factors involved in self harm in Asians, suggesting a mediating role of self identity and self esteem. However, the authors do not focus on the function that self harm may serve for Asian individuals. They do cite research by Hendin (1969) on suicide in black Americans, which suggested that self harm may serve as a discharge of aggression towards oneself and others, which results from cultural and racial experiences of rage and self-hatred. This appears to relate to the above affect regulation/systemic functions of self harm. No culture specific models of the functions of self harm have been found in the research literature.

The broader socio-political context

The environmental model of self harm is supported by Babiker and Arnold (1997) who state that an individual's behaviour must be understood within the context of the communities in which it occurs. They argue that distress is often individualised, pathologised and treated rather than taken as a marker of pathology in the society. The authors note the high incidence of self injury in populations which are marginalised in society, for example, gay men and women, physically and learning disabled people and prisoners, suggesting that the individuals concerned take on the role of scapegoat for community tension, thereby allowing maintenance of social harmony.

This systemic perspective points to the importance of considering the broader socio-political context. Indeed, the difficulties experienced by South Asian women who self harm fall

within the context of widespread gender and ethnic disparities in physical and mental health. The impact of these inequalities on psychological wellbeing is discussed below.

Ethnic disparities in health Black and minority ethnic groups as a whole are more likely to report ill-health than the white British population, and that ill health starts at a younger age (Health Survey for England, 1999, cited in Nazroo, 2003). The role of socioeconomic factors in these health inequalities remains a contentious issue; however, there is growing evidence that the social and economic disadvantage experienced by ethnic minority groups is a significant contributory factor (Nazroo, 2003). There is also evidence that experiences of racial harassment and discrimination, and perceptions of living in a discriminatory society, contribute to ethnic inequalities in health outcomes such as psychological distress; poorer self-rated health and days spent in bed unwell (Karlsen and Nazroo, 2000; Nazroo, 2003). Thus the authors described how there may be three interrelated dimensions of social and economic inequality operating simultaneously: economic disadvantage; a sense on being a member of a socially devalued, low status group; and the personal insult and stress of being a victim of racial harassment.

Gender disparities in mental health In a report for the World Health Organisation, Astbury (2001) conceptualises gender as a structural determinant of mental health which is interrelated with other socioeconomic determinants such as income, employment and social position (Wilkinson & Marmot, 2003). Gender differentially influences power and control over these socioeconomic determinants; access to resources; and social status, roles, options and treatment. Gender is also related to differential susceptibility and exposure to mental health risks and differences in mental health outcomes. Many gender acquired risks of mental health result from women's exposure to poverty, discrimination and socioeconomic disadvantage. The social gradient disproportionately affects women, as they constitute around 70% of the world's poor and earn significantly less than men (UNDP, 1995, cited in Astbury, 2001). Women are more likely to be lone parents and therefore more likely to experience social isolation and reduced mobility (Office for National Statistics, 2004, cited in Kotecha, 2009). Indeed, pregnancy, childbirth and child care stresses are determinates of women's physical and mental health.

The impact of this disparity is also felt at a more subjective level, whereby awareness of low social rank leads to a sense of loss, entrapment and humiliation, factors which are strongly related to poor mental health (Gilbert & Allan, 1998). These factors are reinforced by traditional gender roles which stress passivity, submission and dependence and impose a duty to take on the care of others as well as unpaid domestic and agricultural labour. Thus women

may carry the burden of productive, reproductive and caring work (Astbury, 2001). Women's subordinate social status is emphasised in the workplace where they receive significantly lower wages and are more likely to occupy low status, insecure jobs with no decision making authority, and to experience the negative effects which go with such occupations (UNDP 1995, cited in Astbury, 2001).

Gender based violence is highly predictive of mental ill health and women are much more likely to experience domestic violence (Kotecha, 2009). This may compound feelings of humiliation, subordination and entrapment. Furthermore, it is argued that the way mental health problems are conceptualised in mental health services, from an individual pathology rather than a holistic perspective, results in further pathologising and oppression of women (Kotecha, 2009).

Self harm and women

Given the above descriptions of gender inequalities in the determinants of mental health, it is perhaps unsurprising that self harm has been reported to be more common in females than males (Sutton, 2007). However, recent epidemiological studies have found the ratio to be more equal than previously thought, with women accounting for 57% of those attending hospital with self harm (Hawton et al., 2007). The female to male ratio was also found to decrease with age, with 15-19 year old females accounting for the largest numbers by age group.

Various factors have been suggested to explain why females may be at elevated risk of self harm. Self harm has been associated with experiences of trauma, such as sexual assault, rape and domestic violence, of which women are more often victim (Sutton, 2007). Indeed, childhood experiences of physical and sexual abuse, parental neglect and separation have been linked to self harm (van der Kolk, Perry, & Herman, 1991).

Gender differences in the expression of emotion have been implicated, as self harm has been linked to the inability to articulate emotions such as anger, frustration or resentment. It is suggested that, whereas men externalise these emotions, social norms regarding what is acceptable behaviour for women mean that women's anger is instead turned inwards on the self (Sutton, 2007). This fits with the Affect regulation model of self harm and the concept of internalised aggression.

Smith, Cox and Saradjian (1998) attribute the higher incidence of self harm in women to gender role expectations, namely that women are expected to hold less power; to place the needs of others above their own; and to tolerate passively situations in which they feel used, abused and powerless. Furthermore, the authors suggest that due to these gender role

expectations, the consequent worthlessness, anger and frustration felt by women is then turned in on the self rather than directed outwards. It has been suggested that in the face of such powerlessness, self harm can be understood as way of women gaining control (Shaw, 2002).

Self harm and control

The concept of self harm functioning as a means of gaining control is prevalent in the accounts of individuals who self injure (Babiker & Arnold, 1997), and in South Asian women's accounts of self harm (Marshall & Yazdani, 1999). Lack of control has been cited as a causal/contributory factor in the development of anorexia nervosa in young South Asian women (Littlewood, 1995).

Several authors have emphasised the importance of control, for example, from interviews with young people who self harm, Spandler (1996) describes control as *"a crucial thread running through many of the functions of self harm"*, and from experience of working with women who self harm, Burstow (1992) states that *"control is a meaning that I have found to be absolutely invariable and the most fundamental"*. Arnold (1995) reported that women described using self harm as a means of controlling their feelings of anger which they otherwise feared could hurt someone else. This was echoed by the findings of Spander (1996) who suggest that self harm may allow the expression of emotions in a more controlled way, in order to prevent them from being expressed elsewhere. Thus self harm may be a means of controlling emotions in order to conform to gender role expectations of passivity described above. Again, this fits with the Affect regulation model of self harm and the concept of internalised aggression.

The multifaceted nature of control has been outlined by Spandler (1996), as self harm may be a means of controlling oneself; of doing something which others cannot control; or as a way of actively losing and regaining control. The paradoxical nature of control is also noted, as women may feel unable to control their self harming behaviour (Shaw, 2002).

Burstow (1992) notes how women who experience themselves as weak may derive a sense of strength and success from their self harm. The author also links self harm to power and resistance, suggesting that women who self harm are defying those who attempt to control them. It is argued that self harm involves women taking control and objectifying their own bodies in a way that contradicts cultural norms regarding women's behaviour (Shaw, 2002).

Related to the concept of control are those of subordination and entrapment whereby individuals are trapped in an inferior position or subject to the authority of another. In

discussing the impact of gender and ethnic disparities in mental health, Nazroo (2003) and Astbury (2001) referred to the significance of experiences of subordination, entrapment and perceived low rank. Indeed, subordination and entrapment have been linked to psychopathology (Gilbert and Allan, 1998).

In his 'cry of pain' hypothesis of suicidal behaviour, Williams (1997) proposed that suicidal behaviour occurs as a response to situations that encompass defeat, with no possibility of escape or rescue (O'Connor, 2003). Gilbert, Gilbert, & Sanghera (2004) comment on the variety of reasons why people may be trapped in subordinate positions, for example, socio-economic adversity or racism. However, they also highlight how people can be entrapped by values and traditions, noting that the level of entrapment experienced by an individual will depend on whether they feel empowered or oppressed, and whether the values form an appreciated part of their identity.

Self harm and South Asian women

The above findings suggest that self harm in South Asian women occurs in the context of widespread gender and ethnic disparities in the determinants of health and mental wellbeing. Thus, South Asian women may experience dual disadvantage. Furthermore, as females are reported to be at elevated risk of self harm, the high incidence of self harm in South Asian women is perhaps an amplification of universal gender differences.

This highlights the issue of specificity when considering the factors which may relate to South Asian women's self harm. Some factors could be described as specifically related to ethnicity, for example, racism. Other factors may be conflated with ethnicity, for example, as discussed earlier, socioeconomic disadvantage has been linked to the experience of ethnic minorities. Finally, some factors may be non-specific to ethnicity, for example, experience of abuse.

A small body of research has investigated the factors related to self harm in South Asian women. This falls into two main camps: epidemiological studies which have identified characteristics correlated with self harm; and, more rarely, qualitative studies which have explored women's views and experiences. This research is discussed below.

Epidemiological research Epidemiological studies have identified various factors which are purported to explain the high incidence of self harm in South Asian women. In their original study, Merril and Owens (1986) compared the characteristics of patients admitted to a Birmingham hospital following self-poisoning. The authors concluded that marital problems, particularly related to 'culture conflict' (for example, rejection of arranged marriages or demands by husbands to behave in a less 'westernised' way) were a significant factor in self

harm by South Asian women. Bhugra, Baldwin, Desai and Jacob (1999) reported that South Asian women who self harm were more likely to have less traditional values, experience family conflict and be in an interracial relationship than matched controls. Broader interpersonal issues were implicated in a further study of hospital attendees, which found relationship difficulties within the family to be a major precipitant of self harm (Cooper et al., 2006). Bhugra (2002) linked self harm to relationship problems, cultural conflict and cultural alienation. It was purported that young women who self harm have a more 'modern' view of their cultural identity, thereby creating conflict with older, more traditional generations regarding cultural expectations and values. The author hypothesised that the higher rates of self harm in young Asian women may be due to their having left home for college or university and therefore experiencing greater conflict between cultural expectations (Thompson & Bhugra, 2000). This relates to the findings that rates of self harm are similar between South Asian and white women during adolescence (Hawton, Rodham, Evans, & Weatherall, 2002), but appear to increase for South Asian women during the transition to adulthood (Cooper et al., 2006), suggesting particular stressors for women at this time. From their review of the literature, Hussain et al. (2006) suggest that the increased incidence of self harm amongst 16-24 year olds may relate to increased stress resulting from gender role expectations, pressure for arranged marriage, culture conflict and individualisation. The authors also note how young Asian men and women may face significant pressure as a result of cultural expectations regarding academic and economic achievement.

The concept of the self is reported to vary across cultural belief systems. For example, people of Indian ethnicity have been described as showing a greater tendency towards allocentricity, whereby the self and family are seen as integrated rather than separate and the wellbeing and integrity of the family take precedence over individual needs and self-identity. It is suggested that developing a separate identity is not emphasised in this collective value orientation (Inman, Ladany, Constantine, & Morano, 2001).

The boundaries psychological model of self harm, discussed earlier, implicated conflict regarding identity, suggesting that self harm serves to define the boundaries of the self from others. Given the above descriptions of collective identity, one could hypothesise that conflict regarding identity plays a role in South Asian women's self harm. Indeed, separating and individuating from one's parents is purported to be a key task of identity formation and necessary for good psychosocial adjustment (Erikson, 1969). However, some authors have questioned whether it is appropriate to apply this model to non-western cultures (Gupta, Johnstone, & Gleeson, 2007). For example, a recent study of adolescents in Pakistan reported that low-detachment from parents is associated with good psychosocial adjustment (Stewart

et al., 2003). Thus different cultural norms may be adaptive in their cultural context. However, the compatibility of so-called individualistic and collective values systems is questioned and it is suggested that South Asian women in Britain may struggle to balance their personal and family identity (Inman, 2006).

'Ethnic identity', incorporating self-identification as a group member, a sense of belonging to the group, attitudes about one's group membership and ethic involvement, is purported to be of central importance to the psychological functioning of members of ethnic minority groups (Phinney, 1990, 1991). The author proposed a stage model of ethnic identity formation proceeding from unexamined ethnic identity; exploration and search; and finally achieved ethnic identity. Higher self-esteem is predicted for individuals in the final stage; however, it is noted that ethnic identity is dynamic and influenced by an individual's context. Restrictions by parents and racism have been purported to limit young Asian women's identity formation, resulting in a poorly developed sense of self (Ghuman, 1999).

The concept of acculturation has also been implicated in the psychological wellbeing of ethnic minority groups (Bhugra, Bhui, Desai, Singh, & Baldwin, 1999). This is defined as the process by which ethnic minority individuals adapt to the dominant culture and the associated changes in their beliefs, values and behaviour that result from contact with the new culture and its members (Berry, Trimble and Orlmedo, 1986, cited in Farver et at. 2002). In a study into the effects of the family on adolescents' acculturation, ethnic identity achievement and psychological functioning, adolescents reported higher self esteem, less anxiety and less family conflict when there was no acculturation gap between themselves and their parents (Farver, Narang, & Bhadha, 2002). Bhugra, Bhui et al. (1999) developed a cultural identity schedule and used it to compare acculturation between Asian adolescents who self harm, their parents, women who self harm and matched control groups. They found greater dissonance between parents and adolescents who self harm in terms of their attitudes to work and marriage compared to control group adolescents and their parents. Parents of control group adolescents were more 'traditional' in their aspirations than parents of the self harm group, suggesting a protective effect of traditionalism (although the meaning of this concept was not explicitly defined). Finally, women who self harm were found to be less traditional in their attitudes towards social contact and aspirations than controls. Thus the authors concluded that acculturation on specific domains may be related to deliberate self harm.

However, Shaw (2000) notes that intergenerational conflict occurs in families in the UK and Pakistan, so in implicating 'cultural conflict', cultural explanations are be privileged over broader explanatory theories that would apply across cultural groups. This highlights the importance of not essentializing - attributing characteristics to ethnicity. Thus, it appears that

although identity may be relevant when considering self harm in South Asian women, the concept of 'culture conflict' is unlikely an adequate explanation. Indeed, the formulations involving 'culture conflict' have been criticized along methodological, conceptual and political grounds (Burr, 2002; Marshall & Yazdani, 1999). The use of the term culture in explaining self harm has often relied upon researchers' assessments, rather than the perspectives of the women concerned. Furthermore, the concept of culture has been criticised as it implies a homogeneous 'Asian culture' which can be differentiated from a homogeneous 'British/western culture'. In doing so, it is argued that cultural stereotypes form a racist discourse in which an idealised 'western culture' is presumed superior to a rigid and repressive 'eastern culture'. These stereotypes are then incorporated in explanatory models and are inadvertently accepted as fact (Burr, 2002). Finally, Marshall and Yazdani (1999) highlight the importance of the frame through which different cultures are understood and the importance of viewing the broader socio-political context. For example, it has been documented that the social disadvantage experienced by ethnic minority groups is often attributed to cultural difference, rather than to socioeconomic disparities and discrimination (Nazroo, 1999).

The above authors advocate the use of qualitative methodologies whereby research is grounded in the first hand accounts of women who self harm, as oppose to researcher defined concepts and categories. Indeed, there are limitations in the conclusions drawn from the above epidemiological studies. For example, the sample sizes are often small and the recruitment methods (predominately from Accident and Emergency departments) mean that only those who reach clinical services are represented. This is an issue across epidemiological studies of self harm as it is estimated that the incidence of self harm in the community may be more than twice that which is seen in clinical settings (Horrocks & House, 2010). It is possible that some findings, for example that self poisoning is the most common method of self harm (Hawton et al., 2007), are artefacts of the research methods (perhaps other forms of self harm are more common, but do not routinely lead people to access services).

The terms used, including self harm, culture and ethnicity, are indeterminate and therefore different studies probably utilised different conceptualisations, with consequences for their findings. A major factor to consider when reviewing this research literature is the use of the term 'South Asian women' as a singular category. This term fails to recognise the diversity that exists within South Asian communities, including national and religious identity, culture, socioeconomic status, linguistics, generation, levels of integration, circumstances around settlement and lifestyles (Chew-Graham et al., 2002; Husain et al., 2006). In particular, considerable variation is probable in terms of perceptions of self harm between members of different religious groups, as they uphold different values and beliefs regarding self harm and

suicide. For example, suicide is strictly forbidden in Islam; however, in Hinduism views on suicide are more ambivalent (Bhugra, 2004; Canetto & Canetto, 2008). Indeed, in many South Asian countries suicide is illegal and stigmatising (Bhugra, 2002). This could also have implications for understanding self harm in South Asian women. The Anti-suicide model describes self harm as a compromise between life and death drives. In the context of these religious restrictions, self harm may allow the individual to express their suicidal intentions without contradicting their religious beliefs.

Qualitative research The following paragraphs review the factors implicated in self harm by South Asian women. These studies involved individual interviews with South Asian women who have self harmed and focus group discussions with community groups. The studies enquired about the women's views of self harm in the context of their culture and experiences.

A recurrent theme in the women's accounts was the importance of *izzat* (honour/respect) in Asian family life, whereby the individual is positioned as a family member within the context of the family's standing within the cultural community (Marshall & Yazdani, 1999). The respondents felt that the burden of the family's *izzat* was unequally placed upon women, leading to high expectations and control over their behaviour (Chew-Graham et al., 2002). Thus pressure to fulfil gendered familial expectations, such as for young Asian women to get married by a certain age, were not simply an issue for the individual or their family, but related more broadly to the family's status and prestige in the community (Marshall & Yazdani, 1999).

Gilbert, Gilbert, & Sanghera (2004) conducted focus groups with South Asian women regarding the meanings of *izzat*, shame, subordination and entrapment in relation to hypothetical scenarios of women's experiences. The concept of *izzat* (shame/honour) and the importance of maintaining family honour were related to subordination and entrapment which they implicated in mental health difficulties. For example, *izzat* was given as a reason why women may stay in difficult relationships and why they do not access support services. Furthermore, some participants gave personal accounts of restrictions on their behaviour, for example not being allowed out in the evening unless accompanied by their brothers in order to protect *izzat*, and described a consequent negative impact on their self perception. Thus maintaining *izzat* can be both externally imposed, e.g. through restrictions on behaviour by others; but also internally imposed, affecting women's own behaviour. The women in this study perceived disempowerment and lack of control as significant factors in the aetiology of mental health problems. This is congruent with the literature on self harm in women where experiences of lack of control related to gendered positions were related to self harm. Self

harm in this context could also be understood with reference to the boundaries model, where self harm serves to define the boundaries between self and others.

Izzat was also described as having implications for the women's ability to speak out about their problems (Gilbert et al., 2004), a difficulty which was further compounded by an efficient 'community grapevine' (Chew-Graham et al., 2002). The resultant lack of privacy led women to fear disclosing personal issues in case it was fed back to their families or members of their community. The consequent lack of a trusted confidant or ability to discuss difficulties was described as leading to feelings of isolation, a factor implicated in the cause and maintenance of distress by South Asian women (Hussain & Cochrane, 2002). The inability to express one's emotions verbally has been linked to self harm; indeed, the Affect regulation model proposes that self harm allows the individual to express intolerable emotions through externalisation.

Domestic abuse has been described by South Asia women as contributing to their self harming. Indeed, in a questionnaire based study by Hicks and Bhugra (2003), the three causes of suicide attempts that received highest endorsement from South Asian women were violence by husbands; being trapped in an unhappy family situation and depression.

Experiences of social exclusion were also implicated in self harm by South Asian women. Racism was a repeatedly occurring theme in the women's accounts. Young South Asian women described stereotyping by their white peers, particularly in relation to culture and religion (Chantler, Burman, Batsleer, & Bashir, 2001; Chew-Graham et al., 2002). Systemic models of self harm or the concept of internalised aggression may be relevant in here.

English language difficulties were reported as contributing to a sense of isolation, due to problems communicating with professionals; lack of knowledge of services and support; or awareness of rights. This was particularly relevant in relation to domestic violence, as some women who had migrated for marriage described feeling trapped in abusive situations due to lack of alternative accommodation; immigration law which bars their access to public funds; and fear of being repatriated with consequent shame on their families (Chantler et al., 2001). Thus experiences of shame, subordination and entrapment are at the forefront of these women's experiences.

Loss of culture and family due to migration have been suggested as antecedents of self harm. This could be related to the boundaries model of self harm, where loss of others is experienced as a loss of identity or self. Indeed, if low-detachment is related to positive psychosocial adjustment, as reported by Stewart et al. (2003), then separation from family through migration may be particularly difficult.

Further difficulties implicated in self harming included sexual and physical abuse; forced marriages; difficulties with in-laws; children and health problems; and socioeconomic adversity. Thus, the difficulties described span individual, familial, cultural, societal and political domains. For this reason, researchers have stressed the importance of understanding women's attitudes and experiences of self harm within the broader context and culture (Chew-Graham et al., 2002). This advocates a systemic perspective on the women's self harm.

Meanings of self harm A small number of studies have explored the meanings South Asian women make of their self harming behaviours (Bhardwaj, 2001; Chantler et al., 2001; Marshall & Yazdani, 1999). Themes identified in women's accounts include self harm as a coping strategy for managing the intolerable distress they faced in their lives, allowing the release of built up feelings. Self harm was also described as a way of effecting change through communicating with others. A further function of self harm was to provide individuals with a sense of autonomy and control. Finally, self harm was seen as a form of self punishment and was linked to suicide ideation.

Several of these themes reveal how often self harming was not viewed as problematic itself, as it served a function in the women's lives. This closely resembles the meanings of self harm from women of other cultures (e.g. Babiker & Arnold, 1997) and is congruent with the responses from focus groups in which self harm was viewed as a logical response to extreme psychological distress (Chew-Graham et al., 2002). Furthermore, the meanings identified appear to map on the psychological models of self harm discussed at the outset of this review.

Accessing of services by South Asian women

Despite the high rates of self harm amongst South Asian women, perceived barriers to services have been reported to result in women only accessing support at the point of crisis (Chew-Graham et al., 2002). Consequently opportunities for early intervention are missed. The following paragraphs explore current service provision for South Asian women who self harm by reviewing women's perceptions and by considering wider systemic issues.

Perceptions of services

Various factors have been reported to result in reluctance to access support services by South Asian women. Chew-Graham et al. (2002) described a recurrent theme that women lacked trust in mainstream services. They feared breaches of confidentiality which would result in personal information reaching their families or community, with resultant impact on *izzat*. This included GPs and practice staff who may know their family or be part of their community. This

also resulted in reluctance to use interpreters by women with limited English. Some young South Asian women reported that their parents disapproved of the sharing of problems or accessing help outside of their community (Marshall & Yazdani, 1999).

In a literature review regarding depression in South Asian communities, Hussain and Cochrane (2004) described how beliefs regarding mental illness inhibit help-seeking behaviour. It was reported that there is greater stigma attached to mental health difficulties by South Asian communities than by white communities. They attributed this to a perception of mental health problems as incurable and their impact on arranged marriage prospects. Gilbert, Gilbert, & Sanghera (2004) suggest that the shame of consulting and openly discussing symptoms and the fear of treatments and stigma found in western societies (Meltzer, 2000) are compounded by shame and honour systems in South Asian communities. However, rather than proposing an additional culture specific process, shame and honour can be conceptualised as different manifestations of stigma. Participants in their study reported that in extreme cases, suicide was a less shameful option. It was also described how women were sometimes blamed for the difficulties they faced, including domestic violence and other abuse (Gilbert et al., 2004).

Further barriers to accessing support included the responses women anticipated from professionals, particularly in relation to their cultural identity (Chew-Graham et al., 2002). This included fears that cultural bias would affect the treatment they receive, either resulting in pathologising, stereotyping or simplistic solutions by the majority white professionals; or blaming or patriarchal responses by Asian professionals. When combined with confidentiality concerns, these issues had implications for the women's preference for the culture of professionals from whom they would seek support; some women expressed that they would prefer someone from the same cultural background who could share cultural understandings and some stated that they would prefer to work with someone from a different background as this would reduce the likelihood of breaches of confidentiality. These barriers probably contribute to another recurrent finding in this research, namely that South Asian women who self harm do not feel heard or understood by their families or mental health professionals (Chantler, Burman, & Batsleer, 2003).

In considering these findings the themes of control and identity again appear relevant, both in terms of the women's decisions over whether to access services and the consequences to themselves if they do. Indeed, it is possible that inability to access appropriate help further compounds the feelings of powerlessness that are associated with self harm. Furthermore, the fact that self harm is purported to provide individuals with a sense of control has implications for treatment interventions. In interviews with young people, it was described how outsiders'

attempts to remove or regulate their self harm were experienced negatively as a loss of control (Spandler, 1996). The author suggests that approaches to self harm need to work with, rather than undermine the individual's sense of control. Burstow (1992) states that in supporting individuals, their need for control and its expression through self harm should be respected.

Service provision

The reluctance of South Asian women to initiate help seeking is compounded by the reality of service provision for those who do. The following paragraphs reviews the systemic difficulties faced by these women in accessing mainstream services.

Studies of self harm attendees at an Accident and Emergency Departments have found that South Asian patients are less likely to be assessed by a mental health specialist than white patients (Cooper et al., 2006; Cooper et al., 2010). Furthermore, despite the high incidence of self harm, clinicians rated them as lower risk and were more likely to refer them back to their GPs without referring on to specialist services.

In their study of mental health professionals' explanations for suicide and depression, interviews with professionals revealed racial stereotypes about the value of psychological therapies for Asian people (Burr, 2002). For example, that people from collective cultures receive support from within their own communities so do not require outside help (Williams, Turpin, & Hardy, 2006); or that Asian people are not sufficiently 'psychologically minded' to use therapies as they 'somatise' their distress rather than using western terms. Subsequent research has found no difference in somatisation between Asian and white patients; indeed, the previously reported differences were probably due to GPs' assessments (Burr, 2002).

In their study of responses of health and social care staff to South Asian women who attempt suicide or self harm, Batsleer, Chantler and Burman (2003) discussed the concept of 'race anxiety', whereby white professionals were reluctant to discuss issues of race and culture for fear of causing offence or being misinterpreted. It is argued that this can result in failure to recognise the distress of South Asian women in the name of respect for cultural diversity (Burman et al., 2002). Furthermore, when professionals lack understanding of cultural practices, abusive situations may be misattributed to culture or religion, for example, failing to differentiate forced from arranged marriages. These anxieties within mainstream health professionals can result in South Asian women being either disproportionately allocated to South Asian professionals, or being re-referred to voluntary sector services which may not have the specialist knowledge required to support their difficulties (Burman et al., 2002). Thus, it is argued that there is a functional neglect of South Asian women's needs in current service

provision whereby the focus on culture prevents exploration of gender dynamics relevant to self harm. This can result in professionals neglecting to explore women's oppression and the pathologising of specific cultures (Batsleer et al., 2003).

A recent literature review regarding clinical psychology service provision to ethnic minority groups within the UK highlighted how ethnic minority individuals are often excluded from, marginalised, unable or unwilling to access clinical psychology services. It is argued that the predominately white, middle class, female cohort and ethnocentric knowledge base contribute to a profession which is inadequate to meet the psychological and clinical needs of people from minority ethnic groups (Williams et al., 2006).

As a result of the recognition of the failure of mainstream mental health services to engage women from South Asian communities and the inadequacies of ethnocentric service delivery policy, there has been increasing emphasis on the importance of understanding the views and experiences of South Asian women in order to develop interventions that meet their needs (Chantler et al., 2003). Indeed, the National Institute for Clinical and Health Excellence guidelines for self harm (2004) recommend that qualitative research be conducted regarding the meanings of self harm to individuals of different cultural and ethnic backgrounds and to explore user experiences of services.

Conclusion

A number of epidemiological studies have reported higher rates of self harm in South Asian women than South Asian men or white British women, particularly within the 16-24 age group. Various factors have been implicated in self harm by South Asian women, including concepts such as 'cultural conflict' which have been criticised for their ethnocentric perspective.

In qualitative research conducted with South Asian women, respondents reported difficulties across individual, familial, cultural, societal and political domains as contributing to social isolation, psychological distress and self harm. However, the self harming behaviour itself was described as serving a function for the women and was viewed as a logical response to distress.

Thus, in attempting to understand self harm in South Asian women, it seems important to consider multiple interconnected factors and levels of explanation. Certain themes appear to be recurrent in these explanations, namely issues of control and identity, although their relationship to self harm has not been explored from the perspective of South Asian women themselves. Psychological models of self harm allow consideration of the intra, interpersonal and systemic processes; however, they need to take account of this perspective in order to be relevant across diverse cultural contexts.

The difficulties experienced by South Asian women in accessing services were discussed in terms of perceived barriers to accessing care and systemic issues. Again, the themes of control and identity appear relevant to South Asian women's decisions over whether to access services and the perceived consequences to themselves if they do. Furthermore, inability to access help and the responses of services to these women may compound their feelings of powerlessness and lack of control. The research emphasises the necessity of developing culturally appropriate services with South Asian women's perspectives as central in order to meet the needs of this population.

CHAPTER 2: RESEARCH AIMS AND QUESTIONS

In the light of the above research and recommendations for qualitative research to be conducted into the meanings of self harm to individuals of different cultural and ethnic backgrounds and users' experiences of services (NICE, 2004), this study will aim to explore the experiences and meanings of South Asian women who self harm and their experiences and perceptions of support services. In doing so, this study aims to increase understanding of the factors which influence help-seeking behaviours which could inform the provision of appropriate services. Finally, this study aims to provide an opportunity for the accounts of individuals from a marginalised group to be heard.

This study will aim to consider the following questions:

1) How do South Asian women understand and make sense of their experiences of self harm?
    a) *How relevant are issues of control and identity in South Asian women's understandings of their experiences of self harm? **
2) How do South Asian women who self harm experience and perceive support services?

* In addition to the primary research questions, the study will consider this second-order theory-driven question which is based on the apparent pertinence of the concepts of *control* and *identity* in the literature regarding South Asian women and self harm. Thus this question aims to consider whether the concepts are relevant in South Asian women's *own* understandings of their self harm. However, as recommended by Smith, Larkin and Flowers (2009), this secondary research questions will only be considered following the establishment of a phenomenological account of the women's meanings and experiences.

CHAPTER 3: METHODOLOGY

Chapter summary

The following chapter outlines the methodology employed to address the above research questions. Qualitative research will first be briefly introduced, including the reasons for the selection of Interpretative Phenomenological Analysis over other methodologies, the epistemological basis of the approach and its appropriateness to the current study. Semi-structured interviewing and the construction of the interview schedule are then discussed, before moving on to the study sampling. The rationales for the study sample size and inclusion criteria are explained, and the recruitment strategy and procedure are outlined. Ethical issues are considered, including formal ethical approval. The demographic characteristics of the participants recruited to the study are then described. The stages of analysis are outlined, along with means of ensuring quality, and a plan for the dissemination of the study results. The chapter ends with a reflexive statement, including reflections upon reasons for interest in the subject, personal characteristics of the researcher, research experience and reflections on the process of recruitment.

Qualitative research

Selection of methodology

Qualitative research tends to focus on meaning, sense making and experience; thus is well suited for the current research aims. However, different qualitative methodologies take different epistemological positions regarding the kind of knowledge which is produced, the assumptions made about the world and role of the researcher in the process (Willig, 2008). Various methodologies were considered for the current research, including Grounded theory, which aims to develop explanatory theories of basic social processes studied in the environment within which they take place (Starks & Trinidad, 2007); and Discourse analysis, which examines how language is utilised by individuals to negotiate and construct knowledge, meaning, identities and social goods (Willig, 2008). However, the method chosen for this research was Interpretative phenomenological analysis (IPA), which focuses on personal meaning making by individuals within a particular context and with a shared experience (Smith, Flowers, & Larkin, 2009).

IPA was favoured over Grounded theory as the present study is concerned with developing an in depth understanding of individual's experiences, rather than generating a theory which can generalise across experiences. IPA was chosen over Discourse analysis, as

although Discourse analysis emphasises the possibility of multiple meanings/realities and the impact of the researcher on the discourses obtained, both of which are relevant to this study, it focuses on how phenomena are 'talked into be being' (Willig, 2008) rather than the content of the individual's experiences, which is of interest in this study.

Epistemological basis of IPA and relationship to the present study

IPA aims to explore how participants make sense of their lived experiences and to study the meanings that those experiences hold for them. It is concerned with an individual's personal perception of events, rather than attempting to produce an objective record of the event itself or to understand experience using predetermined or overly abstract categories (Smith & Osborn, 2008). This approach is congruent with the aims of this study and the recommendations in the extant literature, which stress the fundamental importance of understanding self harm from the perspective of South Asian women.

IPA takes a symbolic interactionist perspective as it recognises that the meanings ascribed to events are constructed by individuals within both a social and personal world (Willig, 2008). This theoretical standpoint argues that people act toward things based on the meaning those things have for them; and these meanings are derived from social interaction and modified through interpretation. This is relevant to the current study as previous research has highlighted the importance of considering the impact of the broader context and culture; and that in making sense of their self harm, participants will draw upon pre-existing socio-cultural accounts (Marshall & Yazdani, 1999). Thus the meanings given will be derived through social interaction and interpretation.

IPA also acknowledges the active role of the researcher, describing IPA as involving a 'double hermeneutic', whereby the participant is attempting to make sense of their world and the researcher is attempting to make sense of the participant attempting to make sense of their world (Smith, 2004). This is deemed particularly important in the current study in considering the impact of sameness and difference between participant and researcher.

The position of the IPA researcher is both empathic and questioning. It involves trying to understand the phenomena in question from the individual's perspective, whilst concurrently asking critical questions of the responses, for example, wondering what a participant may be unconsciously communicating in their account (Smith & Osborn, 2008).

Finally, IPA holds that individuals are 'experts on their own experiences' (Smith, Larkin, Flowers, 2009), which fits with the aims of this research which hopes to allow the voices of a marginalised group to be heard.

Smith (2004) described IPA as having three central characteristics:

- Idiographic, as it starts with the detailed analysis of each case in isolation before any attempt is made to conduct cross case analysis. IPA aims to comment on the perceptions and understanding of the individuals rather than prematurely making more general claims.
- Inductive, as it does not attempt to test specific hypotheses based on the extant literature, but instead is flexible and broad enough to allow unanticipated themes to emerge during analysis.
- Interrogative in its relationship to existing psychological research, so that although IPA involves analysis of a small number of cases, the results of the analysis are not considered in isolation, but discussed in relation to the existing psychological literature. Thus there is theoretical as opposed to empirical generalisability and the power of the study is based upon the light it sheds within the broader context.

A potential problem of using IPA in this study was the anticipated difficulty in obtaining a homogeneous sample, discussed further below.

Semi-structured interviews

The method of data collection chosen for this study was semi-structured interview. This approach was felt to be most appropriate as is allows the facilitation of a conversation regarding the topic of interest, whilst simultaneously allowing the participant to tell their own story and to talk about what is significant for them (Smith, Flowers, & Larkin, 2009). This is in line with the research aims to allow the participants' voices to be heard and recognises their experiential expertise. Indeed, the method of semi-structured interviewing has been advocated by feminist researchers (Dyck, Lynam, & Anderson, 1995). Semi-structured interviewing also allows the interviewer to establish rapport and take an empathic stance (Smith & Osborn, 2008). This is considered particularly important in the current study, given the highly sensitive nature of the topic.

With these aims in mind a semi-structured interview schedule was constructed to explore the issues identified in the research questions. This consists of a small number of open ended questions with prompts and probes *(see Appendix 1 for the interview schedule in full).* Interviewees were first encouraged to talk broadly about their experiences of self harm, including their appraisals and perceptions of the behaviour. They were then asked about how they see themselves in the world, and finally, about their experiences and perceptions of support services. The interview schedule was used as a guide, rather than a rigid protocol in order that the participants' accounts were not limited and to allow the researcher to follow

their interests and so that novel aspects of the subject which had not been predicted could arise (Smith & Osborn, 2008).

Prior to commencing the interview proper, participants were asked demographic questions including their age, ethnicity, religion, marital status, educational history, occupation, cohabitants and dependents. The purpose of these questions, to help place their responses in context, was explained to participants at the time.

Sampling

Sample size

Since IPA is concerned with obtaining a detailed, interpretative account of individual cases, it is suggested that this can only be done with a small number of cases. Smith and Osborn (2003) recommended six participants, although more recently the authors have stressed the advantages of using even smaller sample sizes, noting the potential equilibrium between numbers and depth of analysis (Smith, Flowers & Larkin, 2009). Thus, the current study aimed to recruit approximately six participants.

Inclusion criteria

IPA is interested in common features of a lived experience so participants are often recruited from a homogeneous group for whom the research question will be significant (Smith & Osborn, 2008). This has implications for the current study, because, as discussed previously, South Asian women are a far from homogeneous group. However, restricting the target population, for example, according to national or religious identity, was not deemed to be feasible as it would be too restrictive to recruitment. As highlighted in the research literature, South Asian women do not routinely access support services, limiting possible recruitment contact. Furthermore, it was suspected that the issues discussed in relation to accessing services, such as stigma and concerns regarding confidentially, would probably also apply to participating in the research. Given the anticipated difficulties in recruiting participants, the inclusion criteria were set as wide as possible. This is in line with previous research which, although highlighting the limitations of the term, has used 'South Asian' ethnicity in their recruitment criteria (for example, Marshall and Yazdani, 1999). However, in order to increase the homogeneity of the sample, being British educated was used as an inclusion criterion, thus including women who are not British born, but ensuring some shared experience.

Previous research highlights the particular risk of self harm in young South Asian women (Cooper et al., 2006), therefore recruitment focused on women under the age of 40.

However, due to the potential vulnerability of the women involved a lower limit for participation was set at 18 years of age.

For the purposes of recruitment the NICE guidelines (2004) definition of self harm was used, so including self injury or self poisoning, but excluding harm resulting from behaviours such as smoking or alcohol use, excessive eating or dieting. Recruitment focused on individuals who have experience of self harm, therefore including people who have harmed themselves in the past and those who continue to harm themselves.

In summary, the recruitment criteria were: South Asian ethnicity; experience of self harm (including self injury or poisoning); aged between 18 and 40 and British educated.

Recruitment strategy

Due to the anticipated difficulty of recruiting several recruitment methods were pursued:

- Self harm assessment teams within two NHS trusts – Clinicians working in hospitals, assessing individuals admitted to hospital following self harm;
- Community organisations supporting South Asian women and individuals with mental health difficulties;
- Advertisements at four higher education establishments - Posters were placed on the back of toilet doors to allow potential participants to read and take the contact details in a confidential setting;
- Advertisements through service user and self harm organisations - Information on their websites and a link to an online version of the participant information sheet.

A participant information sheet was produced which outlined the background and purpose of the research, including reference to the research on the high rates of self harm in South Asian women and low use of support services. As recommended by previous research with South Asian women who self harm (Chew-Graham et al., 2002), a statement by the researcher was also included which acknowledged the potential barriers to taking part in the research and the difference in ethnicity between researcher and participant. It was hoped that by being open and explicit at this stage, this may address some people's anxieties regarding participation. *See Appendix 2 for the information sheet and other recruitment documents.*

Recruitment procedure

In the case of the self harm assessment teams and community support organisations, professionals identified service users with whom they work who met the inclusion criteria. They introduced the study to the potential participant and provided them with an information sheet. If the service user indicated willingness to participate, the professional enquired as to

whether they would be happy to be contacted by the researcher and, if so, what the most appropriate means of contact would be. These details were then passed on to the researcher. Otherwise the potential participant was encouraged to contact the researcher directly using the contact details on the participant information sheet.

Service users assessed by one self harm assessment team were contacted retrospectively by letter on behalf of the service. The letter did not include any reference to self harm in order to ensure confidentiality, but informed them of the research project and asked them to make contact if they would like more information.

In the case of the higher education sites and the self harm and service user organisations, potential participants were encouraged to contact the researcher directly if they were interested. Individuals who had not already seen it were then sent the information sheet.

Once in contact with the researcher, potential participants recruited through either method were given further information regarding research and were invited to ask any questions. If still willing to participate, a meeting was arranged to conduct the interview. This was at a safe, confidential and convenient location for the participant.

On meeting the researcher clarified the information regarding the research and answered any questions. This included discussion of risk issues and the limits of confidentiality. Formal consent was requested and the participant was asked to sign a written consent form which included an agreement to be audio-recorded. The interviews lasted approximately an hour and a half.

Immediately following the interview, participants were asked for feedback on their experience of the interview and were given the opportunity to discuss any concerns or issues arising with the researcher. They were also provided with a list of support services. As the interview involved discussion of the individual's use of support services, it was possible to suggest further sources of support if necessary.

Participants received a voucher to the value of £15 as acknowledgement of their contribution. This was felt to be particularly important in the context of researching a marginalised group, as lack of reciprocity in the researcher-participant relationship has been reported to reduce acceptability and credibility of research (Mir, 2008).

Ethical considerations

A primary ethical issue in conducting this research was the potential distress evoked in participants by their recounting difficult personal experiences. In order to manage this it was ensured that participants had adequate information on what the research entailed before taking part; were aware that they could withdraw at anytime; and were given opportunity to

debrief afterwards. Participants will also be informed of the limits of confidentiality prior to commencing the interview.

In the event that someone should become acutely distressed, the researcher planned to stop the interview and offer immediate support. The researcher has a sufficient level of clinical training to qualify them to do this. If applicable, participants would also be encouraged to talk with the service provider who introduced the study to them if further support is required at a later time. As mentioned previously, all participants were provided with a list of support services and as the interview involves discussion of their use of services it may have been possible to suggest further sources of support if necessary.

A protocol for managing risk issues was planned in advance. If immediate risk issues were indicated so that it was felt that the participant was at grave risk of harm to themselves, this would be discussed with the participant and if appropriate, further action taken, either contacting their GP or seeking formal assessment. Risk to others, including child protection concerns, would be reported to social services or the police. Under these circumstances the researcher would receive clinical supervision.

The impact of hearing participant's stories on the researcher was considered and specific supervision was organised with a member of the Doctorate in Clinical Psychology staff to discuss personal reactions to the interviews. This included preparatory discussions before interviewing commenced and debriefing sessions afterwards.

Ethical approval

Formal NHS ethical approval for the research was obtained from Leeds Central Research Ethics Committee. Three amendments to the original proposal were submitted, all aiming to extend recruitment opportunities. The first obtained permission to write retrospectively to attendees of the self harm assessment team; the second amendment (which was rejected) requested permission to recruit from secondary sources; and the third obtained permission to advertise the research using websites and communications of organisations who include South Asian women and individuals who self harm. Letters of approval are included in *Appendix 3*. Local Research and Development approval was obtained for recruiting through the two NHS trusts. The research was also reviewed by the ethics bodies of the higher education establishments and the researcher underwent a separate Criminal Records Bureau check.

Sample demographics

A total of six participants were recruited to the study; however only five have been included in the analysis. The sixth interview was not completed as significant risk issues arose which required immediate action. Of the remaining five participants, three responded to posters within higher education establishments; one responded to an advertisement on a service user website and one was recruited via a NHS self harm assessment team. The demographic characteristics of the women are shown below.

Pseudonym	**Farida**	**Salma**	**Adeeba**	**Yasmin**	**Rashida**
Age	Early 20s	Early 20s	Early 20s	Early 30s	Early 20s
Ethnicity	*"Pakistani"*	*"Pakistani"*	*"British Pakistani"*	*"British Asian"* Bangladeshi origin	*"British Muslim"* Pakistani origin
Country of birth	England	England	England	England	England
Religion	Muslim	Muslim	Muslim	Muslim born, not practising	Muslim
Highest educational level	A levels	Degree [ongoing]	Degree [ongoing]	Degree	Degree [ongoing]
Occupation	Working	Student	Student	Not currently working due to mental health difficulties	Student
Co habitants	Parents and siblings	Parents and siblings	Parents and siblings	None	Parents and siblings
Marital status	Single	Single	Single	Single	Single
Dependents	None	None	None	None	None

Figure 1: Demographic characteristics of the sample population

As shown in *Figure 1,* the women form a relatively homogeneous sample. They are all British born, from Muslim backgrounds, single with no dependents and have attended higher education. Farida, Salma, Adeeba and Rashida are all in their early 20s, of Pakistani origin, living with parents and siblings, and currently studying or working. Yasmin is in her early 30s, of Bangladeshi origin, Muslim born, but not practising. She has also attended higher education and described having left work due to her mental health difficulties. The relative homogeneity of this sample is ostensibly somewhat surprising given the diversity of recruitments routes. However, this perhaps highlights how willingness to participate in the research will have impacted on the sample characteristics. Indeed, four of the five participants were self-selecting.

Analysis

Stages of IPA analysis

Audio recordings of the interviews were transcribed by the researcher or a university employee who signed a confidentiality agreement. The transcripts were then analysed, one at a time, using the following IPA process (outlined in Smith and Osborn, 2008). Although, described using a series of linear stages; the process was iterative, whereby the researcher moved back and forth through different ways of thinking about the data (Smith, Larkin, & Flowers, 2009):

- The researcher repeatedly read through the transcript in order to become familiar with the individual account. The audio-recording of the interview was listened to in order to allow the researcher to comment on *how* things were said, for example, the fluency and emotional tone of the account.
- The transcript was annotated in detail. This was structured by descriptive comments, focusing the context of what was said; linguistic comments, describing the use of language by the participant, and conceptual comments, which took a more interpretative and interrogative position. To aid this process, particular strategies were employed for example, attention was paid to apparent contradictions in the account; and the development of the narrative over the course of the interview was considered in relation to the timeframe of events described.

  Throughout this process the researcher attempted to retain a reflexive awareness, trying to put aside her own assumptions and preconceptions (and during subsequent transcripts apparent links between the interviews) in order to engage with the meanings of the particular account. To aid this separation, personal reflections and links between transcripts were 'bracketed off' (Smith, Flowers, & Larkin, 2009) by recording them in a separate location.
- From the exploratory comments, emergent themes were identified, with the aim of capturing the complexity of meanings. An example of this process is shown in *Figure 2*.
- The themes were then clustered according to relationships between them, shared meanings or references. This was done physically, by printing the themes on to separate pieces of paper and experimenting with different groupings. This also allowed exploration of the relationships between themes, by organising them spatially. Each cluster was then given a name which captured its essence. At this stage, the researcher went back to the transcript and compiled tables of quotes which were represented by each higher level theme. This allowed the researcher to check the representativeness of the themes as well

as their internal consistency. The researcher also reread the original transcript to consider the fit between the narratives and the emerging analysis.

Transcript	**Descriptive comments [Conceptual comments]**	**Linguistic comments**	**Emergent themes**
Researcher: "Just a really, really broad question to start, if you can just kinda tell me about your self harm?"			
Yasmin: "Okay, I think it started about 5 years ago really. I think it worked with my depression because, I think, I had my depression. It started, my depression started when I was studying at university and then they didn't really give any help; or there wasn't any information out there; so I think when my depression started 10 years ago I was kind of low and I was miserable, isolated and as worse as you can get. And I think, from that, I think to recover or to deal with that because people, you don't attract people when you're down or miserable, or if people can hurt you, my self harm just came out of the blue as a coping mechanism and I was trying to progress into my work and my career; trying to build my social life and I think it was more like frustration for me so it was like an outlet and it felt better than the depression because depression means you can't go out; you can't go to work; you can't eat well; self harm felt more like an outlet for that basically."	Started to self harm 5 years ago [Mid twenties]	Links self harm to depression	Self harm *worked with* my depression	Self harm related to depression
	Depression started whilst at university	Didn't give any help or information [Feeling unsupported?]	Speed of talking [nervous?]	Unsupported, isolated
	Low, miserable, isolated	Self harm to recover - to deal with depression [SH useful?]	"A*s worse as you can get*" [Emphasising how bad she felt]	Self harm to recover from low of depression
	Don't attract people/people hurt you [isolated; others as malevolent]	Self harm as a coping mechanism	"*Just came out of the blue*" [implies externally imposed?]	People as malevolent Self harm as a coping mechanism
	Trying to progress in work; trying to build social life [striving?]	Self harm as outlet for frustration		Trying to progress in life frustration Self harm providing an outlet for emotions
	Self harm felt better than depression	Debilitated by depression	Emphatic	Self harm better than depression

Figure 2: Extract from a transcript illustrating initial noting and emergent themes

- Having completed this process with one interview the researcher, repeated the process with the next. Whilst inevitably influenced by the prior analyses, the researcher attempted to minimise the impact of this on the next through the process of bracketing, thus maintaining IPA's ideographic focus (Smith, Flowers, & Larkin, 2009).

- Once each interview had been analysed separately, the next stage involved looking for connections between themes across cases. Both convergence and divergences in the accounts were considered.

Ensuring quality

Several processes were employed in an attempt to ensure the validity and quality of the research:

Reflexivity A central component of the IPA process is reflexivity, whereby throughout the course of the research the researcher engages in critical self-reflection. There is recognition of the role of the researcher at all stages of the research and that the accounts heard will be influenced by the questions asked; the interaction between researcher and participant during the interview; as well as the interpretations made during the analysis. The aim is that by being aware of one's own assumptions and preconceptions, the researcher can be open to meanings of the participant with whom they are engaging (Hunter, 2010).

Several strategies were employed to facilitate this: I used a reflective diary to record personal reactions through all stages of the process, including reflecting on the process of recruitment and interactions during interviews, for example, where I felt positioned by the participant. During the course of analysis, I attempted to set aside my own assumptions and preconceptions through the process of 'bracketing'. Particular attention was paid to the impact of similarity and difference between myself and participants on the analysis and interpretations made. This was aided by discussions with supervisors who highlighted issues outside of my own awareness.

Data checks As recommended in the IPA literature (Smith, Flowers, & Larkin, 2009), the researcher employed a systematic and transparent method in conducting the analysis with the aim that it would be possible for someone external to follow the process taken from initial noting to the final report.

The analyses were shared with research supervisors who verified the stages from initial noting through to themes and write up. A section of anonymised transcript, initial notes and emergent themes was shared with a fellow researcher who assessed whether she believed the interpretations made were coherent and credible. A completed analysis of an individual's account was shared with an academic with expertise in IPA. Finally, through attending a qualitative research support group, the researcher was able to discuss issues, raise concerns and receive guidance from an expert and peers, relating to the methodology throughout the process of the research.

Credibility The construction of tables of supporting quotes during the analysis phase and the use of extracts from the transcripts in writing up have been used to evidence the interpretations made and ensure they are representative of the accounts of the participants.

Feedback on the analysis was not sought from participants, partly because ongoing contact with participants was not planned, but also in acknowledging that the interpretations made will belong to the researcher. However, in making interpretations, I reflected on what the participant's view would be on reading it. This was felt to be particularly important in the current research, where I am attempting to represent the perspectives of a marginalised group. Indeed, there was recognition of the potential power imbalance between myself and participants. Thus there was a desire to empower participants through making interpretations which accurately reflect their perspectives and recognise their experiential expertise. This is in line with feminist approaches to researching women and researching socially excluded populations which have highlighted the potential for research to be disempowering and exploitative (Mir, 2008).

Dissemination of results

Several of the participants indicated their interest in hearing about the results of the study, as did several of the professionals involved in recruitment. Thus a summary report will be produced and circulated. This will include only the group level analysis in order to preserve anonymity of the participants. A copy of the completed research will be kept in the University of Leeds library and the national online thesis database. The study will hopefully be written up for publication.

Reflexive statement

Interest in self harm by South Asian women

My interest in this subject began whilst working as a trainee clinical psychologist within an adult psychological therapies service in West Yorkshire and noticing that the ethnic demographic of the service users did not match the demographic of the surrounding population, with black and minority ethnic individuals being under-represented. Around the same time I was working with a service user (of white British ethnicity) who harmed herself. Whilst reading up on self harm I came across an article discussing the high rates of self harm in South Asian women. I remember being surprised by this, leading me to reflect on my assumption that self harm is '*something that white Western women do'*. This insight, combined

with the awareness that South Asian women were not accessing the service I was working in, prompted my desire to learn more about self harm by South Asian women.

Personal characteristics

To answer the same background questions as asked of the participants in this study, I am in my late 20s, of white British ethnicity, born in England and an atheist. I have completed degree level education and am currently undertaking a doctoral training course in clinical psychology. I live alone, my marital status is single and I have no dependents.

In many respects I am similar to the participants in this study, including gender, age, country of birth and educational background, and as a result we may share many experiences and frames of reference. Perhaps the most salient difference between myself and the participants was that of ethnicity. Indeed, in the context of researching individuals from a different ethnic minority to myself it was easy to focus on this difference. Thus, it has been important for me to reflect on whether I am myself essentializing - prioritising the significance of ethnicity over other factors in the women's experiences.

Nonetheless, the potential impact of the difference in ethnicity between participants and myself was considered at all stages of the research. There has been much discussion in the feminist literature regarding the impact of sameness and difference on the research process, including with regard to ethnicity. For example, Bhopal (2001) argues that '*racial identity can and does affect the research process, whereby women who have some shared experiences with researchers may be more willing to speak to researchers who reflect this'*. From her experiences of interviewing South Asian women, Hall (2004) concludes that a white researcher is likely to be viewed as an 'outsider' by ethnic minority participants, regardless of shared gender. However, she states that the status of outsider had positives and negative effects on her relationship with her interviewees. Furthermore, it has been noted that there are numerous dimensions along which researcher and participant may claim commonality or difference (Song & Parker, 1995). Indeed, even with shared ethnicity, one cannot assume shared experience, as there are multiple groups and identities to which one can be an insider or outsider (e.g. ethnicity, religion, someone who has self harmed); and group membership is complex and can be problematic as well as advantageous (Chaudhry, 1997).

Researchers have also noted the how assumptions made by participants regarding the cultural identity of the researcher may influence the accounts given, for example, withholding or disclosing certain information. The authors also note that there are likely to be multiple connections and disconnections through the course of an interview (Song & Parker, 1995).

Thus, I attempted to remain reflexively aware of where I was positioned by participants in relation to themselves, and where I positioned myself in relation to the participants.

It was hoped that with regard to ethnicity, there may be an advantage of holding a naïve stance, as it could encourage participants to explain concepts comprehensively rather than assuming a shared understanding and therefore uncover implicit assumptions and expectations (Willig, 2008).

Whilst working in mental health settings and in my personal life I have encountered self harm and so the concept of self-destructive behaviour is not unfamiliar to me. Given this, it was important to remain reflexively aware of the meanings and understandings I hold regarding self harm, so that I was not projecting these ideas into the women's accounts. Hunter (2010) talks of the importance of recognising the sense of familiarity with accounts as a marker that one may be drawing conclusions on the basis on one's own assumptions rather than engaging with the participants' meanings. Thus, I attempted to be aware of this whilst analysing the accounts. *Reflections on the interviews and analysis are discussed later.*

Research experience

Although I have conducted several small scale research projects in the past, this is my first experience of conducting formal qualitative research. I was eager to use a qualitative design as the principles behind the methodology, of hearing individuals' stories and privileging their knowledge, fit with my own values. Indeed, undertaking this research is congruent with my belief in social equality and enthusiasm to support women's rights.

Reflections of the recruitment process

As anticipated recruiting participants to the research was extremely difficult. Advice was sought from researchers and professionals working with South Asian women and more than twenty organisations were approached whilst setting up recruitment sites. The response of professionals was often interest and enthusiasm, but as predicted from the literature, also stating that they were not seeing South Asian women who self harm.

Furthermore, it seemed that recruiting through gatekeepers led to the inevitable difficulties of professionals struggling to recruit due to pressures on their time and possibly some understandable reluctance to ask women to participate in a research project when managing already complex situations. Indeed, I was aware of my position as an external researcher and that I could be perceived as demanding without contributing. Ideally, I would have liked to spend more time building up relationships with gatekeepers; however, in

practice, I felt I needed to spread recruitment as widely as possible in order to maximise opportunities.

As a result it is perhaps unsurprising that the most effective means of recruitment were appealing to women directly. Interestingly, those who did volunteer to participate were eager to do so, sometimes travelling considerable distances, overcoming significant barriers regarding disclosing their self harm and talking about distressing experiences.

The women's motivations for participating were discussed during the interviews. The most common reason given was a desire to raise awareness and improve access to services in order to help other South Asian women who self harm. Indeed, one participant stated that she volunteered because she thought *"if no one turns up then you'll think there are no women who self harm*"; however, the same participant also described wanting to talk about her self harm in the hope that this may help her reduce the behaviour. This demonstrates how there were likely several motivations acting simultaneously. In the context of the women's experiences, it seems probable that they valued the opportunity to talk about their experiences and have their perspectives heard. Indeed, two participants contacted me following the research to state that they had found the experience positive.

It is impossible to know how much my personal characteristics affected the recruitment process; however, the responses of the women who did participate suggest that they probably did. During recruitment it was anticipated that the difference in ethnicity may act a barrier to participation, as suggested by Bhopal (2001); however, as discussed in relation to service use, some individuals may be more willing to speak to people from a different ethnic background (Chantler et al., 2003). This prediction was born out in the interviews, whereby one participant explicitly stated that she was more willing to talk to someone outside of her community. Indeed, I began routinely asking participants whether my ethnicity had impacted on their taking part. The fact that the women volunteered to be interviewed by a non-Asian researcher may have implications for the accounts given, as it perhaps reflects where the women position themselves in terms of their culture and ethnicity.

The fact that all the participants have attended higher education is perhaps significant, as they may have been more familiar with the concept of university research and participation. Indeed, they may have felt more inclined to support a fellow student.

CHAPTER 4: ANALYSIS

Chapter summary

This chapter presents the phenomenological analyses of the participants' accounts, completed using the method outlined in the previous section. Initially some issues regarding the presentation of the analysis are discussed. Individual analyses of each participant's account are then presented, including a pen portrait, summary and description of themes. A group level analysis is then described and discussed. The chapter ends with some reflections on interviewing and the process of analysis.

Presentation of analysis

Ensuring anonymity and constructing pen portraits Throughout the research process mechanisms have been employed to maintain the anonymity of the participants. For example, names, locations, family relations and identifying details in the women's accounts have been changed or omitted. A balance has been sought between confidentiality and representativeness (Smith et al., 2009); whereby, it was felt that in order to accurately reflect the participants' experiences and meanings of self harm, it was necessary to include the context within which these experiences and sense-making occurs. Thus, pen portraits have been constructed to provide a chronological outline of the experiences participants described as related to their self harm and their use of support services.

Individual versus group focus Related to the above issue regarding representativeness is the dilemma between focusing on the individual or group level analyses. For the purpose of this research where there is some commonality between accounts, it is hoped that by presenting the individual accounts in depth that the idiosyncrasies of the participants' meanings are captured.

Experiences of self harm and experiences of support services Initially it was assumed that the experiences and meanings of self harm and experiences and perceptions of support services would be considered and presented separately in the analysis. However, it became apparent that they were interrelated in the participants' accounts, thus they have been presented together in the individual analyses. However, because these inter-relationships were particular to the individual, the two facets are presented separately in the group analysis.

Interview 1 – Farida

Pen portrait

Farida is in her early twenties, living with her parents and siblings. Having completed college level education, she is now working. Farida described her ethnicity as Pakistani; she is Muslim, single with no dependents.

Farida began harming herself during her mid-teens by cutting herself on her arms with a knife. She attributes this to violence by an older sibling and her mother's failure to intervene. She was also sexually assaulted at this time by her uncle, which further damaged her family relations.

Farida stopped harming herself during college; however, having been offered a place at university, her parents told her that she would not be allowed to go and that she would be sent to Pakistan to be married. This precipitated Farida taking an overdose of painkillers, which she explained was done with suicidal intent.

Soon afterwards Farida fled to a different city and broke off contact with her family. Farida began a relationship; however, her boyfriend was abusive towards her. During this period she took several overdoses and cut herself on the legs and arms.

Farida later returned to her family, although she continues to have an acrimonious relationship with them. At the time of interview, Farida was working and had recently ended a relationship. Farida had not harmed herself since she returned to her family home.

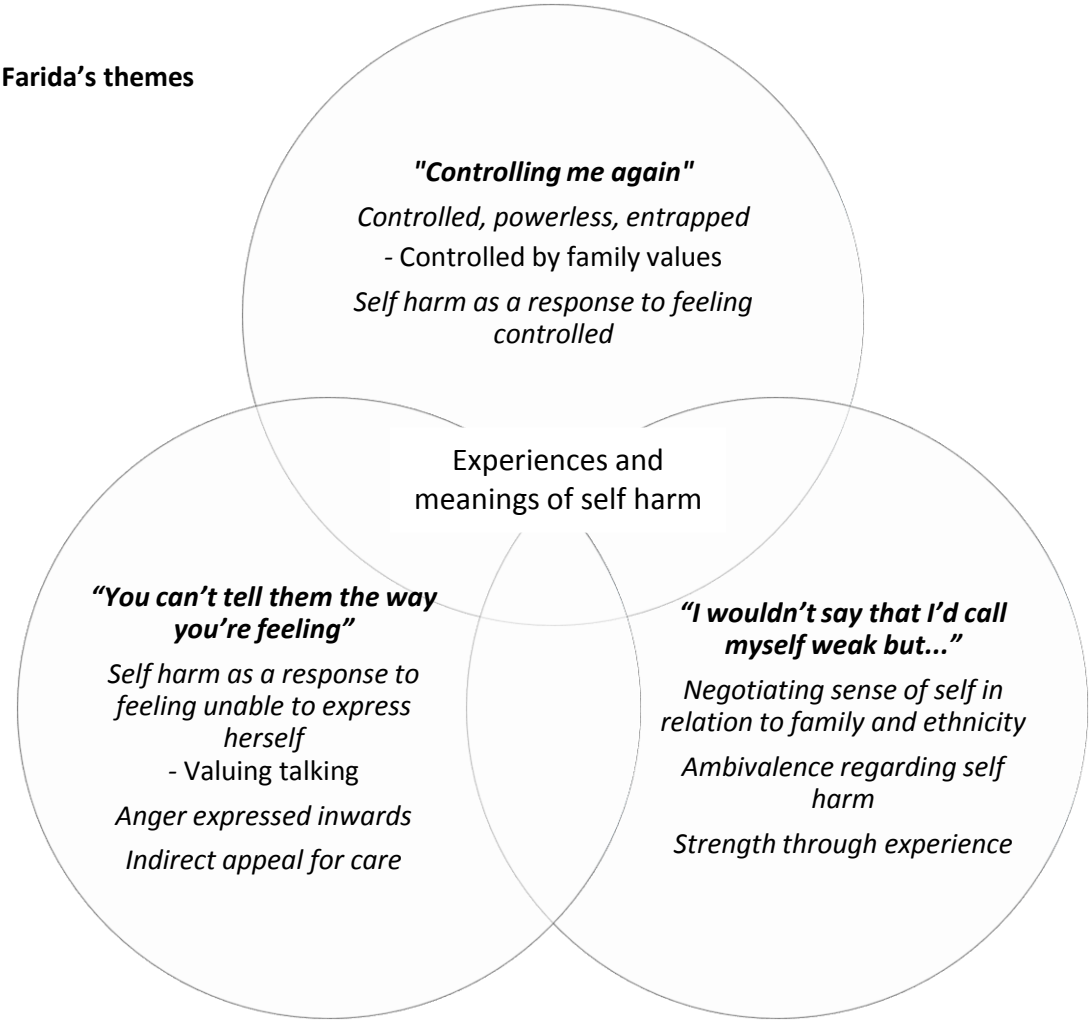
Accessing of support services

Farida has undertaken several courses of counselling, accessed through education, statutory and voluntary sector mental health support services. Following her suicide attempt she was hospitalised and was offered an assessment by a psychologist; however, she was encouraged by her parents not to attend.

Presentation during interview

Farida attended the interview dressed in western style clothing. Her manner matched her self description, "*when I'm meeting new people I be quiet at first, but when I get to know them, I can be, I'm quite funny actually*". Initially shy and nervous, she became more animated and assertive through the course of the interview. Farida recounted her narrative at speed and there was a sense of her outpouring her experiences. She was tearful on two occasions, indicating that her feelings are still raw. She was reticent in recounting her experiences of abuse, perhaps reflecting her experiences of being blamed by others.

Farida's themes



"*Controlling me again*"

Controlled, powerless, entrapped

Recurrent in Farida's account are experiences of her feeling controlled by others. This includes the violence by her older sibling; her parent's preventing her from going to university and plans for her to be married abroad; and her ex-boyfriend's abuse. In response to these situations Farida describes her fear and uncertainty over what she should do. Underlying this is a sense of her feeling powerless and unable to effect change over her situation. Farida describes a sense of entrapment - wanting to escape, but having nowhere to go; and a resultant sense of resignation to accept the situation.

> *"So in the end I just went home and my mum moved me back into my sister's room and like, the problems started all over again."*

- *Controlled by family values*

Farida described instances where her parents controlled her behaviour, in particular pressurising her to remain silent, using notions of shame and family honour. This impacted on

her use of support services, whereby her parents encouraged her not to disclose she had taken an overdose and to discharge herself from hospital before talking to a psychologist.

> *"My mum looked at me and was like 'ah, this is what you wanted, now everyone is gonna find out and its gonna put our family to shame and la de da'."*

Farida also describes how "*Asian women, they've been brought up not to talk back*" to their elders as this is seen as "*bad in Islam*". She gives the example of opposing parents' wishes regarding marriage, reflecting her own experience of feeling unable to assert herself. Farida rejects the use of these ideas to control her, separating, in this instance, the values of Islam from the way the teachings are used by her family to influence her behaviour.

> *"So basically if your family just tells you to go back home and get married, like Pakistan and get married, you can't turn around and say no to 'em coz then it's bad, it's like 'oh in Islam its bad to talk back to your parents'. But in Islam it's wrong to force your daughters to get married."*

This conflict has an impact on her sense of self in relation to her family and ethnicity which will be discussed further later. Feeling pressured to remain silent and the concept of not talking back to elders link Farida's experience of being controlled to the following superordinate theme "*You can't tell them the way you're feeling*".

Self harm as a response to feeling controlled

Farida explicitly links feeling controlled by others with her self harm. For example, she describes how her cutting herself was initially triggered by her sibling's violence and mother's collusion with this to subjugate her behaviour. Farida's suicide attempt was also precipitated by her sense of powerlessness whereby she felt she had no control over her situation. Congruent with this is the fact that she stopped harming herself as she began to gain influence over her life.

> *"My mum, she was controlling, like 'Oh, you can't go uni' then I self harmed. And then my uncle, he was controlling my family 'Oh no, nothing happened' and then I self harmed. And then my sister, she was doing all that stuff and no one was saying nothing to her, she was controlling me basically, and I self harmed. So it's all linked. And then in Liverpool, he* [ex-boyfriend] *was controlling me and I self harmed so yeah, I think it's totally, like, linked."*

"*You can't tell them the way you're feeling*"

Self harm as a response to feeling unable to express herself

Farida explicitly links being unable to "*talk back*" to family members and the consequent inability to express her feelings or say no to their demands with her self harm. Indeed, she described the inability to express herself as a key process in her beginning to harm herself.

"And it got to that point where I couldn't say nothing back to her and I couldn't tell my mum so I started cutting myself on my arm using a like blade."

Farida was blamed and disbelieved by her family for the sexual assault by her uncle. This led to a breakdown in communication with them leaving her feeling she had no one to talk to and was unable to express herself, precipitating her self harm.

"When there's no one to talk to and when no one can be bothered to listen. Then that's why I self harm."

- *Valuing talking*

Consistent with the above are Farida's descriptions of accessing support services in which talking is highly valued. She describes feeling better after talking, indeed she states that her counselling was influential in her not harming herself. Farida explains that talking is an alternative means of expressing herself, rather than self harm.

"Coz like when you talk, you can show your emotions, you can get angry, you can cry, just like what I did now, I was crying, that was releasing my emotions, but when you cut, you do the same thing. But, it's sort of similar I think."

Farida also states how she values consistency in professionals, explaining that recounting her story afresh with each new professional is distressing. She also described her distress when a professional with whom she had built up a strong relationship left suddenly. This was probably particularly painful as it mirrored the experiences of lack of care and inconsistent attachment that she describes in her interactions with her parents.

"And then she just left. And I got really upset. And after that I didn't really wanna get counselling no more."

Anger expressed inwards

Farida states unequivocally that her self harm was a response to feeling angry. She describes her self harm as a means of releasing anger and that in this context self harm was the only option for managing her emotions. Farida articulates that self harm is a means of suppressing emotions and taking them out on oneself.

"I was angry. It's always been because I was like angry...when you get really angry and you don't know what to do and that's the only thing there is to do. So that's why I used to do it."

There are several instances in Farida's account where abuse or lack of care by others precipitates her self harm. Through self harm she internalises her anger, so that her response to attacks by others is to turn against herself.

"First I got the knife and he thought I was going to come for him, but then in the end, I like did it to myself."

Although Farida talks of her self harm being an expression of anger, she did not directly express any anger during the interview. This likely reflects Farida's experience of being

required to repress her anger by her family. Indeed, Farida describes how self harm is a means of expressing her anger which she feels unable to express to them directly, allowing her to "*be normal*" with her family.

> *"I used to be really angry and then I do it and then I just feel really calm and then I just go downstairs and just be normal and I'd just like forget about everything that happened and just be normal."*

Indirect appeal for care

Farida describes several instances of being unsupported and having to cope alone; however, she does not explicitly state a desire for help. The exception is when with her boyfriend: Farida is able to articulate that she wanted him to respond to her self harm with care. She differentiates this from 'attention seeking', a term which implies problems are not serious and that seeking care is negative, explaining that people may harm themselves because they have no one to talk to, as a "*cry for help*" or because they want support, all of which apply to herself. Thus rather than expressing her desire for care verbally, Farida does this indirectly through her self harm.

> *"The first time* [took an overdose], *erm, no, like, I didn't do it for attention and stuff. But the second time, when I was with him, I think it was for attention. Not attention, as in – oh, I can't explain it to you – it wasn't attention, I wanted him to like, care for me. I wanted him to turn round and say 'No Farida, don't do it, what are you doing to yourself? You're messing your body up, stop it'...so it wasn't attention, I just wanted him to care."*

This extract demonstrates how the motivations behind Farida's self harm changed over time. Through discussion she differentiates her initial overdose, where she describes wanting to die, from her cutting and later overdoses.

Farida described how the rejection she feels when she is uncared for can lead her to self harm. Thus when her expression of need is ignored, this is then turned on herself.

> *"I just wanted him to care, but he wouldn't so I just like, did it anyway. I was like 'Fine if you don't care, neither do I.'"*

Apparently counter to this desire for care is Farida's assertion that she was pleased that her mother did not respond affectionately when she saw the marks on her arms. However, it is likely from her account that she is defending herself against her disappointment at her mother's response. Similarly, Farida describes how she is pleased that her family do not talk about what she has been through as this would be upsetting; however, in other instances she repeatedly expresses as desire to talk to her family.

> *"I didn't want her* [mum] *to turn around and say 'Oh, why did you do that for?' and they she'd hug me and then I'd cry and I didn't want that."*

Farida also enacted this ambivalent communication with support services, hoping that the hospital staff would interpret her sudden change of mind about attending a psychology assessment.

> *"I thought the hospital would click on, as soon as my mum came, as I was already, 'Yeah, I want to talk to someone' but as soon as my mum came I said 'No I don't wanna' and I thought they'd pick up on it but they didn't."*

"I wouldn't say that I'd call myself weak, but..."

Negotiating sense of self in relation to family and ethnicity

Throughout Farida's account is a sense of her attempting to negotiate her identity and sense of self in relation to others and to manage often conflicting feelings. Central to this is her relationship with her mother and immediate family. Her sense of self is closely bound with her family, demonstrated by her feeling of emptiness when she fled. Indeed, despite the many negative interactions she describes, she retains a strong attachment to them. This is apparent both physically, in her returning to the family home following fleeing; and emotionally, in her continued sense of concern and desire for relations with them.

> *"I don't know, because, even though, no matter how she like, I just still need her there, coz I dunno, like, she's my mum."*

Farida's descriptions of her interactions with ex-boyfriends also show her difficulties negotiating her sense of self in relation to others. For example, she described feeling "*lost*" and out of control when with an ex-boyfriend, demonstrating the link between being controlled and her sense of self. Furthermore, she described how being belittled and devalued by an ex-boyfriend precipitated her self harming. Thus the conflict she feels is expressed through her self harm.

> *"My ex, he was just being really nasty and stuff and he was like, putting me down...And then he used to just go out, and when he used to go out, that's when I used to do it."*

Through the course of her experiences there is a sense of Farida developing her identity as separate from her family, perhaps allowing her to preserve her self esteem in the face of their abuse. A key issue over which Farida has established this independence is that of arranged marriages. She positions herself as different from her siblings who have had arranged marriages and from her mother who does not understand what it is to have a "*love marriage*". She attributes her mother's lack of understanding to her being from Pakistan, and aligns herself with the researcher, as *"we're brought up here, and like we know how it is*". It seems that Farida's perception of the difference between arranged and love marriages is polarised, believing that "*I don't need to go and look for husband, he'll just, I'll just meet him"* and seeing

no role for anyone except herself and the person she hopes to fall in love with. This polarisation of arranged versus *love* marriages, reflects how Farida has responded to the conflict with her family by positioning herself as different from them. She rejects her mother's and family's "*traditional values*" and, as she associates this with their being Pakistani, this leads her to reject her ethnicity.

> *"Sometimes like when I look at my family and the way they are and what they, the way they see things and everything, I just don't like being a Pakistani"*

However, this rejection is not absolute. Farida qualifies the above statement with "*I don't mean for it to sound bad on like, on other Pakistani girls,"* indicating how she doesn't want to stereotype or portray other women in a bad light. Whereas on one hand she states *"I am proud of who I am"* and describes choosing to wear a headscarf in the past, she rejects the idea that a marriage will not work if the parents have not given their blessing and her mother's questioning of her when she chose not to wear the headscarf. Thus it seems that Farida's ambivalence about her ethnicity reflects her ambivalence regarding her family, as she rejects their selective use of religious teachings to control her behaviour.

> *"The values that they* [family] *have and the traditions and the whole arranged marriage and stuff. I really don't like it. I hate it."*

Related to this is Farida's view of receiving support from women of Asian ethnic origin. She states that she would expect them to "*treat her differently*" if she disclosed her overdoses, and drug and alcohol use. She cites her experience of seeing an Asian female counsellor whom she perceived as having "*traditional values like my mum*" and experienced as overly directive in her approach. Again, it seems that Farida rejects her Pakistani ethnicity as she associates it with her mother and being controlled. However, again this is not absolute, qualifying her statements with "*I'm not trying to be like, sound bad or anything*", "*some of them*" would treat you differently, and "*in my experience*".

Farida states that she would prefer to see a counsellor who was born and raised in the UK, again distinguishing between being Pakistan or UK born. She describes how she was motivated to take part in the research from an awareness that "*there's loads of other girls who do it* [self harm] *and stuff and they don't receive the help"* and in talking about this she comes to the realisation that counselling is something she would be well placed to do due to her values. This demonstrates how Farida constructs a positive sense of self as separate from her family.

> *"There should be more counsellors who are like born and raised here. Coz like, actually, that's like, what I really wanna be doing, like counselling, coz I think, like, I'd be good at it, coz I don't have the traditional values that like, you know, women do nowadays, Asian women, 'specially if they're not brought up from here."*

Congruent with Farida's sense of self relating to her family is that fact that Farida seems to have a more positive and defined sense of self in relation to her friends. Indeed she described feeling happy when with friends, in contrast to feeling stressed when she is at home, perhaps reflecting her sense of being valued and accepted by her peers.

> *"Whenever I go home, I'm just stressed. And stuff, and when I'm outside with my mates and stuff. And I see my old mates from that are uni, I be like totally happy and everything. And um, it's just the home part of me that's stressed."*

Ambivalence regarding self harm

Farida expresses contradictory perspectives regarding her self harm. When reflecting on it in general, she says "*I don't know why I did it";* however, she later answers her own question and is clear that self harming makes sense to her within the context it occurred. Farida is adamant that self harm helped her, that it made her feel better, and that is was the only option.

> *Researcher: "What do you think self harm did for you at that time?"*
>
> *Farida: "It helped me. It helped me, like. It just helped me."*

She described how she didn't want to cry in front of her mother as she didn't want her to see she was weak, so self harm allowed her to hide her emotions. However, Farida also states that self harm was "*not the right way*" to manage her emotions and expresses regret and self doubt. Thus her self harm is both a way of preserving and a threat to her sense of self.

> *"When I think about it, I don't know, I wouldn't say that I'd call myself weak at that time, coz I was going through a lot. But I donno, I feel I should have done something else instead."*

Related to this is her assertion that she has moved on from her self harm, that it is in the past, and that she has developed alternative ways of managing her distress. Farida states that she no longer wants to talk about her experiences; that she wants to forget what she has been through and wishes that the scars on her arms would disappear.

> *"It's been kind of a while now and I think, it's in the past and I've moved on and I'm not going to do it again because I know, like, you know, it's not worth it, nothings worth it. Like taking all the anger out on to yourself, it's not worth it. There's different ways, and I know that now. At the time I didn't know."*

In contrast to this is Farida's continued desire to talk about her experiences; indeed, participating in this research project. However, this makes sense in terms of her valuing talking as an alternative to self harm and feeling unable to talk about her experiences with her friends or family.

Strength through experience

As mentioned previously, there is a sense of Farida developing through her experiences. Alongside her developing sense of self, she has gained a greater sense of control over her life

and ability to express herself. For example, Farida describes how she had recently ended a pressurising relationship with a boyfriend and is pursuing a career against the opinion of her mother, both of which contrast with her previous descriptions of being subjugated.

As a result of these changes Farida no longer uses self harm as a means of expressing herself, gaining control or managing her conflicting feelings about herself. Farida described feeling that she is stronger as a result of all she has been through, having developed a sense of her capacity to manage situations. Indeed, she expresses her surprise as having survived her experiences. Her realisation that she would like to be a counsellor herself also reflects her sense of being an expert by experience.

> *"Everything that's happened, when I look back on it, it's sort of made me stronger...When I look back on it and everything I've been through, oh God, I don't know. I'm just surprised I'm still here."*

Interview 2 – Salma

Pen portrait

Salma is full-time student in her early twenties, living with her parents and siblings. She described her ethnicity as Pakistani; she is Muslim, single with no dependents.

Although Salma described her childhood as happy, she experienced bullying by her adult siblings and with the onset of adolescence became increasingly anxious during social interactions. This impacted on her ability to make friends and undertake valued activities. Despite this she pursued her educational ambition, but was subject to racism by a member of staff and subsequently experienced an escalation of her anxiety.

Following this Salma was engaged to be married in Pakistan; however, on returning to the UK she decided she did not want to go through with it. This precipitated her taking an overdose. Although describing it as a suicide attempt, Salma stated that she did not really want to die.

Salma persuaded her parents to cancel the engagement; however, she continued to experience anxiety and felt stuck and without direction in her life. During this time she began to harm herself by scratching her arms with a blunt knife.

Salma later returned to education, completing A-levels and at the time of interview was at university. She described continuing to harm herself occasionally, although this was less frequent.

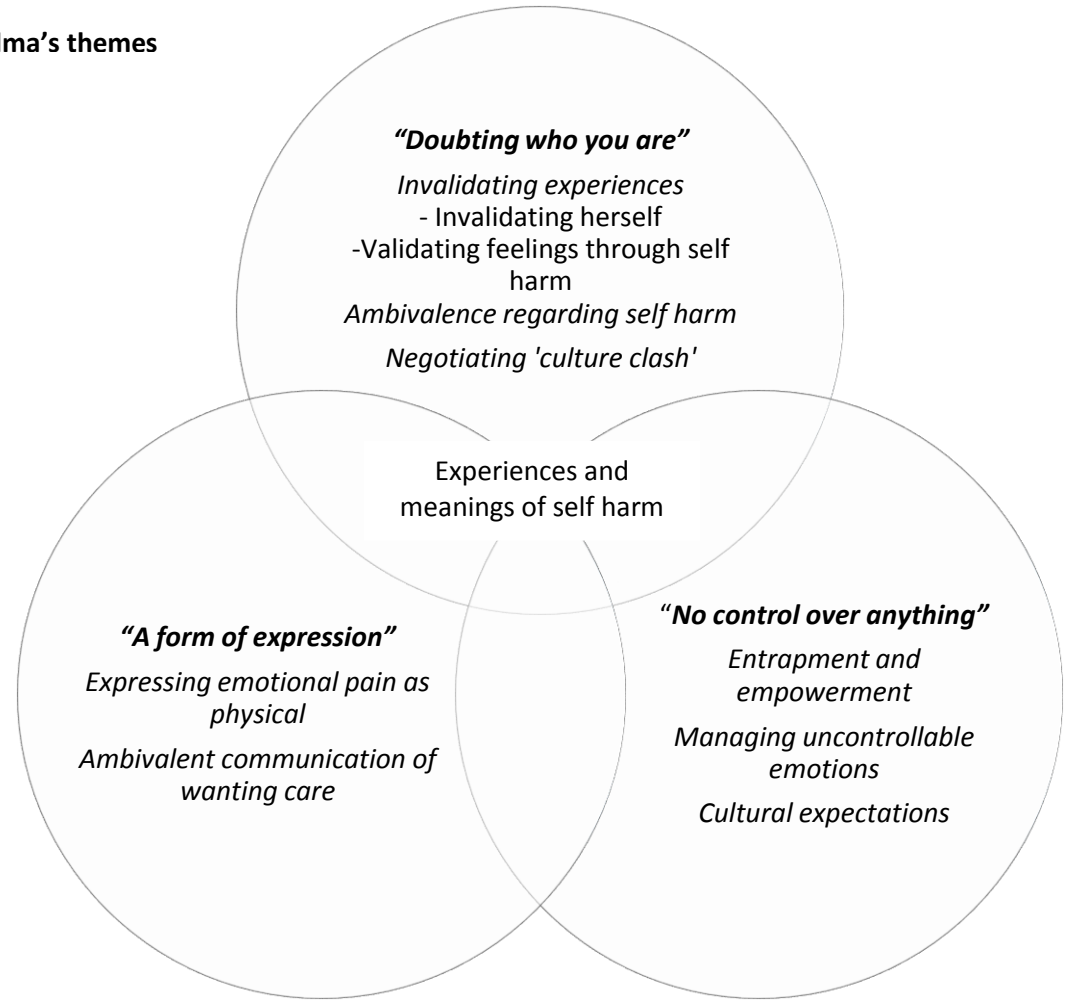
Accessing of support services

Salma first accessed professional help regarding her difficulties with social interaction. She did not seek any medical treatment at the time of her overdose, but later sought support from her GP regarding her low mood, self harm and social anxieties. She was referred for psychological therapy; however, following several assessment sessions, Salma was referred on to another professional at which point she disengaged. She has not accessed support services since.

Presentation during interview

In contrast to Salma's descriptions of herself as quiet and insecure, she presented as sociable and confident. Salma was articulate and reflective in telling her story. She was not openly emotional when narrating her experiences and at times became dismissive of herself and self critical. Salma was dressed in western style clothing.

Salma's themes



"Doubting who you are"

Invalidating experiences

Central to Salma's account of her self harm is her experience of interpersonal anxiety, reflecting a fundamental issue of doubting herself in relation to others. Although Salma is uncertain about the aetiology of these difficulties, she describes several experiences in her narrative which impacted on her sense of self, undermining her confidence.

As a child Salma was bullied by her adult siblings. She states that she felt attacked and her continued sense of hurt and injustice was apparent in her account, reflecting her personalisation of these experiences.

> *"I did feel like it was a personal attack on me…I suppose I still see it more personal because, you know it's really unfair. I see it as unfair...obviously those were major players in my lack of confidence as well."*

Salma's interpersonal anxieties are based on the expectation that others will judge and criticise her. During her adolescence this resulted in her feeling acutely self conscious in social situations, to the extent that she felt unable to interact with others, make friends or do the things she wanted to do.

> *"You're afraid of judgement and um, you're, if someone laughs and they're looking your way you think they're laughing about you they're laughing at you um, when someone's looking at you or they're having a conversation you think, 'Oh God!' You know, 'They're talking about me' and they're saying, you know how ugly I am or how quiet I am."*

This was compounded when, as a teenager, Salma experienced racism by a member of teaching staff. An abusive experience on any account, this was felt more keenly by Salma who was already struggling with her self confidence. Indeed, the experience probably resonated with the bullying she was subjected to as child, feeling attacked by people in position of power. Furthermore, Salma described how she had chosen to study a subject which was unusual for someone of her ethnicity. Thus the attack in this context may have been particularly undermining to her sense of self.

> *"It meant a lot 'cause I was trying to, I was trying to follow my passion...that a lot of ethnic minorities well, Asian people don't go into. Um, and it did mean a lot to me because it was something I was trying to do er, along with my anxiety and then I got that and it made it worse."*

As well as these overt invalidating experiences, Salma described feeling uncared for, unconsidered and that her distress was not acknowledged or taken seriously by her parents. She partially attributes this to lack of emotional expression and a "*just get on with it"* attitude which she ascribes to Asian families.

> *"No one bothers about you, you know you're, you're the person no one ever considers. That's how I felt."*

There are parallels between Salma's interpersonal processes and her experiences and perceptions of accessing support services. She described feeling she was not taken seriously by professionals.

> *"There was this one lady who began helping me...but, after, after a few sessions when we didn't even start CBT, she, she came back to me and said um, she wanted to refer me to someone else...And I just thought that the reason that she wanted to refer me could possibly be because she's not taking me seriously."*

In this case the service's procedure of assessment and re-referral inadvertently resonated with her anxieties. Furthermore, in response to feeling she was not taken seriously, Salma disengaged from services, leaving her without support.

> *"So I thought, 'No, you know what forget it, I don't want, I don't wanna talk to anyone else now and you're not helping me at all!' I didn't tell her that but um, that's how I felt, so I left, I stopped getting that and since then I, I haven't had no therapy."*

- *Invalidating herself*

As well as experiencing other people as dismissing her feelings, it is recurrent in her account that Salma dismisses them herself. She minimises how difficult experiences were for her and when describing her self harm, Salma laughs at herself and admonishes herself. She views her self harm as less serious in comparisons to others' and that she is less deserving of care. It seems that the severity of the wounds inflicted is significant to her, as she sees her scratching as less important.

> *"I did at that point in my life try and commit suicide.* [Laughs] *Not a very good attempt…It wasn't a very serious um, attempt. I just, I was being stupid basically."*

Similarly, as well as perceiving others as judging, Salma is intensely critical of herself. She views her anxiety as a barrier to her achieving and interprets this as a personal failure. Thus her low confidence became something which she criticised herself for. She describes how being told she is quiet reinforces her perception of herself as a failure and that this continues to affect her. In reaction to this sense of herself as failing, Salma describes self harm as a means of expressing self-criticism.

> *"That was a failure when I was quiet and not having any confidence in myself so now, every time I achieve something I don't see it as a great achievement. Talking about it makes me realise that I am really, really critical of myself and I suppose, and I suppose um, using self harm as an expression for that is not good."*

- *Validating feelings through self harm*

In response to these external and internal experiences of her feelings being dismissed, Salma's self harm is a way of her acknowledging her own distress. She states that self harm is a way of validating her feelings and that it makes her feel normal. Thus it seems that by harming herself Salma is validating her sense of self. Salma also describes wanting to feel like a "*victim*". The physicality of self harm is relevant, as she feels her difficulties have been ignored because they are psychological.

> *"When I'm really distressed I'd do that and I'd feel a bit better. I'd feel validated. My feelings would be validated"*

Ambivalence regarding self harm

Salma's account of her self harm includes mixed perceptions regarding the behaviour; indeed, she acknowledges feeling confused by her contradictory views. On one hand she defends her self harm as a coping strategy, minimises its importance, and due to its validating her feelings, states that it makes her feel normal.

> *"I don't see it as anything bad. I don't even see it as a mental issue. I just see it as something I do to cope."*

However, Salma also criticises herself for self harming, stating that it shouldn't be normal to her, and that she should stop. Consequently her self harming becomes another reason to criticise herself.

> *"Overall, I don't think it's helpful at all; I think it's a very terrible way to express your emotions. I think it's um, I think it shouldn't be normal to me – it is normal to me but it shouldn't be."*

Salma's negative view of self harm perhaps reflects the internalisation of what she perceives others would think. She describes how self harm is shameful in her culture and against her religion, although she does not explicitly apply this to herself. However, Salma does state that she would feel embarrassed if her friends discovered she self harmed and that she does not let her family know, suggesting the notion of shame.

> *"It's seen as a shamed thing um, shameful and it's seen as, you know seen as a very, very bad thing. It's seen, in fact, in some ways because of the um, the religion aspect too, it's seen as, as if you do that you're gonna go to hell basically 'cause, you know in religion, if you commit suicide, people, well, in the religion it says you're definitely going to hell. Um, so it's seen in that same light."*

Salma states that fear of judgement by her family and outsiders are major barriers to accessing mental health support. She describes how people are laughed at for attending therapy and that this and gossiping are attributes of her culture. Salma also describes how she perceived her accessing help for self harm as counter to cultural expectations.

> *"'This is not how I'm supposed to be' kind of feelings, you know, and I'm an Asian girl and I probably shouldn't be going to the doctor for self harm!...Well um, um, you know you feel like you have to conform to certain things."*

Indeed, Salma states that shame and the negative perceptions of self harm in her culture are barriers to people accessing support for self harm. However, she believes that with increasingly modern attitudes, more people will feel able to access help.

> *"I think as we, as we progress and start getting more modern and starting to relax on those old traditional attitudes such as women are just the 'homemakers' kind of thing, er, we're starting to relax on that and I think more people will get help, you know more people should get help."*

Negotiating 'culture clash'

Salma states that having two cultures results in *"culture clash"* which requires negotiation. She describes a choice between following traditional Pakistani cultural values and adopting western values. Salma states that she manages this by behaving differently in different settings. She describes how following Pakistani culture at home is more familiar and comfortable to her, but when she is away from home she feels more free to be herself.

> *"I think 'cause I've been brought up that way, I'd feel more at home, you know in my house, you know and doing you know and doing housework and stuff, which is a typical example of Asian women! But then when I'm out, you know I'm, I'm more*

free to be who I am rather than being pushed into who I'm being. So I'd say I'd feel more at home at home, but I feel more free outside."

Salma expresses cynicism regarding the traditional role of Asian women as *"homemakers",* the cultural norms of staying at home, getting married and having children in order to "*please parents*". She described how certain behaviours, such as leaving home before marriage, drinking alcohol and going clubbing are perceived negatively in her culture and can bring disrespect on one's family. However, this conflicts with her behaviour and aspirations. Indeed, Salma describes wanting to move away from the town of her upbringing and away from the cultural expectations, so that she can do what she wants to do and be herself. It seems that Salma feels externally imposed pressure to conform, but that she also internalises this, leading to feelings of guilt. Separately, Salma states that her self harm is way of managing feelings of guilt.

"You know culture does hinder you in that respect, because you're, you do have feelings of guilt, you know, you think, and it's happened to me 'I shouldn't be out clubbing' because my dad he um, he, you know, he sees it as a bad thing, um, 'cause, you know, Muslim, Pakistanis, sort of thing, sees it as a bad thing. So I shouldn't be out clubbing. So in that respect, yeah, it does hinder."

"A form of expression"

Expressing emotional pain as physical

Salma states that her self harm is a means of expressing her feelings, perhaps reflecting her difficulty expressing her emotions verbally. This relates to her feeling that her emotions were not taken seriously by her parents and that "*emotions are not expressed well in Asian families*". Thus as she cannot express her emotions verbally, she does it physically through self harm. Indeed when reflecting on the reasons why South Asian women may self harm, she attributes their self harm to being unable to tell anyone how they are feeling. Furthermore, Salma describes how by causing herself physical pain she is externalising emotional pain.

"By hurting yourself, you're, you're um, causing yourself physical pain. So you're actually feeling the physical pain and then you can put the, you know, then you can express your emotional pain as physical."

Ambivalent communication of wanting care

Salma states that she wanted her parents to notice her self harm, to take her feelings seriously and to care for her. Thus, it seems her self harm was an indirect communication of her distress and desire for care and attention.

"It was a 'Notice me' kind of thing, I wanted to be noticed. I wanted my mum to care…"

However, Salma is ambivalent about this, for example, she describes how by harming herself she is marking on her outside how she feels inside, but she chooses to harm herself on her arms as it is easy to hide. She did not seek help following her overdose and she is adamant that she does not want her family to know about her continued self harm.

> *"Obviously I don't let any of my family know that I still do* [self harm]"

Salma's ambivalence reflects her expectation to "*just get on with it*". Indeed, although Salma states her desire to be noticed, she struggles with the idea that she was 'attention seeking', indeed this concept compounds her self criticism.

> *"Talking about it this way makes me feel like it's just an attention seeking silly thing."*

Salma's ambivalence regarding receiving care is also apparent in her responses when her self harm was noticed. When her parent commented on the marks on her arms, Salma dismissed it as nothing. Seemingly, her family accept this, so her ambivalent communication results in unreceptive responses from her family, reinforcing her perception that she is not taken seriously.

> *"I did obviously feel upset um, because you know, I felt that I'm feeling this way and my mum doesn't care and. But as time went by, you know I did, my mum, she does care, it's just the way that um, it's just this sort of 'Get on with it' attitude, you know."*

"No control over anything"

Entrapment and empowerment

It seems that Salma's difficulties with interpersonal interaction led to a sense of entrapment. She described feeling stuck, unable to make friends or achieve her goals. Salma also described feeling trapped in the arranged engagement, that she had no choice but to go through with it.

> *"When I started the self harm obviously I felt like I had no decision obviously because, you know, I was going through some engagement thing and I thought I'd have to marry him. And I thought, you know, 'How am I going to get back into college? How am I gonna do this?' And I did feel like, I couldn't, I couldn't drag myself out of that hole."*

In the face of this sense of entrapment, Salma described how harming herself was a means of regaining a sense of agency; seemingly the act of self harm was empowering.

> *"You'd feel like you were achieving something - not achieving - but doing something; you know, keeping busy; not just sat there thinking about all these things; you're actually putting your effort, concentration into doing something and that would be the best thing to do."*

Reinforcing the link between her sense of entrapment and her self harm, Salma described how she harmed herself less as she regained a sense of control over her life.

> *"So I feel in that point of my life I felt no control over anything, but then, as I went along, then I went back to college and everything, that influence, you know came back to me, I had, I had power for my own life again and so that's why the self harm got less and less as I came out of that hole."*

Salma implicates women not being able to influence or escape from their situation and feelings as a reason why South Asian women may self harm.

> *"So I feel maybe women do that because their, as a way out of how they are feeling. They can't influence their situations. They can't get out of the situation therefore they, they self harm."*

Managing uncontrollable emotions

Salma describes harming herself when she cannot control, manage or regulate her emotions. In contrast to this, she describes her self harming as a controlled activity – emphasising how it was a conscious decision and that she controls the amount of pain she causes herself.

> *"It all just sort of just gets to me and it just comes, you know and I can't control that when that happens. Um, and the best way to do it* [manage emotions] *is by self harming."*

Cultural expectations

Further to Salma's descriptions of negotiating her sense of self in relation to 'culture clash' is her description of feeling controlled by cultural expectations. At the time of the arranged engagement Salma described a huge pressure to conform to the expectations of her parents and cultural ideas regarding respect and honour. She describes how she was only able to persuade her parents to cancel the engagement because they are "*modern*" in their perspective, implying that she felt control was ultimately theirs. She acknowledges the role this conflict had in her distress and self harm. Indeed, she states that "*limitations of culture*" are a reason for people's unhappiness.

> *"Being told you're disrespecting the family, you know you're dishonouring your family, it does play a part in actually feel like, you know, making me feel terrible. Um, so, yeah, that, that, um, whole case of me trying to fight my parents on this very stupid thing, issue* [the engagement] *um, did upset me and that was one of the reasons why you end up self harming in the end."*

Although Salma disagrees with the cultural values she associated with being controlled, she does not want to be disparaging of her culture and she offsets her criticisms and highlights similarities with other cultures. It seems she is reluctant to reinforce negative social perceptions of the Pakistani community, but at the same time highlights what she believes should change.

> *"Traditional stupid thing about getting married to someone and then having this respect thing on your family. I see that as a really stupid thing...Respect and honour is like a major thing in a lot of cultures, not just Pakistani."*

Interview 3 – Adeeba

Pen portrait

Adeeba is a university student in her early twenties. She lives with her parents and siblings. She described her ethnicity as British Pakistani; she is Muslim, single with no dependents.

A major event in Adeeba's life occurred during her childhood when her immediate family were made homeless by her grandfather following a dispute. Following this she experienced bulling by her cousins and was socially isolated. Adeeba stated that since this time she has struggled to interact with others and now has limited numbers of friends.

Adeeba was unable to recall exactly when she began harming herself, but remembers banging her head against the wall as a teenager. Later she began scratching herself, hitting herself with objects and most recently cutting herself.

Accessing of support services

Prior to the interview Adeeba stated that she had not spoken to anyone about her self harm, this included family, friends and health care professionals. She was adamant that she did not want anyone to know and that she would only access support on her own terms. Adeeba has used the internet to search for strategies to manage her self harming.

Presentation during interview

Adeeba attended the interview dressed in a salwar kameez and headscarf. Initially she seemed self-conscious and uncomfortable, although she connected with the researcher. She was hesitant in recounting her story and required encouragement and prompting. However, when speaking of her feelings towards her grandfather Adeeba became animated and passionate. In contrast, when talking about her sadness at her lack of friends, Adeeba was quiet and dejected.

Adeeba's themes

"This is my identity"

Family stress

- *Betrayal and injustice*

Adeeba began her narrative of her self harm by stating she has had a "*stressful family life*" which she attributed to the close knit nature of Asian Pakistani families. A seminal event in this occurred during her childhood when her immediate family were made homeless by her grandfather. This rejection and her relatives' failure to intervene were experienced by Adeeba as a profound betrayal. She described a continued sense of injustice and intense anger; indeed, she described how this event continues to affect her.

> *"No one spoke up for my mum and us when we were kicked out. No one, none of our neighbours did. All they did was stand outside in the street and just watch. And these neighbours were also our relatives and now they're acting like nothing's happened like we've been friends all these years."*

- *Scrutinised by society*

Adeeba described how within her community people's actions and mistakes are scrutinised; resulting in people doing what is thought best by society rather than themselves.

> *"That's why it's quite awkward, especially our society. The majority of the Pakistanis, every move they make, they think ten times before they make it in case people who, their community start talking and bad mouthing them. So every movement we make is scrutinised."*

She describes her frustration and sense of being attacked when compared to someone who behaves in a way she never would; rejecting such scrutiny as a means of gaining an accurate assessment of people.

> *"There's this girl...She gets up to all sorts, yet the rest of the older generation, she is perfect. And to be compared to her is just frustrating...It's like, 'I know what she's like and you're comparing me to her, so what do you take me for then'? It's like an attack on me."*

- *Hypocrisy and neglect*

Adeeba explained that the consequence of people gossiping about other's problems is that they overlook what is occurring in their own families. Adeeba expresses anger at the hypocrisy of this, but she also states that it results in people's difficulties being neglected. Indeed, she links this to women self harming. Adeeba explains that the fear of "*community stereotyping*" results in South Asian people managing their problems "*within your own closed doors*" rather than accessing external support. However, the family members who women would go to for help are so "*busy involved in other people's situations that they don't realise how their own people are suffering*". Indeed Adeeba describes how a recent occasion she harmed herself was triggered by her father putting wider family and society above her feelings.

> *"Coz he's one of those goody two shoes types who wanna keep the rest of our society and our family members happy regardless of what happens, regardless of what they've done to us."*

Loyalty to family

In response to the experiences of betrayal and injustice, Adeeba sees herself as intensely loyal to her family. This manifests overtly in Adeeba feeling responsible and sticking up for them. However, on a more fundamental level, she has adopted her mother's values. Adeeba describes how her parent's views influence her decisions, for example, asking their permission to go to university and choosing which course to study. Furthermore, she considers the impact of her behaviour on them in terms of society's judgments. Thus although she rejects the perceived scrutiny of wider society, her loyalty to her family means that it impacts on her behaviour.

> *"I wouldn't ever do anything that makes our society talk kind of bad about our parents and their upbringing."*

Adeeba describes how she chose to live at home with her family, but at times she wonders whether she should have moved away from her community, indicating the tension she experiences between loyalty to her immediate family and stress regarding the wider community dynamics.

- *Protecting mother*

A particular manifestation of Adeeba's loyalty to her family is apparent in her relationship with her mother. She states how she does not want her mother to find out about her self harming as she worries that her mother would be hurt that she had not told her and she does not want to put her mother under more stress. Unfortunately this means that Adeeba does not receive support from her family.

> *"I don't know, I've never actually gone to anyone for help for it, because my mum's health is really bad as well...I can't let my family know my situation, so I have to like, I don't know, I just suffering on my own sort of."*

Ambivalence regarding ethnic identity

- *Valuing values*

Adeeba described herself as an "*old fashion type Pakistani with old mentality",* differentiating herself from her Pakistani university peers whom she sees as "*21st century types*". Indeed, she attributes her values more to *"the way I've been brought up*" rather than "*being general Pakistani*". Adeeba believes strongly in her values and described building an image of herself based on them. She states that she has chosen to be the way she is and wants people to respect her for how she is.

> *"I've chosen to be like that and if I wanted to, I could go around dressing like them, acting like them, but that part of me doesn't want to, because then that won't be me. And then like, this is my identity."*

- *Feeling inferior*

Despite her description of valuing her identity, Adeeba states that *"there's pros and cons to being Pakistani"*. She describes choosing to wear traditional Pakistani dress, but how this results in her feeling different from others. Adeeba describes feeling awkward, weird and inferior in comparison to her peers and that they judge her negatively. She feels unable to interact socially in the same way and that she doesn't do what *"normal Pakistanis"* do such as mixing with people of the opposite sex.

Adeeba's ambivalence about her identity is also reflected in her body image. She states that she feels fat and ugly and how sometimes doesn't like to look in the mirror. She linked her negative self-perception to her self harm, explaining that *"that's why I take it out on me, not anyone or anything else"*. Unfortunately it seems that Adeeba's self harming compounds her sense of feeling different from others and abnormal, leading her to feel ashamed of her self harm and hide it from others as she anticipates judgment.

> *"At times I really don't like myself and then I see the scars and I then, that negatives more on my feelings towards yourself" Adeeba*

Shame regarding self harm

The fact that Adeeba harms herself has a significant impact on her self esteem. She views her self harm as wrong, explaining that self harm is against her religious views. Resultantly she describes feeling shame and disgust when she sees her scars, which compounds her negative self-perception.

> *"Awful, coz it's against our religion. We're not supposed to harm our body. Because we see it as a gift"*

Adeeba states that prior to the interview she had not spoken to anyone about her self harm and is adamant that she does not want anyone to know. This was exemplified in her using a pseudonym when taking part in the interview, despite being assured I would change her name anyway, and her assuring me she is not suicidal and therefore does not need me to break her confidentiality. When asked during the interview how it felt to be talking about her self harm she stated that "*I feel like hiding*", indicating her shame regarding her self harm. Indeed, at times Adeeba seemed to distance herself from her experiences by referring to her academic understanding of self harm.

Adeeba explained that she does not want anyone to see the marks on her arm so tries to keep them as minimal as possible so that she is able to hide them. She states that this impacts on her use of method of self harm, preferring hitting herself as this will only leave temporary marks, and how cutting is more contained than scratching.

> *"I've tried to stop it because I don't want to leave any marks...I've tried to make it as minimal as possible so just one patch...coz I don't want to leave any marks in case someone asks."*

- *Anticipating judgment*

Adeeba states that she does not want people to know about her self harm because she does not want to be judged. She anticipates being labelled, seen as "*problematic*" or "*stupid*". This fear of judgment impacts on her use of services, acting as a barrier to her seeking support. Adeeba initially stated that if she were to access services she would prefer to talk to someone

of the same ethnicity, as they would be better able to understand her perspective. Indeed, at one point during the interview she stated, "*think you need to be a Pakistani to understand*", demonstrating the importance of her ethnicity to her understanding of her experiences. However, when exploring the impact of the difference of ethnicity of the researcher on her willingness to take part in the interview, Adeeba contradicted this, saying it is easier to talk to someone who is different from her, because of her fear of judgment by people within her community.

> *"I can't tell them* [GP of Pakistani ethnicity]. *I know they won't break your confidentiality and yet, I don't want to be judged. I don't want to be judged as someone who 'Oh look, she's a self harmer' I don't want anyone to know about it."*

- *Feeling a fraud*

As a result of keeping her self harm secret from her family, Adeeba states that she feels like she has an alter ego and is a fraud as she is not portraying her true self. She describes how she is lively and outgoing with her family; however, this is also the time she is most stressed. Adeeba later describes how her self harm is an alternative to expressing her anger at her family, thus it serves the function of enabling her to behave as she does with her family. This connects to the next superordinate theme, *"I can't talk"*.

> *"It was either screaming out, letting everyone know basically how pissed off I was, or just stop and just [self harm]"*

"I can't talk"

Social isolation

Adeeba describes how she finds it difficult to talk to people and has been socially isolated since her childhood. She attributes this to bullying she experienced by cousins and subsequently having no one to play with. Furthermore, as a result of her childhood experiences, she struggles to trust people. Adeeba links the onset of her self harm during her teenage years to her inability to make friends, indeed, her hurt at this was apparent during the interview where she became very quiet and dejected.

> *"I think it* [self harm] *started when I was a teenager, when I was in high school. I, like, find it really really hard to talk to people. I find it really hard to make friends. So even in uni, I haven't got any friends in uni."*

Expressing emotions through self harm

- *Taking it out on herself*

As a result of her social isolation and protecting her mother, Adeeba described having no one to talk to about her difficulties and subsequently having to manage her distress on her own.

She described how she harms herself because "*there's only me to take it out on*", thus her self harm is a means by which she expresses her emotions. This also links how her feelings of anger and urges to be violent towards her grandfather, are instead taken out on herself through self harm.

> *"I don't have any friends to talk to about it so I just deal with it myself."*

- *Physical release*

Adeeba describes how self harm is a means of physically releasing emotions which she is unable to express verbally. She states that the pain provides a distraction and allows her to dissociate from her distress. Indeed, she states that this release from her emotional pain is the reason why she harms herself.

> *"Once I cut, once I feel that pain, it doesn't feel painful it just feels numb. Yeah, the rest of the feelings just disappear. It's sort of a calming sort of feeling I get. Basically, that's why I do it."*

Motivation to talk

Although Adeeba describes barriers to talking, she believes that it could be an alternative to her self harm. Indeed, she states that a motivation for taking part in the research was to see whether talking would help. A further motivation was to raise awareness of self harm amongst South Asian women, as she believes this would allow women to access help before their self harm escalates, something which she also applies to herself.

> *"I thought I'd try to talk about it to someone coz I've never tried that one before and maybe if I talk about it if I address it, hopefully address my problem, I might be able to reduce it. That's why I thought I'd come in."*

"I don't want to lose control"

Uncontrollable emotions

Adeeba describes a build up of emotions, including frustration and intense anger. She describes how the stress impacts on her physically, leaving her feeling suffocated, trapped and scared and that her body is "*about to explode*". She also described fearing losing control of her anger at her grandfather and that although she struggles to show her emotions to people, "*once I start crying, I can't stop*".

> *"I don't want to lose control in front of him because I don't know what will come out of my mouth."*

Faced with these overwhelming emotions, Adeeba describes she does not know what to do; she has a choice of either harming herself or losing control, thus self harm is her only option.

"*It's either that or, I don't know, just breakdown.*"

Out of control of self harm

Adeeba describes how she wants to stop harming herself, but has been unable to. She feels that it has got out of her control.

> *"I've tried to deal with calming myself. But I think my situation has got to the stage where it's escalated, it's too, I can't calm myself, I can't control it anymore."*

Support on own terms

Adeeba is very clear that she does not want to seek support at this time, but if she did, it would need to be on her terms and when she chooses. This reflects her ambivalence regarding accessing help, feeling motivated to talk as she wants to stop harming herself, but at the same time fearing judgment.

> *"I think if it ever comes to a time when I want to get help, I'll go and get it, but on my own terms, my own conditions, not forced into it, pushed into it."*

Adeeba states that if she were to access support she would want support and strategies in helping her to control her self harm. Indeed, she described how she has "*gone on the internet to try and find out ways of controlling* [self harm]".

Interview 4 – Yasmin

Pen portrait

Yasmin is in her early thirties, single with no dependents. She lives alone and is currently unemployed having left work due to her mental health difficulties. She describes herself as British Asian of Bangladeshi origin. She was born Muslim, but does not practice.

Throughout her childhood, Yasmin was subject to emotional and physical abuse by her step-mother, neglect by her father and bullying by her older siblings.

Whilst attending university she became depressed, precipitating her taking an overdose. Yasmin later embarked on her career; however, she experienced bullying by her manager. Combined with the pressure to succeed and social isolation, this precipitated Yasmin beginning to cut herself. This escalated to the extent that she left work. Although less frequently, Yasmin continues to harm herself occasionally when under stress.

Experiences of accessing support services

Yasmin described having received counselling, CBT and psychotherapy. She now is involved in local and national mental health voluntary sector and service user led organisations.

Presentation during interview

Yasmin presented as warm and sociable and was highly articulate and reflective when narrating her experience. She was animated and passionate in her account, particularly in her criticism of government policy. Yasmin attended the interview dressed in western clothes.

Yasmin's themes

"I couldn't talk"

No one to talk to

Yasmin links her self harm to feeling depressed, lonely and isolated. She describes how she started harming herself when alone at the weekend, feeling depressed and having no one to talk to. Furthermore, Yasmin described how she was unable to talk back to her bullying manager and so she would harm herself at home instead.

> *"It's like, say if I had a bad day at work and um, it was like a routine: so I'd come home on an evening; I couldn't talk to anyone; I felt isolated; did that [self harm]... But next day I go through the same cycle again and again: be miserable; can't, I feel frustrated; can't talk to anyone and then I'll do it again as well."*

Yasmin stated that she has always felt isolated as a result of her neglectful upbringing. She described how she was abused more than her siblings because she spoke out against her step mother, whereas they *"kept it in their heads";* and her father was *"cold"* and uncommunicative. Yasmin explained that this contributed to her social isolation as it resulted

in her having poor social skills and struggling to bond with people as she fears being vulnerable and is unable to trust. As a result of these difficulties and resultantly having no one to talk to, Yasmin found self harm was an easier way of expressing her emotions.

> *"I couldn't find it easy to bond with people so that was my way, I think it* [self harm] *was easier basically – especially when I lived on my own"*

Yasmin described how over recent years she has tried to communicate with her family; however, they are unable to acknowledge what she has been through and she is seen as a *"black sheep"* or *"crazy"* for having emotional problems. She feels she is seen as the *"bad one"* for speaking out and so her attempts to communicate *"bounce back"* as she is blamed. Again, Yasmin describes how it is easier to harm herself than to communicate with her family.

> *"I think it's easier 'cause like I say, I don't mention anything now about my depression. I've learnt."*

Yasmin explained that her overdose was also precipitated by feeling depressed and isolated and having no one to talk to. She stated that in some ways it was a "*cry for help*".

Fighting the system

Recurrent in Yasmin's account is her criticism of the government and system for not providing adequate support, both whilst she was employed and when out of work. She passionately objects to the government policies which she perceives as cutting services and pressurising people to go back to work, as they do not consider the implications in terms of compounding people's mental health difficulties.

> *"That's why people break down and have to do self harm and do things. Because if there's no support at work, you're damned if you work, 'cause you try and keep it all, and damned if you don't, because then they try make it so hard, make it so complicated."*

Indeed, Yasmin states how pressure and stress caused by difficulties with chasing the benefits system had contributed to her recent self harm. She described feeling that she is fighting against the system and that she feels unheard and misunderstood.

> *"They just ignore it even when you tell 'em, 'Look, I do something* [self harm]*'. When you try and explain the story, they, you know people, they just wanna, it falls on deaf ears really"*

There are similarities between Yasmin's descriptions of feeling neglected and unheard by her family and by government systems. Indeed, she compares her experiences, feeling blamed by both parties for expressing herself.

> *"It's like if you're open, or say something,* [to family] *you're the bad one, you know, it's like, I don't know, it's like 'Campaign against the cuts'. You're the bad person. That's how it feels like."*

- *Dealing with emotions physically*

As a result of her difficulties communicating, Yasmin describes how self harm is a way of dealing with her emotions physically by diverting her attention and providing an alternative focus. By releasing her blood, she is releasing her emotions; providing an outlet for feelings of depression or frustration; making her feel better. She also describes how the pain following self harm acts a reminder of what she has been through.

> *"It helps me by seeing it as a physical thing rather than an emotional thing."*

- *Punishing herself*

Related to her description of feeling blamed, is Yasmin's explanation of self harm as a means of her punishing herself. She described how as a child, she felt she was wrong and blamed herself for the abuse she suffered. She learnt to keep things inside rather than express herself. Thus, whereas her siblings take their feelings out on others, she takes them out on herself. She described how, as an adult, she continued to blame herself for everything that was not good in her life.

> *"Maybe to punish myself or hit myself, it's just when I had my depression, I took things out on me and everything that happened in my life: me not being sociable; me not, you know having this great life. I just felt you know, it was all down to me and I was blaming myself. I don't know whether that's because of my childhood, but I always learnt that, I don't know how else to get out to people; be aggressive or horrible to them. So I've learnt that to keep doing it to myself."*

"The whole thing controlling me"

Forced into being

In Yasmin's account the concepts of control and identity are closely linked. She described how during her childhood her step-mother used religion to control her behaviour and that this impacted on her developing sense of self.

> *"She was trying to restrain me and like I said all this putting me down and I was conflicting where, on me growing up and how I'm supposed to be. And I think all that confused me."*

As a result of this, Yasmin states that she is reluctant to follow organised religion as she doesn't want to be "*forced to do some hypocrisy or something with someone*". Yasmin also described feeling *"forced to be someone you're not"* by her bullying boss as work; and how, when accessing services she perceives "*you fit into their rules, not they fit into yours".* Yasmin described how fitting in to society left her feeling she has no influence and control.

> *"Fitting into the whole of society, there is no influence. It's like the whole thing controlling me, whether it's family, friends, the system."*

Losing control over self harm

Yasmin described how harming herself became a routine way of managing her distress and how she would repeat the same cycle daily. She described how it became a habit, which she felt a compulsion to do. This escalated to her feeling she had "*lost control*" over her self harm and herself more generally, describing how she had a "*breakdown*" which resulted in her having to stop work. Thus self harm began as a means of her controlling her emotions, but became something which she felt was outside of her control.

> *"I think my self harming was a sign that I had to leave my workplace because it got that bad that I couldn't control it."*

"I never knew who I was"

Conflict over cultural identity

Yasmin describes feeling "*comfortable with my skin colour*", but does not identify with her Bengali heritage, Islam or culture. She relates this to her experiences within her family, describing how her family weren't religious and she was brought up *"quite modern";* however, her step-mother would use religion to control her behaviour. She described her step-mother's hypocrisy, as behind the pretence that they were a *"good family",* was the reality of the abuse and neglect. These conflicting messages left Yasmin feeling confused about her identity.

> *"It's kinda like these conflicting messages you get about how to be and where to fit in, you know I couldn't understand all that and I think that didn't help because I don't know where I'm supposed to, who I'm supposed to kinda be."*

Yasmin also felt judged by the wider community because she was not religious, and, as a result of not having a mother, they were not a "*normal*" family. She described feeling guilty for not fitting into religious expectations and links this to her tendency to blame herself. However, she does not attribute this solely to religion, stating that "*Asian women"*, regardless of culture and religion, *"grow up saying 'this is bad'"* and that certain behaviours, such as drinking, are not acceptable. Furthermore, Yasmin describes how Asian women are taught not to be outspoken or express themselves, which results in confusion over one's identity. She links this to self harm in that it is a way of resolving these conflicts when they cannot be discussed or accepted by others. Thus her identity conflict is compounded by feeling unable to communicate.

> *"That doesn't help as well and like if the whole community are against you, that doesn't help as well. It's not like you can go to somebody and talk about it and you're accepted; when you've got that conflict and the inner-conflict then you kinda just deal with it privately, I think."*

Yasmin sees herself as spiritual and values this, but is ambivalent about religion due to her experiences. Yasmin recounts how she was seen as a "*bad person*" and "*frowned upon*" within her community for not fasting during Ramadan. She rejects this as a basis for judgement,

describing how she always had to survive with minimal food. Yasmin described how her life experience is in conflict with the judgements of others, leading her to question the assumptions behind their beliefs. However, she also acknowledges, *"I can't stereotype everyone – because there's lots of things about Muslims, but some of it's good and some of it's bad"*, indeed, throughout her account she acknowledges the differences in people's experience of family, religion and culture.

Yasmin states that she has lived within and outside of Asian culture, and although she now considers herself "*an outsider*", she does not completely reject it. Indeed, she describes having moved away from the town where she grew up and "*too many Asian people*" and feeling more comfortable in a more mixed environment as she feel accepted for who she is. However, she also described having learnt to accept her Asian ethnicity and how this continues to influence her. Indeed, through the course of the interview she positioned herself both within and outside of Asian culture.

> *"Over the years I've admitted I can't, I'm still who I am. I'm Asian no matter how much, like I say, I'm not trying to cover it, but no matter how much, all those shape you still. So there's some influence about being Asian"*

- *Ethnicity of health care professionals*

Yasmin stated that on a few occasions she has felt uncomfortable when working with therapists of different ethnicity to herself, leading her to disengage. Otherwise, she describes feeling able to explain herself and build up rapport, seemingly taking on responsibility for the relationship. Indeed, in taking part in the research interview she described how she was able to clarify things as she can imagine the researcher's perspective as "*I live that life*", positioning herself alongside the researcher as outside of Asian culture.

However, Yasmin also states her concern regarding talking to professionals of different ethnicity about cultural issues which maybe controversial in western culture. She describes this as a barrier to her opening up about some issues which may be related to her self harm as she is unsure how much therapists will know and how they will react.

> *"If I said half these things, it would sound weird in this country. Even though I'm modern, I live here and I mix. I've still got some of these other things that happen in my family that I feel, again maybe, yeah, with someone in this culture might not understand. That's where I have an issue."*

Yasmin also describes how she has felt judged when talking to professionals who are Muslim/Asian. This has led her to censor what she says, for example regarding drinking. In both instances, Yasmin suggests that professionals should be more open about what they know and their position of not being there to judge.

"Maybe they should think about saying something like 'whatever my background is we won't'. Automatically you're thinking, they're up there in that position as it is, so yeah, you're worried."

Yasmin suggested that concern over talking about cultural issues may be a barrier for more religious women participating in this research project. However, she moderates this by stating that some religious people women will be able to talk openly. Yasmin states that although Asian women may feel able to talk about depression, no one is talking about self harm. Indeed she states that there are few Asian people attending mental health services and a lack of appropriate services.

"They might be getting together as Asian women, but self harm, I don't think, no information is out there. It's not been, you might see the odd leaflet stuffed away, but no-one's saying it's okay."

Valuing self harm

Yasmin understands and accepts why she harms herself. She sees it as having helped her and values it as a coping strategy, allowing her to manage her emotions. Indeed, she describes how her self harm is often triggered by feeling unable to cope and in these instances it is the only option available to her. She states that she does not hate herself for doing it and sympathises with others who self harm.

"You sympathise with it; it's accepted because what else are you supposed to, yeah, kind of, do when you're kinda within, yeah, yourself with all these issues?"

During the time she was being bullied at work, Yasmin describes feeling that she didn't know who she was and so self harm allowed her to "*get rid*" of emotions; be strong and fit in. Yasmin stated that her self harm became "*a part of me*", thus in the context of her having no sense of herself, self harm became part of her identity.

"It became more my identity that I do this. It's like black and white. You do this at home; you go to work and that's that."

Yasmin states that her self harm began as a means of dealing with and recovering from her depression. She explains that she continues to self harm in order to avoid becoming depressed again as there is "*no way out*" of depression and it would have worse consequences for her.

"And with self harm, I don't know if I am gonna self harm again. I think I probably will do to be honest. That's not me just saying it, but it's like it's a coping mechanism, so what else can you do? 'Cause the minute I go on my depression, I will neglect things; the minute I neglect things, the whole system will come up on you. Then you lose your house, your benefits, you know, you've got to keep up the whole system."

Limits of self harm

Alongside the above descriptions of valuing self harm, Yasmin also states that she is not happy about the fact she harms herself; that "*it makes you feel worse at the end of the day*"; and that she feels guilty about the consequences. She states that a reason she cuts herself rather than overdosing is because she doesn't want to damage her liver; demonstrating how she wants to harm herself, but there are limits on this.

> *"So self harm seems easier 'cause the consequences are less. And it sounds horrible to logically think like that but that is how maybe my brain has to cope with all the stresses that is trying to work the pros and cons from my experiences."*

Yasmin also states that she does not want her scars to be seen by a future partner or children. Indeed, she states that the reason she cuts herself on her arms is that it allows her to hide it. This relates to her comment that she does not feel guilty about her self harm herself, but feels guilty in terms of other people's perceptions of it.

> *"My self harm was kinda hidden and it felt like such a taboo. I felt, yeah, kinda guilty, not like I said about me doing it, it's because the way they would, people would see it. But I, that's the only way I could cope really."*

Yasmin describes how self harm is a taboo subject that no one is comfortable talking about. She also talks of the stigma of depression, stating *"it's not to do with you"*; however, she explains that the difficulty talking about self harm is far worse than depression. This results in her feeling more isolated.

> *"I feel isolated already with the mental health for my depression as it is. Even though you've seen how open that is more. But that is, you know that is nothing compared to how closed self harm is really."*

Professional versus service user

Yasmin describes feeling stuck between her identity as a professional and as a service user. She describes valuing her professional identity; wanting to work, be successful and fit into "*functional society*" with "*intelligent people*". However, she also understands and relates to people who have had problems. Indeed, she describes how through her experience of mental health services she has met many professionals who are not working due to psychological difficulties; and she rejects the stereotype that people who have mental health problems are "*stupid, uneducated*" and "*wanna be on benefits*". Yasmin describes how from her experience, you can either work or have a support network; it is not possible to have both. This is source of Yasmin's criticism of the government as she states, *"I wanna go back to work but I'm so scared because of the lack of support, 'cause I don't wanna go back to a place where I am self harming".*

Learning who she is

Yasmin described that since leaving work she is taking time out to get to know herself; *"mentally catching up*"; and developing the skills she feels she did not learn as a child. She also described how, through therapy, she is processing her experiences. Yasmin's narrative conveys a sense of her personal development. She has become increasingly comfortable in herself and able to judge what is right for her, be that regarding when she is ready to return to work or what her religious beliefs are. She is learning new coping strategies and ways of relating to others. She describes seeing herself happy and doing well in the future.

> *"It's helped me being off work 'cause I'm getting, yeah, therapy from a mental health team just clearing my head. It's like all the junk that's gone in all the time, it's kinda clearing a little bit."*

Interview 5 – Rashida

Pen portrait

Rashida is a full time University student in her early twenties. She lives with her parents and siblings, is single with no dependents. Rashida described her ethnicity as British Muslim and is of Pakistani origin.

Rashida witnessed conflict between her parents during her childhood. She first harmed herself during her mid-teens by cutting herself on the arm with a pair of scissors. This was precipitated by feeling unfairly blamed by her mother for an argument with her brother. At the time Rashida described also feeling under pressure from her father's academic expectations and being under confident socially. She described feeling down and contemplating suicide.

Rashida continued to cut herself frequently over the following years and deliberately threw herself down stairs. She described harming herself less on commencing university, as she felt happier as her father was supporting her, although the decision to go to university was her father's preference, not her own.

In the course of the past year, Rashida had a significant relationship. She described feeling extremely happy with her partner; however, she would harm herself when they argued. The end of the relationship precipitated her attempting suicide by overdosing on pain killers. Rashida was interviewed within a month of this suicide attempt. She described continuing to feel down and harming herself by cutting.

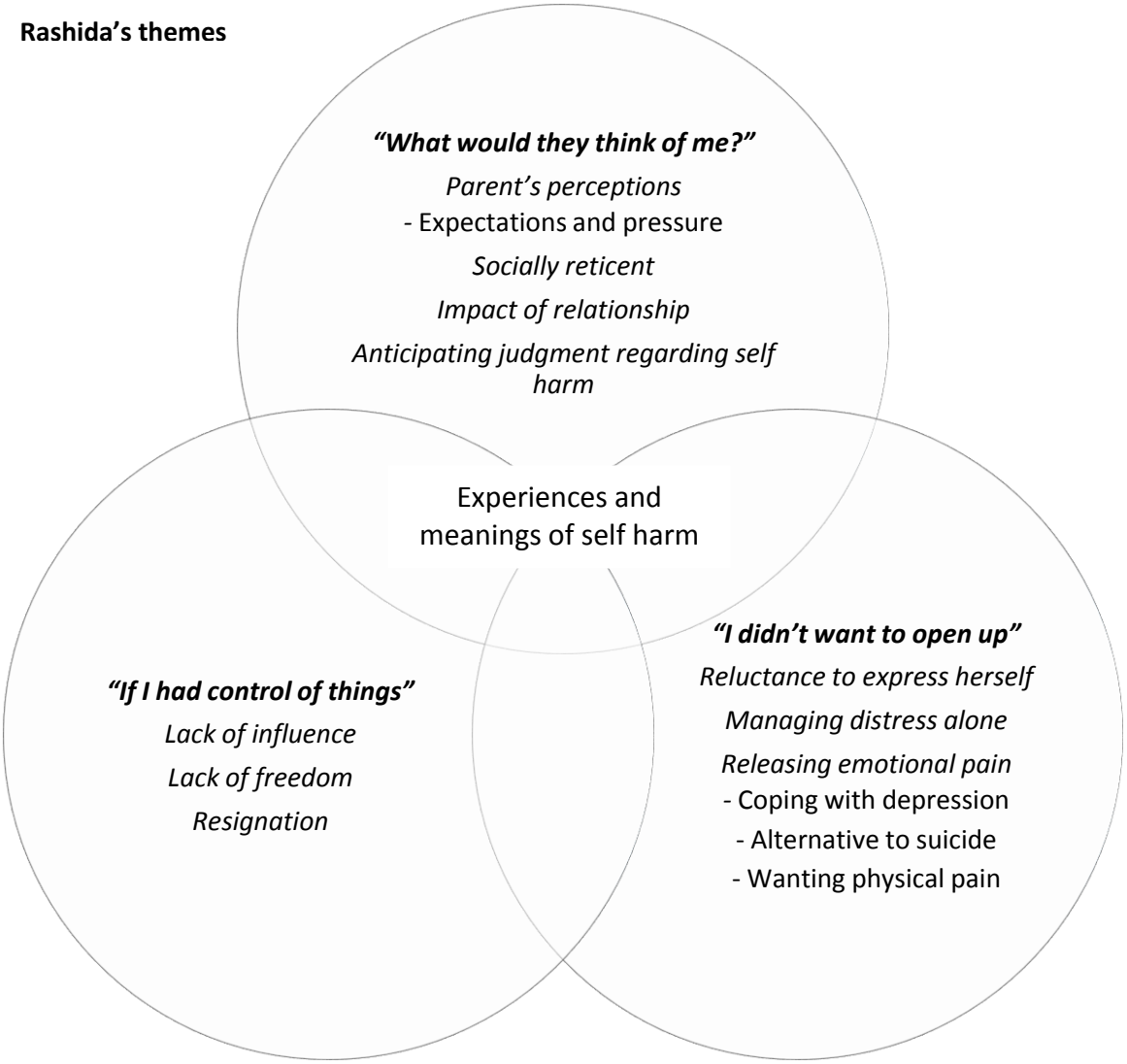
Accessing of support services

Rashida had not spoken to friends or family about cutting herself. She told one friend about her overdose, but was adamant that she did not want her parents to know. During the past year Rashida has accessed support through the student counselling service. Following this she attended her GP who prescribed anti-depressants and later referred her for psychological therapy. She attended an assessment within Primary Care and was referred to secondary mental health services. During this time Rashida took the overdose. She did not seek medical support, but went to university where she collapsed. She was hospitalised and later assessed by a self harm assessment team. Rashida has subsequently attended an initial appointment within secondary mental health services.

Presentation during interview

Rashida was eager to take part in the research, despite the recentness of her suicide attempt. She appeared low when describing her difficult experiences, but there was also spark about her. She seemed timid and nervous; however, in describing her self harm, Rashida communicated a sense of her strength and potency. At times there was a scripted nature to her narrative, suggesting that she is practising talking about experiences. Rashida attended the interview dressed in a shalwar kameez.

Rashida's themes



"What would they think of me?"

Parent's perceptions

Rashida stated that her parents play an important role in her life; that their perception of her is important; and that this affects her behaviour. For example, she explained that because clubbing and drinking are disapproved of by her parents she wouldn't do this as she doesn't want to be seen negatively by them, as "*You just want to like, live like the way your parents want you to*". She also described how she has been brought up to believe that her behaviour affects her family. Furthermore, she states that her parent's perceptions are important to the way she sees herself.

> *"What they view me as, it does affect me, my decisions, the way I see myself, everything."*

Fitting with the importance of her parent's perceptions is Rashida's description of the events precipitating the first time she harmed herself, where she felt unfairly blamed by her mother following an argument with her brother. Furthermore, Rashida was adamant that she did not want her parents to know about her overdose, stating *"if they found out I think I would probably just like end my life for good. I don't think I would be able to live with the guilt that with like 'why did she attempt suicide?'".* This reinforces how important the perceptions of her parents are to her as it is the idea of them knowing which is unbearable for her, rather than their feelings regarding her being dead.

- *Expectations and pressure*

A particular manifestation of Rashida's concern regarding her parents' perceptions was regarding her father's academic expectations. She described how he would compare her to an older sibling who was more academically able and pressurised her to attend university. Rashida felt that he did not value her opinion; and would "*put her down".* Indeed, Rashida described feeling depressed as a result of their arguments and that this precipitated her harming herself. Conversely, when she followed his wishes and felt his approval, she harmed herself less, reinforcing the link between her self harm and parental perceptions of her.

> *"Things started to get a lot better because I was coming to university so my dad used to support me a lot. I didn't really feel a need to self harm"*

Socially reticent

When considering the cause of her unhappiness Rashida states that she has always been shy and reserved and consequently has limited friends. She linked this to the impact of her father's comments on her self esteem and describes feeling awkward in social situations. Rashida

stated that she does not like to open up to people and struggles to know what to say when meeting new people. She contrasts this with her cousins who are more sociable and able to adapt their personality to who they are with. Although she states that "*I like to keep my own personality*" she also states the importance to her of her fitting in.

Rashida also comments that "*if I didn't let people get to me, then I guess I wouldn't self harm",* again suggesting the importance of other people's perceptions of her to her self esteem.

> *"I won't like to open up to a lot of people and even if I do I can't pretend to be what they want"*

Impact of relationship

Rashida described how during the past year she had been in a relationship. This was significant for her because of her shyness and because she only wanted to date with the intention of marriage. Furthermore, Rashida stated that as a result of seeing her parents arguing during her childhood, love was very important to her. Rashida described feeling the happiest she had ever been in this relationship and that she felt better about herself. However, their arguments triggered a re-escalation in Rashida's self harm and following the end of the relationship she took an overdose, stating that she didn't want to live with anyone else. The impact of this relationship on Rashida in terms of her self harm and suicide attempt seems to reflect its significance in terms of her sense of self.

> *"That relationship it did mean a lot to me. Em, like I think every single day like, it used to make me. Like when he text me, that used to like, it was like he blew life into me. I used to want to live. You know, I think that was the only period in my life when I was actually happy. But when we used to have arguments I used to become really down."*

Anticipating judgment regarding self harm

Rashida has not spoken to her friends or family about cutting herself and only disclosed her overdose to one friend. She states that she does not want anyone to know as she is concerned over how they would perceive her, anticipating that they would see her as "*weird*", "*mental*" or "*stupid*". She described feeling uncomfortable when in hospital following her overdose, as she worried about other patients overhearing the doctors talking about her. In line with this, Rashida stated that she felt more able to talk to counsellors than friends as, "*You know you won't have to see them again; you know that they won't judge you*".

"If I had control of things"

Lack of influence

Rashida described feeling she has little influence over her life. She stated that her most major decision, to go to university, was highly influenced by her father, and was not what she really wanted to do. Indeed, she described how she made the decision because she wanted her father to view her like her older brother. Rashida explicitly links this lack of influence to her self harm stating, "*If I had control of things...then I guess I wouldn't self harm."*

> *"The only decision I have made in my life was, was probably to come to university and that was influenced by my dad. Coz it wasn't something that I wanted to do, so I just followed what my dad wanted me to do."*

Lack of freedom

When asked her thoughts regarding self harm in South Asian women, Rashida states that Asian parents allow their children less freedom and gives her own experience that she would feel unable to say to her parents that she is going out at night time or away for a weekend with friends. She described how as a result of always staying at home her negative feelings build up and she is more likely to become depressed and resultantly self harm.

> *"If you're going through a really bad time and then if you go out at night-time or whatever...It makes you like, not think about the situation, whereas if you know 'I've only got my room upstairs to go to', and then that obviously builds up."*

Related to this is Rashida's description of self harm as a means of releasing built up emotions. Indeed, she describes how she discovered going out for a walk is an alternative method to self harm.

> *"I think I started when I be upset, I'd go out for a walk...it made me feel a lot better as well. So I used to walk, walk when I was down."*

The idea that Asian parents give their children less freedom is the only reference Rashida makes to her ethnicity. Indeed, she denies that her ethnicity is important to the way she sees herself or that it has any impact on her experiences of accessing support services.

Resignation

Rashida describes her regret at having followed her father's wishes rather than her own career goals and her anticipation of looking back on her life when she is elderly with a lot of regret. Despite this apparent incentive to act, there is a sense of her despondency and resignation to the situation.

> *"So I guess now that I'm here I just have to try my best."*

Rashida describes how she has no motivation to live and is unsure about her future. This ambivalence about life was perhaps reflected in her actions following her overdose, whereby she did not directly seek help, but chose to go to University where she could be helped, rather than to stay alone and die.

"I didn't want to open up"

Reluctance to express herself

Rashida describes how she is reluctant to assert herself with friends. She explains how, when standing up for herself she may say hurtful things and she doesn't like to apologise. Resultantly she states that she will "*let a lot of things just go"* and *"put up with a lot*". However, she described how this can result in a "*build up of so much hatred*".

Rashida also states that she felt unable to express her opinion and wishes regarding the decision to attend university. She explains that her father was struggling with her brother, who was experiencing problems (of undisclosed nature), so she did not want to add to the stress on him. These descriptions seem to reflect Rashida's difficulty expressing herself, so that rather than risking upsetting others, she keeps her feelings inside.

> *"I wish I could have like said 'No, actually this is what I want to do' but I think at that point of time I couldn't do that because I was 18 then. And em, it wasn't something that I could do. It was a period when my dad was going through a really difficult time with my brother so you know, I didn't want to put him down."*

The above description of feeling hatred towards her friends is the only occasion during Rashida's account that she declares any negative emotions towards others. She does not express any negativity towards her father, despite feeling pressurised and put down by him; nor does she describe feeling angry towards her mother for unfairly blaming her for her brother's arguments. It seems likely that these feelings are not acknowledged by Rashida and are perhaps internalised.

Managing distress alone

Rashida was clear that she did not want to talk about her low mood, particularly not to her parents. Indeed, she described how she would retreat to her bedroom following arguments and cry on her own. Although adamant that she did not want to open up about her difficulties, Rashida struggled to articulate why. One reason she gave was that her parents were preoccupied with her brother, so she did not want to put them under further strain or provoke arguments between them. From her descriptions of fearing judgement and the importance of

her parent's perceptions of her, it seems likely that she may also have been motivated to hide her distress from her parents in order to preserve their opinion of her.

As a result of this she describes how self harm allows her to deal with her distress on her own; that it allows her to "*cover up*" her feelings; and "*put a smile on your face and just get on with life, whereas inside you're hurting*". Indeed she stated that she would not feel able to use alternatives strategies to manage her distress, such as drinking, as this would highlight to her parents that there was a problem and she did not want them to know.

> *"If I cut myself I've relieved myself, I felt the pain and I can go downstairs, I can pretend to act as if I am happy."*

Congruent with this is Rashida's description of talking to professionals, describing how she initially found it extremely difficult to open up. Rashida stated that it has become easier to talk; however, afterwards, "*I just feel like the same person I guess"*, and so believes she has to deal with her problems herself. Indeed, she is very positive about the support she has received from services although concluding that nothing can help her.

> *"You can like just like get what's on your mind off by telling someone else, but then you know like, you have to deal with the problems yourself."*

Releasing emotional pain

- *Coping with depression*

Rashida was clear that her self harm was a means of coping with her situation, particularly feeling down. She described how other people use alternative techniques, such as drinking, smoking, to manage their mood, but self harm was the most available to her.

> *"And then because, I think it was a way of coping with the situation I started to do it whenever I get down, like on a regular basis."*

Rashida described how when she accessing counselling she was provided with strategies to help her reduce her self harming. However, she described her difficulty in implementing them when feeling low or overwhelmed by her emotions. Indeed, she stated that she felt that self harm was the only strategy that helped her manage her mood.

> *"I don't really think I would find anything useful. I think it is just self harming what gives me the release. I don't think there is really anything else."*

- *Alternative to suicide*

Rashida states how in the past she felt suicidal, but that her self harm was an alternative. Indeed, she states that she believed she would have killed herself if it wasn't for self harm, thus her self harm was a survival mechanism.

> *"I guess I didn't used to act on the suicidal thoughts, I used to act on the self harm thoughts."*

- *Wanting physical pain*

Rashida described how she would cut herself until she felt pain and saw blood, at which point she would feel better. She stated that self harm provided a temporary release from her emotional pain, that it would divert her attention. She stated that she wanted to feel pain and that she chose to cut herself rather than other means of self harm as the pain lasts for longer. It seems that seeing her blood was a physical maker of her pain, verifying her emotional pain.

> *"I think when you see blood it just makes you feel that, 'Yeah I am actually in pain'."*

Although wanting pain, this is within limits as Rashida also described how an occasion when she cut herself particularly badly, resulting in more pain usual, triggered her to reduce her self harming.

> *"One day I self harmed a lot, like I used a shaver, it really really hurt, it wasn't something what I'd used. Really really painful even afterwards and I think that made me realise that it's stupid what I do and then I stopped a lot."*

Participant 6 – Parveen

One further participant was recruited through a community support organisation; however, the interview was not completed as Parveen raised significant risk issues which required immediate action. The interview has not been analysed along with the other transcripts as insufficient data was collected; however, in recognition of her willingness to participate and in line with the study aim of hearing the voices of a marginalised group, a brief summary of her experiences is included.

Parveen understood English, but was not confident in speaking so the interview was conducted with the aid of an Urdu speaking interpreter. The course of the interview was unusual in that the interview schedule was not followed as Parveen began recounting her story without prompting. However, she disclosed having recently taken a serious overdose and described feeling acutely suicidal. The researcher discussed her concerns with Parveen and her support worker was involved. Together it was agreed that she would be supported in accessing her GP.

Parveen is in her mid 30s; born in Pakistan, she moved to Britain as a child and received some education at that time. She is estranged from her son and wider family and now lives with her husband, who emotionally and financially abuses her. Despite this, Parveen fears that one day he will leave her and she will be left alone.

Through the interpreter Parveen describes her longing for care.

> *"She goes, 'I've never got loved from no-one, not my parents, not my sisters, my brothers, not my son, not my husband. She goes 'all I want is a bit of love and someone to just sweetly talk to me. That's all.'*

She describes how her family and now husband have controlled her.

> *"She's had no control over her life, there's always someone controlling her."*

Despite feeling deeply unhappy, she doesn't feel able to express this to anyone.

> *"She goes 'I don't tell anyone, I just take it and take it and bottle it up.'"*

Indeed, she described a sense of resignation to accept the situation.

> *"She goes 'a lot of time has passed, a little is left'. It's like a saying in Asian, it's like, most of the life is gone but a little is left, might as well, you know, pass it."*

However, she also describes a sense of personal strength from managing her situation.

> *"And she goes, I feel, I've got courage that I take it on."*

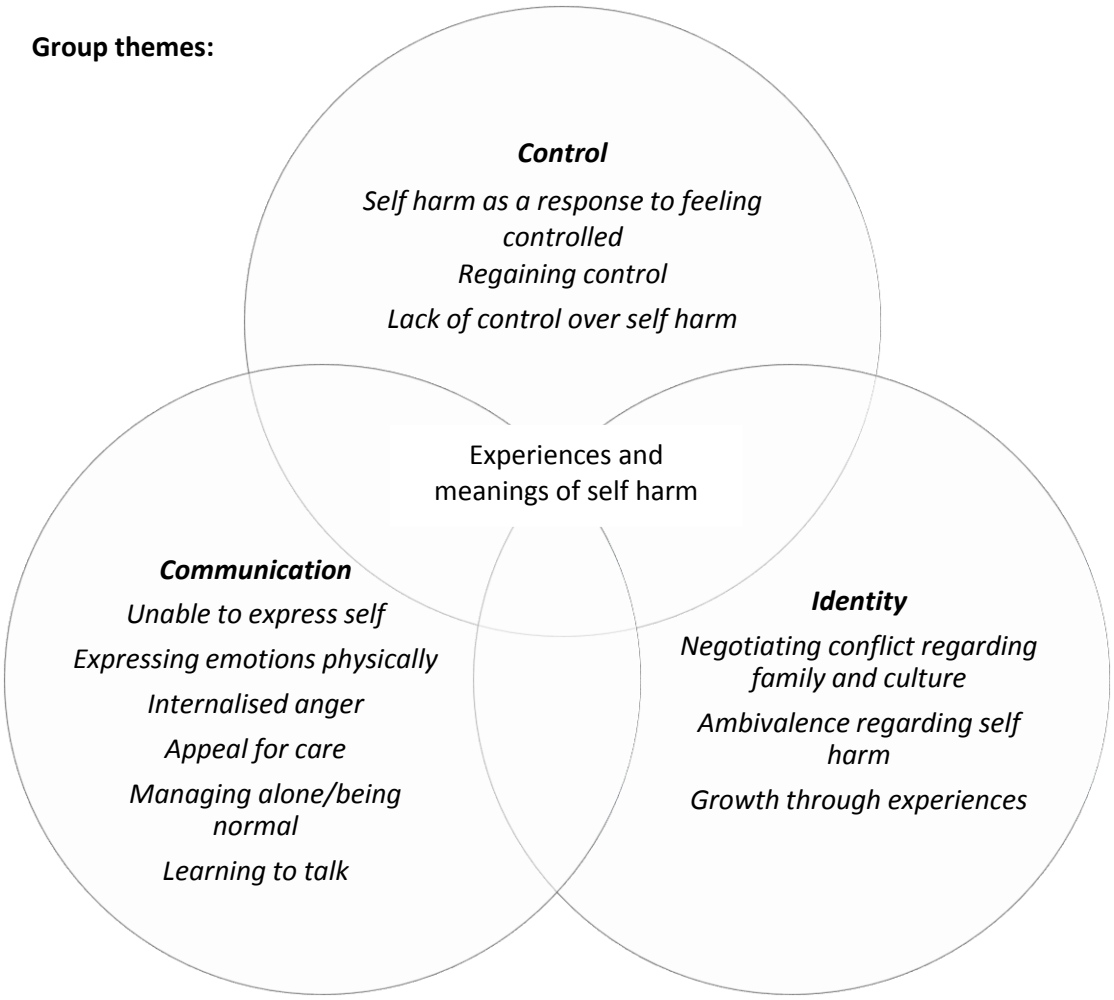
Group analysis

In terms of their demographic characteristics Farida, Salma, Adeeba, Yasmin and Rashida form relatively homogeneous sample. Furthermore, there are similarities in their experiences and meanings of self harm. The following section elucidates these group level connections, as well as noting some of the instances in which their accounts diverge.

With the exception of Yasmin, all of the women began harming themselves during their adolescence, and, with the exception of Farida, all were continuing to self harm at the time of the interview. They describe using a variety of methods including cutting, scratching, hitting themselves and throwing themselves downstairs. Farida, Salma, Yasmin and Rashida also reported having taken overdoses. The women did not include their overdoses as part of self harm, differentiating between them on the basis of suicidal intent, although they acknowledged the overlap and their ambivalence about living even at these times, demonstrating the complexity of this issue of intent.

All of the women have experienced negative life events or relationships either during their childhood or in adult life. These include emotional and physical abuse, sexual assault, bullying, criticism by parents and racism.

Group themes:



Control

Self harm as a response to feeling controlled

Many of the women described feeling controlled and entrapped by the expectations of their family and/or wider community, and that their self harm is a response to this.

> *"The self harm, it just makes you feel better for, like cutting and everything, it just makes you feel better for a while, until it all starts up again, until you argue again or until so and so person starts controlling you again." Farida*

Regaining control

It seems that by harming themselves, the women regained a sense of control. Salma's account provides an explanation, describing how self harm gave her a sense of agency. Self harm is also described by several of the women as a means of managing uncontrollable feelings. Congruent with this, many of the women describe harming themselves less as they regain control over their lives.

"So I feel in that point of my life I felt no control over anything. But then, as I went along, then I went back to college and everything, that influence, you know came back to me, I had, I had power for my own life again and so that's why the self harm got less and less as I came out of that hole." Salma

Lack of control over self harm

In contrast to the concept of self harm being a strategy employed by these women, Yasmin and Adeeba described how their self harm had felt out of their control; that they had wanted to stop but felt unable.

"I've tried to deal with, calming myself. But I think my situation has got to the stage where it's escalated, it's too, I can't calm myself, I can't control it anymore" Adeeba

Communication

Unable to express self

All of the women describe difficulties expressing themselves, feeling isolated and having no one to talk to about their distress. Farida, Salma and Yasmin explicitly link this to their ethnicity, explaining that South Asian women are brought up not to express themselves.

"It's kinda, women, I don't want to say suppressed because that's like a stereotypical media word, but it's kinda like you learn not to be outspoken; not to say things, you know to express yourself." Yasmin

Expressing emotions physically

As a consequence of feeling unable to express themselves verbally, self harm is described as a physical means of expressing their emotions, externalising their internal pain. Indeed, feeling pain is significant in many of the women's accounts as a means of validating their distress.

"I felt like all the pain I was feeling was being, was coming out in the scratches um, that sting, the sting that you feel and all the emotional pain" Salma

Internalised anger

Several of the women particularly relate their self harm to feeling angry, but as they are unable to express it at others, they instead internalise it, taking it out on themselves through self harm. The absence of expressed anger is notable in Rashida's account; however, when viewed alongside the other women, it is possible to hypothesise that her anger is internalised before she is aware of it.

"Can't take it out on anyone else; there's only me to take it out on." Adeeba

Appeal for care

In the context of feeling unsupported, uncared for and that their distress was not heard, Farida, Salma and Yasmin talked of their self harm as an indirect expression of their need for care and attention. However, although describing self harm as a *"cry for help*", the women reject the notion of "*attention seeking*" as this belittles their needs. Furthermore, they are ambivalent in their communication, as they described hiding their self harm from others and how, when their self harm was noticed, they dismissed it. This ambivalent and indirect communication reflects the responses they received in their difficult relationships, in which their distress was neither heard nor understood.

> *"I think it was for attention. Not attention, as in – oh, I can't explain it to you – it wasn't attention, I wanted him to like, care for me. I wanted him to turn round and say 'No Farida don't do it, what are you doing to yourself? You're messing your body up, stop it'...So it wasn't attention, I just wanted him to care." Farida*

Managing alone/being normal

Perhaps as a result of the above, for these women self harm is a means of managing their emotions on their own. Indeed, they described how it allows them to hide their distress from others and be "*normal*" within their family or work context.

> *"If I cut myself I've relieved myself, I felt the pain and I can go downstairs, I can pretend to act as if I am happy." Rashida*

Learning to talk

All of the women are undergoing a process of learning to talk about their experiences, from Farida and Yasmin who have had therapy; Rashida who is beginning to open up about her feelings; to Adeeba who talked for the first time in the interview. They described how difficult it is to express themselves, but that talking is an alternative to self harm.

> *"Coz like when you talk, you can show your emotions, you can get angry, you can cry, just like what I did now, I was crying, that was releasing my emotions, but when you cut, you do the same thing. But, it's sort of similar I think." Farida*

Identity

Negotiating conflict regarding family and culture

A recurrent theme in these women's accounts is their difficulty negotiating their sense of self in relation to their families and wider community. This often originates from experience of family conflict, feeling controlled and/or differences between their wishes and those of their

parents. The women have managed these conflicts in different ways, for example, Farida rejects her mother's values, whereas Adeeba embraces them.

> *"It's kinda like these conflicting messages you get about how to be and where to fit in, you know, I couldn't understand all that and I think that didn't help because I don't know where I'm supposed to, who I'm supposed to kinda be." Yasmin*

Often the values of their parents, wider community and religion are conflated, resulting in ambivalence regarding their cultural identity. However, there is acknowledgement in their accounts of alternative ways of identifying with religion, culture or ethnicity that they have not experienced.

> *"I don't mean for it to sound bad on like on other Pakistani girls, but like, sometimes like when I look at my family and the way they are and what they, the way they see things and everything, I just don't like being a Pakistani." Farida*

Ambivalence regarding self harm

The women described conflicting perceptions of their self harm. On one hand, they value the behaviour, viewing it as a coping strategy and sometimes the only available means of managing their distress.

> *"That's the only way I could cope really, 'Cause I don't really drink alcohol so I'm not gonna go down that route...to me it's a different way of coping." Yasmin*

However, they also express guilt, shame and regret regarding their self harming. This often reflects their ideas about how other people perceive self harm, including friends, family and the wider community, resulting in them hiding their self harm as they fear judgment. Unfortunately, these appraisals can also serve to exacerbate their negative feelings towards themselves, thus their self harming impacts on their sense of self.

> *"At times I really don't like myself and then I see the scars and I then, that negatives more on my feelings towards yourself" Adeeba*

Growth through experience

Explicit in all of the accounts of Farida, Salma and Yasmin is their sense of growth through their experiences. Several of the women explain how they have developed alternative ways to manage their emotions, such as talking or going for a walk. Indeed, all of the women demonstrate resilience in the face of adverse experiences and describe a journey of personal development.

> *"Everything that's happened, when I look back on it, it's sort of made me stronger...When I look back on it and everything I've been though, oh God, I don't know. I'm just surprised I'm still here." Farida*

Relationships between super-ordinate themes

The accounts of all of the participants speak to the superordinate themes of *identity, communication* and *control.* However, the salience of these concepts and subordinate themes that comprise them vary for each individual. This is reflected in the analysis of the individual accounts, whereby the order in which the superordinate themes are discussed corresponds to their significance in each woman's account. Furthermore, the themes have been presented in venn diagrams to illustrate the dynamic interactions between them. Thus, as well as capturing independent aspects of the participants' experiences, the inter-relations between the themes of *identity*, *communication* and *control* are important in understanding their experiences and meanings of self harm.

For example, one of the reasons for the women's describing feeling controlled and lacking influence over their lives, is their being unable to express themselves. This is linked to their experiences of family and cultural expectations, resulting in them feeling ambivalent about their cultural identity. Thus feeling controlled, unable to communicate and conflict regarding sense of self, combine to contribute to their self harm.

> *"Asian women, they've been brought up not to talk back, like - Oh, I can't explain - You know when they're married, they shouldn't talk back to their husband because it's meant to be, it's meant to be a bad thing. And when they're living with their family, 'Oh you can't, oh, you can't talk back to your elders 'coz it's a bad thing'. So if you can't talk back to them and you can't tell 'em the way you're feeling, what can you do? That's what you do* [self harm]*." Farida*

This overlap between the themes is also apparent in the functions of self harm the women describe. For example, self harm is a means of their expressing emotions that cannot be expressed elsewhere and of gaining a sense of agency when feeling controlled, both of which impact on their sense of self, as they both value and identify with self harm as a coping strategy, but simultaneously feel guilt and shame regarding the behaviour.

> *"I used to be really angry and then I do it and then I just feel really calm and then I just go downstairs and just be normal and I'd just like forget about everything that happened and just be normal. So yeah, that's what it used to do for me but, it's, I know now it's not the right way. There's different ways of dealing with your anger and that ain't it." Farida*

A further illustration of the inter-relationship between themes comes from the women's descriptions of beginning to harm themselves less, whereby they describe a process of simultaneously regaining control over their lives, becoming more able to express themselves, and a positive development of their sense of self.

This highlights a further issue whereby, not only are there interactions between *control, identity* and *communication,* but their relative salience for individuals change over time. The accounts obtained from the women are narratives which describe a trajectory of their

experiences and changing meanings of self harm. Indeed, the women were interviewed at different points in their experience of self harming, from Rashida who was talking within a month of having taken a significant overdose; to Farida, who described having moved on from her self harm having developed alternative ways of coping.

In making sense of their experiences, the women are reflecting on their past as well as projecting into the future. For example, although both Salma and Yasmin describe harming themselves less, they both state that they may continue to self harm. This seems to reflect their continued valuing self harm as a means of managing their emotions and their anticipation that this maybe something that they may need in the future as the experiences that lead to these emotions are likely to continue too.

> *"And with self harm, I don't know if I am gonna self harm again. I think I probably will do to be honest. That's not me just saying it, but it's like it's a coping mechanism, so what else can you do?" Yasmin*

A further example is in Rashida's description of lacking motivation for life as a result of her of feeling she has no influence to change her current situation. Thus, despite being increasingly able to express herself, her continued sense of lacking control is reflected in her continued valuing of self harm.

> *"I don't really think I would find anything useful. I think it is just self harming what gives me the release. I don't think there is really anything else." Rashida*

However, Rashida also describes how self harm is a means of surviving, as in the past she has harmed herself as an alternative to suicide. This highlights an important issue in that all of the women demonstrate significant strength and resilience in the face of adverse life experiences. The danger of focusing on their self harm is that this becomes a problem saturated account of their experiences. Thus it is important to recognise that these women are not passive in response to feeling controlled or unheard, but make concerted efforts to resist these pressures and define themselves. For example, Farida escaping to another city, Salma persuading her parents to cancel her engagement; and Yasmin speaking out against her step mother despite it provoking further abuse.

> *"That was the one night where I just sat, stood in the kitchen for like two or three hours telling my parents that I didn't really want to marry this guy. And I think in the end they came round." Salma*

Finally, it is noteworthy that all of the participants view their self harm as a meaningful phenomenon which is understandable in the context of their wider life experiences. They do not perceive their self harm to be externally imposed or as a symptom of mental illness, but rather see it as a meaningful response, causally linked to their experiences.

> *"I understand why it's comfortable to do. So, I don't um, um, hate myself to do it." Yasmin*

Experiences and perceptions of services

The women have had differing amounts of contract with support services and describe varied experiences. Several of the women stated how they valued having a forum within which to talk.

Service responses inadvertently exacerbating distress

A commonality across accounts is that the women's perceptions and experiences of services reflected their interpersonal processes and difficulties. For example, Salma interpreted being referred on to another professional following assessment as not being taken seriously by health care professionals, leading her to disengage. This demonstrates how service responses can inadvertently replicate the patterns of women's previous interactions and consequently exacerbate their distress. A further example of this is the stress caused to Yasmin by her difficulties negotiating her benefit claims which triggered her to self harm.

> *"It was actually to do with claiming benefits and all the problems. You know that is a hard business in itself...When you've got depression to chase the complications of a whole system, it's just, yeah, those sorts of things that cause it." Yasmin*

Fear of judgment

The fear of judgment described earlier in relation to others' perceptions of their self harm also affects the women's willingness to access support from friends and family or health care professionals. For example, despite being motivated to talk about her difficulties, Adeeba had felt unable to overcome this barrier.

> *"I can't tell them* [GP of Asian ethnic origin]. *I know they won't break your confidentiality and yet, I don't want to be judged." Adeeba*

Impact of ethnicity

Farida, Yasmin, Adeeba and Salma all described an interaction between their ethnicity and feelings regarding accessing services. There is ambivalence regarding working with health care professionals of the same and different ethnicity. Although on one hand, shared ethnicity is valued due to shared understanding of cultural issues, there is also an increased fear of judgement by professionals of the same ethnicity who are perceived as holding similar values to those used against the women.

> *"I don't really like talking to - I'm not trying to be like, sound bad or anything - but when it comes to like Asian people, I don't really like talking to them. Coz, they look at you differently." Farida*

In contrast, Rashida stated that she was not concerned by the ethnicity of health care professionals and had not felt this impacted on her interactions with them. This seems to

reflect the above point, in that she did not identity her ethnicity as important to her own sense of self, and because of this it was not important in her interactions with others.

Improving services for South Asian women

The women expressed their desire to raise awareness of self harm by South Asian women. They felt self harm was unheard of within the South Asian community and that this is a barrier to women accessing support. Although, they acknowledged that South Asian women may have different perspectives and preferences, they felt that current service provision was not adequate and suggested various ideas that they felt would improve services for this population:

- Access to a confidential forum, to talk and feel understood:

  "I just want someone to listen and understand. Without the judgement." Adeeba

- For professionals to openly acknowledge cultural/ethnic similarities and to state their position as not being there to judge. For non-Asian professionals to state their position regarding openness to discuss cultural issues.

  "Psychiatrists don't do that, say 'we're not here to judge whatever my background is' maybe they should think about saying something like 'whatever my background is we won't'" Yasmin

- Non-directive therapeutic approach:

  "As soon as she came in and I started telling her everything, she was like "Oh, it'll be better if this and that, and I why don't you try" she started saying "Why don't you try talking to your parents again" and stuff and I didn't like it." Farida

- Consistency of professionals:

  "What I used to find helpful was like having the same counsellor all the time. But what I didn't find helpful was like, when I had to change the person and then I'd have to go right from the beginning and start again from what happened right at the beginning and stuff and it'd just bring back memories." Farida

- Strategies to help manage self harm:

  "I think techniques to know, to be able to, to be told techniques on how to calm down before you get all out of hand." Adeeba

  "My CBT [Cognitive Behavioural Therapy] was all right because again she, yeah, it was more practical. I think with and also self harm is that it worked well because again, that's about practical solutions, how to think; quite a practical thing to do so they kinda worked hand-in-hand." Yasmin

- Psychotherapy to understand underlying issues:

  "I preferred the psychotherapy because it goes deeper. But then I think, yeah with the psychotherapy it's understand the deeper why you do it." Yasmin

- Helplines or internet based forums:

"I say online and telephone because it's easier than going somewhere by yourself to go to the actual surgery and make an appointment and stuff; so, easy access, online telephone for specifically for Asian women." Salma

- Raising awareness and de-stigmatising self harm in South Asian communities:

  "If they don't understand it, they think they're doing something wrong so they keep it a secret. Because they fear that they're doing something wrong, rather than they're doing something that's, that can be helped, in some situations before it gets worse." Adeeba

- Giving women confidence:

  "Giving women confidence is the key issue I think. If you give, if you give someone confidence enough to help themselves they will help themselves. You've just got to give them that confidence, to do that. So it's like: help you; help yourself, kind of thing. I think Asian women would find that much easier." Salma

Process reflections

Reflections on interviews

My experience of the interviews reflected Song and Parker's (1995) prediction there are likely to be multiple connections and disconnections between researcher and participant through the course of an interview. In terms of gender, age and educational background, I am similar to Farida, Salma, Adeeba, Yasmin and Rashida, and I certainly felt connection to all of the women on these grounds. In terms of ethnicity and culture, I felt sometimes that I was positioned as an outsider; whilst on other occasions participants aligned themselves with me, for example, Farida stating "*we're brought up here and like we know how it is*". This seemed to reflect where they were positioning themselves in relation to their cultural identity at that point time. Adeeba's comments of "*think you need to be a Pakistani to understand" and "I think it was a positive side that you are not the same ethnicity as I could talk more openly"* demonstrates how my ethnicity may have been both a hindrance and have allowed me access to their accounts. Indeed, Farida stated she felt more able to talk to me about having taken an overdose and her drug and alcohol use than she would an Asian professional. However, I wonder whether this was as much about our shared identity as young women as regarding our ethnicity.

The women's accounts will have been influenced, not only by the questions asked, but by the decisions I made regarding when to probe an issue further or when to move on to another question. I attempted to remain aware of this, so that the participants were facilitated in talking about what was important to them, rather than what I felt was important. However, in reality, my own assumptions and preconceptions may have been active in shaping these interactions. For example, it was noted by a supervisor that I had not picked up on a participant's comment that a recent occasion she had harmed herself was triggered by a relationship ending and stress from exams. On reflection, I wonder whether the reason I did not pursue this was, at least partially, because the ideas of being distressed by a relationship ending and exam stress are familiar to me – perhaps an example of my assuming a shared meaning (Hunter, 2010). Another example of my projecting my own perspectives occurred within the first minutes of the first interview, when Farida answered the background question regarding her marital status. At the time, I interpreted her laughter in response to this question as her also feeling *too young to be married;* whereas it later emerged that she almost had been married. Recognising this assumption was a useful early warning to me.

At times I was aware of struggling with my role as a researcher, as opposed to my more familiar role as a psychological therapist, so that on occasions I felt drawn to respond in ways which were perhaps over-empathic and potentially leading. My dual role was felt most

keenly during the sixth interview where I became increasingly worried regarding the participant's expressions of suicidality. Furthermore, I was aware of feeling protective over several of the interviewees at times and it was an important realisation that I was perhaps underestimating their strength and resilience.

Reflections on analysis

A major challenge whilst conducting the analysis was to condense the enormous amount of information without losing the richness or complexity of the women's narratives, particularly as I was attempting to produce an account which reflects their idiosyncratic concerns and meanings.

Initially I was struck by apparent contradictions in the women's accounts; however, on closer analysis their ambivalence was understandable in terms of the different contexts they were describing. In these instances it was important to ensure I was focusing on the women's understandings of their experiences, rather than attempting to make sense of them from my own perspective.

The overlap between themes and the occurrence of the concepts of *control* and *identity* lead me to question whether they arose from the women's accounts or whether they were imposed, either through the interview or the analysis. This issue will be discussed further under *strengths and limitations.*

CHAPTER 5: DISCUSSION

Chapter summary

The following chapter will consider the phenomenological analysis in relation to the research questions and the wider research. Initially, this will focus on the participants' experiences and meanings of self harm, including consideration of the secondary research question regarding the concepts of control and identity and the extent to which the women's accounts speak to psychological models of self harm. The participants' experiences and perceptions of support services will then be discussed. The chapter ends by considering strengths and limitations of the study, clinical implications and possibilities for further research.

How do South Asian women understand and make sense of their experiences of self harm?

The accounts of all five participants speak to the superordinate themes of *identity, communication* and *control.* Whilst these themes capture independent aspects of the participants' experiences, the interrelations between them are also important in understanding their experiences and meanings of self harm.

The meanings of self harm offered by the women in this study are similar to those described in other studies with South Asian women (Bhardwaj, 2001; Chantler et al., 2001; Marshall & Yazdani, 1999) and women of other ethnicities (Babiker & Arnold, 1997; Spandler, 1996). For example, self harm was viewed as a coping strategy for managing distress, a means of releasing emotions, communicating with others, providing a sense of control and as a form of self punishment. Indeed, the participants' accounts are in keeping with the notion that self harm can serve multiple functions simultaneously and that those functions may change over time (Horrocks & House, 2010). It is hoped that by focusing on the individual accounts, this study has captured some of the ways in which these meanings inter-relate, for example, how feeling unable to express themselves, controlled by others and conflict regarding sense of self interplayed in the participants' experiences and meanings of self harm.

Previous studies have described how South Asian women view self harm as a logical response to psychological distress (Chew-Graham et al., 2002) and not problematic itself (Marshall & Yazdani, 1999). The participants in this study also viewed their self harming as a logical response, indeed, sometimes the only available option, and valued it as a coping strategy for managing their distress. However, they also expressed conflicting perceptions, including guilt, shame and regret regarding their self harming and some participants described wanting to stop but feeling unable. These feelings reflected their expectations about how

other people would perceive their self harm. Thus the participants' ambivalence regarding their self harm was more salient in their accounts than in previous research.

Alongside *control* and *identity (discussed below)* a third superordinate theme to arise from the women's accounts was *communication.* All of the participants described difficulties expressing themselves which they linked to their self harm, a relationship which has been reported in the wider literature (Spandler, 1996). Some of the participants attributed their difficulties expressing themselves to their ethnicity; however, this may also reflect cross-cultural gender role expectations. For example, the concept of the internalisation of anger which arose in the participants' accounts has been related to gender role expectations regarding the expression of emotions, whereby social norms regarding what is acceptable for women result in their anger being turned inwards on the self (Sutton, 2007).

The participants' descriptions of having no one to talk to about their distress reflect the findings of Hussain and Cochrane (2002), where the lack of a trusted confidant or ability to discuss difficulties was described as leading to feelings of isolation, which was implicated in the cause and maintenance of distress by South Asian women.

Several of the participants described their self harm as an appeal for care and attention. This reflects previous descriptions of self harm as a means of communicating to others (Marshall & Yazdani, 1999). However, the participants' communications were indirect and ambivalent, as they simultaneously hide and minimise their self harm. This perhaps reflects the responses they have received from others in which their distress is neither heard nor understood. Furthermore, although describing self harm as a *"cry for help"*, the participants struggled with the notion of "*attention seeking"*, a term which implies their problems are not serious and that seeking care is negative, rather than reflecting a genuine need. Research into service providers' perceptions of self harm has described how perceptions of self harm as a form of attention seeking can result in patients being seen as manipulative, less deserving of care and being shown a lack of empathy or understanding (Batsleer et al., 2003). Thus it seems the over simplistic concept of 'attention seeking' can serve to devalue women's distress both in the individual who harms themselves and those who care for them.

It is important not to overlook the significance of the traumatic experiences that the participants have experienced, including childhood emotional and physical abuse, bullying, parent neglect and separation, sexual assault and racial discrimination, all of which have been linked to self harm and poor psychological wellbeing (van der Kolk et al., 1991). The women demonstrate considerable strength and resilience in the face of this adversity and there is a sense of their growth through their experiences. Indeed, it is important not to pathologise these women, who, in line with other research regarding self harm (Chantler et al., 2003), do

not consider themselves to be mentally ill, but are using self harm as a coping strategy to manage their distress.

How relevant are issues of control and identity in South Asian women's understandings of their experiences of self harm?

In answer to the study's secondary research question, the concept of control seems highly relevant to the participants' experiences and meanings of self harm and arose as a central theme in all of the women's accounts. Lack of control has been linked to self harm in the wider literature on self harm in women (Shaw, 2002); has been cited as a contributory factor in the development of anorexia nervosa in young South Asian women (Littlewood, 1995); and is perceived by South Asian women as a significant factor in the aetiology of mental health problems (Chew-Graham et al., 2002). The responses of the participants in this study corroborate the link between the experience of being controlled and self harm.

One of the means by which participants described feeling controlled was by family and/or cultural values. This relates to Gilbert, Gilbert, & Sanghera's (2004) description of how people can be entrapped by values and traditions, with consequent negative impact on their psychological wellbeing. However, the authors note that the level of entrapment experienced by an individual will depend on whether they feel empowered or oppressed, and whether the values form an appreciated part of their identity. This fits with the experiences of participants in this study, whereby it is the way cultural or religious values are used to control them that they found disempowering, and that they can see alternative ways of being within their culture or religion. This links the experience of being controlled to identity, in that it has a negative impact on the women's sense of self, a link which has been noted in previous research (Chew-Graham et al., 2002).

The theme of self harm being a means of regaining control is reflected the wider literature (Babiker & Arnold, 1997), including by South Asian women (Marshall & Yazdani, 1999).

The concept of identity also arose as a central theme in the participants' experiences and meanings of self harm. Previous research has implicated 'culture conflict' (Merril and Owens, 1986; Bhugra et al., 1999; Hussain et al., 2006) and difficulties due to an acculturation gap between generations (Bhugra, Bhui et al., 1999) in South Asian women's self harm. These concepts seem pertinent to the participants in this study, as negotiating conflict regarding family and culture was a recurrent theme. The women were ambivalent regarding their familial and cultural identities, leaving them struggling to negotiate their sense of self. Some of the women spoke of conflict between their own values and aspirations and those of their

parents and wider culture and how restrictions placed on them limited their developing sense of self. This is congruent with authors who have implicated difficulties with individuation in self harm by young South Asian women (Ghuman, 1999; Husain et al., 2006; Inman, 2006). This also speaks to Erikson's (1968) theory of identity formation whereby separating and individuating from one's parents is purported to be a key task and necessary for good psychosocial adjustment; and Phinney's (1990) concept of ethnic identity achievement requiring a search and exploration of ethnic identity.

Furthermore, the familial and cultural expectations that the participants struggled with were partially internalised, impacted on their own behaviour and led to feelings of guilt and shame. This perhaps reflects findings of Chew-Graham et al. (2002) who described how *izzat* can be both externally and internally imposed. However, rather than endorsing these values, the participants in this study rejected them and were critical of the perceived judgemental nature of their communities. Some of the participants considered of the impact of their behaviour on their family in terms of society's judgments; however, it seems that this was driven by the importance of their parents, rather than the importance of society's perceptions. This may relate to the study sample, as the participants were born and raised in Britain as opposed to abroad, so perhaps *izzat* is less pertinent to them personally, but they are aware of its significance to their parents.

The concept of 'culture clash' has been criticised for implying a homogeneous Asian culture which can be differentiated from a homogeneous British/western culture; thus reinforcing cultural stereotypes (Marshall and Yazdani, 1999). This is apparent in the women's narratives which at times polarise western and Asian cultures in relation to their experiences. However, the women also describe their awareness of alternative ways of living within their culture, and were reluctant to employ stereotypes.

This issue highlights the impact of the broader context and culture on an individual's perspective, so that the participants' meanings of their self harm and experiences reflect pre-existing accounts (Marshall & Yazdani, 1999). For example, one participant used the term 'culture clash' and several participants described their self harming as a 'cry for help', which are commonly held ideas. This demonstrates how wider culture impacts on individuals' meaning. However, these concepts are not accepted uncritically by the participants of this study, as their personal experiences of the complexities and contradictions underlying these ideas lead them to reject simplistic explanations.

Considering psychological models of self harm

Various theoretical models have been proposed to explain self harm; however, it is not known whether these models apply cross culturally. Indeed, it is questionable whether it is appropriate to apply western models and theories to other cultures. For that reason a major strength of the qualitative approach is that it is grounded in the participants' accounts, rather than imposing external ideas. Rather than 'testing' a theory, it is possible to consider whether the phenomenological analysis speaks to these theories.

The experiences of self harm described by the participants relate to several of the psychological models of self harm outlined by Suyemoto (1998):

The participants' descriptions of self harm as a means of managing uncontrollable emotions, expressing emotions which cannot be expressed verbally and externalising emotional pain are referred to in the affect regulation model. The suggestion that self harm allows the individual to dissociate from distress also received some support from the participants' accounts.

The group theme of *internalised anger* reflects Klonksy's (2007) conceptualisation of self harm as an expression of anger towards the self. The description by one participant of self harm being an alternative to suicide relates to the psychodynamic anti-suicide model, whereby self harm is viewed as a compromise between life and death drives. Furthermore, the experiences of some of the women of their sense of self being closely tied to their families and thus struggling with their own identity related to the boundaries model, which views self harm as an attempt to distinguish self from others.

The environmental model highlights the interaction between the individual and their wider system, suggesting that, on one hand, self harm results in environmental responses which reinforce the behaviour, for example, secondary gains of care or attention. At the same time, self harm serves the needs of the environment, by deflecting attention from systemic dysfunction. Although systemic factors are clearly relevant for all of the women interviewed the mechanism by which they act seems different from the one suggested. Although some of the women do describe their self harm as an appeal for care and attention, they did not receive this from their environment, thus, rather than being reinforced by others' responses, their self harm became a means of them managing alone. Indeed, the lack of care and attention perhaps reinforced that self harm was the only option available to them. This theme in the women's accounts speaks to the second function in the systemic model, whereby self harm is described as a way of allowing these women to be *"normal"* within their family context despite the difficult dynamics they are experiencing. This seems particularly relevant in the

case of the women who have experienced abusive family relationships, whereby they were blamed for the abuse rather than the families acknowledging the dysfunction.

The participants' experiences and meanings of self harm relate to various models of self harm, congruent with Messer and Fremouw's (2008) conclusion that aspects of several models likely contribute to the understanding of self harm. It also corroborates the idea that the meaning of self harm is complex and needs to be understood on various levels, through intrapersonal to interpersonal and systemic explanations.

How do South Asian women who self harm experience and perceive support services?

The amount of contact participants have had with support services ranges from none to having had multiple experiences of therapy. Although two of the women had attended Accident and Emergency departments following self harm, they had both had previous contact with mental health services, therefore the participants in this study do not support the idea that South Asian women only access support in crisis (Chew-Graham et al., 2002). The four participants who had accessed services described mixed experiences. Several of the women expressed the value of a forum to talk about their experiences, feel listened to and understood; however, they also described difficulties.

A recurrent theme in the participants' accounts is that their perceptions and experiences of services reflected their interpersonal processes and difficulties; and that service responses sometimes inadvertently replicated the patterns in their previous interactions and consequently exacerbate their distress. The potential for treatments to exacerbate the psycho-developmental origins of individuals' distress has been recognised, for example, focusing on reducing self harm being experienced as controlling (Ryle & Kerr, 2002). Furthermore, negative experiences of accessing services following self harm have been documented (NICE, 2004), particularly in relation to poor staff attitudes and knowledge regarding self harm. Indeed, service users were reported as feeling that they are not listened to. This reflects the description by Chantler et al. (2003) that South Asian women who self harm do not feel heard or understood by their families or mental health professionals and so services responses replicate difficult interactions within their families.

The experience of one participant of being re-referred following an assessment is routine practice in the current 'stepped care' model of mental health services; however, some authors have asked the question of whether repeated changes in treatments leave service users 'discouraged from subsequent treatments' and 'demoralised by treatment failure' (Arthur, 2005). In the case of this participant it seems that this suggestion is justified.

The description by one participant of the stress caused by changes in the welfare system triggering her to self harm is significant in the current political climate; indeed, the idea that these changes are exacerbating people's mental difficulties has been reported in the media, where difficulties with welfare claims have precipitated people attempting suicide (Taylor & Domokos, 2011).

In contrast to previous research (Chew-Graham et al., 2002) the participants did not cite fear of breaches in confidentiality as a barrier to accessing services; indeed, they expressed their trust in the confidentiality of services. Instead, it was fear of judgment by professionals which acted as a barrier. At the same time, some of the women stated that they preferred to talk to professionals as they perceived them to be less judgemental than friends or family. Indeed, fear of judgment regarding their self harming acted as a barrier to accessing support from friends, family and support services. This was often related to the stigma of mental illness and the perceived judgmental nature of their communities. Some of the participants described how accessing services was counter to their family or cultural expectations. This is in line with previous research in which fear of the 'community grapevine' (Chew-Graham et al., 2002) and resultant damage to *izzat* was given as a reason why women do not speak out about their problems and do not access support services (Gilbert, Gilbert, & Sanghera, 2004). However, the fact that the majority of the participants had managed to access services perhaps reflects how the concept of *izzat* is less pertinent to them. Indeed, three of the participants stated how they did not want their parents to find out about their self harm, again demonstrating the importance of their parents over the broader community.

Some of the participants spoke of their concerns regarding talking to professionals of the same and different ethnicity. Again, fear of judgement was central, whereby participants anticipated misunderstanding of cultural issues by non-Asian professionals and judgemental attitudes from Asian professionals. As reported by Chew-Graham et al. (2002) these concerns had implications for the women's preference for the culture of professionals from whom they would seek support. For example, one participant expressed that she would prefer to talk to someone from the same background who could share cultural understanding; however, she later changed her mind, stating she would prefer someone from a different background. This was not due to fearing breaches of confidentiality as in Chew-Graham et al.'s (2002) research, but because she feared judgment.

In this context, the recommendation of one of the participants, that professionals should state they are not there to pass judgment and are happy to discuss cultural issues, seems very pertinent. These findings may reflect the recruitment for this research, in that stating no preference for the ethnicity of professionals or a preference for non-Asian professionals is

congruent with the fact that participants volunteered to be interviewed by a non-Asian researcher. It could also have been a reaction to being interviewed by a white interviewer, so that participants may have been reluctant to express criticism.

The concept of control is also relevant in terms of participants' accessing services. One participant was adamant that she would only access support on her own terms. This seems congruent with Spandler's (1996) recommendation that approaches to self harm need to work with, rather than undermine individuals' sense of control. Indeed, another participant described a counsellor's directive approach as unhelpful, in contrast to previous research which has stated that people from Pakistani backgrounds may initially prefer a more instructive and educational therapeutic style (Rathod & Kingdon, 2009).

Although some participants stated they wanted strategies to manage their self harming behaviour, others valued a more exploratory approach in order to understand the underlying causes of their self harm. Thus, listening to women's opinions and choices seems essential in order to provide acceptable care. This is particularly important in the context of individuals who struggle to express themselves or exert control over their lives, as the inability to access appropriate help may further compound the feelings of powerlessness that are associated with self harm – an example of how service responses can inadvertently replicate interpersonal difficulties. This is in line with Burstow's (1992) recommendation that rather than challenge self harming behaviour, the underlying reality of powerlessness should be explored and addressed, arguing that women who are empowered will not need to harm themselves.

The themes of *control*, *identity* and *communication* which arose from the participants' accounts could also be said to relate to self harm in women of other ethnic backgrounds. This is perhaps unsurprising given that the experiences the participants implicated in their self harm, including childhood abuse and neglect, sexual assault, bullying, trans-generational family conflict and social isolation, are not specific to their ethnicity.

However, there were some aspects of their experiences which the participants did link to their being South Asian. These included difficulties expressing themselves which they related to cultural norms regarding emotional expression; their families' use of religious or cultural values to control their behaviour and specific experiences such as threatened marriage; feeling judged and pressured to conform to the expectations of their families or wider community; and the resultant difficulty negotiating their sense of self. Although these concepts are perhaps more salient to South Asian women and the way they manifest is culturally influenced, they are not specific to their ethnicity. For example, as mentioned

previously there are cross-cultural gender role expectations regarding the expression of emotion and trans-generational family conflict is ubiquitous. Thus it seems the participants (perhaps influenced by media stereotypes of South Asian women) conflate these experiences with ethnicity, rather than them being inherent in to it. An experience described by one participant which was specifically related to ethnicity was that of racism; indeed, racial discrimination has been described elsewhere in relation to service provision for South Asian women (Burr, 2002).

In contrast to the participants' experiences and meanings of self harm which appear similar to those of women from other ethnic backgrounds, the participants described experiences and perceptions of support services which seem more specifically linked to their ethnicity. For example, their fear of judgment and anticipation of being misunderstood by both Asian and non Asian professionals. These issues have implications for service provision for South Asian women, suggesting that services must take account of these differences.

Strengths and limitations

Sample size and generalisability

Due to the small sample size it is not possible to generalise from the experiences of the participants in this research to all South Asian women who self harm. However, qualitative research works on the concept of 'theoretical transferability' whereby the analysis of the accounts aims to be adequately rich, contextualised and situated within the wider literature, to allow readers to evaluate its transferability to individuals in other contexts (Smith et al., 2009). Although the sample size recruited to this study was small even by qualitative standards, it is hoped that this allowed a deeper analysis.

Sampling

As discussed previously, the term 'South Asian women' fails to recognise the diversity that exists within South Asian communities (Marshall & Yazdani, 1999); however, restricting the target population, for example, according to national or religious identity, was not deemed to be feasible as this would be too restrictive to recruitment in the timescale available. In the event, the participants recruited and analysed form a relatively homogeneous sample in terms of ethnicity, faith identity, age and educational background. It is important to consider the impact of the sample recruited on the accounts obtained as this has implications for the transferability of the findings. For example, all of the women had attended further education perhaps resulting in a bias in socio-economic background. However, one could argue that this

is a strength of the current research as it has tapped a particular demographic of South Asian women who self harm. Indeed, four of the five participants are within the age range deemed at highest risk of self harm.

The accounts given are likely to have been influenced by this ethnic difference between researcher and participant. For example, it is perhaps unsurprising that the women interviewed stated they had either no preference for the ethnicity of professionals or that they would prefer to talk to a non-Asian professional, as the same concerns that lead to these preferences would likely be active when choosing to take part in the research. Furthermore, it may have been harder for participants to express criticism of white professionals. At the same time, the difference in ethnicity allowed participants to talk about issues which they were unwilling to talk to someone of the same ethnicity about and perhaps reduced assumptions regarding shared reality (Willig, 2008), so that the participants were more explicit in describing their experiences.

It is also possible that the difference in ethnicity between researcher and participant impacted on the interpretations made during the analysis; however, as discussed previously the researcher attempted to remain reflexively aware of this.

Imposing concepts on to the data

The overlap between themes and the occurrence of the concepts of *control* and *identity* lead to the question of whether they arose from the women's accounts or whether they were imposed, either through the interview or analysis.

Considering the first question, in constructing the interview schedule, a balance was sought between asking questions which were informed by the literature and the fundamental importance of not imposing ideas on the participant. It was felt necessary to invite participants to talk about particular issues, for example, regarding the possible impact of their ethnicity on accessing services, as it was thought that women may be reluctant to raise these themselves. In practice, participants were first asked about their experiences before being invited to comment on findings from the literature, for example, regarding the high rates of self harm in South Asian women. This method aimed to allow exploration of identified areas of interest, but without introducing ideas into their accounts. Indeed, care was taken not to be leading in these questions, and the words 'control' and 'identity' were not used. Furthermore, participants were explicitly told that although there was an interview schedule, the researcher was primarily interested in hearing their stories.

In the event, the majority of the women required minimal prompting to recount their experiences and so researcher input was minimal in shaping these accounts. Evidence against

the idea that the interview structure led to these concepts occurring comes from the sixth participant who spontaneously spoke of feeling controlled and her inability express herself without any questioning by the researcher.

The second question, whether the concepts arose due to the analysis, is harder to answer. The ideographic commitment in IPA asserts that each account should be considered separately and ideas from previous analyses should be 'bracketed off'. This was followed during the process of analysis. Indeed, when it became apparent that the superordinate themes were overlapping, the data was reanalysed to consider alternative groupings. However, it was felt that the three themes were the best representation of the accounts.

In retrospect it was possibly unnecessary to ask the secondary research question, as the previous literature indicated that these concepts would be likely to arise. However, it was hoped that it would allow a greater depth of understanding of these concepts. Furthermore, one could argue that explicitly asking this question was a means of 'bracketing off' these prior assumptions, which allowed other concepts to arise.

Clinical implications

The National Institute for Health and Clinical Excellence guidance recommends that clinicians who work with people who self harm should be provided with training to help them understand and care for people self harm (NICE, 2004). Perhaps included this training in this could be recognition of how services responses can inadvertently cause distress by replicating the patterns in individual's previous interactions. This should also be considered in relation to the impact of service procedures and government policy.

South Asian women who self harm may value access to a confidential forum, to talk and feel understood. In therapy, either strategies to manage self harm or an exploratory approach to consider underlying causes may be preferred. South Asian women should be offered choice and be involved in decision making regarding their care in order to promote their empowerment. Treatment procedures such as referral on to other services should be explained and individuals should be supported in making these transitions, including consideration of their attachments to professionals.

Professionals should openly acknowledge cultural/ethnic differences or similarities and state their position as not being there to judge. Non Asian professionals should state their willingness to discussion issues related to culture/ethnicity if the service user wants to.

South Asian women who self harm may feel more able to access help-lines or internet based forums than attending support services in person. The anonymity may allow women to overcome barriers regarding fear of judgment.

Raising awareness of self harm within South Asian communities more broadly may reduce stigma associated with self harm and allow more women to access help.

Further research

Participants in this study suggested that internet based support would be helpful to them, indeed, one of the participants reported having used the internet to search for strategies to help manage her self harm. Previous research has concluded that individuals find internet information regarding self harm valuable (Prasad & Owens, 2001). Further research could evaluate the feasibility and impact of such a service for South Asian women.

Exploring the perspectives of friends and family members of South Asian women who self harm may be helpful in understanding how to raise awareness within South Asian communities. This would allow 'triangulation', whereby perspectives and obtained from different sources can be compared to produce a more in-depth understanding of an issue (Mir, 2008).

CHAPTER 6: CONCLUSION

The present study explored the experiences and meanings of South Asian women who self harm and their experiences and perceptions of support services. Analysis of interviews with five women of South Asian ethnicity and experience of self harm gave rise to three superordinate themes of *control*, *identity* and *communication*; although the interrelations between them were also important in understanding the women's experiences and meanings of self harm.

The meanings of self harm offered by the women in this study are similar to those described in other studies with South Asian women (Bhardwaj, 2001; Chantler et al., 2001; Marshall & Yazdani, 1999) and white western women (Babiker & Arnold, 1997); and speak to identified psychological models of self harm (Suyemoto, 1998). However, the participants' ambivalence regarding their self harm was more apparent.

Participants simultaneously described both positive and negative experiences and perceptions of support services, including valuing a confidential forum within which to talk and feel understood. Themes which emerged included *service responses inadvertently exacerbating distress; fear of judgment* and the *impact of ethnicity*; which give rise to clinical recommendations.

Limitations of the study include the potential impact of the difference of ethnicity between researcher and participants, including the impact of this on the sample recruited, the accounts given by participants and the researcher's analysis. Strengths of the study include the qualitative methodology which allowed participant' voices to be heard and recognised their experiential expertise; and the small and relatively homogeneous nature of this sample which allowed an in depth analysis of their accounts.

Final reflections

Through a process of ongoing reflection during this research project, I have become increasingly aware of my assumptions and preconceptions. This has helped me to consider the complexities and ambiguities of the participants' experiences and meanings and to resist the urge to impose my understandings, including where my concern with what was different may have lead to me to overlook what was similar or to me essentializing.

I was struck by the strength and resilience of these women and their courage in volunteering to participate in this project. I am extremely grateful to them for allowing me access to their lives and experiences. It has been an enormously enriching experience for me.

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APPENDICES

Appendix 1: Interview schedule

Background questions: Age; ethnicity; religion; marital status; cohabitants; children/carer; occupation; educational history.

- *Could you tell me about you experiences of self harm?*
  - *Was it a one off or is it something you have done many times?*
    - *How often do you harm yourself?*
    - *How long have you been harming yourself for?*
  - *What do you do [method] when you self harm?*
- *Can you tell me about the first time you harmed yourself?*
  - *What was going on for you at the time?*
  - *What happened?*
    - *How did you feel before?*
    - *What did you do?*
    - *How did you feel afterwards?*
  - *What do you think self harming did for you at that time?*
  - *Does the fact that you self harm make sense to you?*
  - *Why do you think you [individual's method of self harm] rather than some other way of harming yourself?*
- *Can you tell me about a recent time that you self harmed? [Same prompts as above]*
- *Has your self harm changed over time?*
  - *Do you think the meaning behind your self harm has changed?*
- *Could you identify any particular experiences or events in your life which may be related to your self harm?*
- *Would you say that harming yourself has been helpful/unhelpful in any ways?*
- *Some people say that self harm can be like a language. Do you have any thoughts on this?*
- *How would you describe yourself?*
  - *What would your friends/family say about you?*
  - *What are your most important characteristics?*
  - *Is your ethnicity important to how you see yourself? In what way?*
  - *In what situation do you feel most/least comfortable in yourself?*

- *How would you describe yourself compared to society as a whole?*
- *Does the fact that you have harmed yourself affect how you see yourself?*
- *How do you make decisions in your life, for example, [from participant's account]?*
  - *How much influence do you feel you have over your life?*
  - *It seems that when people are in circumstances where they feel they have no influence over their lives they are more likely to self harm. Do you have any thoughts on that?*
- *Research has shown there to be a high rate of self harm in women of South Asian ethnicity. Do you have any thoughts on this?*
- *Have you spoken to anyone about your self harm?*
- *Have you ever sought help from a professional like your GP or a care worker about your self harm?*
  - *If yes: What was it like?*
    - *Do you think the fact you self harm affects how professionals see you?*
    - *Do you think your ethnicity affects the reactions you get from professionals?*
    - *Did you have any fears about accessing support?*
  - *If no: What stops you?*
    - *Do you have any fears about accessing support?*
    - *Would you like professional help with your self harm?*
    - *What kind of support would you find helpful?*
- *Do you think current services meet the needs of South Asian women?*
- *Can you imagine any place or a service where you could go which would help?*
    - *What would it be like?*
- *Is there anything else you would like to say which we have not covered?*
- *What motivated you to take part in the study?*
- *Did my ethnicity have any impact on you taking part in the study?*
- *Do you have any questions of me?*
- *Do you have any feedback about the questions I have asked during this interview?*

Appendix 2: Recruitment documents

Participant information sheet

UNIVERSITY OF LEEDS

Exploring experiences and meanings of self harm in South Asian women

Research information sheet

You are being invited to take part in a research study. If you have any questions or would like to take part, please contact me on the details overleaf.

What is the purpose of this study?

Research studies have reported high rates of self harm in women of South Asian ethnicity (including British-Pakistani, Indian and Bangladeshi). However, they are unlikely to access mental health or support services, so many individuals may be suffering in silence.

Various explanations have been suggested, but there is limited research which asks South Asian women's *own* views.

This research intends to interview South Asian women about their experiences of self harm and their thoughts about services.

The aim is that gaining women's perspectives may increase understanding and help inform the development of services which are appropriate to South Asian women's needs.

Why have I been asked to take part in this study?

Women of South Asian ethnicity (including British South Asian) who have experience of self harm are being asked to take part in the study. This research is hoping to recruit women who are aged between 18 and 40 and are English educated.

Self harm includes all acts of deliberate self injury or self poisoning, such as cutting, hitting, scratching, burning, overdosing on medication or swallowing objects.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part you will be asked to sign a consent form. Your taking part will be kept strictly confidential. You will be free to withdraw at any time and without giving a reason. Your decision will not affect any support you receive.

What will I have to do if I take part?

If you agree to take part I will contact you to arrange a meeting at a convenient time and place. This will be somewhere safe and confidential. I will reimburse you for any transport costs.

During the meeting I will ask you some questions about your experiences of self harm and your thoughts on mental health services. With your permission, the interview will be recorded so that I do not miss anything you feel is important. All information you give will be kept strictly confidential. Recordings will be destroyed after the project is finished.

The interview can be stopped at any time if you don't wish to carry on and you don't have to answer all the questions if you don't want to. The interview will last approximately an hour.

Will my taking part in this study be kept confidential?

Only myself and the person who introduced the study to you [if applicable] will be aware that you are taking part in the study. All information which is collected about you during the course of the research will be kept strictly confidential and any information about you will have your name and personal details removed so that you cannot be recognised.

What are the possible benefits of taking part?

Some people find talking about their experiences in a confidential and non-judgemental environment a positive experience.

Participants will also be contributing to a research project which may ultimately help develop appropriate services for other women who are experiencing similar problems.

Participants will receive a voucher worth £15 for their time.

What are the possible disadvantages of taking part?

You may find talking about your experiences difficult or upsetting. If you need to talk to someone after the interview I will be available and we can discuss other possible options for you to receive support.

What happens to the results of the research?

The results will be written up in a thesis report which will be submitted to the University of Leeds as part of my Doctoral degree in Clinical Psychology. Anonymised reports will be sent to Research and Development and other relevant committees. Results may also be written for publication and conferences.

Your name or any other personal details will not be mentioned in any way that would mean you could be identified.

What if there is a problem?

If you have any concerns about any aspect of this research, I will do my best to answer your questions. If you are still unhappy you can complain formally by contacting:

Clare Skinner, Faculty Head of Research Support
Faculty of Medicine and Health Research Office
Room 10.110, Level 10, Worsley Building, Clarendon Way
University of Leeds, Leeds, LS2 9NL
Tel: 0113 343 2274

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Leeds Central Research Ethics Committee.

If you have any questions or would like to take part, please contact me on the details overleaf

Why are you conducting this research?

I am conducting this research as part of my doctoral training to become a Clinical Psychologist.

Although I am not of South Asian ethnicity myself, so may not share certain experiences related to ethnicity, I believe it is important to ask individuals about their own experiences and understand their perspectives rather than making assumptions or imposing stereotypes.

I am aware that there are lots of barriers to taking part in this research, including opening up to a stranger, fears about confidentiality, or creating a negative perception of Asian Women. However, I assure you that I am sensitive to these issues and would highly value your contribution.

How do I contact you?

If you would like to take part in the study or if you have any questions, problems or wish to get more information at any point please contact me:

Sarah Wood Psychologist in Clinical Training

Address: Clinical Psychology Program
Institute of Health Sciences, University of Leeds,
Charles Thackrah Building, 101 Clarendon Road,
Leeds, LS2 9LJ

Telephone: 0113 233 27321
(Please leave a message and I will get back to you)

Email: SAWSHresearch@hotmail.co.uk

Thank you for your time

UNIVERSITY OF LEEDS

Poster

Doctoral research study

Recruiting Oct 2010 – Apr 2011

UNIVERSITY OF LEEDS

Exploring experiences and meanings of self harm in South Asian women

Research studies have reported high rates of self harm in women of South Asian ethnicity (including British-Pakistani, Indian and Bangladeshi). However, they are unlikely to access mental health or support services, so many individuals may be suffering in silence. Various explanations have been suggested, but there is limited research which asks South Asian women's *own* views.

This research hopes that gaining women's perspectives may increase understanding and help inform the development of services which are appropriate to South Asian women's needs.

Are you female, aged between 18 and 40, and of South Asian/British South Asian ethnicity?

Do you have experience of self harm?

Would you be willing to talk about your experiences in a confidential setting?

If you are interested in taking part or would like more information, please contact me on the details below:

Sarah Wood, Clinical Psychology Program, Institute of Health Sciences, University of Leeds, Charles Thackrah Building, 101 Clarendon Road, Leeds, LS2 9LJ Tel: 0113 233 27321 (leave a message)

Please take a slip

Sarah Wood SAWSHresearch@hotmail.co.uk
Sarah Wood SAWSHresearch@hotmail.co.uk
Sarah Wood SAWSHresearch@hotmail.co.uk
Sarah Wood SAWSHresearch@hotmail.co.uk
Sarah Wood SAWSHresearch@hotmail.co.uk
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Sarah Wood SAWSHresearch@hotmail.co.uk
Sarah Wood SAWSHresearch@hotmail.co.uk
Sarah Wood SAWSHresearch@hotmail.co.uk
Sarah Wood SAWSHresearch@hotmail.co.uk

Version 1 18.4.10

Dear X,

I am writing to you following your attendance at hospital. This is an invitation to take part in a research study that is being conducted by a researcher from the University of Leeds.

The study intends to interview South Asian women (including British South Asian) about their experiences and thoughts regarding services. The aim is that gaining women's perspectives may increase understanding and help inform the development of services which are appropriate to South Asian women's needs.

If you are interested in taking part or would like more information, please contact the researcher on the contact details below:

Sarah Wood Psychologist in Clinical Training

Ghazala Mir (Supervisor)

Address: Clinical Psychology Program
Institute of Health Sciences, University of Leeds,
Charles Thackrah Building, 101 Clarendon Road,
Leeds, LS2 9LJ

Telephone: 0113 233 27321
(Please leave a message and she will get back to you)

Email: SAWSHresearch@hotmail.co.uk

Thank you for your time.

Yours sincerely,

xxx
Clinical Team Manager

UNIVERSITY OF LEEDS

Exploring experiences and meanings of self harm in South Asian women

CONSENT FORM

Please initial each box

I have read the participant information sheet for the above study *(Dated 9.06.10, version 2).*	☐
I have had the opportunity to ask questions and discuss the study and am satisfied with the answers to my questions. I have received enough information about this study.	☐
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and this will not affect any support I maybe receiving.	☐
I agree to the audio-recording of the interview.	☐
I understand that quotes from the interview maybe used in research reports, but that my personal details will be removed so that it is not possible to identify me and that all material about me will be kept strictly confidential.	☐
I understand that relevant sections of the data collected during the study may be looked at by individuals from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data.	☐
I agree to take part in this study.	☐

Name of participant _____

Signature_____ **Date**_____

Name of person taking consent_____ Signature_____ Date_____

Thank you for your time

Version 2 – 9.06.10

Appendix 3: Letters of ethical approval

NHS
National Research Ethics Service
Leeds (Central) Research Ethics Committee
Yorkshire and Humber REC Office
Millside
Mill Pond Lane
Meanwood
Leeds
LS6 4EP

Telephone: 0113 3050108
Facsimile:

17 June 2010

Miss Sarah Wood
Psychologist in Clinical Training
The Leeds Teaching Hospitals NHS Trust
Leeds Institute of Health Sciences
Charles Thackrah Building
101 Clarendon Rd, Leeds, West Yorks
LS2 9LJ

Dear Miss Wood

Study Title:	**Exploring experiences and meanings of self harm in South Asian women in the UK**
REC reference number:	**10/H1313/46**
Protocol number:	**2**

Thank you for your letter of 11 June 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is

available in the Integrated Research Application System or at http://www.rdforum.nhs.uk. *Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.*

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Covering Letter		18 April 2010
REC application		13 April 2010
Investigator CV		18 April 2010
Evidence of insurance or indemnity		08 October 2009
CV - Ghazala Mir		
Research poster	1	18 April 2010
Summary of research for professionals	1	18 April 2010
Research panel feedback form		30 November 2009
Participant Information Sheet	2	09 June 2010
Participant Consent Form	2	09 June 2010
Interview Schedules/Topic Guides	1	26 May 2010
Protocol	2	09 June 2010
Letter of invitation to participant	2	09 June 2010
Flow chart of protocol	2	09 June 2010
Response to Request for Further Information		11 June 2010

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports

- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/H1313/46	Please quote this number on all correspondence

Yours sincerely

RFBell

Dr Margaret L Faull
Chair

Email: Rachel.bell@leedspft.nhs.uk

Enclosures: "After ethical review – guidance for researchers"
Copy to: *Mrs Rachel E de Souza*

R & D Office: Leeds Teaching Hospitals NHS Trust

Research and Development approval was also gained from two separate NHS trusts. The letters of approval have not been presented in order to preserve anonymity of the participant recruited through this means, as they include the locations of the hospitals.

Amendment approval letters 1 and 3 (amendment 2 was rejected):

NHS

National Research Ethics Service

Leeds (Central) Research Ethics Committee

Yorkshire and Humber REC Office
First Floor, Millside
Mill Pond Lane
Meanwood
Leeds
LS6 4RA

Tel: 0113 3050127

18 November 2010

Miss Sarah Wood
Psychologist in Clinical Training
The Leeds Teaching Hospitals NHS Trust
Psychologist in Clinical Training
Leeds Institute of Health Sciences
Charles Thackrah Building
101 Clarendon Rd, Leeds, West Yorks
LS2 9LJ

Dear Miss Wood

Study title: **Exploring experiences and meanings of self harm in South Asian women in the UK**
REC reference: **10/H1313/46**
Amendment number: **1**
Amendment date: **26 October 2010**

The above amendment was reviewed on 11 November 2010 by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Letter of invitation	1	20 October 2010
Notice of Substantial Amendment (non-CTIMPs)	1	26 October 2010

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

This Research Ethics Committee is an advisory committee to Yorkshire and The Humber Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

10/H1313/46: **Please quote this number on all correspondence**

Yours sincerely

Mrs Nicola Mallender-Ward
Committee Co-ordinator

E-mail: Nicola.mallender-ward@leedspft.nhs.uk

Enclosures: *List of names and professions of members who took part in the review*

Copy to: *Mrs Rachel De Souza*

NHS

National Research Ethics Service

NRES Committee Yorkshire & The Humber - Leeds Central

Yorkshire and Humber REC Office
First Floor, Millside
Mill Pond Lane
Meanwood
Leeds
LS6 4RA

Tel: 0113 305 0168

06 April 2011

Miss Sarah Wood
Psychologist in Clinical Training
The Leeds Teaching Hospitals NHS Trust
Leeds Institute of Health Sciences
Charles Thackrah Building
101 Clarendon Rd, Leeds, West Yorks
LS2 9LJ

Dear Miss Wood

Study title: **Exploring experiences and meanings of self harm in South Asian women in the UK**
REC reference: **10/H1313/46**
Amendment number: **2/1**
Amendment date: **02 April 2011**

Thank you for submitting the above amendment, which was received on 05 April 2011. It is noted that this is a modification of an amendment previously rejected by the Committee (our letter of 01 April 2011 refers).

The modified amendment was reviewed at the meeting of the Sub-Committee held on 05 April 2011. A list of the members who took part in the review is attached.

Ethical opinion

I am pleased to confirm that the Committee has given a favourable ethical opinion of the modified amendment on the basis described in the notice of amendment form and supporting documentation.

The Sub-Committee did however want to stress that the method of recruitment proposed in the original amendment, which was given an Unfavourable Opinion, was not acceptable and that approval is only being given to the methods proposed in the modified amendment.

Approved documents

The documents reviewed and approved are:

Document	Version	Date
Modified Amendment		02 April 2011

This Research Ethics Committee is an advisory committee to the Yorkshire and The Humber Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

10/H1313/46: **Please quote this number on all correspondence**

Yours sincerely

Dr Margaret L Faull
Chair

E-mail: marc.neal@nhs.net

Enclosures: *List of names and professions of members who took part in the review*

Copy to: *Mrs Rachel De Souza, University of Leeds*