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You want to know why I cut? Reflections on doing research with people who self-injure

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Title: **You want to know why I cut? Reflections on Doing Research with People Who Self-Injure.**

You want to know why I cut?

Reflections on Doing Research with People Who Self-Injure.

Abstract: At the core of understanding why people do what they do, they should be posited as authorities on their own behaviour. When a behaviour is sensitive or stigmatised, it can be challenging to facilitate an environment in which their perceptions can be invited, obtained and accurately represented. Drawing upon the qualitative research study presented in the book [title suppressed] (McShane 2012) on the experiences of 25 people who self-injure, the author offers some methodological reflections relevant to the processes of researching sensitive topics from first-person perspectives. In particular, the paper focuses on challenges highlighted in the course of the research related to; recruitment of participants; conducting interviews on sensitive topic matter; motivating factors cited by those who took part; and managing negative effects on both participant and researcher.

Key words: Self-injury; qualitative; recruitment; interview techniques; sensitive topics; stigma; motivation

Introduction

This paper is a narrative of reflections on some of the issues that arose in my experience of doing research with people who cut, burn or otherwise injure themselves. It details some of the challenges and barriers encountered in investigating a sensitive and stigmatised topic and where attempts were made to overcome or minimise obstacles in order to facilitate the cultivation of rich, deep and in-depth data reflecting first-person experiences of people who self-injure.

Interest in social issues that provoke negative emotional responses has been growing for some considerable time (Farberow, 1963). There are many definitions of what constitutes sensitivity

in research. Sieber and Stanley (1988:49) describe 'socially sensitive' research as 'studies in which there are potential consequences or implications, either directly for the participants in the research or for the class of individuals represented by the research'. In theory, this broad description could be applied to most social research as all research has the potential for negative consequences for participants, some more harmful than others. More unambiguously, topics 'may be defined as "sensitive" if they are private, stressful or sacred, and discussion tends to generate an emotional response ... [They can refer to] phenomena that deal with potential fear of stigmatisation (McCosker et al, 2001:1). Death and dying, sexuality, homelessness, HIV/AIDS and cancer (Dickson-Swift et al, 2008) are some examples of areas of research often categorised as sensitive. Self-injury is a highly sensitive topic and the greater the sensitivity or taboo surrounding a phenomenon such as this, the greater the necessity it is investigated.

One thing I quickly discovered when I began researching the self-injury literature was that with the exception of the work of a few (mostly American) sociologists (for example Adler and Adler, 2005), the dominant self-injury paradigm was the medical model and the behaviour was generally viewed as a symptom of underlying personality disorder or other mental illness. There is now a growing body of scholars outside this discipline, contributing to a widening knowledge of self-injury (such as Brossard, 2014, 2018; Chandler, 2012; and Inckle, 2007) and around how people understand their own behaviour influenced by personal, social and cultural conscious. However, the dominant discipline remains medically centred and evidence is focused on patients who seek help (Greenhalgh et al, 2015). Data upon which this model of self-injury is based is mainly collected in clinical settings such as hospitals; on people who present at A&E departments for treatment; or within counselling situations. It has been argued that the practice of data collection in these settings is problematic (Chandler et al, 2011; Chandler, 2012; Inckle, 2010), including due to unethical practices of practitioners placing

material, disclosed in private counselling sessions on the public domain, without client knowledge or consent to be drawn upon for analysis of ‘a particular pathology or stigmatised behaviour’ (Inckle, 2010:32).

Although my research data was obtained from participants who were consensually aware of my intentions to analyse and publicise their experiences, I was still faced with the daunting methodologically challenging task of finding them in a somewhat hidden population of people who do not necessarily seek help, and persuading them to share their self-injury experiences and meanings with me.

Methodology

Ethical approval for the study (McShane 2012) was granted by Queen’s University Belfast. The study employed a qualitative methodology and data was collected via semi-structured interviews with people who were self-injuring at time of participation or previously. Interviewees who were self-injuring in the data collection period were given the opportunity to keep diaries over four months. This approach yielded three diaries in which they recorded their thoughts and feelings, adding depth to data already generated in the interview process. Diaries can reinforce and strengthen validity of interview material (Lee, 1993). Previous research on self-injury found that asking individuals to write about their lives produces extremely detailed accounts of their experiences (Harris, 2000). Additionally, three participants provided me with poetry, written mainly in periods of active self-injury as literary expressions of their thoughts and feelings. The use of poetry as a tool in social science research is ‘an untapped source of ethnographic information’ (Johnson and Chernoff, 2002:141). Johnson and Chernoff’s *Opening a vein: Inmate poetry and the prison experience* (2002), is an example of the use of poetry as a ‘window’ on experiences of prisoners in prisons. These authors advocate poetry as

a ‘uniquely concentrated form of creative writing and communication’ (2002:141). It restricts the writer to pick out one particular word or phrase to candidly express thoughts and experiences. Additionally, poetry allows secretive or shameful phenomena to be aired, which might otherwise remain hidden due to social constraints.

In addition to the above means of gathering data for the study there were telephone conversations and text messages. I also kept a diary of fieldnotes detailing these interactions and observations.

Interview questions were overall, broad and themes were identified in the self-injury literature and used to structure a topic guide for interviews. Interviews were transcribed and coded into thematic codes for analysis (Jorgensen, 1989) aided by Nvivo software. Three broad themes relating to suffering, stigma and rituals emerged from the data and these are presented elsewhere (McShane, 2012).

Sample

The final sample of participants consisted of both, people who had experiences with medical professionals regarding their self-injury and those who had not. 20 women and five men aged between 19 and 44 years took part. This ratio of female to male suggests a gender bias in the behaviour and is in line with most research on the topic (Brossard, 2014b; Inckle, 2010). Conversely however, other ‘risk factors’ have been highlighted as more significant to the study of self-injury, such as ‘upbringing, context, and personal circumstances’ (Borrill, 2012:391). Nevertheless, it is worth keeping in mind that men may be less willing to take part in research than women (Babiker and Arnold, 1997).

Participants represented a range of backgrounds and included two students, a university researcher, a lab technician, an ex-teacher, a social worker, an ex-member of the armed forces,

an office clerk, a clergyman and a community volunteer. Nine participants were unemployed and two described themselves as stay-at home parents. At the time of interviews, approximately two third of participants were regularly self-injuring. The rest had not self-injured for periods of time ranging from months to years. Every participant had experienced trauma in childhood. All had suffered emotional invalidation, usually from a significant adult such as a parent. Over half revealed they had been sexually abused and 13 out of 25 experienced physically abuse. Seven participants described experiences of abuse in all three ways: emotional, sexual and physical.

Recruitment

I hoped to include as broad a range of people as possible, who were willing to talk about their experiences of self-injury. I wished to recruit self-injuring men and women who had both presented themselves in medical settings and also those from the more hidden pool of people who do not necessarily disclose their self-injury to professionals, or anyone for that matter. I envisaged if I could achieve a sample from this broader population of participants it would be the most effectual means of contributing to a broadening of the existing medically dominated body of knowledge and bring more ethnographic experiences of people who self-injure to the debate.

I planned to recruit by way of two main approaches. As it transpired, one method was successful, the other to a lesser extent.

My first (and least productive) recruitment method was to approach medical gatekeepers by writing, emailing and telephoning with the intention of enlisting their approval and small amount of assistance to recruit participants at clinics, hospitals and mental health units. With all but a few exceptions, this tactic failed and I was met with disinterest or disregard. I was offered some clarification regarding the reluctance of gatekeepers to assist in my research by

one professional who posited the position that people who self-injure are not best placed to present authoritative insights into the behaviour, as the act is a symptom of underlying psychopathology and therefore their narratives about cutting or burning themselves are erroneous. Consequently, they cannot be considered with much gravity or significance. This stance concurs with what Greenhalg et al, (2015) regard as patient experience being devalued by the hierarchy of evidence based medicine.

My second recruitment tactic was to bypass gatekeepers and attempt to reach people who self-injure directly. I erected poster advertisements in shops, drop-in centres, charitable organisations, church halls and community centres. I also placed the advertisement in local newspapers. This approach transpired as productive and became the means by which I recruited most of my participants onto the study.

Figure 1 illustrates the recruitment advertisement. People who present with self-injury in clinical settings are often instructed by authoritative figures regarding their self-injury and why they engage in certain behaviours. As a result the voices of individuals who self-injure are significantly under-represented. My aim when I designed this advertisement was to acknowledge those who cut, burn or similarly injure themselves as experts on the behaviour. I wanted to remove existing hierarchical barriers of understanding and position them as authorities on their own actions.

Figure 1. Recruitment Advertisement

PLEASE HELP ME UNDERSTAND SELF-INJURY

Have you ever ... self-injured (by cutting, burning ... etc) either currently or in the past?

Would you ... like to take part in a study involving one-to-one interviews about the experiences of people who self-injure?

If so ... or for more information please contact [Author] (in the strictest confidence) XXXXXX or XXXXXX@XXXX

Please tear off details

Theresa: 07743 XXXXX t.mcshane@qub.ac.uk
Theresa: 07743 XXXXX t.mcshane@qub.ac.uk
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The simple and straightforward terminology – *Please help me understand self-injury*, it transpires, is quite disarming. Several of the people who took part in my study had experienced *felt* and *enacted* stigma - expressions borrowed from Scambler and Hopkins’ (1986) work on the stigma surrounding epilepsy to describe both a fear of, and actual negative experiences from others in regard to their behaviour. Reaching out in this way with jargon-free and plainly-worded request has a reduction effect on felt stigma and places individuals at the pinnacle of expertise on self-injury, a sentiment echoed by a participant who commented:

When I saw your poster, it made me feel wanted ... that I could contribute something of value by talking to you about my self-injury. I didn’t feel like I would be judged or that you would think badly of me because I cut myself. It felt welcoming and made me

feel like you would value my experiences and you just wanted me to talk about them
(Sam, a 42 year old sales manager).

That unassuming request – *Tell me about it*, swiftly neutralises or at least reduces impressions of judgemental undertone, laying foundation for trust and rapport. Seemingly, no matter how taboo, sensitive, or stigmatising the topic under discussion, people like to talk about themselves, particularly when they feel validated or that they are making an important contribution to awareness of suffering. I believe the advertisement was as successful as it transpired in my research due to reflecting this ethos at its core.

Conducting interviews on sensitive topics

Contact with participants before the interviews consisted of telephone calls, text messages and emails. This initial contact was overtly about logistical objectives of dealing with enquiries about the research, participant requirements, research expectations and their choice of venue etc. However, this preliminary period is also an essential part of initial relationship building and scene setting whereby potential participants test the water before deciding to fully commit to the research as active contributor. Indeed, according to Heath et al (2018), these pre-interview contacts facilitate opportunities for individuals to get a ‘feel’ for the researcher before deciding to proceed with the interview or not.

At the outset of conducting interviews, I discovered the importance of tact, something in hindsight I may have I been lacking as I nervously and rather clumsily stumbled my way through my interview schedule for the first time, face to face with my first interview participant as an inexperienced researcher in this area.

In my misguided wisdom when designing the study interview plan, I assumed that an effective and well-structured schedule should ascertain from the outset particulars such as methods of

self-injury engaged in before getting into the deeper interview. This approach transpired in practice to be an error of judgement. The expression of shock and alarm on the face of my first interviewee when I asked the abrupt and intrusive question ‘What form does your self-injury take?’ brought a valuable learning opportunity for me and I was prompted to re-evaluate my approach. In subsequent interviews I relied on more of a loose topic guide to assist a much more participant led discussion.

I also noticed that as the data collection period progressed, the interviews became more autobiographical in character. Participants placed significant emphasis on how their self-injury fitted into timelines of their lives and I discovered that when allowed a greater deal of control interviews, many were inclined to talk for long interrupted periods about their life stories. Biographical interviews are an ideal method for this topic as they create a fertile environment for the generation of rich, in-depth material (Miller, 2000). Using their biography as a frame of reference, allows the participant to not only deepen their understanding of self-injury but also to be able to appreciate it within the broader context of their own life history. Having made this point I feel I should add that although the first interview suffered a few hiccups in getting started it was still useful in the generation of valuable data.

I became more confident as interviews continued and tended to set the scene once the atmosphere seemed relaxed with broad but simple statements of request and expectation such as the following:

I am interested in finding out about self-injury from the perspective of people who self-injure. I'd like to hear about your experiences, what self-injury means to you ... There's no right or wrong way to tell me about your self-injury. You are the expert and I want to hear your story in any way you would like to tell me.

It is important to allow participants to set their own pace. Interviews about a person's experiences cannot be forced or rushed. They must be facilitated to take the lead in terms of what they are comfortable talking about (Legard et al, 2003). Once this was established with my participants, it became apparent there was actually no necessity to ask directly about self-injury methods or other sensitive particulars at all. These specifics were organically forthcoming. The notable difference was that these interviews were on participants' terms time had been taken to develop a connection beforehand and ensure we were both at ease with each other. The pre-interview period is a fundamental opportunity for groundwork rapport and trust building and smoothes entry into more formal questions. A researcher's level of interpersonal skills can make or break an interview, particularly when the topic under discussion is of a sensitive nature.

In terms of choice of venue for interviews, knowing they can choose where the interview will be carried out can increase feelings of control and encourage participation in the research (Heath et al, 2018). A warm introductory greeting on meeting for interview can establish a favourable tone: Using first names, thanking them for agreeing to take part, offering drinks (where possible) and chatting about topics unrelated to self-injury such as the weather, traffic or sport. General chat around everyday issues while waiting for a kettle to boil should not be underestimated in terms of opening a valuable window to promote a relaxed atmosphere and one in which the participant feels content for interview. These seemingly small gestures build trust and reduce imbalances of power should they exist. This non-hierarchical relationship between researcher and researched is essential (Oakley, 1998) and once you have secured it, the most incredibly rich and detailed data will emerge.

The first premise of research is to do no harm and participants should at least be no worse off after taking part in the study than they were to start with (Hynson et al, 2006).

However, when conducting sensitive interviews there is a real and expected risk of

provoking distress. Talking about reasons for self-injuring is likely to resurrect painful memories. In several of my interviews, participants became tearful as they recalled events and feelings. A researcher may understandably feel compelled to stop an interview that seems to be triggering negative effects. However in responding to these situations as they arose in my study, I chose to acknowledge the hurt respondents were feeling, offer options of terminating the interview (and reassure them that it was OK to do that) or taking a rest, however, to ultimately follow their lead

On all occasions where participants became visibly distressed, none wanted to end the interview for this reason. They all requested to carry on despite their obvious appearance indicating they were emotionally distressed.

No I'm ok. I don't need to stop. Talking about this is helping me. You listening to me is helping me. I've never spoken to anyone as in-depth as I am doing with you about my self-injury [Dawn, a 21 year old student].

It is important to allow participants space to cry or otherwise express their pain. The patience of the researcher in acceptance of displays of distress can help them feel safe and consequently reveal further information, ultimately contributing to the depth and richness of the data (Cowles, 1988; Wilde, 1992).

As well as offering options to stop or rest during interviews, I attempted to counteract participant distress by debriefing at the end of the session and allowing space to recover. Although I made clear to participants my role was not one of counsellor but that of researcher, I did however advocate in terms of signposting them to agencies or trusted websites where they could access further support. Furthermore, text messages the next day to participants to thank them for sharing their experiences and check how they were feeling after an emotionally draining interview transpired as additionally and unexpectedly beneficial to the study in terms

of generating further valuable data. Some participants, at this point commented that although the process may have been emotionally taxing, they had found the experience therapeutic or cathartic.

Why people took part?

Another main reflection concerns motivation for taking part in the study. There were three main reasons offered. Firstly, some people hoped it would assist in helping them focus their minds on their own situations and aid a greater understanding of their personal relationship with self-injury. As Tina comments:

Well I thought talking to you about my self-injury might help me to figure it out a bit myself [Tina, a 39 year old teaching assistant].

Finding out about how others' experiences and meanings resembled or differed from their own seemed to help participants feel less isolated in their own relationships with self-injury. Similarly, Sam anticipated he would benefit from hearing about others. Additionally, he hoped his story would help others who self-injure:

Hearing about people just like me and also the possibility of inspiring other people who self-injure to know that they are not alone inspired me to talk to you like this. So you could say I'm helping myself and others at the same time by talking to you [Sam, a 42 year old sales manager].

Although some participants had disclosed to trusted others, they stated they had never spoken about it as in-depth as during their interviews for this study. Others revealed that I was the first person they had ever told about their self-injury. For them the self-injury experience was a particularly secluded and solitary one. They, like Sam, desired to help others reduce their feelings of isolation:

I know how lonely it is. I thought I invented self-injury and that I was the only person in the world who cut themselves to feel better ... And I thought I'd be locked up for sure if anyone found out about it. It's terrible to feel like you're some sort of freak... So I wanted to tell other people who do it that they are not alone [Sam].

Further, talking to me in this way contradicts the assertion that 'people who have not yet disclosed a personal issue to anyone are likely to be less inclined to disclose it to researchers' (Borrill et al, 2012: 385).

Breaking down some of the stigma associated with self-injury was Sally's main motivating factor for taking part in the research:

The taboo needs to be broken down. We are not freaks. We are not attention seeking and we are not trying to kill ourselves. When we do this [self-injure], it's our way of coping with stuff that happened. We attempt to understand the teenager who binge drinks hoping to find the answer at the bottom of the bottle or to just escape. But if a person sits down in front of us and says 'I cut', we panic, we judge, we medicate. We even lock them up [Sally, a 34 year old unemployed woman].

Sally was particularly active in her plight to change social perceptions of self-injury and had previously given media interviews and spoken at mental health events regarding self-injury from her first-person perspective.

Researcher vulnerability and self-care

As well as focusing on protecting participants and attempting to minimise or negate negative research consequences, it is important, simultaneously, to not to lose sight of effects on the researcher (Dunkley & Whelan 2006). No amount of training can prepare for all the

eventualities of undertaking sensitive research in the field, particularly in terms of the psychological consequences of immersion in an emotion-laden topic with ‘real people’.

Is it possible that rapport can be too successful? We invest considerable effort in building connection with participants to encourage in-depth data, detailing what are often intimate, deeply personal and often upsetting narrations of trauma, abuse and suffering. In my fieldnote reflections I tried to record how I was feeling in the midst of data collection. This excerpt details my attempts to process 34 year old Sally’s suffering, how the impact of hearing about her experiences lingered in my mind and invaded other areas of my life outside the research setting:

Sally initially appeared nervous but after a while chatting about this and that, she seemed more relaxed in my company. As time went on she told me about how she had repeatedly been sexually abused by her brother from her childhood to early teens. This, is why she started cutting herself at the age of 11: ‘Damage limitation – it stopped me from killing myself. If I didn’t do it, I would not be here ... I would be dead’. She also suffered emotional invalidation in the family home and her disclosure of the abuse, intensified by a court case, had deeply divided her family. She was still regularly self-injuring and her suffering was ongoing and very real.

After the interview, as I drove home, I could not stop thinking about Sally. I felt angry and hurt on her behalf. Worse – I felt powerless to do anything to help her. I tried to distract myself with the usual family hustle and bustle at dinner time. Part of me wanted them to know the kind of suffering that goes on outside in the world and to appreciate their nice settled lives and loving family. I realised that of course I am grateful they are oblivious to Sally’s trauma but I couldn’t shift this lingering knot in my stomach that welled up when I recalled her face, twisted with pain and stained with tears. Have I

fallen down a hole that I dug myself in inviting her story? I wasn't expecting this (extract from fieldnotes).

The invasion of professional into personal spheres of the researcher's life can be overwhelming and exceptionally challenging to maintain separation between the two (DeMarrais & Tisdale, 2002). Researcher-participant relationships can become intense, particularly when they feel equal and reciprocal, and uncoupling after data has been obtained can present difficulties. Fahie asks:

Would placing a time-limit on the relationship prior to the interview compromise the depth and intensity of the interview data by undermining the development of a sincere rapport? This is the moral dilemma for the researcher – how to foster a trusting and empathetic relationship with complete strangers over a short period of time and, once the research is complete, leave that relationship honourably without causing distress to the subject (Fahie, 2014:11).

In this study, I did not experience participants who struggled overly to disengage afterwards, or at least they did not make this known to me. I received some emails and text messages in the days after interviews, but these were mostly about something they forgot to tell me or to say they were glad they took part. Whether or not they, like I described in my fieldnotes, were bothered by unwanted feelings and emotions that persisted, I cannot be sure.

Feelings of guilt also manifest as I was torn between excitement at emerging quality data and unease that I had used participants. Despite therapeutic benefits experienced by some participants and my reciprocal attempts to offer feedback and signpost to services, I did not feel this was fair exchange. I believed I had gained most in the transaction. Discomfort ensued at what felt like 'duty of care' box-ticking. Fahie reflects similar emotions while researching work-place bullying:

... my sole intention was to gather the data, provide her with referral details for the counselling and support services, and leave. I possess neither the skills nor experience to ‘make it better’. I knew all of this, but that did not make me feel any better. I felt a kind of disconnect between what I *knew* and what I *felt*’ (Fahie, 2014:8).

Knowing I had acted professionally and had gone through the motions of advocating care, my ethical unease was not evaporated in its entirety as I walked off, interview data in my bag.

Conclusion

Although the self-injury field of research is broadening under the non-medical lens, what we know about the topic is still led by medical research and based on data collected from clinical populations of people who make themselves known regarding their self-injury. This means a population of individuals exists but remains somewhat hidden. Reaching that population is a difficult, however not impossible undertaking, requiring thoughtful approach, one which encourages people to come forward as esteemed authorities on the subject. In my experience, people respond to honest, transparent and jargon-free invitations that value their position as foremost experts on their own behaviour.

Notwithstanding the value of explorations of social and cultural influences on people’s understandings, the appreciation of them as principal authorities on their own behaviour in an attempt to break down hierarchal barriers is an ethos which should pervade. This recognition should not be restricted to interviews but clearly visible in all interactions with participants – from the first telephone call as they make initial contact with researchers, through to any additional communication such as ‘small-talk’ over a cup of tea prior to interviews and text messages after interviews to thank them for taking part. All these nuggets of interaction are valuable opportunities to build trust and rapport and often yield unexpected, additional rich data.

Similarly, when planning interview schedules, the key is to encourage participants to feel as relaxed as possible and to a large degree, in command of interviews. Often participants are forthcoming with information about their experiences of a sensitive topic without the necessity of being asked intrusive questions if they feel it is they who are directing the conversation. Their sense of control should at all times be respected and extend to decisions as to whether or not to continue explorations around painful memories or particular lines of discussion.

Regardless of how taboo the topic under discussion, there are benefits from talking about one's life and experiences - to deepen individuals' own understanding; to reduce isolation; to change societal understanding; and to contribute to reduction in stigma.

Research of sensitive topics has customarily tended to concern itself with techniques to safeguard study participants. However, there are consequences for all parties (Cohen et al, 2007) including those thrown up for the researcher in terms of self-care. I cannot say that I have learned to switch off completely from difficult to hear accounts, nor would I wish to entirely. Perhaps distress is an inevitable part of the process for both parties but countered with the return of rich personal stories and experiences given in trust, a worthwhile journey. Despite the risks involved for both researched and researcher, I believe if we wish to understand a sensitive topic or behaviour, asking people with first-person experiences is primary.

References

Abrams, L. S. & Gordon, A. L. (2003) Self-harm narratives of urban and suburban women. *Affilia* 18(4): 429-44.

Adler, P. A. & Adler, P (2005) Self-injurers as loners: The social organisation of solitary deviance. *Deviant behaviour* 26:429-44.

Babiker, G & Arnold, L. (1997) *The language of injury: Comprehending self-mutilation*. Leicester: British Psychological Society

Borrill, J. Lorenza, E. & Abbasnejad, A. (2012) Using qualitative methods to explore non-disclosure: The example of self-injury. *International Journal of Qualitative Methods* 11 (4): 384-398.

Bowen, A. C. L. & John, A. M. H. (2001) Gender differences in presentation and conceptualisation of adolescent self-injurious behaviour: Implications for therapeutic practice. *Counselling psychology quarterly* 14: 357-79.

Brossard, B. (2018). Why Do We Hurt Ourselves?: Understanding Self-Harm in Social Life. Bloomington; Indianapolis: Indiana University Press. Retrieved from www.jstor.org/stable/j.ctv233px9

Brossard, B 2014, 'Fighting with Oneself to Maintain the Interaction Order: A Sociological Approach to Self-Injury Daily Process', *Symbolic Interaction*: 37 (4) 558-575.

Brown, L. S & Bryan, T. C. (2007) Feminist therapy with people who self-inflict violence. *Journal of clinical psychology*: In session 63(11): 1121-33.

Chandler, A. (2012) Self-injury as embodied emotion-work: managing rationality, emotions and bodies, *Sociology*, 46, 3, 442–57.

Chandler, A., Myers, F., and Platt, S. (2011) The construction of self-injury in the clinical literature: a sociological exploration, *Suicide and Life Threatening Behavior*, 41, 1, 98–109.

Cohen, L., Manion, L., & Morrison, K. (2007) *Research methods in education* (6th ed.). Oxford, United Kingdom: Routledge.

Cowles, K. (1988). Issues in qualitative research on sensitive topics. *Western Journal of Nursing Research*, 10, 163-170.

DeMarrais, K. & Tisdale, K (2002). What happens when researchers inquire into difficult emotions? Reflections on studying women's anger through qualitative interviews. *Educational Psychologist*. 37 (2) 115-123.

Dickson-Swift, V., James, E. L. & Liamputtong, P. (2008) *Undertaking Sensitive Research in the Health and Social Sciences: Managing Boundaries, Emotions and Risks*. Cambridge: Cambridge University Press.

Dunkley, J. & Whelan, T. A. (2006) Vicarious traumatising: Current status and future directions. *British Journal of Guidance & Counselling*. 34 (1) 107-116.

Farberow, N. (1963). *Taboo Topics*. New York: Atherton Press.

Favazza, A. R. (1996) Bodies under siege: *Self-mutilation and body modification in culture and psychiatry*, 2nd ed. Baltimore: The John Hopkins University Press.

Goffman, E. (1963) *Stigma: Notes on the management of spoiled identity*. New York: Simon & Schuster Inc.

Goffman, E. (1967) *Interaction ritual: Essays on face to face behaviour*. New York: Pantheon Books.

Gratz, K. L. (2001) Measurement of deliberate self-harm: Preliminary data on the deliberate self-harm inventory. *Journal of psychopathology and behavioural assessment* 23:253-63.

Greenhalgh, T.; Snow, R.; Ryan, S.; Rees, S. & Salisbury, H (2015) Six 'biases' against patients and carers in evidence-based medicine *BMC Medicine*. 10.1186/s12916-015-0437-x. PMID: PMC4556220.

- Grund, J. P. (1993) *Drug use as social ritual: Functionality, symbolism and determinants of self-regulation*. Rotterdam: Instituut voor Verslavingsonderzoek. The concept of ritualization.
- Harris, J. (2000) Self-harm: Cutting the bad out of me. *Qualitative Health Research* 10 (2): 164-173.
- Hassan, N (2016) Surviving research on sensitive topics with young offenders. *Scottish Journal of Residential Child Care* 15 (1): 102-114.
- Heath, J.; Williamson, H.; Williams, L & Harcourt, D. (2018) “It's just more personal”: Using multiple methods of qualitative data collection to facilitate participation in research focusing on sensitive subjects. *Applied Nursing Research* 43: 30-35.
- Herpertz, S. (1995) Return to sender: Reintegrative stigma-management strategies of ex-psychiatric patients. *Journal of contemporary ethnography* 22(3): 295-330.
- Hynson, J. L.; Aroni, R.; Bauld, C.; & Sawyer, S. M. (2006) Research with bereaved parents: A question of how not why. *Palliative Medicine*, 20 (8), 805-811. Doi: <https://doi.org/10.1177/0269216306072349>.
- Inckle, K. (2007) *Writing on the Body? Thinking Through Gendered Embodiment and Marked Flesh*. Cambridge: Cambridge Scholar's Press.
- Inckle, K. (2010) Telling tales? Using ethnographic fictions to speak embodied ‘truth’. *Qualitative Research* 10 (1): 27-47.
- Johnson, R. and Chernoff, N. (2002) Opening a vein: Inmate poetry and the prison experience. *The prison Journal* 82 (2): 141-167.
- Jorgensen, D. L. (1989) Participant observation: A methodology for human studies. Newbury Park. C. A: Sage publications.

klonsky, D. E. (2007) The functions of deliberate self-injury: A review of the evidence. *Clinical psychology review* 27: 226-39.

Klonsky, D. E. & Muehlenkamp, J. L. (2007) Self-injury: A research review for the practitioner. *Journal of clinical psychology*: In session 63(11): 1045-56.

Lee, R. (1993) Doing research on sensitive topics. London: Sage.

Legard, R. Keegan, J. & Ward, K. (2003). In-depth interviews. In J. Ritchie & J. Lewis (Eds,). *Qualitative research practice: A guide for social science students and researchers* (pp. 138-169). London: Sage.

Mead, G. H. (1934) *Mind, self and society*. Chicago: Chicago University Press.

McCosker, H.; Barnard, A. & Gerber, R. (2001) Undertaking Sensitive Research: Issues and Strategies for Meeting the Safety Needs of All Participants. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 2(1), Art. 22, <http://nbn-resolving.de/urn:nbn:de:0114-fqs0101220>.

Miller, R. L. (2000) *Researching Life Stories and Family Histories*. London: Sage.

National Institute for Clinical Excellence (NICE) (2004) *Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*. Leicester: The British psychological society.

Nixon, M. K. & Heath, N. L. (2009) *Self-injury in youth: The essential guide to assessment and intervention*. New York, NY: Routledge Press.

Nock M. K. & Prinstein, M. J. (2004) A functional approach to the assessment of self-mutilative behaviour. *Journal of consulting and clinical psychology* 72: 885-90.

- Oakley, A. (1998) Gender, methodology and people's ways of knowing: Some problems with feminism and the paradigm debate in social science. *Sociology*. 32: (4) 707-731.
- Ogundipe, L. O (1999) Suicide attempts vs deliberate self-harm. *British journal of psychiatry* 175:90.
- Pattison, E. M. & Kahan, J. (1983) The deliberate self-harm syndrome. *American journal of psychiatry* 140: 867-72.
- Riemann, G. & Schütze, F. (2005) 'Trajectory as a basic theoretical concept for suffering and disorderly social processes. In R. Miller (ed.) *Biographical Research Methods Vol III*. London: Sage Publications Ltd.
- Ross, S & Heath, N. (2002) A study of the frequency of self-mutilation in a community sample of adolescents. *Journal of youth and adolescence* 31:67-77.
- Scambler, G. & Hopkins, A. (1986) Being epileptic: Coming to terms with stigma. *Sociology of health and illness* 8(1): 26-43.
- Shearer, S. L. (1994) Phenomenology of self-injury among inpatient women with borderline personality disorder. *Journal of nervous mental disorders* 182: 524-6.
- Sieber, J. E., & Stanley, B. (1988). Ethical and Professional Dimensions of socially Sensitive Research. *American Psychologist*, 43, 49-55. <http://dx.doi.org/10.1037/0003-066X.43.1.49>.
- Strauss, A. & Glaser, B. (1970) *Anguish: The case history of a dying trajectory*. Mill Valley, CA: The sociological press.
- Strong, M. (1998) *A bright red scream: Self-mutilation and the language of pain*. New York: Penguin Putnam.

Suyemoto, K. L. & MacDonald, M. L. (1995) Self-cutting in female adolescents. *Psychotherapy* 32: 162-71.

Trepal, H. C. (2010) Exploring self-injury through a relational cultural lens. *Journal of counselling and development*. Retrieved 3 February 2011 from <http://www.faqs.org/periodicals/201010/2138475441.html>.

Van der Kolk, B. A; Perry, J. C & Herman, J. L. (1991) Childhood origins of self-destructive behaviour. *American journal of psychiatry* 148: 1665-71.

Whitlock, J. L.; Powers, J. L. & Eckenrode, J. (2006) The virtual cutting edge: The internet and adolescent self-injury. *Developmental psychology* 43(3): 1-11.

Wilde, V. (1992) Controversial hypotheses on the relationship between researcher and informant in qualitative research. *Journal of Advanced Nursing*, 17, 234-242.