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What Does Recovery Mean to Adults who Self-injure? An interpretative Phenomenological Analysis.

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Abstract
A paucity of research has explored the meaning or conceptualisation of recovery from the perspective of individuals who self-injure. This study used semi structured interviews to explore the meaning of recovery from the perspectives of 6 individuals who self-injure, all of whom were accessing support from secondary mental health services. Factors considered to enhance or hinder the recovery process were also explored. Interpretive phenomenological analysis was used to analyse data. Analysis generated three superordinate themes: 'the recovering self', 'evolving relationship with self-injury', and 'inclusion vs. isolation'. Recovery was conceptualised as a multidimensional concept incorporating a broad range of intrapersonal and interpersonal factors. Gaining control over self-injurious behaviour was regarded as an important element in recovery, although it was not a defining feature of recovery for participants. This has implications for clinical psychology practice highlighting the danger of treatment approaches that prioritise self-injury cessation at the detriment of other indicators of recovery.

Key words: Self-Injury, Self-harm, Recovery, IPA.

Introduction
Self-harm and Self-injury
Self-injury has been defined as 'direct pain or injury inflicted by a person on his or her own body in a repeated pattern, usually with a low risk of fatality and without deliberate suicidal intent' (Broers & de Lange,1998, p.4). The term 'self-harm' encompasses a broader scope of behaviours and includes both acts of 'self-injury and self poisoning, irrespective of the apparent purpose of the act' (National Institute of Clinical Excellence; NICE, 2004, pg 16; Hawton, et al. 1999). Self-harming behaviour often emerges in adolescence and persists through to adulthood, occurring disproportionally among females (Favazza, 1989; Hodgson, 2004). However, ambiguity and lack of consensus in relation to how self-injury is defined across various treatment and theoretical studies can complicate generalisation and make prevalence estimates difficult to formulate. Approximately 4% of adults are estimated to have some past history of self-injury, with up to 1% reporting a severe history (Briere & Gil, 1998; Klonsky, Oltmanns, & Turkheimer, 2003). Higher rates are evident among those in receipt of mental health treatment, with self-harm estimated to occur in about 20% of adult psychiatric patients (Briere & Gil,1998) and 40–80% of adolescent psychiatric patients (Darche, 1990; DiClemente, Ponton, & Hartley, 1991; Nock & Prinstein, 2005).

Although mental illness is not uncommon in people who harm themselves, the occurrence of self-harm per se does not imply the presence of any particular diagnosis. Research indicates that individuals who self-harm are diagnostically heterogeneous and may present with a range of psychological co-morbidities (Klonsky et al., 2003; Nock et al., 2008). However, there is a robust literature linking self-injury with Borderline Personality Disorder (BPD; Andover et al., 2005; Klonsky et al., 2003). Some evidence has also shown that self-harm can co-occur in people with eating distress such as anorexia nervosa or bulimia (Jeppson, Richards, Hardman, & Granley, 2003) or in individuals with anxiety and depression (Andover et al., 2005; Klonsky et al., 2003). Although self-harming behaviours are distinct from suicidal behaviours in their characteristics and intent, it is notable that they share psychosocial risk factors (Muehlenkamp, 2005). Whilst many people who self-injure report no suicidal ideation or attempts, a considerable percentage (50% community; 70% inpatients) of individuals who self-injure report a history of at least one suicidal attempt (Nock et al., 2006).

Self-injury: Theoretical Models and interventions

There exists a robust behavioural literature which has enhanced understanding of the phenomena of self-injury. Self-injury has been conceptualised as an operant behaviour maintained by reinforcement contingencies (Nock & Prienstien, 2004). Nock and Prienstien (2004) developed a four factor theoretical model of self-injury which highlighted the importance of two dichotomous dimensions in understanding the functions of self-injury. Firstly, self-injury was found to be reinforced by either its intrapersonal/ automatic consequences (such as the reduction in tension that follows or the release of endorphins that trigger the production of analgesia and engender a sense of well being) or by its social consequences (such as changes in environment that are brought about by self-injury). Secondly, the consequences of self-injury can be positively reinforcing (for example to feel something, even if that something is only pain) or negatively reinforcing (for example, the reduction in aversive emotional states). The conceptualisation of self-injury as a behaviour with potentially many functions indicates that no single intervention will be effective across all cases, thus highlighting the importance of a comprehensive functional assessment to determine the functions the behaviour is serving for the individual.

One function of self-injurious behaviour that has been given extensive consideration in the literature is that of emotion regulation. The centrality of emotion dysregulation in contributing to and maintaining self-injurious behaviour has been widely documented in the literature (Gratz, 2007; Klonsky, 2003). Klonsky (2007) conducted a review of the research and concluded, firstly, that self-harm is often preceded by acute negative emotional states (e.g. anger, distress, anxiety, guilt, loneliness, self-hatred and sadness), and, secondly, that self-harm results in short term emotional relief and a reduction in negative affect (Klonsky, 2007). Whilst self-harm may provide an effective mechanism for the temporary relief of negative emotions, this is balanced against the longer term costs of self-harm such as physical injury, scaring or infection, impact on social relationships and the potential for self-harm to fuel negative belief systems (Klonsky et al, 2007). The literature also reports a vicious circle of emotional intolerance that is prevalent among individuals who self-injure; emotions are often perceived as intolerable and attempts are made to avoid experiencing them. Paradoxically this avoidance of emotion often results in greater distress (Chapman et al, 2006). Thus the individual can become drawn into cycles of maladaptive or impulsive behaviours (such as self-injury) to regulate negative emotions.

Interventions that target emotion dysregulation aim to reduce the need for individuals to engage in dysfunctional behaviours that function to regulate emotions (such as self-injury). Emotion regulation based treatments for self-injurious behaviour are the basis of dialectical behaviour therapy (DBT; Lineham, 1993), which combines cognitive behavioural approaches with techniques such as acceptance, willingness and mindfulness. DBT enhances emotion regulation skills by teaching clients to develop increased emotional awareness/ understanding and adaptive ways of managing emotional distress. Central to this approach is the notion of distress tolerance which teaches clients to accept and tolerate emotions without trying to change them, and to engage in goal directed/ self soothing behaviour (rather than impulsive behaviour) when experiencing distress.

There is emerging evidence highlighting the potential utility of psychodynamic therapies in the treatment of self-injury (Bateman & Fonagy, 2001; Ryle, 2004). Whilst the majority of psychodynamic therapies reported in the literature were intended to treat BPD, self-injury was often present and was highlighted as a target for intervention. The fundamental therapeutic elements of this approach are for clients to develop greater emotional awareness and expression, and develop healthy styles of soothing and self-care through the internalisation of their therapist's concern. Healing occurs when the client is able to process links between their current functioning and their past relationships/ experiences and realise that they are not intrinsically bad or worthless but a victim of abusive circumstances beyond their control (Strong, 1998).

Psychological interventions undertaken with individuals who self-harm vary in the extent to which self-harm is an explicit target of the treatment. In everyday clinical practice clients will be offered a variety of psychological interventions which may or may not focus specifically on their self-injury. However, self-harm reduction will often be the focus of psychological interventions in circumstances where a client's self-injury is considered to have become risky or severe (NICE, 2004).

Treatment and intervention literature

A body of research has investigated the efficacy of various psychological interventions which explicitly target self-injurious behaviour. This research has been predominantly quantitative and has focused primarily on self-injury reduction and elimination often using repetition (or absence) of self-injurious behaviour as a primary outcome measure (NICE, 2004). For example, Hawton et al, (1998) conducted a systematic review of the worldwide literature of treatment studies of patients who have deliberately harmed themselves. Twenty randomised control trials investigating the effectiveness of various psychosocial and pharmacological treatments were included in this review; repetition of self-harm was used as the primary outcome indicator across all of the studies reviewed. However, results concluded that nearly all trials included too few patients to detect clinically significant differences in repetition of self-harm when the interventions were compared to standard aftercare. NICE (2004) replicated this finding when they conducted a comprehensive review of the evidence base in relation to the psychological treatment and intervention for self-harming behaviour and concluded that is limited and equivocal. The guidance reviewed a range of psychological interventions including problem focused therapies such as Cognitive Behavioural Therapy (CBT), inpatient behaviour therapy and DBT. Overall there was insufficient evidence to determine the existence of any clinically significant difference between these interventions when compared to standard aftercare, with the exception of DBT which was found to reduce repetition of self-harm only in people with borderline personality disorder. Whilst the quantitative treatment/ intervention literature is helpful in informing evidence-based-practice, it has several weaknesses. Firstly, when an intervention is multifaceted, it does not enable us to determine which particular component of an intervention was most influential in reducing self-injurious behaviour. For example, despite some literature outlining the efficacy of DBT for the treatment of self-injury, there is an absence of research outlining the specific treatment components associated with reduction in self-injury (Gratz, 2007). Secondly, it fails to acknowledge the factors extrinsic to the therapy that may have contributed to (or hindered) a reduction in self-injurious behaviour. Thirdly it often fails to follow up the effectiveness of the intervention over longer time frames, thus failing to illuminate the process or journey towards stopping self-injury which may be unique for each individual or characterized by setbacks or relapses into self-injurious coping styles.

The overall lack of empirical support for psychological interventions that specifically target self-harm raises several questions. Most notably, given the limited evidence for the efficacy of these interventions at reducing self-harming behaviour, then what does help individuals move forward and reduce their participation in self-harm? Qualitative research that considers the longer term perspectives of individuals who self-harm has been somewhat illuminating in exploring this question.

Qualitative literature exploring the process of stopping self harming

A limited body of qualitative research has explored how people were able to stop or reduce participation in self injurious behaviour. Kool, van Meijel, & Bosman, (2009); Sinclair & Green (2005); and Shaw (2006) all conducted qualitative research with individuals who had stopped self-harming and elicited information about the process of stopping the behaviour and how this had been achieved. Taken as a collective body of literature, these studies convey a message that stopping self-harm is a multifaceted process that draws upon a range of intrapersonal and interpersonal factors. Specific themes considered important in the process of stopping self-harming include a growing sense of autonomy, increased self esteem, and learning alternative strategies (Kool et al, 2009); relational ties, developing self-initiative, and professional treatment (Shaw, 2006); and resolution of adolescent chaos, recognition of the role of alcohol, and understanding self-harming behaviour as a consequence of untreated depression (Sinclair et al, 2005). All papers converge on the idea that stopping self-injury requires shifts in multiple domains of an individual's life and therefore see the process of stopping as something that occurs in the broader context of overall greater psychological health and personal growth.

Interestingly, Shaw (2006) contended that stopping self-injury per se was not a reliable indicator of greater psychological robustness unless it was associated with changes across other domains of participants' lives. This finding raises questions about the prominence of self-injury cessation as a defining outcome measure in the research evidence base and suggests the need for additional research to illuminate the milieu of factors which may contribute towards an improved sense of psychological wellbeing for people who self-injure.

The qualitative research outlined above provides an insight into the process of stopping self-injurious behaviour. However, the research fails to elicit the perspective of those who may consider themselves to be in recovery whist still continuing to self-injure. Inherent within this literature is the message that stopping self-injury is a valued or defining recovery outcome or indicator for individuals. The process of stopping self-injury has been used interchangeably with 'recovery' across some of this literature (e.g Kool et al, 2009) thus making the assumption that this is synonymous with recovery. A review of the literature indicated that no research exists which specifically explores the meaning of recovery for individuals who self-injure or the factors that are considered to enhance and hinder this recovery.

Self-harm and Recovery

There is an inherent assumption within the quantitative treatment literature that the reduction or elimination of self-harm is an outcome that is valued by individuals. The literature positions reduction or cessation in self-harm as a central or defining outcome measure against which the effectiveness of the therapy is measured. Thus self-harm is positioned as a symptom to be reduced or eliminated. Whilst this may represent a valuable outcome measure, little is currently understood in relation to how reduction in self-harm may 'fit' with conceptualisations of recovery from the perspectives of individuals who self injure.

The wider literature on recovery in the domain of mental health asserts that service users often conceptualize recovery as being broader than the reduction in symptoms per se. Central to the survivor movement's understanding of recovery is an emphasis on learning to live a satisfying, hopeful and meaningful life despite the limitations associated with mental illness (Davidson et al, 2005; Capponi, 2003). Important elements of recovery were established to be hopefulness (Anthony, 1993), acceptance (Pettie & Triolo, 1999), redefinition of the self (Ridgway, 2001; Smith, 2000), empowerment (Onken & Slaten, 2000), support (Deegan, 1998), and the pursuit of meaning and purpose (Ahern & Fisher, 1999). Thus, in the domain of self-injury recovery may denote broad changes across a number of domains of an individual's life; individuals may (or may not) position the reduction in self-injury at the fore. There is a growing recognition of the need to develop services that are more recovery orientated (Repper & Perkins, 2003); thus it is pertinent to explore the meaning and conceptualisation of recovery from the perspective of individuals who self-injure.

Clinical Relevance

This research aims to make a unique contribution to the evidence base by generating an in-depth, experiential understanding of recovery from the perspective of individuals who self-injure. It is hoped that this research will enrich professional understanding of the meaning of recovery for this population and therefore aid clinical psychologists and services to promote and facilitate recovery in a way that is meaningful to individuals who self-injure. The research aims are consistent with the DOH mental health strategy 'No Health Without Mental Health' (DOH, 2011) which prioritises recovery as a guiding principle of mental healthcare and asserts that the needs, values and experiences of service users should be placed at the forefront.

Aim

This research aims to hear the voices and elicit the perspectives of individuals who have engaged in self-injurious behaviour in relation to their experiences of recovery. Its primary objective is to explore the meanings of recovery from the first person perspective. Its secondary focus is to explore factors that have enhanced or hindered the recovery process and how individuals have experienced these factors.

Methodology

Setting

This study was conducted at an NHS centre for Psychological Therapies in the West Midlands.

Advertising and recruitment procedure

There were two main recruitment methods; in the first instance a presentation of the research was delivered at a self-harm support group facilitated by a charitable organisation. Secondly pamphlets advertising the research were displayed in two Community Mental Health Teams (CMHT) in the locality. Staff in these community teams were briefed about the research and distributed pamphlets amongst their caseload to clients with histories of self-injurious behaviour. Participant recruitment was via self referral. Interested individuals were invited to contact the researcher directly by telephone, email, or by returning a stamped addressed envelope (contact information was provided on the research pamphlet). The researcher screened all potential participants during a face-to-face initial meeting for eligibility and capacity to consent to the interview. Once capacity to consent was established, written, informed consent was gained.

Inclusion criteria

i) Participants must have self-reported personal experiences of self-injury. An operational definition of self-injury proposed by Favazza, (1996) was used to determine if an individual's past or present experiences qualify them as appropriate candidates for participation: 'superficial or moderate self-injury that is episodic or repetitive, for example cutting, burning, scratching, skin picking or hair pulling'.

ii) Participants must identify themselves as either 'recovering' or 'recovered'.

iii) Participants must be over 18 years old.

Exclusion Criteria

i) Participants must not consider themselves (or be considered by their care co-ordinator at the CMHT) as being in current mental health crisis.

ii) Those experiencing a current episode of psychosis were not considered eligible for participation.

Sample

Seven individuals made contact with the researcher as a result of the recruitment procedure. In total 6 individuals were considered eligible for participation in the interviews. One individual failed to attend the initial screening meeting. All of the participants who were recruited into the study came as a direct result of the presentation made at the self-harm support group. The sample included 6 white British women aged between 23 and 54. All had English as their first language. The predominant form of self-injury used by all participants was cutting (6). Other forms of self-injury included burning the skin with lighters or corrosive substances (4), drinking harmful substances (1), trying to break bones (1), and bruising, picking, pinching or biting the skin

(3). The women had been using self-injury for between 2 and 49 years, although all reported periods of time where self-injury had been absent from their lives. At the time of completing interviews, the period of time elapsed since last episode of self-injury ranged from 1 day to 6 weeks. 4 participants reported prior admissions to acute psychiatric wards. 3 participants reported prior histories of attempting suicide. Participants had been given a range of diagnostic labels which included depression, Borderline Personality Disorder, Bulimia and complex post traumatic stress. 3 participants reported excessive use of alcohol. None of the participants were currently engaged in employment although they reported a range of interests and social/recreational pursuits. Some were active in service user consultation projects. All participants were currently in receipt of support from secondary specialist mental health services and all were members of a local support group for women who self-harm which was facilitated by a charitable organisation.

Procedure
Participants took part in semi-structured interviews which were 50-70 minutes in duration. Interviews were audio recorded using a digital voice recorder and transcribed verbatim.

Materials
Semi-structured interview schedules were developed by the researcher and refined with input from the research team. They comprised 7 open-ended questions which tapped 1) personal meanings and experience of recovery; 2) personal experiences of factors that enhance and hinder recovery; and 3) the role of mental health services in the recovery process.

Ethical Considerations
This study was reviewed and given favorable opinion by Birmingham, East, North and Solihull Research Ethics Committee in January 2011. The following issues were considered most ethically pertinent:

1) Vulnerability of participants
A number of safeguards were in place to ensure that extremely vulnerable individuals who were experiencing current mental health crisis were not inadvertently recruited. Suitability to participate was evaluated during a preliminary meeting between the researcher and each potential participant. Those who considered themselves to be experiencing acute mental health crisis were screened out of the study in the preliminary meeting. Permission was requested from the participants for the researcher to liaise with their care co-ordinator regarding their participation in the study. All participants agreed to this.

2) Capacity to Consent
In line with Mental Capacity Act (MCA) Code of practice (HMSO,2005), a functional approach to the assessment of capacity was adopted. Information about the study was verbally conveyed to each potential participant in an accessible format, with the aid of the participant information sheet. Prospective participants were asked a series of simple questions to determine their capacity to consent to the study. All individuals assessed during initial screening meetings were considered to have the capacity to make a decision about participating in the research, as all demonstrated that they were able to undertake the following steps, outlined in the MCA code of practice (2005):

- Understand the information relevant to the decision (conveyed by the researcher with the aid of the information sheet)
- Retain that information
- Use or weigh that information as part of the process of making the decision (e.g. weigh up risks, burdens and benefits of participation)
- Communicate the decision made.

3) Voluntary Participation

In order to ensure consent was voluntary, individuals were required to 'opt in' to the research, rather than be referred in. The voluntary nature of participation was made clear at each contact. It was clearly stated that the individual was free to change their mind about participating with no consequences to their future care. Also there was a gap (of at least one week) between the initial explanatory meeting with the individual and the actual meeting for the interview; this allowed an opportunity for the individual to reflect about participating and change their mind, should they wish to.

Researcher's Position

The researcher assumes a critical realist epistemological position. This position is underpinned by efforts to capture the thoughts, feelings and beliefs of those who have experience of self-injury in relation to recovery. Central to this position is the researcher's determination to make sense of the participants' internal world which is balanced with an acceptance that it is never fully possible to enter another individual's reality; access to such is always through an interpretive lens (Heidegger, 1962). This position informed the choice of qualitative analysis undertaken, guiding the researcher to select Interpretative Phenomenological Analysis (IPA) as a method of qualitative enquiry. The researcher's epistemological position is compatible with the theoretical underpinnings of IPA which is rooted in critical realism (Fade, 2004). IPA involves a 'double hermenutic' (Smith & Osborn, 2008) and acknowledges that the process of making sense of a participant's internal world will be influenced by the researcher's own preconceptions; the researcher will interpret the participants' experiences through their own experientially informed lens. Given the inevitable presence of preconceptions and bias (Smith et al, 2009), an open, reflexive approach is paramount in IPA research to consider how the researcher's unique preconceptions may have influenced the data collection and analytical processes. In this study, the researcher was a 28-year-old female with clinical experience of working with individuals who self-injure. The researcher also has an interest in the recovery approach which guides and inspires her clinical practice. The researcher has worked within community and inpatient settings where systemic attitudes to self-injury have been negative and psychological understanding of the behaviour has been minimal or absent. In her professional capacity the researcher has worked within contexts where she has observed frustrations and a sense of powerlessness amongst staff teams at feeling unable to intervene effectively to reduce self-injurious behaviour. Thus the researcher developed an interest in exploring and developing understanding of the phenomena of self-injury, particularly in relation to what individuals have considered helpful in their recovery. Therefore, the analytic results presented in this study may have been influenced by the researcher's context and presuppositions.

Interpretive Phenomenological Analysis (IPA)

Theoretical Underpinnings

The analytic focus of IPA relates to how people make sense of their own experiences (Smith & Osborn, 2008). The approach is informed by phenomenological principles insofar as it is concerned with examining patterns of meaning from a first person perspective and developing rich descriptions that may help illuminate human experience. It acknowledges that meanings can be personally constructed but can also be influenced by societal factors or enmeshed within culture. Although IPA is committed to understanding the 'insider's perspective'. (Smith et al, 2009) it recognises that it does so from a third person position. This is in contrast to Husserlian phenomenology, which calls for the identification and 'bracketing off' of assumptions, culture and context in order to focus on the true essence of a phenomenon (Husserl, 1970). Conversely, IPA acknowledges the stance and positioning of the researcher and recognises the role that the researcher's own experiences, background and preconceptions play in the interpretative processes. Hence IPA is considered a double hermeneutic process; participants endeavour to articulate and make sense of their experiences and researchers aspire to make sense of participants' accounts of those experiences.

IPA was considered the most suitable methodology for this study due to the epistemological positioning of the research question which relates primarily to uncovering experiences and meaning of the phenomenon of recov-

ery from the perspective of a group of participants with personal experiences of self-injury. This fitted well with the philosophy of IPA which aims to explore how individuals make sense of their lived experience (Starks & Brown Trinidad, 2007). IPA is considered a suitable methodology for exploring experiences associated with psychological distress (Smith et al. 2009); it has been applied in research exploring recovery from psychosis (e.g. Pitt, Kilbride, Nothard & Morrison, 2007).

Analysis
The analysis was guided by procedures outlined by Smith, Flowers and Larkin (2009). The analytic process followed is detailed in table 1

Rigor and Credibility
To enhance credibility and trustworthiness of the research a number of strategies were employed in the present study.

Analytic Supervision
The rigor and credibility of themes was examined for one case by a research supervisor who was given a copy of a transcript, in conjunction with a list of emerging themes and a table of superordinate themes. The supervisor provided feedback that the analytic procedure was being adhered to and that themes appeared sufficiently grounded in data.

Reflexivity
The researcher kept reflective notes and added to these after each interview and during the analysis process. This reflexive process enabled the researcher to develop a greater awareness of her preconceptions and assumptions in relation to the research as they emerged.

Results

This section will outline the results of the Interpretative Phenomenological Analysis of the participants' accounts of their recovery experiences. The aim of this analysis is to convey a coherent narrative account of how participants made sense of recovery experiences by illustrating a number of higher order themes shared across cases whilst also demonstrating the nuances of the data. Three master themes emerged from the analysis of the data. The master themes and their superordinate themes are presented in table 2.

The remainder of this section will deliver a narrative account of the themes outlined in table 1.

Table 1: IPA Analytic Process

1	The researcher read and re-read the transcript, whist listening to the audio recording of the interviews to ensure a deep familiarity with the data and to begin the process of entering into the participant's internal world.
2	The researcher began a process of line-by-line analysis of the transcript, noting anything of interest within the left-hand margin. This generated a deeper engagement with the data and a growing familiarity with the individual's experiential world. Initial exploratory comments had either a descriptive, linguistic or

	conceptual focus. Descriptive comments had a phenomenological focus and remained close to the participant's explicit meanings; linguistic comments centred on the way language was used to convey meaning; and conceptual comments reflected a more interpretive understanding of the data.
3	The researcher then returned to the beginning of the transcript and began the process of developing emergent themes. This involved working with the exploratory comments and interpreting these in the context of the whole transcript. These emergent themes aimed to capture the 'psychological essence' of the participant's experiences and represent a higher level of abstraction whilst still being sufficiently grounded in the data (Smith et al, 2009).
4	All emergent themes were compiled in a chronological list and the researcher began a process of clustering related themes together and searching for patterns amongst the emergent themes. The researcher experimented with different methods of doing this which involved cutting and pasting themes together on the computer screen or cutting up a typed list of themes and physically clustering these together. The end result was a group of themes that had been clustered together on the basis of their similarity or relatedness. These groups of themes were then given a new over-arching name (development of a superordinate theme).
5	The process was repeated for each case in turn whist being careful to treat each case on its own terms
6	The next stage involved searching for patterns or connections across cases. This involved a process of identifying the higher order themes that may be shared among cases and involved a process of reorganisation of themes or development of master themes.

Table 2: Master themes and superordinate themes

Master themes	**Superordinate themes**

The recovering self **"This is part of me"**	• Inconceivability of recovered self vs. recovery as a process • Changes in internal sense of self • Accepting the self • Rebuilding a new self • Striving for hope
Evolving relationship with self-injury ***"I'm in the mode of trying to recover"***	• Striving for Insight • Paradoxical relationship with self-injury • Ownership and self management
Inclusion vs. isolation ***"it's having somebody on your journey of recovery, not to hold your hand, but to just walk beside you."***	• Presence and absence of support in recovery • Positive and negative experiences of mental health services

THE RECOVERING SELF : "This is part of me"

This theme captures participants' sense of the meaning of recovery and focuses upon the intrapersonal features of recovery that were considered significant in their accounts. Participants reflected on changes in their sense of self-worth and a gradual shift towards self-acceptance. A central element of the recovery process centred around the struggle to maintain hopefulness despite setbacks and challenges. This theme also captures participants' sense of recovery as an incremental process balanced against a struggle to conceptualise the notion of the fully 'recovered' self.

Inconceivability of the recovered self vs. recovery as a process

Recovery was conceptualised by participants in two distinct ways: as an incremental process or ongoing journey and also as a definitive outcome which was largely perceived as unattainable and inconceivable by the participants.

Anna explores the notion of recovery as an outcome and offers a description of the 'recovered self', but states that she is unable to connect to the reality of that description, feeling that is too far removed from her current sense of reality:

> Anna: "I can't imagine what it would be like to cope on a day to day basis without being upset, or despairing or in tears or angry at everything....I don't know what it would be like to wake up every day and feel I'm blessed with having a nice a day to look forward to, because I don't."

Carol's account suggests that she equates recovery with the absence of self-harm and destruction of her body, something that she currently finds difficult to comprehend:

> Carol: "I still can't fully imagine it, it's difficult, to not be constantly, I don't know, destroying my body in some way."

Participants forged a stronger connection to the notion of recovery as an incremental process which is punctuated with both progress forward and setbacks. All participants acknowledged that they had made progress towards recovery, for example in terms of shifts in behaviour, changes in outlook or the assumption of greater responsibility for the management of their mental health. Equally participants described 'blips', 'wobbles', times of crisis, and negative life events which were considered undermining of progress. Setbacks were associated with more frequent episodes of self-harm or a greater use of a repertoire of negative coping mechanisms such as alcohol use or increased binging/purging. For some participants, an increased propensity towards self-injurious behaviour as a coping mechanism compounded feelings of already heightened negativity that were present during these times of setback.

Rachel's account was characterised by periods of progress followed by setbacks. Setbacks were linked to external circumstances or difficult life events and were characterised by an increase in harming behaviour. Rachel demonstrates a balanced and resilient response with regard to her setbacks and conveys an awareness that they are an inevitable part of the recovery process that must be coped with:

> Rachel: "I mean I've had periods where I've not self-harmed for weeks, and then something's happened and I've self-harmed... if you do fall back then it's not the end of the world and that you can pick yourself up and try and carry on".

Changes in internal sense of self

This theme captures the evolving sense of self that was evident in several participants' accounts. Participants described the development of a more positive sense of self and a shift towards a greater sense of self-worthiness. This theme was particularly embodied in Kate's account:

> Kate: "I used to think I don't have any right to eat, I don't have the right to breathe, I don't have the right to do whatever.....I can breathe now without feeling guilty, I can express opinions now without feeling guilty, I can talk, just talking.."

Kate's account shows she has begun to view herself as in a more compassionate way and in doing so has begun to see herself as a worthy person. Recovery for Kate has centred around challenging prevailing feelings of self hatred and beginning to see herself differently as her self-worth increases. The evolving more positive sense of self has also impacted upon her self-injurious behaviour, which was perpetuated by her enduring feelings of self loathing:

> Kate: "people don't realise that for me, it is a pure hatred and that's why I self-harm. And to stop that, to recover, has been literally just been chipping away at that hatred".

Accepting the self

Acceptance was important to participants in various guises. For some participants, this took the form of self-acceptance which was facilitated by acceptance from others. For other participants, acceptance centred around integrating their experiences of illness and distress into their identity and accepting that this was part of them. Acceptance of stigma as a part of life was also important.

Kate's account demonstrates a struggle with self-acceptance as she battles with a sense of incongruence around her own sense of self-worth:

> Kate: "it's bewildering because I think 'why do these people care'? but that leads me to think well maybe that's because they... yeah feeling like poison in my mouth again, maybe it's because they like me, I don't know, maybe it's because I am a good person"

The actions of professionals at Kate's residential placement and the decisions recently made surrounding her care have consistently demonstrated care and acceptance. Kate describes this as 'bewildering' and struggles to make sense of it in the face of a negative sense of self. However, over time the cumulative impact of this has challenged Kate's negative self belief. Kate grapples with a new, more positive sense of self but evidently finds this notion difficult to accept. Her use of the metaphor of 'poison' in her mouth evokes images of this more positive sense of self as being something that feels very unsafe or something that she would want to spit out. Thus, self acceptance is something that is being slowly facilitated by the acceptance others are showing towards her.

Naomi's attendance at a local support group has enhanced her self-acceptance. She feels able to be open within this context and does not feel the need to hide aspects of herself or her experience:

> Naomi: "I can go there and just be myself and don't have to hide or anything because they've all had like similar experiences with mental health"

Anna's account shows that she has accepted her struggles with distress and self-injury as part of the self rather than as a separate or unwelcome entity that she is continually battling against. In doing so she has been able to reduce its dominance in her life:

> Anna: "I have a level of acceptance that this is part of me, rather than something that's happening to me I don't want to happen to me, I've sort of come to the conclusion that it's part of me"

Rebuilding a new self

This theme captures the way in which participants have begun to rebuild their identity following their experiences of mental illness and self-injurious behaviour. Participants' accounts were littered with references of disempowerment, loss of self-identity and internalisation of stigma. This theme reflects the action taken by participants to rebuild this sense of self-identity. For some participants this involved engagement with meaningful and valued roles, for others involvement included advocacy work, awareness raising or participation in systems change. Other participants referred to creative pursuits and participation in recreational activities or sports. Activities that enriched lives and provided a sense of purpose were highly valued by participants. Anna's account describes how she has been able to gradually re-author a more positive self narrative as she participates in service user consultation work and connects with this valued role. This has strengthened her identity as a valued citizen or a 'a person who can contribute':

> Anna: "I'm doing sessional work for the NHS which is a posh way of saying that I do service user work for them...and it makes me feel important when I say it. It gives you a role... Whereas being a mental health patient is degrading. It's the opposite."

Rachel describes her commitment towards awareness raising of issues surrounding mental health and self-harm. Her account demonstrates her passion towards voicing inequalities and challenging the status quo, a role that has engendered strength of character and a sense of purpose:

> Rachel: "we don't want it to be a stigma and we don't want people to be judgemental...we just need to get the message across generally about mental health but also about self-harm"

Striving for hope

The importance participants placed upon hopefulness in the recovery process was strongly evident. However, maintaining hopefulness during low points or times of distress and despair was a challenging feat. Participants' accounts described the hope and strong will which must be channelled into the recovery process if progress forward is to be made. Carol's account conveys the personal efforts and internal strength that she feels will be crucial in addressing and resolving difficulties in order to move forward in her recovery process. She is mindful of the magnitude of the challenge for her but conveys a cautious sense of hopefulness that she has the strength and internal resources to move forward in the process:

> Carol: "I'm hoping that I'll be able to do what's needed to, you know, to get over stuff and look at stuff...People tell me that it is possible so I'm trying to believe what they say"

Evolving relationship with Self-injury: "I'm in the mode of trying to recover"

This theme captures the evolving relationship participants had with self-injury which involved the pursuit of insight and understanding, paradoxical feelings towards self-injury and an urge to take ownership and control of the behaviour.

Striving for Insight

Participants discussed a process of striving to make sense of their self-injurious behaviour and situate self-injury within the context of their life experiences. Participants considered it important to gain understanding of their personal relationship with self-injury and the way it is related to current psychosocial stressors and historic psychological vulnerabilities. The therapeutic relationship was identified as a method of enhancing this understanding. Gaining a greater understanding of past experiences was particularly important for Naomi who considers insight and understanding a prerequisite to gaining control over her behaviour and emotions:

> Naomi : "to deal with everyday things, you have to deal with what's happened, you've gotta figure out what's triggering"

However, Carol was less comfortable with exploring the personal meaning of her self-injury and described feeling unsafe with the intense emotions this would bring up for her:

> Carol: "I just find it difficult to turn up somewhere for an hour and try and get in touch with stuff... I don't feel safe, it wasn't [therapist's] fault, I just didn't feel safe enough to go as deep as I needed to"

Paradoxical relationship with self-injury

This theme captures the paradoxical relationship participants described with self-injury; self-injury was considered a helpful way of regulating extreme emotions yet continued engagement in this behaviour was not compatible with their vision recovery. Participants expressed a desire to stop or gain control of the behaviour

and considered this to be an important element in the recovery process. In spite of this desire to stop self-injurious behaviours, all of the women recognised that they could not fully commit to a future free of self-injury and recognised it as an ever present option available to them for coping with distress. Lucy relays concerns, embarrassment, and unease at the unwanted social attention that her self-injury brings about. As her cuts and scars become increasingly difficult to conceal she accepts that others will cast judgment on her based upon what her scars are continuously communicating about her. She describes a desire to develop alternative ways of expressing emotion which will afford her greater control over who she communicates her distress to and when:

> Lucy: "I do get looked at...I've just got to appreciate that people are going to look really but it's not nice, I know there's a stigma... I guess people just assume you're mentally ill.... I'm at a stage that I can't carry on using that [self-injury] as a coping mechanism"

However, she isn't able to commit with any degree of certainty about a future that is free from self-injury.

> Lucy: "it's been such a crutch if you like, it's been with me for so long that you know, there's always a chance that I'll return to it"

This demonstrates how established and ingrained self-injurious behaviour has become for Lucy. The metaphor of a crutch conveys the supportive role that self-injury has played for her over the years and conjures the image of self-injury being something that she has relied on to prop her up.

Carol's account conveys a similar message of ambivalence and illustrates both a desire to stop self-injury and a sense there is no other conceivable option:

> Carol: "I can't imagine not doing it"

> Carol: "I just want to get rid of it"

Later in the transcript Carol speaks about the role self-injury has played in her survival

> Carol: "I see self-harm... I think of that as keeping me alive really in a way…"

However, she later refers to her episodic and repetitive self-injurious behaviour as 'destroying my body'. Thus self-injury represents two opposing concepts for Carol: survival and destruction. Although it has kept her from taking her life during times of distress and despair, this survival has come at the cost of the perceived destruction of her body.

Anna's account further exemplifies the presence of paradoxical and opposing feelings towards self-injury:

> Anna: "I wake up in the morning and realise I've done it, you know I'm really cross with myself all day, even though I accept that it was necessary, 'cause I only do it when it's necessary."

She wrestles with self acceptance following an episode of self-injury and describes feeling cross with herself despite acknowledging that it was a behaviour that was perceived as 'necessary' for her.

She talks about reaching a point where she 'wants so much not to do it' yet later in her account considers the resolution of self-injurious behaviour to be something she could never guarantee. She introduces vocabulary such as 'taste for it' which conjures up associations with addictions and alludes to the idea that her struggle against self-injury is something that is continually re-enacted in the face of distress:

> Anna: "Once you've had a taste for it and you know that it helps, you can't guarantee in life that you're not going to get so distressed in life that you're not going to turn back to it"

Ownership and self-management

This subtheme illustrates the importance participants placed on taking hold of their recovery and taking action towards recovery directed goals and values. Sometimes these recovery goals included gaining some mastery over self-injurious behaviour which in turn brought about increased feelings of self-esteem. For other participants this included entering into a therapeutic relationship or becoming more involved in community groups/projects. There was some variation in the extent to which participants took ownership of their recovery and exercised responsibility for self management of their distress. Some participants had begun to manage their distress in a more autonomous way whilst others relied to a greater extent on others.

For Anna, her engagement in the therapeutic process signifies something meaningful to her about the direction in which she is moving. She sees herself as an active agent making a significant contribution to her own recovery process:

> Anna: "The fact that I'm putting myself forward to do it [therapy], means that I'm in the mode of trying to recover... I hate it when I'm not in counselling, 'cause that's how I feel, that I'm not actually doing anything to try and get better"

Anna's account further exemplifies this theme by demonstrating the mastery she has steadily gained over her self-injurious behaviour:

> Anna: "One thing that's changed now from the early days is that I don't do it [self-injury] so desperately that I sort of have to run around trying to find something sharp and then just do it. I, I've sort of got time to make a few choices"

This illustrates the greater control Anna is now able to exercise over self-injurious behaviour. She talks about a progression from the 'early days' which alludes to the development of a greater maturity; her self-injurious behaviour is now less governed by impulsivity and seems to be characterised by more thoughtful consideration. Anna talks about having time to make choices which suggests a greater ability to tolerate or cope with distress and despair for longer periods.

Further engagement with Anna's account suggests that this greater control is linked to increased emotional awareness and the development of a repertoire of alternative coping mechanisms for regulating and managing her distress:

> Anna: "can I do something, can I go and have a shower, can I go for a walk, can I phone a friend"

Lucy's account also exemplifies a sense of taking ownership over recovery:

> Lucy: "..trying to do everything to avoid going back like that... and taking action to prevent myself..."

Lucy's determination to avoid returning to her rock bottom state is a powerful deterrent and sufficient as a means of motivating her towards preventative action. She later describes working collaboratively with her psychologist to develop autonomous coping skills and alternative ways of soothing herself and relieving tension:

Lucy: "I need to work more with [my psychologist] in terms of finding alternative strategies of coping with things and problems and frustrations that are more positive"

In contrast, Carol's account illustrates a struggle with taking ownership of recovery which could be understood in the context of readiness for change. She conveys a cautious and more uncertain position towards her recovery:

Carol: "people tell me that it is possible so I'm trying to believe what they say"

Carol describes the way that services have tried to promote greater self responsibility around managing emotional distress. Although she was aware that options other than cutting were available to her she never felt able to choose them:

Carol: "if you felt you were having thoughts of self-harming, you had a choice, you could either knock on the office door and get 5 minutes to distract, or they'd give you a razor, they actually give you one, so I suppose they're giving you a choice, but I kept choosing the razor".

Placing this excerpt in the context of Carol's entire account led the analyst to interpret that, for Carol, the razor represented a way of gaining relief via a method that did not require reliance on anyone but herself. In contrast she found it difficult it make a choice that would require her to trust or use others for support.

INCLUSION Vs. ISOLATION: "it's having somebody on your journey of recovery, not to hold your hand, but to just walk beside you."

Inclusion was experienced in the context of supportive personal and professional relationships in addition to respectful, accepting interactions with mental health services. Inclusion was valued by participants as a factor that enhanced recovery. However, experiences of inclusion were balanced against experiences of isolation which were considered as damaging or detrimental to the recovery process. Isolation was associated with the absence of support, a sense of rejection in personal relationships and interactions with mental health services that were experienced as judgmental or devoid of empathy.

The Presence and Absence of support in Recovery

Establishing a network of support which included both meaningful personal and professional supportive relationships was a fundamentally important aspect of every participant's account of recovery and enhanced feelings of inclusion. Some individuals spoke about their frustrations that their relationships were restricted primarily to those within the mental health system. For others, relationships with fellow mental health service users were highly valued - they provided an opportunity for mutual support, increased opportunities for social inclusion and ameliorated feelings of isolation and alienation that surrounded distress. Needs for care and safety often felt fulfilled in the context of supportive relationships allowing participants to feel greater emotional safety. In contrast, the absence of supportive relationships was felt to impede recovery and was associated with a sense of unmet needs for care and safety.

For Lucy experiential connectedness was a valued aspect of social support. Connecting with someone who had a genuine personal insight into the depths of despair she was experiencing allowed her to feel comfortable sharing difficult emotions:

Lucy: "I could talk to her quite frankly about it [suicidal ideation]..,it wasn't a matter of encouraging each other on, it was just that she had an insight into what it felt to feel like that"

Kate describes her gravitation towards supportive professional relationships. These fulfilled a need for love and care that she felt had been withheld. She draws upon the metaphor of a drug to convey the almost addictive nature of these caring relationships. However, she later describes a sense of trying to 'limit' how much she draws upon these relationships, as she did not wish to conform to stereotypes of 'clinginess' or over attachment:

Kate: "a lot of people who self-harm get over-attached....and I think that's actually quite true, but not in a negative way. You find someone who shows you that slight bit of kindness in your life when you feel so much hatred, of course you're going to latch on to it, of course you're going to want more of it, it's like a drug it makes you feel better".

Participants also described occasions when support was notably absent from their lives, which culminated in feelings of isolation and often left participants feeling like their needs for love, care and safety were being unfulfilled. Naomi's account demonstrates aloneness which is exacerbated by a sense of being rejected by her primary attachment figure at the time when she was most vulnerable and in need of care:

Naomi: "She just said, "you silly girl and she kept saying it, and I said 'mum, I'm not silly', I said 'I'm here and I need your help' and she didn't help me... she just didn't do a single thing"

Lucy's account conveys a sense of longing for those around her to show care or compassion for her wounds. However, her desire to elicit care and have her feelings acknowledged and validated were unmet.

Lucy: "I had a really big burn my arm and I wanted someone to ask me why I'd done it, but no one did"

Positive and negative values and practices of mental health services.

This subtheme captures the way in which mental health services have been experienced by participants and how these experiences were perceived to have enhanced and hindered the recovery processes. Participants conveyed a dichotomy of positive and negative experiences which engendered both feelings of inclusion and isolation. Participants described a range of systemic barriers to recovery which encapsulated responses from mental health professionals that were devoid of empathy, degrading, judgmental or disempowering, engendering feelings of aloneness and isolation.

Naomi recounts her experience of CBT as being at best counter-therapeutic and at worst damaging:

Naomi: "it just made me 10 times worse. You know I wasn't allowed to deal with the situations, I wasn't allowed to talk about what happened to me...I wasn't allowed to cry, she'd always sort of say "can you stop crying"

The structure and rigidity of the therapeutic environment described by Naomi left her feeling invalidated and as though her needs and goals were unimportant. Lack of tolerance for expression of emotion, and rules restricting what content she was 'allowed' to bring to the therapy session, were likely to have left Naomi feeling silenced and disempowered.

Carol's account is heavily embedded with copious examples of times where she has felt pathologised, dehumanised, disempowered and rejected by mental health services. The cumulative effect of this over the years has been to compound her feelings of worthlessness and hopelessness and sometimes even add to her suffering. Carol reflects upon an occasion during her hospitalisation where she felt distressed and desperate and sought support from a nurse:

Carol: "I was upset and they said that they'd come and they never came to chat to me... the nurse who said she was gonna talk to me was playing Scrabble so I was thinking, 'a game of Scrabble's more important'.... you just..feel more worthless than you already felt"

Participants also described an array of positive, supportive encounters with mental health services that engendered feelings of inclusion and enhanced feelings of self worth. Responses that conveyed respect, acceptance, empathy and validation were all highly regarded by individuals as were involvement in decisions around their care and being treated as an individual in their own right rather than as a case or category.

Anna conveys the idea of services walking beside her, rather than holding her hand which alludes to the importance she places upon mental health services being empowering, affirming of her strengths and yet responsive at times of distress.

Anna: "They [services] can enable you to find your own strengths and I think it's, it's having somebody on your journey of recovery or your journey of distress, to sort of not hold your hand, but to just walk beside you."

Discussion

Results of this study highlight recovery as a multifaceted process which is also linked to changes in self-injurious behaviour. Three main aspects of recovery were important to participants: the recovering self; evolving relationship with self-injury; and inclusion versus isolation.

Findings support the wider literature on recovery, but also replicate some of the findings from the literature on self-injury resolution, thus indicating that the process of self-injury resolution may be entangled or inextricably linked with the recovery process. Or it may reflect the fact that participants see reduction in self-injury as a component of their recovery process.

Participants conveyed the notion of 'the recovering self' which included shifts in various intrapersonal domains and a struggle to maintain hope despite the setbacks of the recovery process. The centrality of hope in the recovery process is already widely established in the literature (e.g. Anthony, 1993), however, the struggle to maintain hope in the face of despair and setbacks seemed particularly pertinent to participants in this study. Participants reported the notion of recovery as an incremental process, punctuated with progress forward and setbacks. This replicates an already widely established finding within the recovery literature (Ochocka, Nelson & Janzen, 2005). However, it is noteworthy that for this sample of participants, periods of setbacks tended to be associated with more frequent episodes of self-harm or a greater use of a repertoire of negative coping mechanisms. For some participants increased propensity towards self-injurious behaviour as a coping mechanism compounded feelings of already heightened negativity that were present during these times of setback. Participants found the notion of the recovered self (as a final outcome) difficult to conceive of, feeling as though it was too far removed from their current sense of reality. This perhaps reflects the characteristics of the sample, which comprised those who were still ensconced within secondary mental health services and still experiencing enduring struggle with mental health. However, this could equally provide further substantiation for the conceptualisation of recovery as a process, rather than an ultimate outcome.

Participants' notion of the 'recovering self' embodied growth and development in various aspects of the self. Participants outlined a shift towards a greater sense of self-worth and a growing propensity to see themselves in a more positive, compassionate way. This in turn had a positive impact on self-injury (which had been perpetuated by enduring feelings of self loathing for some participants). This sense of growth following the experience of illness and suffering has been documented in the wider evidence base (Piat, Sabetti & Coutre, 2009).

Increasing self esteem has also been established as an important factor in the process of stopping self-injury (Kool et al, 2009).

In summary, this research has formulated the notion of a 'recovering self' which resonates with individuals who engage in self-injurious behaviour. For participants in the study, the recovering self is characterised by a shift towards a more positive and compassionate sense of self and a greater self acceptance. Individuals within this study identified with the notion of recovery as a process involving steps forward as well as challenges and setbacks during which there can be greater propensity to return to self-injurious coping styles. The recovering self strives to maintain a sense of hopefulness throughout this turbulent process. This has relevance to the body of research around resolution of self-injury (e.g. Kool et al, 2009; Shaw, 2006), which has failed to give due consideration to the broader notion of recovery for individuals who self-injure, instead focusing more narrowly on stopping self-injury and how this has been achieved. For participants in this study, recovery was conceptualised in much broader and holistic terms. There was recognition of the fluidity of recovery and the potential for slips back towards self-injurious behaviour during times of distress, which was not fully acknowledged by the body of literature around self-injury resolution.

Participants conveyed an evolving relationship with self-injury which included the desire to make personal sense of their self-injurious behaviour within the context of their past and present life experiences. Gaining an insight into the psychological vulnerabilities that precipitate and perpetuate self-injurious behaviour was considered as a prerequisite of gaining greater control over their behaviour and emotions, with the exception of one participant who did not feel safe to explore the emotions underlying her self-injurious behaviour. This supports the findings of Kool et al (2009) who highlighted the development of a sense of safety as a foundation to the process of stopping self-injury and identified 'learning to understand' self-injury a key phase in the process.

Participants 'evolving relationships with self-injury' were characterised by paradoxical feelings towards self-injurious behaviour. Self-injury was considered both a helpful way of regulating extreme emotions yet continued engagement in this behaviour was not compatible with their vision of recovery. A desire to stop or gain control of the behaviour was considered tantamount to recovery for some participants, yet paradoxically all of the women recognised that they could not fully commit to or imagine a future free of self-injury and recognised it as an ever present option available to them for coping with distress. This finding has relevance to the body of literature on the resolution of self-injury (e.g. Shaw, 2006; Kool et al, 2009) which explored the perspectives of women who had successfully stopped self-harming and positioned the resolution of self-harm as an end point or outcome. Conversely, this research has voiced the perspective of a group of women who are still engaging in self-injurious behaviour, many of whom felt that stopping self-injury was unattainable and inconceivable to them. This research therefore makes an important contribution to the evidence base, highlighting the paradoxical and conflicting ideas the women held in relation to recovery and the added complexity that may be present for some women in their pursuit of stopping or reducing self-injury.

Participants described the importance of taking ownership of their recovery which included exerting some control over their self-injurious behaviour. Feeling as though they were taking action or pursuing goals had a positive impact upon self esteem. This reflects findings from the wider recovery literature that highlights the importance of self-agency, (Spaniol, Gagne & Koehler, 1999) drive, (Ochocka, Nelson & Janzen, 2005) and taking charge of life (Piat, Sabetti & Couture, 2009). Self-management of emotions (through developing a repertoire of coping mechanisms and emotion regulation strategies) was also highly regarded by participants and this enabled them to gain some mastery over their self-injurious behaviour, which further strengthened feelings of self-esteem. Although participants felt that the notion of stopping self-injurious behaviour was inconceivable, developing a sense of control over self-injurious behaviour was considered important. This corroborates findings within the current evidence base which emphasise the importance of developing alternative behavioural strategies for coping with psychological distress (Lineham, 1993, Shaw, 2006, Kool et al, 2009). Like-

wise, findings from this study also indicate that the development of a repertoire of coping strategies is an important means of helping individuals exert some control or gain some mastery over their self-injurious behaviour. Although gaining control over self-injurious behaviour was regarded as important element in recovery, it did not define recovery for participants. Recovery was regarded in much broader terms and involved shifts in a number of intrapersonal and interpersonal domains of an individual's life.

Findings demonstrate how sources of support, both personal and professional, can engender feelings of both inclusion and isolation which can impact upon the recovery process for individuals. The importance of support is already well established in the wider recovery literature (Mead & Copeland, 2000). However, a unique contribution of this research is to highlight the importance of social support in fulfilling needs for love, care, safety and inclusion among this population. This research also lends support to an extensive body of recovery research which notes the positive impact of mental health services upon promoting recovery through inclusion and professional relationships offering therapeutic, emotional and practical support (e.g. Mezzina et al, 2006). However, this was balanced with negative experiences of mental health services which engendered feelings of isolation, disempowerment and dehumanisation.

Overall the group of participants interviewed in this study indicated that recovery is a broad and multidimensional phenomenon which has a number of behavioural, emotional and cognitive comments.

Strengths

A review of the literature demonstrated that that no research exists which specifically explores the meaning of recovery for individuals who self-injure. This research has made a unique contribution to the evidence base by addressing this previously unexplored area using a rigorous qualitative design. It has provided an insight into the meaning of recovery and enhanced understanding about the key feature of recovery from the perspective of people who self-injure. Whilst research exists that has explored the process of stopping self-injury (from the perspective of individuals who have successfully stopped self-injurious behaviour), that research failed to elicit the perspective of those who may consider themselves to be in recovery whist still continuing to self-injure; inherent within this literature is the message that stopping self-injury is a valued or defining recovery outcome or indicator for individuals. The current study has made a unique contribution to the evidence base by exploring the notion of recovery from the perspective of participants who still continue to engage in self-injury. Use of an IPA approach was considered well suited to the epistemological positioning of the research question; it enabled the collection of in-depth accounts of lived experiences of recovery and facilitated a detailed consideration of the convergences and divergences across the group.

Limitations

The sample recruited was opportunistic and comprised individuals who were motivated to share their stories; furthermore the sample comprised individuals who attended the same self-harm social support group, so it is possible that participants' perspectives on recovery or self-injury may have converged or been influenced by previous discussions or shared forums within the group. Therefore the sample recruited is not necessarily representative of a population of people who self-injure as a whole and results must be generalised with caution. Although the sample represented a homogonous population comprising individuals with personal experiences of self-injury (who met an operational definition of self-injury proposed by Favazza, 1996) the sample was still very diagnostically diverse and comprised individuals with multiple clinical diagnoses. However, this is typical of research concerning self-injury and reflects the fact that people who self-injure are a diagnostically heterogeneous population (Klonsky et al., 2003; Nock et al., 2008).

Future Directions

It is of note that the sample comprised all female participants, although this was not the original aim of the study. Therefore it would be beneficial to replicate this study on a sample that had greater male representation. Future research may also consider exploring specific attributes of recovery for this population. Due to the neg-

ative treatment experiences which are heavily documented in the evidence base (Pierce, 1986, Cresswell, 2005) and replicated within this study, future work may wish to consider the role that mental health services have been perceived to have played in the recovery process of individuals who have self-injured.

Clinical Implications

This research illustrates the importance of conceptualising recovery as a multidimensional concept that incorporates a broad range of personal and social factors; gaining control of self-injury was considered to be just one of these factors. This has implications for clinical psychology practice highlighting the danger of treatment approaches that prioritise self-injury cessation to the detriment of other indicators of recovery. It is particularly important to highlight this implication given the focus placed on repetition of self-injury as an indicator of treatment outcome across the evidence base (NICE, 2004; Owens, 2010). However, it is noteworthy that gaining control of self-injury was important to participants and should not be underestimated in clinical practice. A greater sense of control or management over self-injury was associated with improved self-esteem and feelings of growth and mastery for many participants, which further reinforced the recovery process.

Developing services that are more recovery orientated (Repper & Perkins 2003) may involve offering an array of support or interventions that facilitate growth and development across the range of recovery domains identified by participants in this study. Clinical psychology could have a large role to play in this; the therapeutic environment presents a context for participants to make sense of their self-injurious behaviour and explore ambivalence around self-injury, discuss issues around self management of distress, acceptance and rebuilding identity.

Conclusions

A paucity of research has explored the meaning or conceptualisation of recovery from the perspective of individuals who self-injure. This research addressed this previously unexplored question by interviewing 6 women who self-injure about their recovery experiences. Findings have illuminated the meaning of recovery, defined its key features and identified factors important in facilitating the recovery process from the perspective of people who self-injure. This research identified the notion of 'the recovering self' which was characterised by shifts in various intrapersonal domains and a struggle to maintain hope despite the setbacks of the recovery process. Participants identified an evolving relationship with self-injury which involved the pursuit of insight and understanding, incongruent and sometimes paradoxical feelings towards self-injury and an urge to take ownership and control of the behaviour. Although gaining control over self-injurious behaviour was regarded as an important element in recovery, it did not define recovery for participants. Recovery was regarded in much broader terms and involved shifts in a number of intrapersonal and interpersonal domains of an individual's life. Such information could be usefully taken forward by mental health services in the pursuit of more recovery orientated services.

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