HARM, INTERRUPTED: SELF-INJURY NARRATIVES AND SAME SEX ATTRACTION

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ABSTRACT

This study addresses a significant clinical and social issue: self-injury among gay men. Self-injury can be understood as any act undertaken by the self to cause physical damage to the body without the conscious intent to die.

The existing self-injury literature tends to focus on self-injury as a problem for women. That is to say, because more women than men self-injure, research focuses more strongly on their motivations and treatment needs. The literature that explores self-injury as it relates to gay men is not well developed and focuses strongly on suicidality and the risks associated with various self-injurious behaviours. This has produced useful information for some areas of practice such as risk management and public health suicide prevention strategies. What this literature has not done is explore the contexts and meanings of self-injury for this particular group.

This study is a narrative inquiry, which explores gay men's self-injury through their experiences in context. This thesis therefore tells the stories of gay men who participated in the study and reveals their self-injury across a landscape of time, context, experiences and interactions. This study sought to address gaps in available knowledge by examining how gay men are self-injuring and what their self-injury means in the context of a life lived in relationship with self and others.

Self-injury for the gay men in this study was enacted, according to their stories, through similar methods to those reported for other populations. The men's stories illustrated how self-injury also helped them to manage their distress and cope with a social world that can be invalidating. Through attending to the similarities and differences in experience, as they are told in the men's stories, this thesis introduces two narratives that shape the way self-injury is known. The first, the harm narrative, is a conventional plotline derived from dominant explanations of the risk, pathology and irrationality of self-injury. This narrative has allowed stories of self-injury to be told and re-told in clinical and social contexts that foreclose alternative readings of an apparently destructive behaviour.

The second narrative presented in this thesis is a moral narrative of self-injury. The moral narrative arises by holding the harm narrative to the margins, while allowing the stories of the men to emerge and be thought about narratively, that is to say their self-injury is viewed as part of a life story that is not simply reduced to harm. The moral narrative for the men in this study operates in two ways. The first is to show how, for some of the men, their self-injurious actions have moral value. The second way is to show how acts of self-injury create moral spaces in which the men are able to experience self-care and caring for others. This moral narrative represents a new way of thinking about self-injury as it occurs and is experienced in context.

The thesis concludes with ideas and suggestions for working with gay men and others who self-injure. The suggestions are that nurses defer immediate risk-based responses in order to allow clients to explore the contexts in which their self-injury occurs in order to prevent care from becoming a risk factor for further self-injury. Recommendations for further research are also made, which expand on the insights regarding self-injury and moral narratives, the health care experiences of gay men who self-injure and how self-injury exists in relationship with masculinity.

STATEMENT OF ORIGINALITY

This work has not been previously submitted for a degree or diploma in any university. To the best of my knowledge and belief this thesis contains no material previously published or written by another person, except where due reference is made in the thesis itself.

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Some of the material from chapters two, four and five has been published in conference proceedings as listed below:

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CONTENTS

PROLOGUE

I became aware of my sexual difference in primary school. For the other boys, boys were whom you played with, fought with and to whom you told stories about what you got up to over the weekend, or last night. My experience was different. I looked at other boys and while they appeared physically like me, I knew we were not the same. I did not understand it and I did not talk about it. Even today, I rarely talk about it.

My childhood years were spent in a small village in the English countryside. The environment was pretty on the outside but there were rules and constraints to living in such a close community. I remember the most prominent message for me as I grew up was that it was not desirable to be different—but I knew I was not like the others, I knew I did not really want to be like the others and I knew enough to be quiet about it.

As a teenager, I remember asking my mother about homosexuality. She said *they* "did it" with each other and winced as she spoke the words. I pushed the issue, wanting to know more because I knew we were talking about me. My mother said that men and women did it the proper way and that two men used their bottoms and she pulled another face. I pulled a face too and said "uugh" to please her. I learned a lesson that day: that it might not be possible to be myself and be accepted by others. As a teenager I became a sort of pretend heterosexual. I kissed a couple of girls and did not really like it. I had little power to express myself fully because to do so would have likely courted trouble in more than one form.

I left my local area after school to become a nurse. Mental health nursing appealed to me as a career because it seemed to offer an opportunity to work with different people. It was as a student of mental health nursing that I first found friends who were unconcerned about my sexual orientation. My friends said things like "I don't see someone who is gay, I just see you". I felt accepted and disconcerted because this seemed to imply acceptance but it could also have meant that the gay part was the part they wanted to ignore—I don't know, but it was better than hiding myself away.

I have been a mental health nurse for many years now and my career has progressed from being a clinician to an academic. I have worked with many people and have experienced a professional life characterised by difference and heterogeneity, yet I live in a world that seems to value and sustain illusions of sameness. I am interested in why this should be when people are different from each other and this difference is, in many ways, shaped by our different experiences.

My first memorable experience of difference in a clinical context occurred when I was working with a young man of eighteen who had been admitted from Accident and Emergency to an acute admissions mental health facility where I was working as a newly qualified staff nurse. I was twenty-two at the time. "Daniel" had taken an overdose of Paracetamol. I worked closely with this young man for two weeks and it was a challenging experience, because I identified with much of his distress.

I was allocated as Daniel's primary nurse. I got to know him over the first week of admission. He was struggling with his suicide attempt being unsuccessful. He said he felt like he had failed, but he also said he had never really expected the attempt to succeed. This struck me as an unusual feeling, and for Daniel the situation simply reflected other perceived failures in his life.

After a week, a nursing assistant noticed two small fresh cuts on Daniel, one on his arm and one on his neck. I asked him about them and he said he had scratched himself in the night. I remember saying that night was a good time to scratch, because things always seem "itchier" in the dark. We talked more about one thing and another. At the end of the conversation he said, "They are not really scratches". I said, "I know" and that we would talk more tomorrow.

The next day Daniel told me he was gay and he apologised for it. He cried and his dread at telling me was obvious. I asked if this had something to do with the overdose and his feelings of always failing. He was not very specific, but said that he had felt depressed for as long as he could remember. Daniel felt alone and freakish; he admitted to drinking too much and trying other ways to harm himself. He frequently used a desk stapler to put staples into his forearm and see how long they

would stay there before the skin became inflamed and irritated. It turned out it was my "itchy" comment the night before that resonated with him.

Despite my identification with Daniel's situation, I still talked to him about issues like depression; I reflected on possible personality problems in ward rounds. I listened to psychiatrists decide which antidepressant would be appropriate. I was a complicit clinician in making his other experiences marginal in the health care encounter.

The next two weeks saw Daniel's self-injury worsen. At its height he used a hardback book to beat himself around the head. He said he felt ashamed and out on a limb. It is the closest I have come to wanting to hold a client and reassure them everything will be okay. I realised Daniel was talking about having exposed his homosexuality. It was the first time he had told anyone and it did not feel good. I felt responsible that there was no relief for him in his "coming out".

This sense of responsibility and if I am honest, guilt, led me to re-think how I responded to Daniel and led me to approach him as one gay man to another. I never disclosed my sexual orientation, but instead allowed that side of me that remembered those early coming out experiences to inform how I cared for Daniel. For example, I took him shopping one day and we visited a small bookshop and looked through some gay books and magazines. In them, Daniel saw a world he did not know about, where same-sex attracted men had a voice, were able to be heard and as a result I think he felt a little less out on that limb.

I was criticised for my actions. I was "spoken to" about the inappropriateness of my encouraging him and the risks of getting "over-involved" with a borderline personality. I listened to the advice of my mentors and regretted that I would not be able to work with Daniel in a way that might nurture his emerging sense of self. After a longer, five-week admission, Daniel was discharged home to his parents, on an antidepressant, appointment card in hand. I do not know what happened to him.

I tell this story for a reason. It is a story about Daniel and it is a story about me, but more importantly it is a story about the relationship that existed between us. Within this relationship, spaces were created in which issues of identity, difference and self-

injury were experienced by both of us. For my part, I experienced these issues as both a gay man and a nurse; this created difficulties in establishing the boundaries of care and in understanding what I should do. In my subsequent career I have not found any information that could guide practice with a gay man who self-injures.

I have reflected on this experience many times and it always brings home to me the power of dominant knowledge and practice to shape the way we understand and do things. I easily succumbed to the notion that Daniel's problems were psychiatric in origin and I was persuaded that medical intervention and nursing distance were the best ways to help him. I also reflect on this experience because while Daniel and I were both gay, his life experiences were different from mine. Daniel felt completely wrong and at odds with himself, whereas I felt at odds with the world, but reasonably comfortable in myself. I think even at that early stage in my career I realised the power of labels, such as gay and even "self-injury", to cover over experience and difference.

As I show you around the world that opens up on the following pages, I cannot simply divorce myself from the words that create this world. I cannot be invisible, an objective narrator, because when you see self-injury through the lens of this thesis, you are also looking at me. All description comes from a standpoint (Connell, 1995) and my standpoint is that of a gay man and a nurse who has looked after many people who self-injure. I bring my past and the experiences I have had with me on this research journey.

My standpoint is further informed by my reflections on how little I knew about how to work with Daniel. The care that I provided back then was intuitive and guided by my connection with my own sense of alienation and disconnection at that age. I still think this helped Daniel, but I am also confident there could be a better way of caring. As a lone voice advocating for Daniel, I also felt out on a limb and this mediated my caring responses. Perhaps the answer lies in a shared approach, in which all members of health care teams understand, at least a little, what it is like to be gay and to hurt yourself.

CHAPTER ONE

THE CONFLICTED LANDSCAPE OF SELF-INJURY

Introduction

This study addresses a significant social and clinical issue: self-injury in one social group, gay men. Self-injury is a complicated and troublesome act. The need to hurt oneself and the ways this need are enacted on the body are difficult to understand and explain. Self-injury motivations and practices vary within and between ages, genders, cultures and locations. For these reasons, self-injury is a contested term (Horrocks, House, & Owens, 2004). Despite increased academic interest in self-injury over the last fifteen years, the study of self-injury in clinical and social settings is still at a fairly early stage and even less is known about the self-injury of gay men.

This chapter argues for the need for research into self-injury in gay men. It clarifies terms, discusses the ways that self-injury is understood, and begins the journey into a contested area of research.

Defining self-injury for this study

Self-injury can be understood as an act of physical damage enacted upon the body without a conscious attempt to die and which is not culturally sanctioned (Hjelmeland et al., 2006; Woldorf, 2005). Attempts to refine definitions and cultural meanings of self-injurious behaviours over time have enabled a more precise focus on *how* people hurt themselves, in turn contributing to the development of effective clinical responses.

Given the many terms used to describe self-injurious behaviour and its relationship with suicide, the use of the term self-injury for this study is shaped by two important factors. First, the self-injurious act itself and second, the reasons that someone might choose to injure their own body. Self-injury is an inclusive term (Adler & Adler, 2005) more commonly used to describe a wide range of behaviours that result in some

form of bodily injury (Hodgson, 2004). One study into adolescent self-injury, for example, revealed that some boys were self-injuring in ways that went beyond activities such as cutting (Ross & Heath, 2002). The term "self-injury" is broad enough to include a wide range of potentially injurious behaviours, which a term like "self-mutilation", implying serious bodily injury, for example, might not.

This study is concerned with difference, which means that there must necessarily be a broad starting point for social inquiry that seeks to develop health care practices. Self-injury in one population may not resemble the self-injury of another. The ways that gay men are hurting themselves might be different to the actions or outcomes of other populations.

Further, this study seeks to facilitate broad and open inquiry into self-injury. Using the term "injury" enables an important distinction to be made. That is, self-injury as an act can be separated from volition, which is implied in the use of the term "deliberate" and also from assumption of harm, which negates the complexity of the act and its motivating and mediating forces. In a study that seeks to be inclusive, with a population whose self-injury has not been theorised, this is an important objective. In this study, the term "self-injury" is therefore used.

Self-injury: A clinical and social phenomenon

A broad approach to inquiry is an important objective because self-injury seems to be about more than just an individual pathology. While self-injury is an act that is shown on the body, there are less visible factors that shape how it is enacted. These factors may also influence what self-injury means in the context of a wider community and how it can be understood. As a part of the social world concerned with care and healing, nurses are in the position of needing to respond not only to clinical presentations but also to those other factors that give rise to individual harm. For nurses as well as those who use health services, self-injury is therefore a social as well as a clinical issue.

If nurses are going to respond effectively to the needs of people that self-injure, it is important to understand the social complexities that propagate self-injury. If nurses persist in thinking about self-injury purely in clinical terms, social nuances that provide helpful insights might be missed. Current research and practice agendas, driven as they are by rationalist discourse that emphasises efficiency and individual outcomes over effectiveness and care (McDonald, 2005), favour developing clearer pictures of who is self-injuring, where and how, in order to reduce and manage risk and promote harm reduction (Sharry, Darmody, & Madden, 2002).

Prevalence figures vary, but Favazza (1989a) suggests that around 1.4 percent of non-clinical populations self-injure. Briere (1996) places the figure closer to 4 percent in the general population and up to 13 percent in clinical populations. In terms of gender distribution even though self-injury is believed to affect women more than men (Lambert & de Man, 2007), the actual figures remain unknown (Woldorf, 2005) and some studies have failed to find significant differences between genders (Hjelmeland et al., 2002; McAuliffe, Arensman, Keeley, Corcoran, & Fitzgerald, 2007). Adolescence particularly is theorised as a turbulent time for both females and males (Cerdorian, 2005; Kumar, Pepe, & Steer, 2004; Ross & Heath, 2002) and incidents of self-injury in adolescents have risen over the last ten years (Williams & Bydalek, 2007). Approximately 5 to 9 percent of adolescents are believed to self-injure, and around 5 percent of those who receive treatment for their self-injury commit suicide within nine years (Skegg, 2005).

These estimates are likely to under-represent actual prevalence because people who self-injure often hide it from family, friends and carers (Rodham, Gavin, & Miles, 2007; Van der Kolk, Perry, & Herman, 1991; Vivekananda, 2000). If gay men experience turbulence during their sexual awakening, then prevalence of self-injury in this group may be similar, or perhaps greater than heterosexual adolescents, considering the compounding marginalising effect of being in a sexual minority.

Prevalence of self-injury in gay men

There is some variation in the statistics about self-injury in gay men. Inclusive of psychiatric co-morbidities, estimates of the prevalence of self-injurious behaviours in gay men range from 48.8 percent with the intention to die to 14.6 percent for non-suicidal self-injury (de Graaf, Sandfort, & ten Have, 2006). An earlier review of the suicide risk-factor literature suggests that 31 to 63 percent of gay men have attempted suicide (Brown, 2002), albeit with varying degrees of intent to die. Elsewhere in the literature, gay people are estimated to be four times more likely to self-injure (Bagley & Tremblay, 1997) and seven times more likely to attempt suicide (Cochran & Mays, 2000) than the general population, and as having actual suicide attempt rates at between 20 and 42 percent (D'Augelli & Hershberger, 1993; Gibson, 1989; McKee, 2000; Ramafedi, Farrow, & Deishner, 1991). It is estimated that around 50 to 60 percent of same-sex attracted people have experienced thoughts of wanting to die and have related these thoughts to their sexual orientation (D'Augelli, Hershberger, & Pilkington, 2001; Gibson, 1989).

These are concerning figures. However, a significant problem with the above statistics is that distinctions between suicidal ideation, suicidally motivated acts and self-injury are not well made. Thus it is sometimes unclear quite what many of these studies address. In many cases it appears that apparent self-destructive behaviours are being uncritically subsumed under the banner of suicidality.

What these figures suggest is that it is likely there are people in distress, living in communities, engaging in self-injury and not accessing support services. Furthermore, there are groups of individuals, such as gay men, whose self-injury is not well understood. Currently, gay men's self-injury is strongly tied to suicidal motivation within the literature (Mathy, 2004; Rivers, 2000). That is to say, almost all exploration of self-injury as it applies to gay men, occurs in the context of suicide research. Self-injury as a phenomenon distinct from, although in relationship with suicide is thus currently poorly understood in this population because other factors that might influence self-injury in gay men have not, to date, been explored. This

study therefore contributes to discourse on how self-injury is understood and enacted in gay men, which can help facilitate responsive, individualised health care.

There is good reason to move beyond delivering unresponsive or standardised care. Self-injury is a significant health issue that demands effective care and intervention. There are economic and human suffering outcomes of self-injury (Morgan, 2000), making it an important social issue. Self-injury makes a substantial contribution to global mortality (Parkar, Dawani, & Weiss, 2006) and non-fatal self-injury is one of the strongest predictors of suicide (Gunnell & Bennewith, 2005). In a study of 11,583 people who had self-injured and presented to a UK Accident and Emergency department over a nineteen year period, 300 died as a result of suicide or probable suicide (Hawton, Zahl, & Weatherall, 2003). The researchers in this study suggest there is a persistent and significant risk of suicide following self-injury.

How self-injury is represented

A study that offers a picture of how self-injury is occurring in a given group of people is valuable because self-injurious or harmful behaviours are called a variety of things and terms to describe self-injury have changed over time. Therefore, what self-injury looks like and how it is enacted is likely to be different between groups and over time. Despite its prevalence in clinical populations (Briere, 1996) and its increasing social profile (Brickman, 2004), self-injury is a clinical and social issue that resists definition (Horrocks et al., 2004). There are many working terms for self-injury but there is considerable conceptual variation in how self-injury is understood. For example, self-harm, self-injury, self-mutilation, attempted suicide and parasuicide are terms that are often used interchangeably (Kreitman, 1977; Shaw, 2002), yet they seem to imply different meanings, motivations and acts.

This lack of clarity impedes research and treatment (Kehrberg, 1997). There is no universally agreed definition of self-injury (Clarke & Whittaker, 1998) and no agreed terminology to describe what are a wide range of actions, motivations and consequences (Ross & Heath, 2002). As a result, research aims to understand self-injurious behaviour rather than understand the people who live with and enact it.

Despite the likely wide range of aetiologies, motivations and consequences (Faulconer & House, 2001), self-injury tends to be thought about in two broad ways: as self-destructiveness or as a way to cope with distress and survive.

Self-injury as self-destructiveness

Before self-injury was considered to be distinct from suicide, three domains of suicidal-type behaviour were classified by Beck et al. (1973): completed suicide, attempted suicide and suicidal ideation. Conceptualising suicidal-like behaviour this way provided a framework for clinicians to refine investigations into behaviours that seemed purposefully self-destructive. Beck's (1973) model, however, directs attention towards acts of completed suicide, acts of attempted suicide or to thoughts about suicide. In each instance the topic of interest is the suicide or the self-injury that might be enacted in pursuit of self-destruction. Subsequent clinical inquiry into self-injury has provided insights into the various acts and motivations of certain groups of people who self-injure. Despite evolving disciplinary knowledge about self-injury, there remains a lack of clarity regarding the relationship between self-injury and suicide.

Even though self-injury is now considered a different act from attempted suicide, they are not mutually exclusive; rather, it seems there is a relationship between the two. Those who self-injure can also be suicidal and for some people, self-injury may be about ending life rather than trying to preserve it. For this reason, self-injury and suicidality are sometimes represented as points on a continuum upon which people with self-destructive propensity vacillate (Pearce & Martin, 1994; Stanley, Gameroff, Michalsen, & Mann, 2001; Vermeiren, Ruchkin, Leckman, Deboutte, & Schwab-Stone, 2002). This notion of a continuum seems helpful because it enables different motivations for self-injurious acts to be acknowledged as well as recognising the relationship between self-injury and suicide.

Methods used in self-injury and suicide are sometimes similar (Rayner & Warner, 2003), but self-injury and suicide present different clinical problems and it is generally accepted that attempted suicide is about death, whereas self-injury is not

(Gladstone et al., 2004). Even so, there is a relationship between the acts and self-injury is a significant predictor of eventual suicide (Comtois, 2002; Hawton et al., 2003; Owens, Horrocks, & House, 2002). The risk of eventual suicide for those who self-injure is in the region of thirty times that of those who do not (Cooper et al., 2005). Despite the notion of the continuum, the relationship between self-injury as suicide is further complicated by social factors. Behaviours that are self-injurious and behaviours that are suicidal seem to differ between social groups, making distinguishing self-injury from suicide a "hazardous clinical task" (Holdsworth, Belshaw, & Murray, 2001, p.451).

Being able to separate self-injury from suicide is an important clinical task, because therapeutic responses to self-injury differ from therapeutic responses to attempted suicide. In Chapter 2, I review the self-injury literature as it pertains to gay men, showing that for this group, the suicide/self-injury nexus is not well understood. Poor understanding about the purpose of an apparently self-destructive behaviour, perhaps leads clinicians to "play it safe" and focus interventions towards safeguarding what is perceived to be a vulnerable body, over responding effectively to non-suicidal self-injury (Estefan, McAllister, & Rowe, 2004).

Self-injury to survive and cope

There is also a non-suicidal element to acts of self-injury. A non-suicidal element to self-injury means physical vulnerability might not be as important as emotional vulnerability or distress. In self-injury, the self perpetuates physical vulnerability, whereas emotional vulnerability is brought about, in part, through an individual's response to social living.

Three types of non-suicidal self-injury tend to dominate the literature on self-injury in western culture. First characterised by Favazza (1989a; 1989b) and Favazza & Rosenthal (1993) under the broad rubric of "self-harm", they are major self-harm, stereotypical self-harm and superficial self-harm. These differing types of self-injury open up the possibility of a multitude of motivations and mediating factors affecting the act of injuring the self that goes beyond the suicide paradigm.

Major self-harm, such as attempted self-amputation, is vivid, serious, sometimes life threatening and often equated with, although is not exclusive to, psychosis (Symonds, Taylor, Tippins, & Turkington, 2006). Stereotypical self-harm involves repetitive forms of injury like head-banging, skin-biting and eye gouging and is often seen in individuals with learning disabilities and metabolic disorders (Favazza & Rosenthal, 1993). Superficial self-harm includes diverse self-injurious acts, such as cutting, burning and inserting objects into body orifices which can, at times, have serious physical consequences (Ang & Chee, 2007). Such acts are performed for a variety of motivations, such as to relieve tension (Huband & Tantam, 2004; Skegg, 2005), to claim ownership of the self (Austin & Kortum, 2004; Reece, 2005), and to make things happen (Brockman, 1999; Dear, Thomson, & Mills, 2000).

These behaviours occur in social contexts. Suyemoto (1998) undertook a comprehensive review of the self-injury literature and proposed six functional models for self-injury that help to explain how it becomes embedded as both a social and individual body practice through engagement in social environments. In this way, self-injury becomes a form of self-control (Rayner & Warner, 2003) as well as a way to cope (Hodgson, 2004) and manage confusion and symptoms like depression and anxiety that arise when the demands of social living exceed personal resources (Warm, Murray, & Fox, 2002).

Self-injury can be a way to express emotion (Chapman & Dixon-Gordon, 2007) and self-injury can also help a person to escape unwanted emotion as it arises (Crane et al., 2007). Self-injury can also help to escape traumatic experiences, or, conversely to ground the self in the body (Gratz, 2003; Huband & Tantam, 2004; Klonsky, 2007; Saxe, Chawla, & Van der Kolk, 2002). Self-injury can therefore be variously thought of as a way of either confirming the existence of the self, or as a means to be able to escape the reality of the self. Where self-injury is being used in this way, the needs of the environment are also met because distress is contained within the person who self-injures (Suyemoto, 1998) and that individual becomes the owner of the apparent dysfunction.

Adding a level of complexity, the need for some to be able to distinguish between themselves and others can also provide a motivation to self-injure. An interpersonal view of self-injury (Suyemoto, 1998) explains how self-injury helps to create social boundaries and social identity. Clarification of boundaries and identity occurs in relationship and these relationships based around self-injury are not problem-free. Where individuals experience themselves as fragile, self-injury can become a means to gain and communicate strength, thus mitigating the fragile self (Straker, 2006). Such a motive is not always clear to those exposed to the self-injury and misunderstandings can lead to tension and invalidation (Linehan, 1993).

Two distinct ways of understanding self-injury emerge: first, a response to and means to control an internal state of distress or dysfunction and second, as an act that occurs in and is shaped by the social world of the person who self-injures. The former perspective dominates and provides the basis for most research and conceptual work. The latter perspective is less developed. Taking self-injury to be an internal problem for individuals means research undertaken by nurses and other health professionals predominantly focuses on trying to develop responses and treatment.

Embedded within existing frameworks for thinking about self-injury are the ways people live with and have talked about their self-injury. Recognising self-injury as a means of coping means that people have talked not only of distress and dysfunction but also of surviving in a world that may not celebrate or affirm. Attending to different accounts of self-injury may create new knowledge about living with difference and self-injury that helps communities, nurses and other health professionals to respond empathetically and helpfully.

Significance of this study

Self-injury, sexuality and sexual orientation are social as well as individual phenomena. An exploration of self-injury in gay men promises to reveal further knowledge about the social nature of self-injury. Such a venture can both complement and advance clinical perspectives, which sometimes find it hard to find answers to self-injury problems (Clarke & Whittaker, 1998). Specifically for this study, inquiry

into the practices of gay men who self-injure will illuminate insights into how gay men are managing their bodies while in distress, which has not, to date, been fully explored.

Gay men are a sexual minority and minority status complicates the lives of many gay men. Gay men may have unique experiences of being marginalised or outside of the mainstream that make coping challenging. Some gay men seem to be signalling these complications through their bodies and this powerful language may be misunderstood or unheard. At an extreme for example, some young gay men commit suicide (D'Augelli et al., 2001). Others do not but they still require sensitive, effective responses from the health professionals from whom they might seek help. Currently there is little evidence to inform clinical interventions with gay men who self-injure and thus responses may be culturally inappropriate, insensitive and ineffective.

The self-injury of gay men is likewise under-explored in the extant literature and current women-centred perspectives may be limited in their applicability to self-injury in a male population. This means that current knowledge/practice in healthcare presents a problem for gay men. If there is little or no knowledge of what self-injury means to gay men then how to respond safely or effectively to this population will remain unclear. In the short-term, sensitive, empathetic and appropriate health service provision will be unattainable for gay men.

If existing knowledge/practice regarding self-injury is inadequate or underdeveloped, then some types of self-injury enacted by certain groups remain covered over and possibilities for caring responses are foreclosed. There is scant research on men's self-injury and research focuses predominantly on the pathogenesis of women's self-injurious behaviour (Gratz & Chapman, 2007). A recent study suggests that even though clinical self-injury seems more common in women, sub-clinical self-injury occurs equally in women and men (Croyle & Waltz, 2007). The types of self-injury that men use seem to require further study.

Conclusion

I have argued that self-injury is currently presented as a clinical and social problem: that is, as either self-destructiveness or as a way to cope with and manage distress. Self-injury is a complex and contested area of academic and clinical understanding. Further, little is known about how gay men self-injure. I have opened up the possibility that self-injury can and needs to be thought of in different ways in order to extend understanding of self-injury and develop effective responses for people who seek help for their self-injury.

Thesis structure

This thesis is presented in six chapters. Chapter 1 has established the parameters for inquiry and introduced the significance of research into self-injury with gay men. Chapter 2 reviews the self-injury literature and establishes a conceptual framework around which the study is built, leading to specific research questions. Chapter 3 outlines the research methodology and situates narrative inquiry as an appropriate research method. Chapter 4 presents the stories of the men who participated in the research, and Chapter 5 discusses the theoretical relevance of their experiences to contemporary self-injury knowledge and practice. Chapter 6 concludes the thesis with reflections and suggestions for practice and further research.

CHAPTER TWO

THE VOCAL AND MARGINAL VOICES ON SELF-INJURY: CURRENT KNOWLEDGE

In this chapter, extant literature is reviewed in three parts. First, the research and clinical literature that has shaped understanding and treatment of self-injury is reviewed. This leads to a review of the literature that places self-injury and those who enact it within risk frameworks. Second, the specific risk factors for gay men are discussed. Finally, a difference lens is applied to critique existing self-injury literature to reveal how self-injury is associated with three areas of difference that are pertinent to this study: life-stage, locale and social position. This chapter attends to the way that people who self-injure are represented and understood, to show how certain types of self-injury knowledge are permitted and how other possible ways of understanding it remain marginal. This establishes a conceptual framework for the study. This chapter concludes with questions for research.

From cause and symptom to treatment

A major purpose for research into self-injury is to diagnose a problem, establish risks, and discover ways to respond to and treat the behaviour and its underlying pathology. Consequently, one focus for the treatment episode becomes the identification of an underlying psychiatric disorder (Isacsson & Rich, 2001). In chapter one, I have illustrated how self-injury is a complex phenomenon with multiple causes and explanations that render a psychiatric explanation alone simplistic. Despite the identification of a plethora of possible causes of self-injury, the treatment literature remains limited and little is known about how best to respond (Cumming, Covic, & Murrell, 2006). One result of this is that the person who self-injures is understood as a clinical risk.

In the context of the current impetus towards “gold standard” evidence in the form of meta-analyses and patent experimentation, no “good” evidence exists for either

pharmacological or psychological interventions for self-injury (Gough, 2005; Repper, 1999; Walling, 2002). Such a limitation also extends to the provision of general treatment guidelines (Muehlenkamp, 2006). Despite there being no definitive treatment approach, the literature offers some suggestions of ways to respond to people that self-injure.

Group therapy that blends Cognitive Behaviour Therapy (CBT), Dialectical Behaviour Therapy (DBT) and psychodynamic approaches for adolescents has shown some promise in randomized-controlled trials, over routine care (Wood, Trainor, Rothwell, Moore, & Harrington, 2001). Spirito (2002) agrees that there is evidence group therapy can be helpful for adolescents. Brief Interpersonal Therapy, Problem-based Therapy and DBT have been shown to be effective with a wider range of age groups (Hawton et al., 1998; Hepp, Wittmann, Schnyder, & Michel, 2004; Reith, Whyte, & Carter, 2003; Repper, 1999).

Responding to self-injury also involves attending to co-morbidities such as mood and personality disorders. In this regard, merit for the use of brief therapies (Walling, 2002), particularly for depression is clear, but some treatment approaches, such as group therapy, that target self-injury are less effective in reducing co-morbid mood disorders (Wood et al., 2001). Palmer et al. (2003) studied the effectiveness of an eighteen-month DBT program for people with eating disorders and Borderline Personality disorder. At the end of the program, no participant was self-injuring or showing signs of eating disorder. The authors support the notion that DBT is effective in treatment but call for further research.

A randomised-controlled trial to assess the effectiveness of Brief Psychodynamic Interpersonal Therapy showed that four sessions were effective in reducing suicidal ideas and repetition and increased client satisfaction (Guthrie, Kapur, & Mackway-Jones, 2002). It has been proposed that Manual Assisted Cognitive Behaviour Therapy also benefits clients, with the added advantage of likely being more cost-efficient than standard care (Goldney, 2004). Depot Flupenthixol and Paroxetine also may assist in reducing repetition of self-injury and treating co-morbid mood disorder (Hawton et al., 1998; Reith et al., 2003).

One approach that runs contrary to established care practices is the use of Relationship Management Therapy (Hoch, O'Reilly, & Carscadden, 2006). This approach returns ownership and control to clients, who select their own treatment. This model involves the use of a brief period of discharge where self-injury occurs or is threatened, thus circumventing the otherwise predictable escalation of events that often follow an episode of self-injury in inpatient environments (Hoch et al., 2006). This approach shows how doing something different creates new possibilities for helpful responses and services.

In summary, the findings of meta-analyses and studies of treatment efficacy are gained from research that individualises the problem of self-injury. The result is a body of literature that locates self-injury as a problem that exists within people, rather than as a social issue. There is, however, reason to attend to social issues, because treatment based on what little is known about self-injury is not always successful, is sometimes traumatising for the client (Anonymous, 2006; McAllister, Creedy, Moyle, & Farrugia, 2002) and the nurse who cares for them (Deiter & Pearlman, 1998; Hemmings, 1999; Holdsworth et al., 2001; Huband & Tantam, 2000).

Ongoing problems in treatment mean that care is not always empathetic or effective, resulting in an emotional and financial cost. Mental health nurses are often a significant resource for people who self-injure, so it is important that these nurses grasp the social as well as clinical implications of self-injury (Santa Mina et al., 2006). For gay men, it may be that they bear a dual stigma: socially, by being gay and clinically as someone who self-injures and whose self-injury issues are not recognised or understood.

While the existing self-injury research goes some way towards establishing the hopefulness of various approaches, the focus remains mainly on women and the purpose seems to be to accurately assess and respond to risk by reducing the frequency of self-injury. Minimising reliance on a distressing coping mechanism is an important objective for care, but it is also important to balance this agenda with one of understanding and exploration of issues relevant to the client (Gough, 2005).

Risk as a means of understanding self-injury

The current literature relies heavily on a risk model to frame discussions of interventions for people who self-injure (Reith et al., 2003), a model that shapes current self-injury knowledge. Notions of the risky client possibly go some way to increasing nurses' anxieties about providing safe and effective care (Clark, 2002). In this situation, care might be directed towards reducing nurses' anxieties rather than interpreting the client's self-injury. The risk model seems to lead to a conceptual and interventional stalemate because the sole criterion of success in interventions based on risk-based understanding and care is a reduction in self-injury over time.

Despite the pervasiveness of the risk discourse, the literature points to different ways of responding helpfully. Solution-focused approaches, which give control to the client, foreground strengths and return hope (McAllister, 2006; Sharry et al., 2002), are one way of acknowledging risk but not making it the defining characteristic of care. At present, solution-focused or salutogenic (Horsfall, Stuhlmiller, & Champ, 2001) models of self-injury care and response remain underdeveloped in the clinical literature.

Social risk factors

In some instances, even though people who self-injure are communicating loudly through their bodies, health care providers do not always hear the message (Straker, 2006). The focus on internal pathology means that many social risk factors can be overlooked in care. A recent review of the risk-factor literature clearly points to environmental as well as individual risks (Gratz, 2003). The relationship between environmental risk and individual self-injury is less well theorised. Gratz (2003) suggests further research on the interaction between environmental and individual factors. Specifically, for gay men, little is known about how individual/social interaction may shape and increase vulnerability to self-injury or, conversely, confer resilience that negates its use.

The literature does offer insights into factors that may affect self-injury for some people. For example, Newman and Stuart (2005) conducted an ecological study to determine whether the differences in parasuicide rates between two Canadian districts could be explained by socio-demographic issues. They found that social disadvantage confers risk. An internet survey of people who self-injure found that factors like difficult family relationships, bereavements, physical and sexual abuse can increase risk of self-injury (Murray, Warm, & Fox, 2005). It is likely that these or other social stressors feature in the lives of gay men, but the role they may have in gay men's self-harm is not known.

Individual risk factors

It is not possible to neatly dichotomise social and individual risk factors, because they are mutually informing. For example, a study of 136 Turkish men who used alcohol and other drugs, found a relationship between drug use, self-injury and childhood sexual abuse (Evren & Evren, 2005). This study suggests interplay between internal and external motivators for self-injury. Similarly, in a large scale study of self-injury presentations to a general hospital, men who lived alone and used alcohol were at risk of self-injury (Hawton, Harriss, Simkin, Bale, & Bond, 2004). Here, it seems that the social risk of living alone is somehow in relationship with the individual risk of alcohol consumption.

Sometimes, individual risk factors for self-injury are less visible because they might be socially sanctioned. The existence of an association between regular smoking and suicidality was tested in a study of 157 young people aged twelve to seventeen. The authors found a three times greater risk of self-injury in smokers (Makikyro et al., 2004). A recent study that explored the relationship between alcohol consumption and self-injury in adolescents found that intoxication with alcohol is associated with self-injury (Rossow et al., 2007). Smoking, drinking and using recreational drugs increased the risk of suicidality in gay men in a small study conducted by Fordham (1998). In gay recreational spaces, these risk factors may themselves represent a form of self-injury but smoking, alcohol and recreational drug use might not be able to be

understood as self-injury so distress may be misinterpreted and unable to be risk assessed.

The invisibility of gay men's risk is significant because some authors advocate that care be targeted towards those most at risk in order to reduce repetition and suicide completion rates (Barr, Leitner, & Thomas, 2005). If some types of self-injury and experience are going unheard, then care might not be appropriately targeted. Such a position may serve the interests of some groups more than others. Although the risks of and for self-injury are well documented in some populations (Skegg, 2005), in others they are not. The desire of governments and institutions to reduce self-injury means that services might be targeted to those perceived to be at greatest risk such as women and adolescents, while in other, more silent populations like gay men, distress, self-injury, resilience and ways of coping remain neglected.

Factors that mitigate risk of self-injury

Just as it is important to identify risks in relation to self-injury, so uncovering and exploring protective factors is equally important (Guttierez, Osman, Kopper, Barrios, & Bagge, 2000; Skegg, 2005). Exploring the ways that people negotiate distress or adversity allows insight into coping and resilience and provides options for care that go beyond conventional problem solving (Walsh & Moss, 2006). In other words, it helps nurses to begin to inquire about more than what is going wrong with a person. Such an approach is one way to give voice, expose and respect personhood and develop an understanding of an individual's unique experience (Walsh, 1999).

It appears that cultural factors play a mediating role in self-injury, explaining why there are variations in rates of self-injury (Skegg, 2005). One significant protective factor that features in the literature is ethnicity. Gutierrez, Rodriguez and Garcia (2001) studied undergraduate students to test factors that contribute to suicidal ideation in young people. Black students were less likely to experience suicidal ideation than white students. Another study that assessed risks in young people found that self-injury was less common in South Asian than white women (Hawton, Rodham, Evans, & Weatherall, 2002).

The dynamics of group membership is one way to explain how minority ethnicity might offer some protection or resilience to self-injury. Suicide, for example, is related to the relationship between individual and society, particularly where an individual is isolated from society (Durkheim, 1897). Therefore, group membership, such as family togetherness (Webb, 2002) is one way to increase resilience to self-injury (Kay & Francis, 2006). Self-injurious thoughts are common among young people, but they do not always act upon them (Beautrais, 2003). It is feasible that thoughts of self-injury are tempered and mediated by a person's relationships and connections in-situ. Thus, locality as well as group membership seems to be an influencing factor (Neeleman, Wilson-Jones, & Wessely, 2001).

A number of individual resilience factors might arise for a person who is geographically well situated and interpersonally connected. An internal locus of control, self-esteem and self-efficacy, good social supports, close family relationships and spiritual faith can all protect against self-injury (Beautrais, 2003). Many of these areas are problematic for gay men who do not always experience "fit" with their environments. This means that known resilience factors may be compromised in this group. It remains to be discovered what other protective factors gay men might utilise to manage the need to self-injure.

Risk factors for men who self-injure

The idea that self-injury is a female problem is misleading and there is evidence to the contrary. The impression that self-injury is a women problem serves to create myths about self-injury (Warm, Murray, & Fox, 2003) as well as perpetuate myths about the psychopathologies of women (Hart, 2007). A large-scale study that reviewed admissions to an Accident and Emergency department over a twenty-three year period revealed more men cut themselves than women (Hawton et al., 2004). The literature further reveals specific risk factors associated with male gender. Men sometimes manifest distress externally in forms such as violence that make self-injury as a motivation seem unlikely (Vermeiren et al., 2002). Alternatively, men might manifest their intrapersonal angst in the form of a physical complaint, meaning that

intrapsychic problems are missed by clinicians (Brownhill, Wilhelm, Barclay, & Parker, 2002).

The difficulties for men who self-injure are compounded by a higher risk of eventual suicide (Walker, 2003). The risk of self-injury that culminates in eventual suicide is increased when substance abuse as part of the self-injury picture (Suominen, Isometsä, Haukka, & Lönnqvist, 2004). Men tend to delay seeking help, for health care issues (Brownhill et al., 2002), and even those men who seriously contemplate suicide have been found to be less likely than women to ask for help (Mishara, Houle, & Lavoie, 2005).

Treatment may also be a risk factor for some men who self-injure. A small qualitative study with five men who use mental health services found that men reported poor experiences with treatment (Taylor, 2003). The men reported that self-injury was ignored and they received poor assessment and care in Accident and Emergency departments. The men also reported that they disliked feeling like subjects of the psychiatrist's power, but felt more positive with professionals who got to know them as people. Poor treatment, or the anticipation of it, may be one factor that prevents men who self-injure from seeking help. In health care, gay men sometimes experience prejudice, and have difficulty accessing non-judgmental services. Understanding gay men's self-injury can perhaps go some way to removing some of the misunderstanding, homophobia and negative treatment that are experienced as features of care for people who are same-sex attracted (Alexander & Clare, 2004). This is important in being able to meet the needs of gay men who might anticipate that sexual orientation-related health needs, like self-injury, might not be able to be addressed.

Another possible explanation for non-help-seeking in men is that the taboo of self-injury is probably greater for men (Taylor, 2003). There are social conventions about what behaviour is properly masculine (Connell, 1995) and men who do not conform to their prescribed gender role can experience abuse (McAndrew & Warne, 2004). Self-injury thus becomes a problem for men in two ways: first, it is incorrectly seen as a female issue and second, it implies that the man is in some way failing in his masculinity by violating the imperatives of being strong, resilient and stoic.

The masculine ideal is formed within the multiple discourses and social practices that construct hegemonic masculinity (Connell, 1995). Empirical research shows a relationship between gender-role conflict and self-esteem (Szymanski & Carr, 2008). Hegemonic masculinity prescribes what behaviours are properly masculine and is thus a self-injury variable that might constrain or adapts men's self-injury, by prescribing certain ways to contain and express distress that are not seen in female populations. If this is the case, then self-injury needs to be thought about differently with men. Because gay men are outside of the conventions of normative masculinity, their self-injury also needs to be considered in ways that are sensitive to difference.

For Taylor (2003), it is important to understand the intent behind men's self-injury, because it is sometimes drastic and violent (Vermeiren et al., 2002), which is rarely the case with women's self-injury. Lethality and high suicidal intent are correlated with male gender. Haw, Hawton, Houston, & Townsend (2003), suggest that sometimes, male deliberate self-injury can be understood as suicidally motivated. Taylor (2003), however, argues that some self-injury undertaken by men is subtle and for this reason less visible than traditional conceptions of what constitutes a self-injurious act. Supporting the idea that some male self-injury is hidden, a population-based study, found that more men than women engaged in more obscure forms of self-injury that were not considered conventional by traditional diagnostic criteria (Skegg, Nada-Raja, & Moffitt, 2004).

These findings raise questions about the appropriateness of current self-injury knowledge that is used in practice with men. Gaps and silences in the current literature suggest that there may be many different forms of self-injury that are being enacted and going unnoticed. Furthermore, while it is possible to speculate about the likely presence of as unrecognised self-injury in men in general, such speculation is more difficult for gay men. Men's voices generally are marginal in self-injury debates and for this reason it is important that research into gay men's self-harm does not seek to eliminate the heterosexual voice, but rather to add to it (hooks, 2003). However, because gay men remain significantly under-represented in the self-injury literature an important objective for research seems to be to find a way to advance knowledge

about how gay men are self-injuring and how they are describing their experiences of self-injury.

Same-sex attraction as a risk factor for self-injury

In one of the very few pieces of research that specifically addresses self-injury (not suicide) and sexual orientation, it was found that for men, even transient same-sex attraction can prompt self-injury (Skegg, Nada-Raja, Dickson, Paul, & Williams, 2003). Other researchers argue that rates of self-injury are disproportionately high among gay men (Alexander & Clare, 2004), although self-injury and suicidality are not well differentiated in many of these studies. An internet survey of people who self-injure found more bisexual respondents than estimated for the general population (Murray et al., 2005).

There is some evidence, then, which points to a relationship between same-sex attraction and self-injury. That is to say, same-sex attraction might increase the risk of self-injury and suicidal ideation (Fergusson, Horwood, & Beautrais, 1999). Fordham's (1998) small study found that gay and bisexual men were twice as likely as heterosexual men to consider suicide. Furthermore, among same-sex attracted people, males are more likely to consider suicide than females (Skegg et al., 2003).

Promiscuity, in itself, may not be commonly thought of as a form of self-injury but promiscuity in some men seems to function similarly to self-injury in other populations (Taylor, 2003). This is something that might have relevance for gay men. A study of 174 African American gay and bisexual men demonstrated a link between gay identity, social distress and increased sexual risk-taking (Crawford, Allison, Zamboni, & Soto, 2002). Another study surveyed of 513 men to explore the relationship between sexual compulsivity, internalised homophobia and sexual risk-taking (Dew & Chaney, 2005). This study showed a relationship between moderate sexually compulsive behaviour and increased risk-taking. Risk is further revealed in men who do not form monogamous same-sex relationships, but rather seek multiple sexual partners—perhaps because they cannot disclose their sexual orientation (Lisotta, 2004). As well as being an expression of desire, sex can therefore become a

form of self-injury in itself. A person may engage in promiscuous and unsafe sex (Dew & Chaney, 2005; Lisotta, 2004; Taylor, 2003) or participate in painful or even injurious sadomasochistic sexual activity in order to self-injure.

It has been suggested that same-sex attraction be considered a risk factor for mental distress (McAndrew & Warne, 2004). Since the cause and effect relationship between sexual orientation and mental health is mediated by numerous social factors, such a statement is perhaps rather simplistic. All acts of self-injury need to be placed in their social context (Alexander & Clare, 2004). If the self-injury of gay men is to be explored, then this requires acknowledgement and deconstruction of the role of gay men's social worlds.

In summary, the risk literature provides a lens through which individual self-injury can be understood. The risk literature, while accounting for some social features of self-injury, engages the problem as it is located within the person and attempts to explain how to reduce risk or treat a problem. The risk model thus presents a particular picture of self-injury that is useful in certain situations but it does not offer a complete picture. There may be merit in deferring interest in the person who self-injures as the central point of inquiry and attending closely to the social nature of self-injury. Doing so acknowledges the person in context but does not make the person who self-injures the central point of inquiry. Part of minimising risk is creating standards for care that reduce it. It is important to bear in mind, however, that standards appropriate to one group may not be appropriate or helpful for another.

There seems to be a need for differing interventions or responses for different groups, which grow out of understanding different self-injurious motivation, intent and need. The voices of men, and gay men in particular, remain silent in relation to treatment. In order to achieve an inclusive understanding of self-injury, different voices need to be heard in the genesis/causes and treatment literature, in order that individual needs are met.

Self-injury in gay men: Current knowledge

Studies that are conducted to examine risks and factors involved with self-injury often consider multiple perspectives, yet neglect sexual orientation as a possible issue. In a longitudinal study of referral patterns of people who self-injure for inpatient psychiatric hospitalisation, Carter et al. (2006) consider multiple risks for self-injury but ignore the issue of sexual orientation altogether. A large-scale study comparing the characteristics of those who self-injure by cutting to those who self-injure by overdose also ignored sexual orientation as a characteristic (Hawton et al., 2004). Unsurprisingly then, it is suggested in the literature that health carers may feel ignorant about responding to issues of sexuality/sexual orientation and self-injury, leaving the client feeling at risk of prejudice (Vernon, 1996). Developing knowledge about the self-injury/sexual orientation nexus is one way to begin to transcend obstacles to care. Therefore, a study that explores self-injury in the context of sexual orientation as lived can contribute to knowledge and practice in this area.

This objective is significant because gay is a cultural and social category that mediates health experiences (Boehmer, 2002). Self-injury is a culturally embedded practice and so gay men who self-injure are caught in a double bind. They may not only bear the burden of the stigma that is associated with gay lifestyles, but also the burden of stigma attributed by society and health care providers to the person who self-injures (Adler & Adler, 2008; Slaven & Kisely, 2002). If the stigma of self-injury alone is considered a barrier to effective care, the combined stigmatisation of being gay and someone who self-injures may further complicate access to appropriate care.

People who experience internal conflict over their sexual orientation might engage in varying forms of self-injury (Nakaya, 1996). Sexual orientation is an issue over which individuals can experience conflict, because sexual orientation requires expression, yet that expression can be constrained by the communities in which people live. Gay men are often made invisible in communities through various social discourses and practices which can lead to depression, low self-esteem, withdrawal, reduced acceptance of self and shame (Brown, 2002; Gutierrez et al., 2001).

Non-consensual sexual activity as children is associated with an increased prevalence of psychological disturbance in men, of which self-injury may be one manifestation (Coxell, King, Mezey, & Gordon, 1999). This is a connection shared with women victims of childhood sexual abuse. Consistent with the self-injury literature about other groups, gay men report childhood abuse as a factor in their self-injury. Adam, Sears and Schellenberg (2002) found that some gay men who had been sexually abused in childhood injured through unsafe sex. Men who are subjected to sexual assault in adulthood are 1.7 times more likely to experience psychological disturbance than those who are not, and self-injury is the single most likely emergent problem as a result of sexual assault (King, Coxell, & Mezey, 2002). This may be a problem for gay men who are more likely than straight men to experience being a victim of sexual assault (Nicholas & Howard, 1998).

Establishing gay men's motivations for self-injury

Self-injury is strongly associated with suicide in terms of risk factors for eventual completed suicide (Morgan, 2000) and suicide is a leading cause of death among gay male youth (Gibson, 1989; Green, 1996). Self-injurious behaviours are sometimes, but not always, suicidal behaviours. Attempted suicide rates for gay youth are high (D'Augelli & Hershberger, 1993; Eisenberg & Resnick, 2006; Gibson, 1989; McKee, 2000; Ramafedi et al., 1991), but gay youth are not over-represented in suicide completion rates (Nicholas & Howard, 1998). Establishing the sexual orientation of someone who has committed suicide is difficult, because it may not have been disclosed prior to death (Kitts, 2005). Some people who commit suicide may have done so because of tensions with their sexual orientation. This explanation is not, however, a convincing explanation for the disparity between the number of gay men who attempt and those who complete suicide.

It is unlikely that gay men are particularly inept at suicide. If more suicidal behaviour is seen in gay men than in the population generally, it may be that at least some of these suicidal gestures are self-injury. The study conducted by Nicholas and Howard (1998) showed that same-sex attracted people are more likely than the rest of the

population to engage in multiple suicide attempts by overdose and self-cutting, which are established forms of non-suicidally motivated self-injury.

Viewing gay men's self-injury through a suicide lens forecloses inquiry into other possible motivations for and functions of their self-injury. Apparent attempted suicides, alcohol, substance abuse and unsafe sex are well covered in the literature relating to gay men's health (Platzer, 1998) and each of these areas might be understandable through a self-injury lens. The academic literature emphasises concerns about public health, risk management and developing understanding of the pathological other (Coxon & McManus, 2000). Rarely are the voices of gay men heard or interpreted in the context of their experiences and thus, much self-injury for gay men remains unknown or poorly understood.

Beyond suicide to self-in-context

The focus on suicide in the literature regarding self-injury in gay men means that other behaviour or actions that might have self-injurious motives are poorly understood in this way. One example is that of risky or unsafe sex: an area that receives some academic attention in terms of epidemiology and public health (Longfield, Astatke, Smith, Mcpeak, & Ayers, 2007). Risky or unsafe sex is an example of how particular forms of behaviour can be analysed and theorised according to dominant agendas such as public health targets and disease reduction, yet neglected in others, like self-injury even though the aim of some unsafe sexual practices is self-injury through sexually transmitted infection (Moskowitz & Roloff, 2007).

There is a relationship between risky sex and low self-esteem (Martin & Knox, 1997). If low self-esteem is an indicator of increased sexual risk behaviour, then it may be that unsafe sex is a form of self-injury undertaken to regulate affect. While unsafe sex poses physical and psychological danger to gay men, it exists in dialectical tension with a form of unconstrained ecstasy (Adam et al., 2002) wherein the gay man can experience a sense of liberation and expression of his sexual orientation that is

otherwise contained within social discourses of respectability. Here it becomes possible to see how self-injury can be missed or misinterpreted.

In a study of gay men in London, one third of socially active gay men had unprotected sex between 1996 and 1999 (Dodds, Nardine, Mercey, & Johnson, 2000). At the height of safer-sex education during the late 1990s, this may seem a surprisingly high number of men. The lack of congruence between men's knowledge of safer sex and their behaviour suggests that the reasons for escalation in unprotected sex are not clear (Van de Ven, Prestage, French, Knox, & Kippax, 1998). Unsafe sex appears to be about more than engaging in a social activity that is simply unhealthy. There are sub-cultural practices that inform the type of sex gay men seek. Anonymous sex is a feature of gay cultures and this sex occurs in a number of places from public toilets and parks to cruise clubs specifically for meeting men for sex. Unsafe anonymous encounters are dangerous on more than one level. There is a risk not only of sexually transmitted infection, but also immediate physical risk as anonymity reduces the threshold for antisocial behaviour (Krahe, Schutze, Fritsche, & Waizenhofer, 2000) and these men risk becoming victims of violence.

This is an invisible form of self-injury if indeed the intent is to seek injury, either indirectly through sexually transmitted infection or directly through physical harm. The act goes beyond simple irresponsibility and becomes a profound indicator of the unsettling effects of living in communities that invalidate identity and constrain self-expression. Difficulties that arise in identity formation as well as the experience of prejudice that constrains expression can influence gay men's choices about whether they engage in safe or unsafe sex (Lloyd & Forrest, 2001), which can become either an overt or covert means of self-injury (Odets, 1995).

Tensions in culture and relationships for gay men

Knowledge of self can be understood as being constructed in relationship with others (Gilligan, 1993; Shaw, 2002) and so relationships can be resilience factors which mitigate against distress (Kralik, Koch, & Eastwood, 2003). Gay men are subjects of social constructions of deviance and thus relationships with wider communities are

not always nurturing and problem-free (Paul et al., 2002). For some gay men, internalising social constructions of deviance can lower self-worth (Kralik et al., 2003), and exacerbate distress, with the body as a site of tension and dissatisfaction.

A good fit with social environment, which incorporates a sense of belonging, modifies the risk of adverse outcomes of self-injury (Neeleman et al., 2001). For some gay men it may be that a sense of fit is elusive and therefore they are not well positioned to experience legitimated voice or secure ties with the communities in which they live. Where voice is lost, people can engage in "resistive strategies" to maintain wholeness (Shaw, 2002, p.202). Social constructs are thus potentially enlightening when considering the self-injury of gay men (Clarke & Whittaker, 1998) because they can provide insights into how gay men might adopt certain culturally sanctioned explanations of their self-injury.

Socially imposed silence has been linked with self-injury in young gay people, particularly in relation to substance use, unsafe sex and suicide attempts (Brown, 2002). While it is becoming more acceptable to speak "about" the gay "other", gay men themselves are still not permitted to speak. So, while gay may, from a sub-cultural perspective, be somewhat fashionable, it is not acceptable to link sexual orientation difficulties with self-injury (Green, 1996). If the difficulties of being gay are linked to self-injury, then communities are confronted with a pathology that belongs in two places: within the gay man who enacts self-injury and in the communities to which gay men belong. The former is prominent, perhaps because it absolves communities of a role in gay men's distress—the pathology of self-injury can be understood as individual weakness, or as a consequence of deviant sexuality (James & Platzer, 1999).

It is therefore important to foreground the notion of a pathological environment conducive to self-injury, rather than a pathological individual with self-injurious tendencies (Hiller & Walsh, 1999). Gay men are subject to a different standard with regard to sexual orientation in that where expression of heterosexual orientation is visible and celebrated (Nicholas & Howard, 1998), gay sexuality is not. Being invisible and uncelebrated can lead to self-injury as a way of being seen, recognised

and acknowledged, but it can also be a way to resolve unhappiness within uncaring societies.

Homophobia and self-injury

One particular social problem for many gay men is homophobia. The silencing or marginalisaton of gay men can be the product of individual or institutional homophobia. The presence of covert homophobia and/or overt hostility has been associated with gay men attempting to hurt themselves. Self-injury is more prevalent among young people who are bullied (Hawton et al., 2002) and significant percentages of identified gay youth are the victims of hate crimes (Kendall & Walker, 1998). Young men who are suspected by peers of being gay are frequent victims of abuse and bullying (Due, 1995; Green, 1996; Uribe & Harbeck, 1992) and are thus at risk of self-injury or even suicide (de Graaf et al., 2006). Hiller and Walsh (1999) tell the story of a gay adolescent who started to feel bad about himself once others began to call him names. This led to the young man feeling sinful, dirty and that "people like that die from AIDS" (p.23). These examples are profound and stressful life events that can become a risk factor for eventual suicide (Gould, Greenberg, Velting, & Shaffer, 2003).

In a study of 6020 English school students, Hawton et al. (2002) found those students who were worried about sexual orientation had higher rates of self-harm. Further, Rivers (2000) conducted a comparison study of two groups of lesbian, gay and bisexual adults who had been exposed to homophobia at school, finding that self-injury was contemplated by a significant number and that some made multiple attempts at self-injury. A possible pernicious effect of homophobia is that it might lead the gay man to experience an exaggerated internal locus of control because homophobic taunting situates the individual as responsible for their deviance. Adolescents who experience this internal locus of control are more susceptible to self-injury (Tulloch, Blizzard, & Pinkus, 1997) perhaps because relational means of solving problems are seen as unfeasible.

A strong internal locus of control is one possible explanation of why gay men self-injure in certain ways. For example, gay men have higher levels of substance abuse than their heterosexual counterparts (Blake et al., 2001; Hiller & Walsh, 1999; Knox, Kippax, Crawford, Prestage, & Van de Ven, 1999; McNair, Anderson, & Mitchell, 2001). Kendal and Walker (1998) suggest that 58 percent of young gay men can be classified as having a substance abuse disorder. Given the factors that predispose individuals to self-injury, viewing the problem on a surface level is simplistic—the person abuses substances and thus has a substance abuse disorder. Alternatively, substance abuse could be understood as a means of acting out distress or avoiding problems (Kendall & Walker, 1998), or containing a problem within the self because a relational solution is not possible or easily identified.

Problems encountered in treatment of self-injury

Attending to complex social issues that present as person problems, such as those I have reviewed for gay men, requires nurses to invest in a therapeutic process that engages clients in exploring the many dimensions of their self-injury. One of the outcomes of the clinical preoccupation with risk is that useful social information that can be incorporated into practice might be lost. The literature provides insights into how unhelpful, poorly informed or even abusive care from health providers can compromise therapeutic relationships and client outcomes (Bowers, Brennan, Flood, Lipang, & Oladapo, 2006; Warm et al., 2002).

Both professionals and clients report that nurses do not understand self-injury (Pembroke, 1998; Reece, 2005) and for many clients nursing care is not always satisfactory (Warm et al., 2002). Slaven and Kisely (2002) conducted a qualitative study of health providers' perceived barriers to care and found that 61 percent lacked confidence in working with someone who self-injures. Where nurses are uncertain about the care they provide, it is possible that care becomes focused towards containment and safety rather than relationship and exploration (Santa Mina et al., 2006). There is, then, a clear need to provide nurses with information about the social and clinical nature of different types of self-injury that might increase confidence and augment practice.

Martial constructions of self-injury and care

In situations where containment and safety become mainstay reasons for intervention, efforts to ameliorate and replace self-injury with adaptive coping mechanisms become almost a battle of wills between clinicians and a seemingly intractable behaviour–with the client trapped somewhere in between. It is not uncommon for martial imagery to be applied to working with the person who self-injures (Anderson, 1997). The idea that the body becomes a battleground between client and nurse (Reece, 2005) is well illustrated in the literature, and clients who self-injure are often referred to as challenging (Clarke & Whittaker, 1998; Sharkey, 2003). Emergency care for those who self-injure is particularly problematic in this regard. Where clinicians are engaged with those who self-injure, bodies are sometimes further assaulted and traumatised (McAllister et al., 2002). What seems to occur, is that clinicians are both confronted *and* affronted by self-injury, resulting in behaviours that seek to defeat the enemy, like suturing without anaesthetic (McAllister et al., 2002) or withdrawing empathy (Pembroke, 1998).

Another effect of martial conceptions of self-injury care, as well as the withdrawal of empathy is the reinforcement of the concern for containment. That is, dangerous, chaotic and confronting self-injurious behaviours enacted upon the body must be defeated, or, at the very least, managed. This concern leads to two problems: first, for research, there is a tendency to engage in clinical philosophising (Clarke & Whittaker, 1998) about the best way to contain and ameliorate self-harm; second, for practitioners, a form of behaviourism takes over and it is only reduction in self-injurious behaviour that can indicate client improvement. Knowledge that helps to reduce perceived risk becomes privileged and other ways of knowing about self-injury that might illuminate some of its nuances are lost or silenced.

It is perhaps for these reasons, amongst others, that service use can be irregular and unpredictable. A recent exploratory study that examined patterns of care for people who self-injure over an eighteen-month period revealed chaotic service use, leading the authors to suggest that self-injury is best described as a long-term condition

(Poustie & Neville, 2004). Ignorance of different meanings and motivations for self-injury means that some treatment might not be empathetic. Defining self-injury as a long-term problem goes further, towards making the client responsible for their own distress at experiencing services that might not meet their needs. This further reflects how possibilities for care can be limited by over-emphasising the role of individual rather than social factors that influence self-injury (Warner & Wilkins, 2004). One feature of this kind of care is the tendency to attempt to seek evidence of risk in behaviours. This practice involves over-interpreting the client's meanings and actions, rather than listening and accepting what is being said (Reece, 2005).

One significant drawback to this practice is that over-interpretation relies on available language and discourse. Within some mental health environments, predominant discourses may be characterised as risk-based, behavioural and managerial (Estefan et al., 2004). This means that the client whose self-injury conflicts with the clinical aim of improvement or recovery becomes pejoratively constructed as impeding their own recovery (Slaven & Kisely, 2002) and a barrier to the effective work of the nurse. In other words, the client becomes both risky and at risk. For gay men who self-injure this may be problematic, because gay men might be at risk from both self-injury and also from the care they seek because little is known about gay men's self-injury or how to respond.

What people who self-injure want from healthcare providers

For the person who self-injures, priorities for care seem to be both similar to and different from those of clinicians. On one hand, many people who self-injure seek care in order to be able to explore their self-injury and learn to approach their distress in adaptive ways (Pembroke, 1998; 2006). On the other hand, the notion of treatment and cure rarely features in clients' accounts of good care. Instead, creating a non-judgemental environment that safeguards dignity is appreciated by many clients (Arbuthnot & Gillespie, 2005; Warm et al., 2002).

If the notion of cure does not feature strongly in people's accounts of what they want from care, then therapeutic environments need to attend to more than pathology.

Therapeutic environments also need to attend to the social self and respond to what makes social living difficult or problematic. Warner and Wilkins (2004) suggest that care might be more usefully organised around social issues that compound and are complicated by self-injury. Furthermore, this kind of care might be effectively provided by means other than conventional hospital services. Specific self-injury services or clinics, for example, can reduce admission rates and appropriately involve people in attending to their own self-care (Corser & Ebanks, 2004). This approach returns ownership and control of the body to the client, rather than adopting paternalistic approaches to containment, which safeguard the physical body, yet also invalidate and infantilise.

Locating self-injury in culture

If it is important to attend to the social self, then self-injury needs to be viewed as part of the culture and context in which it originates. One significant limitation of current clinical self-injury knowledge derived from risk frameworks is that it is medically and treatment orientated, perpetuating a "medicalisation and psychiatrisation" of bodies (Kilty, 2006, p.165) which ignores the influence of culture on self-injury. Furthermore, while risk factors for self-injury dominate much of the literature, little of this research delves into the context in which risks for self-injury emerge to explore how risks are culturally framed and how they develop (O'Reilly, Lancioni, & Emerson, 1999). Significant attention is directed instead towards the characteristics and practices of people who self-injure (Murray et al., 2005). This means that little is known about community living and how cultural values and practices are reproduced in relation to self-injury.

There is some research that attests to the likelihood that ethnicity produces both risks for and protection against self-injury. For example, young black men are less likely to attempt self-injury than their white counterparts (Gutierrez et al., 2001). It has also been suggested that the protective nature of "us and them" bonding amongst minority ethnic communities may constitute a resilience factor for self-injury (Gutierrez et al., 2001; Roberts & Chen, 1995), although this finding has not been borne out consistently among different ethnicities (Hovey & King, 1997). Depression, which

features in many accounts of self-injury is moderated by life events that occur in context (Keller, Neale, & Kendler, 2007). It is possible, therefore, that culture intervenes in the self-injury experience and as such there is merit in exploring cultural contexts for different groups who self-injure. Exploration of everyday exposure to and interaction with cultural ideals and experiences that shape these factors might yield useful information that could promote resilience and coping in social living.

Another finding of the existing research is that it might be difficult for people to find meaning to their self-injury that connects them with others, because it is excluded from cultural discourse (Adler & Adler, 2005). There is thus a need to move beyond simply considering psychopathological factors and explore wider social meanings and significance of self-injury (Anderson, Woodward, & Armstrong, 2004). This is an important objective in research with gay men, where psychopathology alone cannot adequately account for or explain self-injury. In order to achieve a wider vision of self-injury, it is necessary to think beyond individual risk factors (Gutierrez et al., 2001) and attend to the ways people are living (Cooper et al., 2005) as well as exposing and critiquing environmental conditions that evoke and maintain self-injury (O'Reilly et al., 1999).

If self-injury knowledge and practice is to be advanced in this way, then a sociology of self-injury is required (Adler & Adler, 2005): that is, an understanding of how people self-injure in their social worlds, rather than examining self-injury as a purely individual phenomenon. This approach may illuminate relevant contextual information, because people might understand and describe their self-injury using what they feel is a culturally reasonable explanation (Redley, 2003).

When certain behaviours are not part of the cultural norm, they can be described as mental illness (Anderson et al., 2004). Western cultural explanations of self-injury focus on problems with people; therefore those who self-injure might construct themselves as deviant, sick or odd (Adler & Adler, 2005). In such a situation, the description provided by the person who self-injures is filtered through available or popular discourse, meaning important rich information may be lost.

It is important, then, to examine ways in which the voices of people who self-injure can be heard more clearly. One way of achieving this might be to stop and listen to what stories are being told by people who self-injure. Such listening involves resisting "carving up" the phenomenon of self-injury in order to provide an explanation of it (Redley, 2003, p.350). Rather, it may be beneficial to find out about *people* instead. Finding out about people is not the same as a fascination with the pathological other. It is about exploring how people live. There are a multitude of reasons why someone might self-injure; self-injury looks and is experienced differently in a variety of groups. Allowing people to speak and listening to what they say becomes an important objective in social research with people who self-injure.

There are steps that need to be taken in order to foreground the limitations to current perspectives of self-injury that shape health care practices. In this third part of the chapter, attention now turns to difference theories in order to develop a conceptual lens through which existing and available self-injury literature can be viewed and critiqued.

Recognising difference

Much self-injury research remains western and woman-focused. Correlations between women's self-injury and abuse or trauma histories tend to obscure the experiences of other groups by creating myths about who self-injures and illusions about what self-injury must look like. Because self-injury research and treatment is predominantly woman-centered, gay men remain under-researched and at the margins of clinical interest in relation to this phenomenon.

Applying a "difference" lens is one way of showing how such a homogenised understanding of self-injury silences many who self-injure. Acknowledging different forms of and motivations for self-injury depends on recognising that self-injury occurs in a variety of contexts and is enacted in many different ways (Clarke & Whittaker, 1998; Eke, 2000; Harris, 2000; Hovey & King, 1997). There are many lenses through which self-injury can be viewed and some of these lenses might

challenge established medical discourse. Disorder or pathogenesis is, however, a powerful standpoint that shapes how self-injury is understood.

Despite the prevalence of the disorder paradigm, paying attention to non-pathogenic acts of self-injury reveals how self-injury can also be understood as a socio-cultural phenomenon (Cerdorian, 2005). Religion, healing, self-adornment (Austin & Kortum, 2004) and claiming informal group membership (Boergers, Spirito, & Donaldson, 1998) provide ways to understand why self-injury might appeal to some people (Cardena, 1999). For example, if one pursues bodily injury as an act of piety, or perhaps even to improve appearance and increase desirability (Claes, Vandereycken, & Vertommen, 2005), the act takes on a social quality. Cultural norms, understood through language, play a role in deciding whether or not a given behaviour is embedded by pathology, socially deviant and able to be thought of as self-injurious (Walsh & Rosen, 1988).

Language, voice and difference

The way people talk about their lives provides rich information for inquiry into social phenomena. Language and the way it connects person to place and time reveals the world that people see and in which they live with others (Clandinin & Connelly, 2000; Gilligan, 1993). Attending to the language that represents phenomena is a form of critique that not only highlights gaps in knowledge, but also shows how knowledge is represented. For example, language creates social identity and functions to consolidate individuals into group membership, permitting acquisition of knowledge and experience that sustains social groups (Tannen, 1982). Knowledge and practice thus become shaped by language and heard through a variety of individual, institutional and social voices.

Not all voices are audible, however, or possess equal power. Some voices can be heard while others are silenced or marginalised, sanitised and filtered. For some groups, like gay men, voices might be filtered or represented in a heterocentric fashion, so that they are acceptable within wider, dominant social groups (Battles & Hilton-Morrow, 2002). Similarly, the voice of the nurse, who seeks to provide

empathetic and reflexive care, may be silenced by institutional voices that are more powerful. The cumulative effect of silencing or altering different voices is that a uniformity of understanding and behaviour develops. Gaining insight into people's lives and recognising differences is one way to acknowledge difference and resist homogenising. Developing this insight involves attending to voices on the margins.

The importance of voice

For the person who self-injures, finding voice is an important step in being able to express distress (Cresswell, 2005). The act of listening for this voice, on the part of the nurse, validates the person who self-injures and helps their voice to be heard. Taking a difference perspective is one way to give voice to those on the margins, by exploring different ways of being and doing as well as showing where commonalities and shared interests might exist. Attending to voice therefore also becomes a way to challenge dominant and pathologising discourse (Burbules, 1996; Gilligan, 1982). In the context of this study, conducting research that challenges assumptions of sameness, and evokes and interprets the voices of gay men who self-injure, might therefore lead to more informed, sensitive and responsive nursing practices.

When authentic voices are obscured

In order to construct effective responses it is important that nurses listen, because listening is a simple act that gives voice. Voices, however, also require deconstruction to expose reproduction of dominant interests in the language of the marginalised. The idea that oppressed individuals reproduce some of the mechanisms of their own oppression is not new (Freire, 1970). This is perhaps a salient point upon which to reflect for nurses, who are themselves sometimes marginalised within healthcare environments and who reproduce dominant medical discourse in their encounters with clients (Estefan et al., 2004).

From a difference perspective, Gilligan (1993) uses the term ventriloquism to illuminate one mechanism for the obfuscation of voice. Ventriloquism is Gilligan's critique of the ways that men's voices have been heard through women's bodies.

Ventriloquism advances understanding of complicity in oppression, by illustrating the subtle dynamics involved in using voice to replicate dominant social interests. Gilligan (1993) theorises that women may replicate male interests even while they appear to be speaking in their own voices. In other words, it was not the women's authentic voices, but rather the voices of their puppeteers—men. Inadvertently then, the marginal body becomes a vessel that reproduces mainstream or dominant interests and ways of knowing.

The idea that it is possible for a powerful force to "speak through" a less powerful force forms a lens that enables a critical review of self-injury knowledge. Perhaps clinicians have taken for granted the authenticity of voice that is represented in the professional self-injury literature. For gay men, applying this lens may help to show how gay men might be spoken for, perhaps inappropriately, by a predominantly female discourse of self-injury that makes it a predominantly female issue (Pembroke & Smith, 1996; Shaw, 2002).

Where authentic voices are unheard because a ventriloquised voice dominates, the status quo is maintained. This status quo acknowledges the right of gay men to speak only in certain contexts such as in relation to issues of health, disease or to entertain (Battles & Hilton-Morrow, 2002; Hartman, 1993; McKee, 1996, 2000) and refuses to hear the voices of gay men in other contexts such as relationships, social structures and equality. In the context of this study, self-injury thus remains a women's issue (Taylor, 2003) and the relevance of the perspective of gay men is obscured by this reality.

The creation of angels and "others"

Seemingly authentic representations of self-injury as a women problem need deconstructing beyond awareness of ventriloquism. Gilligan (1993) suggests that ventriloquism reproduces the interests of a dominant group, in her case, men. Gilligan refers to this phenomenon as the "voice of the angel". For Gilligan, the "angel" is an identity shaped by women reproducing the voice and interests of Victorian man. This is not a natural voice; it is a construction that shapes and

constrains expression, foreclosing the possibility of hearing women's authentic voices. Put simply, the act of ventriloquism constructs subjects.

The angel can thus be viewed as a subject who is an effect of discourse. This subject maintains and is convinced of the legitimacy of male dominance. In the case of self-injury, professional discourse and literature create a different kind of subject. The self-injury literature is written predominantly by those in mental health services (Thomas, Leaf, Kazmierczak, & Stone, 2006) and with a view to understanding how to treat disorder (Adler & Adler, 2005). As such, the person who self-injures becomes the abject other who is "looked at" and sometimes invited to speak. When this subject is heard, however, it may be another type of angel that is speaking, one who supports the legitimacy of an individualist or medicalised interpretation of self-injury.

Hearing the authentic voice

Different accounts of self-injury can help to uncover authentic voices, because a difference approach is cautious of who is talking. Furthermore, a difference approach seeks to ensure that new ideas are not simply assimilated into established clinical perspectives. Where self-injury knowledge is sought it is important to move beyond questions of what, how and why it occurs and instead explore questions of reality and truth—how we know, how we hear, how we see the world and how we speak (Gilligan, 1993).

Applied to self-injury, Gilligan's (1993) notion of ventriloquism makes it possible to understand how the individual voices of people who self-injure become a collective voice—that of *the* self-injurer. Discourses are one means of shaping identity and experience (Brickman, 2004; Foucault, 1972) and because discourses of the essentialised self-injurer are the only ones available that explain motivation and action, a person who self-injures receives an essentialised identity from which they might appropriate motivations for their self-injury. This voice of the essentialised self-injurer illustrates the angel effect, wherein the voice being heard is that of the

disciplines and institutions that seek to treat self-injury, because these voices are the dominant ones in shaping self-injury knowledge (Thomas et al., 2006).

The voice of the clinician

When the voice of the clinician is heard, the dominant discourse through which self-injury is described or explained is a medico/pathological one. Thus, all attempts to explain the relationship of self-injury to the social world are condensed through this reductionist discourse into its implications for the physical body and the individual psyche. This is a problem because it effectively exonerates communities from involvement in the perpetuation of distress that may lead to self-injury and it forecloses the possibility of alternative readings of self-injury.

Medicalised or pathologising discourse is furthered by research that individualises and locates the problem within the person who self-injures. This research is redolent with the voice of the clinician. For example, studies by Esposito, Spirito, Boergers and Donaldson (2003) and Gil (2005), which address individual dysfunction allows pathology to be deposited within a person, who can then be acted upon. This research negates social factors and differences that influence self-injury and makes the person who self-injures responsible for their act.

Social differences become embedded at different life-stages as well as by experiences, degree of social connection and location. These differences further highlight the significance of the social world to discussions about self-injury. The literature review therefore now turns to a difference reading that emphasises how self-injury works differently and has different meaning within and between contexts. Reviewing the literature in this way foregrounds some of the social relevance of self-injury and demonstrates the gaps in knowledge in current self-injury research. A difference review shows how dominant voices are easily heard and how the person's authentic voice can be obscured and tainted.

Self-injury, life stage and development

Nowhere in the self-injury literature is the relevance of psychosocial development more closely tied to self-injury than with adolescents. Adolescence is a time of transition, change and experimentation. Adolescence is also a period of identity development and confusion. Adolescence can be a traumatic and turbulent time for heterosexuals. Differing degrees of same-sex attraction and self-injury are both characteristics of this time (Kendall & Walker, 1998; McBee-Strayer & Rogers, 2002; Rivers, 2000) and might further complicate adolescence for this group. Adolescent self-injury therefore merits exploration from a difference perspective.

Reviewing the adolescent self-injury literature reveals two principal features. The first is that many studies either describe occurrence rates in high schools or study adolescents as inpatients or alongside other age ranges without consideration of their different needs (Ross & Heath, 2002). The second feature is that adolescent self-injury is both similar to and different from the self-injury enacted by other groups. Some behaviours and motivations for self-injury in adolescents correlate with adult groups, but there are also factors that highlight how self-injury operates differently from conventional understandings of the phenomenon.

Testing relationships, making connections

In a study of 120 adolescents who attempted suicide, Boergers, Spirito and Donaldson (1998) found some adolescents reported a desire to die informed their self-injury. Not all of these adolescents used lethal means of self-injury and so perhaps in this instance, for some adolescents, self-injury was about expressing suicidality rather than motivated by intent to die. This highlights the sometimes paradoxical nature of adolescent self-injury that prevents death (Ross & Heath, 2003). Other adolescents in this study sought to escape or obtain relief from their distress and in this regard they shared a similar motivation to clinical populations who self-injure as a form of relief (Bennum, 1984; Clark, 2002).

Within adolescent groups there are gender differences in motivation to self-injure and in forms of self-injurious behaviour (Clarke & Whittaker, 1998). For boys, suicidal behaviour in friends and family, drug use and low self-esteem are related to self-injury whereas for girls, low self-esteem, drug use and others' self-injury feature but depression and anxiety are also common predisposing factors that are less visible in boys (Hawton et al., 2002). While these factors influence adolescent self-injury, it also has a functional value for adolescents that differ from the self-injury of other populations.

Self-injury is a powerful communicator that can motivate others to action. Adolescents have reported that self-injury can help them to communicate desperation, to punish others (Hurry, 2000), and to seek help. Self-injury is also sometimes used by adolescents to exert influence over someone, to show love (McAuliffe et al., 2007), and to test whether someone else loves them or not (Boergers et al., 1998). Perhaps, then, the adolescent body is understood by some as a surface upon which positive feelings of love and attachment can be marked out, but in ways that appear damaging and destructive. Self-injury can communicate a need for or sense of attachment and does not necessarily need to be viewed pejoratively. The notion that self-injury is a way to show love might reflect a form of adolescent romanticism, in which feelings are profoundly embodied and self-sacrifice or pain is used to convey the importance of a relationship.

On a social level, self-injury can serve as concrete confirmation of affiliation between adolescents, where self-injurious rituals are used to initiate members into closed groups (Taiminen, Kallio-Soukainen, Nokso-Koivisto, Kaljonen, & Helenius, 1998). This practice while a powerful means of gaining membership to groups and developing a sense of belonging, might introduce young people to a means of gaining attachments that involves ongoing and peer supported self-injury (Hawton et al., 2002; Johnson, 1994) that may also place them at greater risk of eventual suicide (Kerkhoff, 2000; Pearce & Martin, 1994).

A recent phenomenological study with sixteen to twenty-six year olds found that validation was the main way that young people made sense of the self and was related to a desire for legitimacy and worth (Adams, Rodham, & Gavin, 2005). This is a

problem for young gay men who sometimes grow up in environments that fail to affirm their sense of legitimacy and worth. It also highlights an irony of some adolescent self-injury: that it can be a behaviour that simultaneously can affirm the self, yet confers risk of eventual suicide.

Some adolescents use self-injury as a social mechanism to influence the actions of others (Derouin & Bravender, 2004; Kumar et al., 2004). This motivation is a form of manipulation that is rarely correctly attributed to adults who self-injure. Both exerting influence and showing love highlight how profoundly functional self-injury can be for adolescents. Self-injury can make things happen where conventional methods of effecting change either elude the adolescent or cannot be used.

The metaphor of self-injury as experiment encapsulates another motivation for adolescents (Boergers et al., 1998). Through conducting an experiment with and on the skin, the adolescent can test different hypotheses, for example, "s/he loves me, s/he loves me not". Gauging social responses to self-injury might facilitate a form of reasoning that enables the adolescent to reach a conclusion about how others react to them. The trouble with this use of self-injury, is that some people may not have the knowledge, skills or attributes to helpfully respond (Best, 2005) and so the adolescent's message may go unheard. What is heard instead, might be the voice of the clinician. If so, it creates a problem for the adolescent because what the observer of the self-injury sees is pathological and problematic behaviour. The voice of the clinician conceals the risk that the community and adult role-models pose through their inability to hear the adolescent's message and offer appropriate support or help.

The ways that distress manifests in adolescents who self-injure seems to differ between genders. Adolescent boys tend to self-harm more violently, whereas girls tend to act more anti-socially (Patton et al., 1997). This creates similarities along gender-lines, rather than within age range. Thus, adolescent males, on the surface, seem to share more in common with adult males when the behavioural intensity of self-injury is considered, even though the motivation to enact it may be different. What is missing here is an explanation of why there is a difference. Again, it seems that research is seeking out behaviours to treat and adolescents' explanations for their self-injury are not being sought or heard.

It is reasonable, then, to question whether self-injury is enacted according to gender, or whether the socially constructed nature of gender leads to a conventional analysis of behaviour that reinforces essentialised positions of men as more aggressive and violent and women as passive-aggressive and manipulative. A survey of 6020 pupils in 41 schools in England found that more young males than females get into trouble with the police, but that the association between self-harm and police involvement is stronger in girls (Hawton et al., 2002). An important difference is covered over in these findings. Young men who self-injure are perhaps seen as laddish, reinforcing an essentialised masculinity and young women's expressions of distress are contained through legal discourse/practice.

Current research then, goes some way towards reinforcing judgments about what is normal behaviour for young women and men (Webb, 2002). Hegemonic masculinity, as well as the powerful voice of the clinician, might play a role in constructing adolescent self-injury; where boys' distress might be rendered invisible and seen as a form of youthful masculinity and girls' self-injury as a form of anti-femininity and delinquency. In either situation, the voice of the adolescent is not heard and, importantly for this study, the voice of young gay men is absent.

Fitting in

An examination of the nexus between sexual orientation and self-injury in gay men has the potential to problematise the relationship between gendered experiences and self-injury, by interrogating the relationship between the social worlds of individuals, sexual orientation, identity and self-injury. In doing so, the potential exists to create spaces in which the discomfort of marginal bodies can be foregrounded and contribute to more thoroughly theorising self-injury. The literature points to reasons for undertaking such an inquiry. Difficulties with emerging sexual awareness influence self-injury through tensions that develop between emergent sexuality and identity (Rubenstein, Halton, Kasten, Rubin, & Stechler, 1998). In a study of 444 students from two schools, Ross and Heath (2003) found that 64 percent of respondents reported a sense of non-fit, describing feeling lonely, sad or alone prior to

their self-injury. It is often the experience of young people struggling with issues of emerging sexuality that they feel alone, ashamed, as if they are failing in some way, and disgusted with themselves (Rubenstein et al., 1998; Simpson, 1980).

At this life stage, sexuality and identity are closely linked with cultural expectations such as marriage and procreation (Scottish Executive, 2002). The adolescent experiencing increasing awareness of her/his sexuality, and who does not experience "fit" with this cultural expectation, is perhaps susceptible to dissatisfaction or even disgust with the self (Simpson, 1980) that might lead to self-injury. Where this sense of poor fit is not resolved, self-injury may develop from an adolescent impulse into a longer-term means of self-management (Hurry, 2000). For people whose sexual orientation compounds this issue, self-injury may be operating to contain disgust or shame in some way.

A weak sense of identity or feelings of not belonging can motivate the use of self-injury to secure attachment and identification with groups (Taiminen et al., 1998). This may be particularly so where family attachments are not strong for the adolescent (Webb, 2002). Self-injury as a means of belonging can assist adolescents to feel masterful and powerful over their environments, because self-injury can be equated with a form of badness. That is, the adolescent who discovers that being good does not protect them from bad things can equate being good with weakness and being bad with power (Johnson, 1994). Self-injury serves an interesting function in this regard, because it enables an adolescent to do something bad and thus escape a victim role (Johnson, 1994), but it also helps the adolescent to do so with relative safety and without risk to others.

Adolescent self-injury illuminates the importance of finding ways to experience a sense of fitting in. For young people, self-injury can either promote a sense of belonging or alternatively it might mitigate negative feelings that arise from being on the "outer" of powerful and influential social groups. Thus, the significance of validation and affirmation as developmental challenges for young gay men is further established, particularly given that young gay men might not always feel as though they belong.

Self-injury, location and social position

Location and social position are important aspects of belonging as it relates to self-injury. One specific location in which self-injury occurs is the prison. The literature that describes self-injury amongst the prison population is particularly significant because prisoners self-injure in both conventional and unique ways that are tied to their social position.

There are high levels of self-injury in prison populations (Callaghan, Pace, Young, & Vostanis, 2003; Camilleri, McArthur, & Webb, 1999). Prisoners self-injure for reasons that are documented within the general population, such as to escape punishment, or conversely to punish the self (Brockman, 1999). Women are also over-represented in the prison self-injury statistics (Camilleri et al., 1999), reflecting a similar bias in community samples. Congruent with findings from the general population, self-injury is probably under-reported in prisons (Ireland, 2000; Jackson, 2000; Van der Kolk et al., 1991).

In prisons, the responsibility for deciding what is and what is not self-injury lies with prison staff, meaning that some incidents of self-harm may not be classified as such (Ireland, 2000). In clinical and other community samples, a similar phenomenon occurs, because the voice of the person who self-injures is rarely heard. Therefore, what is and what is not self-injury is decided independent of the opinion of the person who self-injures. This is a significant limitation of much of the current literature on self-injury.

Constrained bodies

In prisons the distinction between self-injury and suicide is unclear, because prison inmates often use high-lethality methods of self-injury such as hanging, but often with little suicidal intent (Livingston, 1997). The control and containment function of prisons might influence choice of method because high-lethality self-injury may be the only kind able to be used (Camilleri et al., 1999).

Unlike inpatient settings, prison is not a therapeutic environment (Brockman, 1999) and because self-injury is a social phenomenon, the influence of the social structure of prisons must be considered (Holley & Arboleda-Florez, 1988). Prisons lack physical comfort and opportunities for self-development, emphasising control and containment instead. Emphasis on containment means that self-injury behaviour is often punished rather than responded to therapeutically (Camilleri et al., 1999).

The punitive attitude to self-injury within prisons is another way that notions of risk serve to cover over the intrapersonal and communicative functions of self-injury. For both men and women prisoners, using risk approaches to determine response means that needs, such as to be heard, to communicate distress or to self-soothe, become security issues (Bosworth, 2006; Kilty, 2006). If institutional responses do not address the needs of the individual who self-injures, then the self-injury can be viewed as a pathology of the prison as well as the prisoner (Thomas et al., 2006). In a focused environment like a prison, it is perhaps easier to establish the role of the institution in propagating inmate self-injury. In wider social settings the relationships are less clearly identifiable and a relevant area for research.

Institutional responses of containment and observation as well as removal of privileges partially mirror responses to self-injury that can occur in therapeutic environments (Duffin, 2006). It seems to be a testimony to the enduring notion that self-injury is manipulative and thus a behavioural or containment response is required to manage any disruption that self-injury causes. Punitive responses to self-injury are, however, often unhelpful and serve to perpetuate the problem (Hartman, 1995; Holley & Arboleda-Florez, 1988). Where self-determination cannot feature in resolving issues that prompt prisoners to self-injury, it may be that focused determination and willpower are all that remain of a prisoner's sense of autonomy (Brockman, 1999) and these features become the mainstay of resistance to a controlling and constraining environment.

Another consistency with therapeutic or caring environments occurs where counter-transference and anger influence the relationship between carer or custodian and the person who self-injures. In this regard, prison staff respond similarly to nurses who

find self-injury difficult to understand and respond to effectively (Brockman, 1999; Mackay & Barrowclough, 2005). If self-injury is labelled as manipulative in prisons, it might be ignored, which makes suicide prevention difficult, because inmates might not receive adequate assessment of motivation and co-morbidity (Dear et al., 2000). As Dear et al. (2000) point out, people who manipulate and those who attempt suicide are not mutually exclusive groups.

Self-injury, as it is influenced by context and social position, is complex. At this level, self-injury cannot just be about what is wrong with a person. Where context and social position are important, self-injury can provide insights into the tensions and difficulties experienced by individuals that relate to place.

Politics of the body and disrupted identity

Being confronted with rules and regulations on a daily basis means self-injury can become a means of exerting control (Holley & Arboleda-Florez, 1988). Using self-injury to exert control situates the body as a device through which a person might experience a sense of autonomy and self-control, where overall control of environment is lacking. Because it is difficult to express or exert autonomy in prison (Brockman, 1999), prisoners can engage in a variety of behaviours from socially symbolic marking of the body, such as tattooing (Eke, 2000), to conventional superficial self-injury such as cutting (Camilleri et al., 1999) through to profound and life-threatening acts such as fire starting, self-suspension (Ireland, 2000) and food refusal (Brockman, 1999). For prisoners, the body seems to become a site where disruptions in identity are located and played out.

Some prisoners use self-injury as a means to try to improve their circumstances: that is, as a way to make something happen that will make their sentence more tolerable, or to protest against perceived injustices (Brockman, 1999). Some prisoners go to drastic lengths, even risking death to make changes happen (Dear et al., 2000). Such radical measures transform prisoner self-injury into a political act, because it intersects issues of liberty, control, autonomy and expression and ties these to how the incarcerated body is socially positioned.

Self-injury might, in this way, be viewed as an individual's critique of their social position. If freedom of expression and self-regulation are prohibited and this is a forced feature of the social space occupied by a person then this is relevant for gay men who do not always (or cannot) fit comfortably into social structures. Occupying a social position outside of the mainstream constructs a form of liminal space (Turner, 2001) in which a person cannot completely know, anticipate or meet social conventions and expectations.

Remand prisoners are often at greater risk of self-injury (Camilleri et al., 1999). The reason for this is not clear and the relationship between self-injury and length of custodial status served is not well understood (Ireland, 2000). In a study conducted with 127 male clients at Rampton Hospital in the United Kingdom, 19 percent were found to self-injure and their time since admission was shorter than for those who did not. The early sentence period is a risk period that can predispose an individual to engage in self-injurious behaviour.

While the early sentence period is undoubtedly a time of adjustment for the prisoner, it is perhaps also a time when the person reflects on what lies ahead and how their current position is at odds with their life-trajectory expectations. It may be that self-injury is a means of expressing that tension—a form of self-punishment, or alternatively a means of dissolving tension that arises from liminal experience. One possible way to address risk of self-injury at this stage is to engage the prisoner and hear their distress in other ways, in other words, to reduce the distance "between the keeper and the kept" (Thomas et al., 2006, p.195)

Another risk for the new prisoner is exposure to assault that might precipitate self-injury. Ireland (2000) argues that prison experiences are a stronger indicator of self-injury than background and Camilleri et al. (1999) suggest that recent interpersonal factors are more salient than longer-term indicators of self-injury. Thus, for prisoners, victimhood might further deepen the liminal experience, where prior to incarceration such experiences were unanticipated. For the prisoner who is subject to bullying, intimidation, victimisation and sexual assault, self-injury may serve as a means not only to express distress, but also provide a way of escaping a traumatic and otherwise

irresolvable situation, through being moved to another environment where they may experience care and respite. Unanticipated assault verbal and physical assaults are features of living for many gay men is a variety of social settings. For prisoners and perhaps also for gay men, self-injury may be a way of gaining mastery of the liminal body.

Reviewing self-injury as it features in two apparently disparate populations is useful because it shows how, despite some similarities in behaviour, it is a fluid and contextual phenomenon. The review, while attending to what is known about self-injury has thus far sought to bring into focus the role of the social world and "fit" with it in shaping self-injury. The literature review therefore casts doubt as to whether self-injury can be properly understood without attention to diversity. This is important for health professionals because it is sometimes hard for nurses to see past self-injurious behaviour and access that which informs it. What motivates self-injury is an important element of assessment and care (McAuliffe et al., 2007). Cardeña (1999, p.333) calls upon nurses to "suspend our dread" of self-injury in order that we listen to people and in doing so learn more about them and us. In learning more about people and their circumstances, clinicians can be moved to care and respond.

Being someone who self-injures is not the only difficulty that a gay man may encounter in health care. In order to experience helpful care, gay men need nurses to suspend dread on two levels: first in relation to self-injury and second in relation to sexual orientation. It is important to recognise that people have specific gendered needs relating to self-injury (Bosworth, 2006) and thus it is likely that people have sexual orientation-based needs also.

Conclusion

While something is known about the nature of risky behaviours that gay men engage in, the literature is divided into two prominent parts: suicide and health risk. The suicide literature largely ignores the important and qualitatively different issue of self-injury. The health risk literature neglects to consider whether certain risk behaviours are informed by an intention to hurt the self and instead focuses on ways to reduce the

behaviour. In either case, the literature review leads to questions for further research. There may be men living in communities who self-injure because it helps them in some way and do not come into contact with services. Their stories are not being told and opportunities to inform and develop helpful caring responses are perhaps being missed.

While understanding of self-injury has advanced, it has done so through research influenced by clinical discourses of psychopathology and risk, which operate to understand, explain and contain a problematic and damaging behaviour. The self-injury research therefore perpetuates a gender dichotomy, in which women are studied as the predominant group that self-injures and men's self-injury is cast as "other", in that it is partially accounted for through reference to hegemonic masculine codes. The self-injury literature is thus also heterocentric. While the wider literature acknowledges the individual strength, coping and survival-drives inherent in much heterosexual self-injury, gay self-injury is discussed from a suicide perspective, negating other possible accounts or explanations.

Research questions

The literature review presented in this chapter provides insights into how self-injury operates in different populations and points to some possible motivating factors for gay men. Self-injury has diverse meanings, motivations and actions and these features are fluid and contingent within and between different populations. The literature review also points to some questions that are yet to be addressed in relation to self-injury and gay men.

1. How are gay men self-injuring?
2. What does this self-injury mean in the context of a life lived in relationship with others?
3. What do gay men's authentic voices say about their self-injury?

CHAPTER THREE

NARRATIVE INQUIRY APPROACH AND PROCESS

Introduction

In undertaking the present study I wanted to achieve three things. The first was to provide a faithful yet evocative representation of each man's story of his self-injury, without attempting to reduce it to its component parts. I wanted to give voice and for that voice to be clear and to say something about gay men's self-injury that helped nurses to think about self-injury in new ways and to reflect on and consider the care that they provide. In other words, I wanted to be able to show the possibilities for being a gay man who self-injures beyond those currently addressed in the academic literature (Lindsay, 2006). My second objective was a function of ethical research practice: to make explicit my involvement in the process through declaring my presence and my interests and how these influenced the discussion. Finally, I wanted to be able to achieve these aims through constructing a research text that, in itself, told the story of the research (Clews & Newman, 2005). In order to address these objectives a narrative inquiry approach was adopted. In this chapter, the approach taken to conduct the study is discussed. The methods used to undertake the study are also set out.

Narrative inquiry is a situated and interpretive approach that focuses on the story of the person and their experience in time (Riley & Hawe, 2005), connecting this to what happens and what the narrator does in the story (Reissman, 2002). Narrative inquiry attends to both experience and the social setting in which experience occurs. Approaches to narrative studies are diverse, however, there is some consensus among narrative scholars that narrative studies begin with an interest in experience (Clandinin & Connelly, 2000; Pinnegar & Daynes, 2007). Narrative is therefore relevant to the aims of this study because it offers useful insights into experience, context and time.

Narrative has been described as the linguistic form of experience (Polkinghorne, 1995). Narrative inquiry is thus interested in how narrative functions as a way of apprehending knowledge derived through experience in the everyday world and communicating this knowledge and experience through stories. When people tell stories, they themselves use different analytical techniques to construct an account of experience (Smith & Sparkes, 2006) that conveys more than the experience itself. A told story is therefore both experience and an interpretation of experience.

In describing their research approaches, Clandinin and Connelly (2000, p.50) offer a simple yet profound response to the question "why narrative"? —That answer is, "because experience". Narrative inquiry shares a kinship with phenomenology insofar as narrative inquiry sees meaning as being ascribed to phenomena through experience (Eastmond, 2007). Whereas phenomenology turns to the things themselves (Crotty, 1996; Husserl, 1970), narrative inquirers' interest lies in stories that arise from experience. Stories are engaging and evocative. A good story, well told, can provoke a curiosity that otherwise might remain dampened by the expectations and illusions held within the dominant paradigm. Stories then, facilitate exploration of the phenomena and cultures of narrators (Ospina & Dodge, 2005). Stories can provide a context for understanding actions (Polkinghorne, 1995) like self-injury. In the context of self-injury, many experiences are traumatic and, if told, might prevent trauma happening again to others. In the case of gay men who self-injure, stories can evoke the "otherness" of the tellers (Harden, 2000), helping to reveal marginalities and factors that exacerbate harmful behaviour.

Narrative inquiry and the study of gay men's self-injury

For those who self-injure, I have argued that there is a need for research that can give voice, articulate a sense of self and activate compassion from others. This has been a problem for people who self-injure. Because the self can become lost in difficult experiences and compassion, understanding or empathy from others is not always forthcoming. It is therefore an important objective for social research to foreground how people who self-injure live but at present there is a notable absence of such research. Faircloth (1998) put this argument in relation to her research into epilepsy.

She argued for the value of research into how illnesses affect identity and pose challenges for social inquirers and health carers.

A narrative inquiry into self-injury has the ability to foreground knowing the individual over the so-called disease or illness. Thus, narrative research in self-injury is important, because a tendency exists to attempt to meld and reduce multiple identities and experiences towards an explanatory model of a disease that facilitates efficient and cost-effective treatment. Since it is likely that multiple identities, experiences, affects and intrapsychic phenomena operate around self-injury, it is unlikely that a one-size-fits-all endeavour will meet the needs of people who present to services for care.

The identities and experiences of those who are on the social margins are perhaps most likely to be neglected. Narrative can provide one way of creating voices for these individuals in health care settings. As such, narrative represents a useful way of knowing about self-injury for clinicians and non-clinicians alike.

For those who are same-sex attracted, the telling of stories can therefore reveal aspects of identity and relationship between self and other and self and world. Stories allow insights into identities and inner-selves to be revealed and explored (Abes & Jones, 2004; Carson, 2001). Stories provide a means for people to reveal themselves and their worlds in ways that capture the attention of the listener. There are many ways of giving voice and the telling and hearing of stories is one of them (Balan, 2005).

Narrative offers an authentic way for people to explore what it means to interpret and experience the world (Ospina & Dodge, 2005). Because stories involve interaction, either in the story itself or the telling of it, they are one way of understanding constructions of social experience. This is particularly helpful for a study of self-injury, because the social function of self-injury is an area of scholarship that is often neglected. Furthermore, it is likely that the motivations for self-injury in gay men are as complex as within heterosexual populations. A narrative study, through generating rich data from stories can enable the complexity of the act and the meaning gay men make of it to emerge (Abes & Jones, 2004).

This study is concerned with difference and what makes self-injury different in a population of gay men. The purpose of this study is to evoke experience and to allow self-injury to emerge onto a landscape that is richer than a medicalised construction of deviance or disorder. There are risks to this approach, however. Narrative research can lead to over or under-interpretation of data (Clandinin & Connelly, 2000). Over-interpretation can drown out the voices of participants and does not attend to data (Riley & Hawe, 2005). Instead, attempts might be made to generalise in a way that can "take the life out of the inquiry" (Conle, 2000, p.57). Under-interpretation involves the researcher avoiding the social and instead attending too strongly to individual experience. The result of this approach is work that is overly descriptive rather than incisive (Riley & Hawe, 2005).

Different and sometimes ambiguous language is used to explain narrative research. This study adopted a narrative inquiry approach, drawing substantially on the work of Clandinin and Connelly (2000) and Frank (1995). Narrative approaches may take a number of forms, however, these may be reduced to two broad types: narrative inquiry and narrative analysis. The current study uses both approaches. Narrative inquiry assumes people live storied lives and hence stories become the means for understanding experience (Pinnegar & Daynes, 2007). Narrative analysis is different, in that a story may be analytically reduced to a narrative, which becomes the data unit for analysis and interpretation (Frank, 1997b; Reismann, 1993). Polkinghorne (1995) views this dichotomy of approaches as a product of what Bruner (1986) terms narrative and paradigmatic cognition. Narrative cogniton, allied with a narrative inquiry style, is about locating differences between people by attending to individual plots, narrative structures and relationships. Paradigmatic cognition, upon which the analysis of narrative is based, seeks to classify and find themes and concepts. Narrative analysis focuses on similarity or fit with a concept, whereas narrative inquiry asks what makes each situation (or person) remarkable.

The present study seeks to explore the unique experiences of gay men who self-injure in their contexts. Chapter 4 presents the stories of gay men who self-injure. These stories unfold across a narrative landscape that attends to time, place, individual and social experience (Clandinin & Connelly, 2000). These stories allow the voices of the

men to be heard and to engage the reader. Each man tells an evocative story about his experience of self-injury, which also contains a story of life that embeds self-injury in context. In Chapter 5 I work with the men's stories and draw upon Frank's (1995) illness narratives, to explore how the men's stories can be told and understood. This approach means that each man's story remains unique, yet it also enables a robust discussion of the way self-injury is able to be thought about and what other possibilities for understanding might be embedded within the experiences of the men in the study.

What narrative inquiry can tell us about nursing people who self-injure

Narrative research is no longer solely the purview of literary and educational studies; instead narrative is a multidisciplinary practice (Clandinin & Rosiek, 2007). For nurses, it is not only the understanding of self-injury that can be enhanced through a narrative approach. Narrative Inquiry offers a means of enriching nursing practice, because narrative is one of the means by which caring nursing practice is generated (Bowers & Moore, 1997). That is to say, clients tell stories in response to a number of clinical questions (Frank, 2002) and nurses are moved to respond to clients' stories by planning and implementing care.

Experience is lived through the body. A postmodern perspective assumes the body to be an effect of discourse—that the physical body is created in and understood through language (Foucault, 1990). The body thus takes on a passivity, becoming a channel through which discourses operate (Radley, 1997). Narrative inquiry offers a means for the body to speak itself, because experience is filtered through the body (Frank, 1995). Therefore, the body, hitherto subverted or passified by discourse, can be realised and understood through the stories of people who experiences illness or adversity (Frank, 1997a; Radley, 1997).

Narrative builds identity and therefore the opportunity to tell stories offers a way for people who self-injure to engage in identity building rather than self-defeating or damaging talk. Furthermore, stories of self-injury as it occurs within a wider

narrative of community living are a means of developing knowledge about a complex phenomenon as well as building understanding and openness about the issue amongst people who are concerned about self-injury.

Being open and receptive to clients' stories represents a vital element of nursing practice, because it facilitates care (Bowers & Moore, 1997). For this reason, narrative inquiry is an appropriate methodology for advancing nursing knowledge. Emphasis on local, particular and individual knowing is congruent with nursing's interest in caring for and responding to individuals and opens possibilities for working therapeutically with people who injure themselves.

Another way narrative might be a useful way to think about self-injury lies in the polysemic nature of stories and the fact that the meaning made may not be only that which was intended. For example, Horton (2005) tells of his struggles as a gay academic and his experiences of alienation, but reflects in his writing about how his account is really a story about de-alienation, resistance and hope. Many current perspectives on self-injury are based on accounts or stories of pathology, risk, trauma and treatment. A narrative study of self-injury with gay men provides an opportunity to "hear past" old stories and find new voices and new ways of thinking about the phenomenon.

The subject matter of stories, expressed through plot, is about what is experienced, and also what is done (Polkinghorne, 1995). Careful attention to stories can therefore provide a balanced description of self-injury and the person who enacts it, without over-emphasising the act and neglecting the social elements that shape the behaviour. Because there are no rules for attributing meaning to behaviour (Emihovich, 1995), alternative readings of self-injury are possible. Undertaking a narrative study of gay men can help nurses to challenge the dominance of medicalised understandings and explore new aspects of a complicated behaviour. Stories can therefore become "gathering places of meaning" (Gordon, McKibbin, Vasudevan, & Vinz, 2007, p.326) and sites of commonality, recognition and kinship. This is an important aim for research with a marginalised group whose differences are foregrounded but whose similarities and kinship with the mainstream is obscured by discourses of deviance or pathology.

Foundations for narrative inquiry

A central tenet of narrative inquiry, is that people lead storied lives that are both personal and social (Clandinin & Connelly, 2000; Connelly & Clandinin, 1990, 2006). What this means is that people's lives, which includes knowledge of self, other and community are comprised of stories of what it means to be a person living in relationship in a particular time and place. The way surroundings and contexts are interpreted rely on stories to shape knowing and to give meaning to being in a certain place at a certain time. Narrative is a way of understanding self, self in relation to other, and the conventions and mores of the social world in which the self is tenuously placed. Narrative is thus a way of knowing (Bruner, 1986; Mello, 2005) and also a way of extrapolating knowledge from lived experience (Dodge, Ospina, & Foldy, 2005). Narrative inquiry represents a particular way to understand people, their experiences and their social worlds.

One way of thinking about how we know is to apply the metaphor of a "lens", which filters what is seen and known in the social world. If narrative can be thought of as a lens, and stories are embedded in everyday living, then narrative ways of knowing reflect an epistemology of action, interaction, relationships and culture that becomes a standard for how we conduct our lives (Shields, 2005). In everyday life, stories are embedded practices within family and culture and offer a means to understand how experiences occur and to explain their meaning. Stories, as social phenomena of interest, are both a creative endeavour and a survival skill (Mello, 2005); that is to say, they transmit information necessary for living, reinforcing their relevance to culture, identity and convention. In narrative inquiry research, stories are therefore the object of and the method for inquiry (Clandinin & Connelly, 1994; Clandinin & Connelly, 2000).

Constructing meaning

Narrative Inquiry assumes an epistemology of constructionism. This implies that meaning is constructed rather than discovered and this construction occurs with others, in context (Crotty, 1998; Dodge et al., 2005; Gergen, 1985). Therefore, individuals are central to the development of meaning because consciousness must engage objects for meaning to be generated. For this reason, meaning can never be objective rather it is derived subjectively through action and interaction (Crotty, 1998).

One of the ways people make sense of the world is through thinking about their experiences. Experiences are mediated, shaped and moulded through language and understanding. Some experiences become puzzles, problems or challenges that can be understood in different ways, depending on the standpoint or perspective of the viewer. Gay men's self-injury, for example, may be experienced as a product of the stress caused by an inequitable society, or alternatively as a feature of a more embedded clinical problem.

These differing constructions do not mean that people simply *create* the meanings associated with their realities. The everyday world presents humans with objects and actions from which meaning is *constructed* (Crotty, 1998). As such, any attempt to understand individuals, groups and their worlds involves attention to the objects that present themselves to those individuals. People do not live in isolation from their contexts and interaction with context is required for the construction of meaning (Clandinin & Connelly, 2000).

Constructionist understanding also requires that in order for the object to be understood and given meaning, the person experiencing the object must also be understood (Crotty, 1998). Herein lies an important foundation for narrative understanding: the subject is located in and in interaction with their social world. When people tells stories of themselves, a narrative identity is created (Sparkes, 2004). This narrative identity reflects not only who a person is now, but also who they were and who they hope to become.

For the narrative inquirer then, stories are the means through which meaning making occurs and is analysed (Dodge et al., 2005). Narratives are constructed by individuals

to tell their stories, but narratives also construct individuals and their worlds (Gergen, 1985) because stories do not just "tell of" they also create identity, purpose and meaning (Berger & Quinney, 2005a). Therefore, even though narrative inquiry is primarily concerned with individual experience, producing the meaning of a thing, or things, is not an individualist venture. It is a habit of people to tell stories to communicate ideas (Feldman, Skoldberg, Brown, & Horner, 2004) and so narratives can be understood as deeply embedded social practices. For this reason narratives are likely to be rich sources of information about the way lives are lived. In narrative inquiry, then, meaning making is an interactive practice because story generation and telling is inherently social.

Constructing self, constructing the social

Drawing attention to the way the social nature of living shapes narrative inquiry, Clandinin and Rosiek (2007) highlight the relevance of the critical social theories to narrative knowing. Knowing objects through social means is crucial to the Marxist notion that the social aspect of being determines consciousness (Marx, 1971). That is to say, ones consciousness can only be known as a product of the world in which it is produced and worldly experiences are, in turn, filtered through that consciousness. As such, Marxism stands as a critique of the humanism inherent in constructionist epistemology (Clandinin & Rosiek, 2007). Humanism holds knowledge to be the produced by individual consciousness that is unitary and autonomous (Alvesson, 2002). That is to say, people possess a coherent identity and are in control of their beliefs and social practices.

Clandinin and Rosiek (2007) use a border metaphor to explain how narrative inquiry is located in a web of existing understandings. At this particular border, narrative theory tempers the notion that ideology alone generates consciousness. Instead, narrative follows a pragmatic line, which elucidates and evokes experience. Embedded within experience lies social interaction, which can be explained through a constructionist epistemology. The social world can be embedded in the bodies of narrators (Berger & Quinney, 2005b) and narrative provides a means of gaining insight into the individual/social boundary. Narrative inquiry is therefore a useful

approach for a study of self-injury in gay men who may experience tensions at this boundary.

In this way narrative is a way to explore questions of identity for people in context. For some scholars, identity is understood as being generated within narratives and those identities are synonymous with the narrative itself (Lieblich, Tuval-Masiach, & Zilber, 1998). For others, identity can be understood as a narrative, or life story that is expressed (McAdams, 1997; Singer, 2004). Identity might therefore inform or be produced in a narrative.

Extending the concern with identity, postmodern perspectives render the self fragmented, and identity as constituted rather than intrinsic. Postmodern identity cannot be viewed as stable; rather, it is partial and contingent (Jolly, 2001; Reed, 2004; Ridge, Plummer, & Peasley, 2006). If identity is partial and contingent, then identity also has the capacity to be generated. Since people live in social contexts, identity generation is something that occurs through interaction and forms part of experience. Identity positions for gay men who self-injure are not well understood and how identity for gay men who self-injure informs their experience of the social world is of interest in this study.

Narrative enables the organisation of individual experience by attending to how individuals' actions are shaped by the whole situations in which they are located (Dewey, 1997). Individuals can also shape situations, creating a reciprocal and interweaving series of transactions that result in individual meaning and truth being deeply tied to context. Similarly, thinking and doing exist in relationship, whereby neither is privileged in the construction of truths that are used by individuals to shape the ways that they act and interact in and with their contexts.

For the narrative inquirer, interested in how identity and experience are constructed, lived and told, attention to what happens for people in their world is thus important. Because knowledge about self and other is acquired in context and in interaction, people learn citizenship by becoming citizens of a community or society (Dewey, 1944). Experiences therefore cannot be viewed in isolation. Instead, experience

always exists on a continuum, where something has come before and something will follow.

This notion is reflected in how people tell their lived stories. These stories are often organised in a linear way: experience builds on past experience and implies, in some fashion, a future experience (Clandinin & Connelly, 2000). Stories about experience are told in context and context implies some sense of history and place. Stories have a purpose and are told for a reason, which creates a sense that the story is somehow implicated in an ongoing project of self or community: "each utterance picks up from a previous utterance and leads on to another in mutual construction between narrator and listener. Nothing in human consciousness or discourse (and they are often the same thing in human experience) occurs in isolation" (Bowers & Moore, 1997, p.71). Listening to the way stories are told can therefore afford insights into how people construct and make meaning from their experiences.

Attention to the social experience is directed outwards from the starting point of individuals' experience rather than starting with, for example, discourse, which reflects a more post-structural way of knowing. Post-structuralism is concerned with the ways language represents realities. For post-structuralists like Foucault (1972) realities are not independent of language. In post-structuralism language is taken as constitutive and local knowledge is privileged over grand narratives. Furthermore a postmodern position takes language as plural and meaning as un-fixable (Harden, 2000). For this reason, neither the telling nor the representation of the telling of a story portrays exactly what happened (James & Platzer, 1999). There is no "single authoritative meaning" to be found in a story, because meaning is derived through social position, politics, age, education and so on (Mello, 2005, p.200). This perspective suggests that individuals cannot independently make meaning and instead become subjects of language and discourse.

The constructionist/pragmatic foundations of narrative inquiry, however, render the subjectivist stance more often associated with the post-structural paradigm problematic (Crotty, 1998). Narrative inquiry is able to show the different ways individuals interact with their contexts.

Narrative inquiry adopts an individual perspective, focusing on the meaning that people make about their circumstances (Clandinin & Connelly, 2000; Clandinin & Rosiek, 2007). But narrative inquiry also recognises that meaning occurs in relation (Craig & Huber, 2007). The practice of narrative (or storytelling) thus mediates the tension between post-structural and constructivist/pragmatic philosophy, through its "acknowledgement-in-the-telling" of the interaction of subjective realities and relationships. This means that it is possible, starting from a standpoint of experience to theorise outwards to show how people live and know their worlds, which include language and discourse as mediating factors.

To synthesise this position, reality, or experience, conveyed through narrative, is constructed reflexively, using language. As such, knowledge about a phenomenon is not revealed (and asserted to have truth value), but rather produced (Carson, 2001). What is viewed as having truth value is that which is useful to people in their respective contexts (Williams, Labonte, & O'Brien, 2003). Narrative inquirers attend to the language of production (Riley & Hawe, 2005). Texts that are analysed in narrative inquiry are understood to be "multidimensional: fractured, luminous, partial, smooth on some edges and jagged on others" (Patterson & Brogden, 2006, p.2) because of the instability and fluidity of language. Thus the knowledge claims that arise from narrative studies are tentative and acknowledge the possibility for alternative readings.

Narrative research texts (Clandinin & Connelly, 2000), in this case a thesis, provide a further space for the exploration of knowledge construction within the narrative/post-structural borderland (Clandinin & Rosiek, 2007). Research texts tell a story that will be read. It is a story of listening to other stories about storied lives on storied landscapes (Clandinin & Connelly, 2000).

Within this "geodome" of stories, multiple realities reflexively collide. The narrator's reality meets and intersects with the reader's, creating another, differently nuanced reading of the experience told in the story. In this way, narrative resists total subjectivism, yet values and plays with the subjectivity revealed through language in order to generate novel insights and new ways of thinking. Either way, meaning is

embedded in and by the experience—of the objects in the story (for the narrator) or the hearing of the story for the reader.

Stories and narrative

A story is a modified account of experience that reveals something of an individual's experience as well as revealing something about the person telling the story. Stories are descriptive and as such relate situations and events in a meaningful and coherent way (Eastmond, 2007) even if reality does not possess the unity implied in the story. Stories are therefore interpretive but also evocative and storytelling is central to narrative inquiry.

Stories and narratives are not the same thing. For Frank (2000) people tell stories, but narratives are units of analysis that arise from stories. Loosely described, a narrative can be a sequence of events, experiences or actions tied together into a whole with a plot (Feldman et al., 2004; Franzosi, 1998). Stories provide a sense of taking the reader from a beginning point to an (albeit tentative) conclusion through creating a sense of temporal progress (Dodge, Ospina, & Foldy, 2005). This enables narrative researchers to provide voice to narrators who cannot liberate narratives that are embedded in and inseparable from their own stories (Riley & Hawe, 2005). The potential for research to evoke is important with a marginalised group whose needs, interests and social/body practices are hidden and not well known. In the present study, the term story is used to identify the stories that participants told. Narrative is used to describe ways that stories are shaped and experienced.

Stories draw upon language conventions and social customs in the telling and as such reveal important personal information about the experience of living with self-injury as a gay man. Any account of experience and stories of self possesses organisation and structure. Narratives use a plot as a way of organising thinking about personal and social issues. Narratives can be thought of as "a discourse form in which events and happenings are configured into temporal unity by means of a plot" (Polkinghorne, 1995, p.5). Plot is not a simple chronology that gives life events logic (Berger &

Quinney, 2005b); rather it establishes continuity between past, present and future. It is by attending to plot, that it is possible to interpret events that occur within a story.

A recognisable plot is not the only means of accessing the point of a story. Attention also needs to be paid to why the story was told. The context of the storytelling is important and gives rise to what Frank (2000) refers to as the storytelling relation. The storytelling relation is one of the means by which useful insights emerge from the relationship between narrator, listener and where and why the story is told. The reason a story is told influences choice of language affects plot and sometimes colours the agenda of the storyteller, resulting in some elements being given prominence and others downplayed. Narrative researchers attend to these inclusions, exclusions and interpretations through focusing on the reflexive space between narrator and teller (Frank, 1997b; Frank, 2000).

A listener is thus implicit in storytelling. Sometimes, the listener is internal and people engage in a form of storying, which involves self-talk, in order to make sense of experience (Bakhtin & Holquist, 1981). At other times, stories are told to external listeners both to convey experience and to continue the process of constructing self, other and experience through the ongoing story. In either case, this is an intersubjective practice, in which co-construction of meaning occurs between teller and listener (Bowers & Moore, 1997; Cutter, 2000). Attending to this aspect of storytelling provides an analytic opportunity to theorise not only the experience, but the mode of telling as well. Cumulatively, these elements of how and why a story is told can help give narrative inquirers insights into individual experience, its context and social phenomena. In the present study, I return to the notion of the storytelling relation in chapter five, where a discussion of self-injury narratives is presented.

The three dimensional narrative inquiry space

In order to think about how stories are lived and told and how narrative inquiry is conducted, Clandinin and Connelly (2000) conceptualise a three-dimensional narrative inquiry space in which stories of experience and action can be understood. The three-dimensional space consists of the personal and social, past, present and future, and place as they are revealed in stories.

Each dimension allows for elements of experience to be understood. For example, the personal elements of a story include what is being thought, felt and happening for the person "on the inside". The social elements of a story show the individual's social world and its significance in the person's story, which may be valuable in better understanding self-injury (McAndrew & Warne, 2005). Past, present and future, or the question of "when" something happens opens the possibility for questions like "why now?" in relation to phenomena or experience. Descriptions of place or situation add to the richness of context and also help to show how individuals interact with place, in order to construct meaning. Each of these dimensions bears some important relevance to understanding self-injury, which is both an individual and social phenomenon.

This approach offers an important new way of thinking about self-injury. Exploring gay men's self-injury within a three-dimensional narrative inquiry space means honouring the experiences of the men who self-injure: it also means that more than the individuals who self-injure can be talked about. This approach enables multiple factors to emerge as relevant and related, without adopting a reductionist approach, in which a person is reduced to their self-injury alone. The result is a story in which self-injury is part of an account of a life much richer than reductionist medicalised discourse has hitherto revealed. In order to explain how stories were told in this study, I now turn to the research process, which involved engaging in the lives of gay men who self-injured.

Methods

One of the benefits of narrative inquiry is that it confers upon the researcher, the opportunity to enter and join a community, particularly where studies occur over longer periods of time (Clandinin & Connelly, 2000). The hidden nature of much self-injury and the limited places for experiencing togetherness mean it is extremely difficult, if not impossible, to enter a community of gay self-injurers. Therefore, the challenge was to find a way to construct a study that could balance issues of gaining entry and access to gay men who self-injured, with the need to collect data that facilitated narrative understanding.

Data collection occurred in two phases over a ten-month period and in two countries. In the first phase, data were collected from participants who were recruited to the study through a young gay men's community-based support organisation in the United Kingdom. This organisation has been working with young gay men, lesbians, bisexuals and transgender people for some years. The organisation has a supportive ethos and an activist agenda. This phase of data collection occurred through late summer and autumn of 2005. The second phase of data collection occurred in early 2006 in Queensland, Australia following an advertisement in a gay men's newspaper.

Ethical considerations

There is an inescapable need for safeguards when research is being conducted with potentially vulnerable populations. In the first instance, ethical approval was sought and gained from the Griffith University Human Research Ethics Committee. Approval for the research protocol involved attending to a number of issues to ensure that the study met the standards for ethical research conduct as prescribed by the National Health and Medical Research Council of Australia (NHMRC, 2007).

Safeguards for participants

Informed consent to participate was obtained in the following way. First, both advertisements (Appendices 1 and 2) contained a contact number and an email address so that men could speak directly to me. During this initial phone call, participants were briefed about the purpose of the study and what was involved. This was followed up with an "Information for Participants" form, which reinforced points raised in the phone call (Appendix 5). Men who agreed to participate were asked to sign a consent form (Appendix 6), which clearly stated they were free to withdraw from the study without penalty at any time.

There is a recognised need to conduct research with stigmatised or marginalised groups, but this need must be balanced with possible under-resourcing of this research, which can lead to harm (James & Platzer, 1999). Participating in studies where people are asked to recall past difficulties or trauma can be a difficult emotional experience. Recalling self-injury or that which precipitates it can be re-traumatising and give rise to thoughts and feelings that are not easily resolved. For these reasons, free independent counselling was arranged in case participants felt they might need to speak with someone about past or current issues that were raised through participation in the study.

A further concern was that the men might feel pressured to disclose information because of a perceived power imbalance between researcher and participant. There is a greater power differential between researchers and gay men than is the case with some other groups as a result of the social outsider status of gay men (James & Platzer, 1999). My first discussion with possible participants included information on my background as a nurse and as a gay man, in order to minimise, if and where possible, any sense of difference, marginalisation or being subjected to a heterosexual gaze.

If research has the potential to be difficult or traumatising, then it also has the potential to be a cathartic and useful experience as well. None of the participants took up the offer of counselling and two of the men verbally indicated they had found the process of being interviewed helped them to gain some insights into their self-injury.

Confidentiality

Confidentiality was protected from the outset of the research. Potential participants contacted me by telephone or email. This meant that at no time did I have access to any information about men who were self-injuring. Those who indicated they wanted to be interviewed were asked how they would like to receive further information. Some men chose to receive forms by email and regular post. One man asked to meet and read the forms at the meeting. All men provided at least an email address or telephone number for further contact if needed.

Interviews were conducted where participants felt most comfortable but this practice poses a risk to the researcher. I ensured one person knew I was conducting a research interview and I rang this person before and after each interview as a safeguard. Prior to the interview, participants were informed they could stop at any time with the option to resume or cease the interview if they felt that was necessary. The men were made aware that a pseudonym would be used and other potentially identifying information, such as combinations of job-role and location, for example, have also been made anonymous.

Risks to researchers

As well as the risks involved in interviewing men in community settings, a further risk in this study is that, as someone who aspires to an academic career, I am disadvantaging myself by conducting this research. Research with sexual minorities is sometimes controversial and for researchers it can also be stigmatising (James & Platzer, 1999). Such a claim is easy to dismiss in a heterocentric world, where a "surely not" mentality, at least in my experience, tends to predominate. Lesbian and gay researchers do, however, experience difficulties as a result of their research and academic practice (Horton, 2005) and this difficulty is particularly well evoked by James and Platzer (1999, p.78):

> Our openly lesbian and gay status invites judgements that are not entirely based on our academic or clinical abilities. Some of us have been publicly (and privately) disassociated from in work settings and harried by anonymous

> sexually explicit phone calls. Bearing witness to the distress, pain and alienation of lesbians and gay men, and listening to stories of physical and sexual abuse and denial of care by health care practitioners, is motivation of the kind that saddens and angers us. Being "insiders" ourselves, it is a constant reminder of what may be in store for us one day.

As a gay nurse researcher I am aware of how this thesis, a doctoral study on which, arguably, I should start to think about building a career, might not enhance my employability. Indeed, it may even be a way of courting social and academic disadvantage. I also reflect on the similarity between the stories of some of the men I interviewed and my story and I imagine myself in the marginal situations described by them. I have pursued the topic, nonetheless, because the purpose of research is not to maintain the status quo, but to challenge, transform and change established beliefs and practices. While it may bring disadvantage it will also doubtless create other stories that might be told.

Data storage

All interview data were digitally recorded and transcribed verbatim by the researcher. Each transcript was then re-read while listening to the recording to ensure accuracy and completeness. The digital recordings were then erased and the transcripts kept in a locked filing cabinet. Electronic copies of the transcripts were kept on a computer file protected by a password known only to the researcher. Field notes were also stored in a locked cabinet. As field notes were written, participants were identified only as "participant one", "participant two" and so on.

Participant recruitment

I became aware of Jones Road Centre (pseudonym), an organisation in the United Kingdom that supported young gay men. At this point I was in the early stage of my doctoral candidature and considering different ways of looking at self-injury in gay men. I emailed Jones Road about my interests. The response was enthusiastic and I developed an email-exchange relationship with a senior project worker. At this time I was also preparing to return to England for a year in order to spend some time with

my family. The irony of returning to the scene of my childhood hiding, shaming and awkwardness to collect data for a doctoral study on why gay men self-injure was not lost on me.

I returned to the UK in 2004 and sought approval from Jones Road to approach potential participants. I placed an advertisement at Jones Road to recruit men for the study (Appendix one). As such, the sampling for this study was both purposeful and convenient. While this can be viewed as a limitation, this study does not seek to showcase a representative sample of gay men who self-injure. Instead, the aim of this study is to develop insights into self-injury in this group. The purposeful convenience sample can also be viewed as a research strength, in that people who are willing to participate are often rich sources of information (Patton, 2002).

Seven men responded to the initial advertisement at Jones Road Centre. In the period between first discussion and interview I had several conversations and email exchanges with each man, establishing the parameters of the study and what would be involved. Several men wanted to discuss their self-injury prior to the interview and I felt it was important to respond to this need. Three of the seven men finally agreed to an interview.

In 2006 I returned to Australia. Here I sought further participants for the study. This second phase of data collection began with an advertisement in a publication for gay men to participate in the study (Appendix two). This phase of the study occurred without any formal support organisation and the men with whom I spoke did not use any specific support services related to their sexual orientation.

The second phase of data collection yielded a similar influx of inquiries about the research. I spoke on the telephone several times with three men who expressed an interest in participating and exchanged a number of emails with a further three who were interested in the research aims and objectives. Of this combined group of six men, two finally agreed to an interview.

Inclusion and exclusion criteria

In total, five men participated in a research interview[1]. Each man was asked beforehand about whether he was self-injuring currently and receiving any professional support. I explained the way an interview would work and encouraged those men who were currently self-injuring to reflect on how they felt the experience might be for them, before agreeing to participate. Of the men I spoke to, three (Arun, Justin and Matt) were currently self-injuring and two (Brian and Paul) were not. Regardless of current self-injury each man was eager to share his experiences. The literature review for the study showed how attempts to refine or narrow down definitions of self-injury possibly foreclose inquiry into self-injury that is different. For this reason I did not exclude any man from participating based on his type of self-injury. Instead I allowed those who felt they self-injured to discuss this and participate if they wished.

The field texts

Field notes

I kept field notes for two reasons: First, field notes provided a means by which I examined how data were collected and thought about. The field notes became a reflective record of my own practice and conduct in the field—a way of self-monitoring. Second, I kept field notes so that I could integrate them into the story of data collection, as a fidelity measure (Tuckett, 2005).

I began making field notes early in the research. My first was made at the conclusion of my confirmation[2] seminar, where I reflected on how some audience members found it difficult to grasp why I wanted to speak with gay men about self-injury. This established another purpose for my field notes—a means by which I could think

[1] Pseudonyms are used for each man, their significant others and locations.
[2] Confirmation is a stage of PhD candidature at Griffith University. Confirmation involves an independent assessment of the viability of the proposed doctoral study and of the candidate's progress. A preliminary document outlining the research is prepared for the independent examiner. The candidate then presents a seminar to an invited audience, supervisors and the independent examiner.

through the doing of narrative inquiry (Clandinin & Connelly, 2000). The field notes became a resource for me to think through things that I was going to find intellectually and emotionally challenging.

I started to keep a diary alongside the field notes in order to maintain a timeline of what I had done and where. At the outset of the research this seemed important, because I wanted to keep a memoir of the experience. Just like every other diary I have tried to keep, however, this was also quickly abandoned and instead I dated and expanded my field notes to incorporate my own personal thoughts, feelings and reflections as well as my observations and ideas about the research process and data collection. References to my field notes are included in the forthcoming chapters, as I explore the stories of the men who self-injure.

Conversational interviews

Face-to-face individual open-ended interviews were used as the primary source of data. Each participant took part in an open-ended interview. Open-ended interviewing has previously been used in narrative inquiry (Glover, 2003; Grace, Cavanagh, Ennis-Williams, & Wells, 2006b) and allows a space for people to tell their stories (Bazylak, 2002) and include what they consider to be relevant (Migliaccio, 2002). This type of interviewing is appropriate to a study that sought to remain open to the possibility about how self-injury might be experienced (McCance, McKenna, & Boore, 2001).

I started with a broad question where I asked participants to "tell me about a time when you have self-injured". This question opened up a conversational style of interviewing designed to elicit stories (Clews & Newman, 2005; Lieblich et al., 1998; Reismann, 1993; Ussher & Mooney-Somers, 2000). I occasionally interjected to show interest, prompt for more information, to clarify or to affirm what was being said (Reismann, 1993). This style of interaction has been described as more intimate, egalitarian and useful in sensitively exploring why people act in certain apparently health damaging ways (Whitley & Crawford, 2005). Given that I was talking to men who self-injured this seemed an important aspect of data collection.

Narrative understanding informed how the interviews were constructed, lived and ultimately analysed and interpreted. Because participants came to the interview expecting to talk about self-injury, and self-injury is almost exclusively thought of as harmful and damaging, in the fieldwork planning stage, a small number of questions were designed, as prompts to elicit balanced information (Appendix three). That is to say, I wanted to seek personal stories from the men (Glover, 2003), but not exclusively stories of conflict, difficulty or healthcare intervention. To do so, would have been to assume characteristics of a normative self-injurer: an assumption contrary to the aims of this study.

Attention to individual, personal stories was also a way to avoid assuming a normative gay identity (James & Platzer, 1999). That is to say, it was a means to ensure that characteristics and situations unique to the men could be evoked in the analysis and presentation of the data. When the discussions with the men took place, I did use some prompt questions within the conversations, but in the context of a collaborative conversational style. In the interviews I found myself unable to "act upon" the men by imposing questions that each had to answer. Instead, I found myself taking the perspective that both participant and I were reflexively engaged in the story of self-injury, its meaning and experience.

Reading the interview transcripts and analysing the information contained in them involved attempting to make sense of what the men had said. At this point I was acutely aware of how even though interviews are sometimes taken as the "gold standard" of data collection in qualitative studies, they remain constructs that reflect culture, relationship between researcher and researched, and a wider story of the research process (Clandinin & Connelly, 2000; Frank, 1997a, 2000; Sandelowski, 1996, 2002). As such, and in a narrative sense, interview data contain no objective knowledge, only constructions of experience that are open to interpretation and revision. Interviews and resulting analyses and interpretations in this study thus offer a partial account of experience and other interpretations are possible.

I have already argued that it is important in narrative inquiry to attend to how a story is told. The interviews for this study were transcribed by me and then read while

listening to the tapes in order to gain a sense of closeness to the information relayed in the interviews. Transcribing the data helped me to listen to the men as they told their story and to recognise and appreciate moments of humour, sadness or irony, for example, which could have been lost without this opportunity.

Following up on the interviews

Once each participant had been interviewed, I invited him to review his interview transcript, comment upon it and use this to promote further discussion, clarification and story telling. The review was also intended to provide participants with the opportunity to sanitise and modify their original words, if they felt uncomfortable with any content. I also intended that this process might provide information on which to conduct a subsequent interview to gain deeper information or insights.

Once each interview had concluded and been transcribed, the participant was contacted with a request from me regarding how they would like their transcript sent—by mail or email. Arun, my first interview participant was the only person to respond to this request and he asked that his transcript be emailed. With the exception of a few subsequent emails telling me of his plans to visit Australia, no further contact was received from him. Each subsequent email from Arun ignored the issue of self-injury altogether. No other participant responded to any subsequent attempt at contact from me.

I found, and still find, this a startling and unsettling end to my very personal contact with these men. My experience as a clinician had led me to expect that these men would wish to continue their dialogue about their self-injury, but this did not happen. It felt very much as though once we had met, for them, the job was done. Reflecting on it later, as I read a field note I made at the time (Appendix four), I realised I experienced a sense of abandonment usually reserved for the person who self-injures in the client-clinician relationship and I still wonder what is happening for them now.

This study does not, therefore, rely on a conventional member checking process. I was left uneasy that I had not been able to return to the five men with my

interpretations for their comment. Member checking, however, does not necessarily bring interpretations or findings any closer to a knowable truth. Participants' agreement with interpretations can instead confirm the authority of social science researchers (Frank, 2001). That is, a member check might do little more than establish the authority, rather than credibility, of the researcher's interpretations.

From field text to research text: Turning transcripts and notes into stories and narratives

In this study I first undertook several readings of the transcripts to gain an overall feel for what was included in the men's accounts of their self-injury. Then, the transcripts were cleaned and any of my comments or participant's comments that did not relate to the topic of self-injury were removed (Emden, 1998). Complete narratives with a beginning, middle and end as defined by Denzin (1989) were located in the research transcripts. Complete narratives were used in this study because they enable in-depth engagement with the participants' experiences and contexts. Segments were placed together in order to construct a story of self-injury that revealed each man's life as it was lived. Each story presented contains a plot, characters, is set in a place and time and told from the narrator's point of view (Clandinin & Connelly, 2000).

The stories of five gay men who self-injure

In the following chapter I present the stories of each man in two stages. Each man features in his own voice, without researcher interference, except to signpost where shifts in the narrative space occur. Each man's story can be read as a product of Frank's (2000) "storytelling relation", because the stories were told in response to a request from a health researcher to talk about self-injury. The stories in the forthcoming chapter are therefore presented as five "talking heads" in order that each man's voice stands alone and unique. Each man's voice resonates with his own experience of self-injury.

The second stage of presenting the stories in this study involves turning to Frank's (1995) notion of illness narratives in order to enable different meanings in the stories to be articulated. In Chapter 5 the literature is blended with the men's stories, and theory is explored as the narratives are developed (Lindsay, 2006). The aim of this approach is to create an evolving theoretical narrative alongside the story of each man without attempting to reduce the man's story to theory. To augment the analysis and interpretation I drew upon practices and recommendations within the narrative literature. Specifically, I attended to the following:

- Who the important characters were in each man's story were and why they were important (Riley & Hawe, 2005);
- Examples of where the men might be ventriloquising (Gilligan, 1982, 1993) or replicating dominant understandings;
- Examples of men finding their own voice, in order to explore identity, authenticity and the "body in the narrative" (Frank, 1997a);
- The men's metaphors as a way of locating and understanding possible silences or hidden meanings in the text (Davies, 2001; Lindsay, 2006).

Rigour

As a result of conflicting terminologies and practices surrounding narrative research, there is no clear consensus about how the quality of narrative research is best determined (Blumenfeld-Jones, 1995). However, it is incumbent upon qualitative researchers to provide a "comprehensive account" of the phenomenon under investigation (Whitley & Crawford, 2005, p.109) and to report the research process in ways that permit judgements about its relevance to practice and research, its believability and hence value.

In narrative inquiry, believability is linked to the craft of storytelling (Fisher, 1998; Glover, 2003). For Bruner (1986) this involves the creation of stories that are evocative and lifelike. In establishing relevance to practice as a point of rigour in qualitative research, Frank (2004) extends the idea that it is important to tell good stories by arguing that a research story needs to engage its reader and provoke their

interest. It is therefore important to attend to interpretive rigor, as much as to the rigorous application of method (Dodge et al., 2005). The latter implies an assumption that the correct questions have been asked and the right theory used, whereas the former is concerned with whether the interpretations arise from defensible reasoning (Dodge et al., 2005).

Whereas some qualitative approaches seek to generate criteria that mirror the positivist agenda for truthfulness, narrative studies need criteria that reflect the ongoing reflexive and co-constructed nature of stories. In nursing research it is also necessary to produce findings that have relevance for practice. This is a further "critical standard" by which the quality of research may be judged (Dodge et al., 2005, p.287).

To summarise, there is a need to tell good stories because good stories possess transformative potential. In context of a study conducted with gay men, a good story is one that demystifies and does not marginalise. To meet this aim for this study, individual stories provide texts for analysis. Proper representation of the subjectivity and bias in individual stories is a research strength and are one way to demystify the experience of being a gay man who self-injures. Uncertainty, tentativeness and contingency are characteristics of this epistemological position (Schwandt, 1996). Because narrative inquiry is concerned with subjective experience, how stories are analysed, interpreted and told needs to be explicit. This chapter has explicated the process by which stories for analysis were generated and presented.

Both believability and relevance are enhanced in the degree to which findings can be transferred to other situations (Tuckett, 2005). Narrative inquiry is local and particular and linked to time and thus the aim of this thesis is to present a discussion that is generative rather than transferable. That is, I seek to present new and challenging insights or ways of thinking about self-injury.

The concept of fidelity is pertinent to the practice of Narrative inquiry in this study. Whereas truth may be understood as "what happened in a situation", fidelity can be understood as "what it means to be teller of the tale" or, fidelity to what happened *for the person* (Blumenfeld-Jones, 1995, p.26). Put another way, fidelity is about the

acknowledgement of subjectivity and a commitment to narrating that subjectivity in ways that allow the experience to emerge and be told: arguably, an important objective for nursing research. Fidelity promotes believability: the sense in the reader that what is represented is congruent with or analogous to their experience (Blumenfeld-Jones, 1995) or whether the research resonates (Dodge et al., 2005) with other audiences.

In the case of this research the audiences are predominantly, although not exclusively, gay men and nurses or health professionals who work with people who self-injure. In the present study, the first story told is my own, of working with a young gay man who self-injured, which gives insight into a motivation for conducting the research. Another story is presented in the literature review that explores current knowledge about self-injury. In the forthcoming chapter each man tells his personal story of self-injury.

Fidelity is also realised and enacted in the relationship between teller and inquirer: in the way that the narrative inquirer attends to elements of context, events and history (Blumenfeld-Jones, 1995) so that the resulting story shows itself to be an account of experience, rather than a claim to truth or reality. In the context of this study, fidelity is closely related to the concept of reflexivity and why a story is told.

Reflexivity and the storytelling relation

The relationship of researcher with topic, participants and study process is central to the rigour of a study. Attending to the role of the self in research represents part of the narrative turn in qualitative approaches (Clandinin & Connelly, 2000; Grace et al., 2006b). An important consideration in a narrative inquiry is the experience and background the researcher brings. Understanding my own perspectives while in a research relationship with others in their settings is important in meaning making in a qualitative narrative study (Hunter, Lusardi, Zucker, Jacelon, & Chandler, 2002). The prologue to this dissertation narrates the evolution of my personal and professional interest in the topic of gay men's self-injury (Balan, 2005) and how I came to embark on this doctoral study. As Clandinin and Connelly (2000) state, "we are in the parade

we presume to study". I am not in this parade as an expert in the self-injury of gay men, but rather as a participant in a dynamic area of scholarship (Grace, Cavanagh, Ennis-Williams, & Wells, 2006a).

Stories are told for a reason that needs to be made clear in the presentation of any research findings (Frank, 2000). The stories told in Narrative Inquiries are a co-creation between participant and researcher (Wiklund, Lindholm, & Lindstrom, 2002). For this reason, reflexivity plays an important and valuable role, as it enriches discussion in and, later, about the research (Grace et al., 2006b) as well as opening possibilities for interpretation of research findings (Clandinin & Connelly, 2000). In narrative inquiry, researcher and participant co-construct research texts. The men in this study told their stories for their reasons. In turn, I tell the story of this research for my reasons and from my multiple frames of reference as a nurse, gay man, activist and bystander. For these reasons, I am also "autobiographically present" in the conduct and findings of the research (Lindsay, 2006, p.36).

By virtue of the narrative approach used, this study embeds some postmodern assumptions. Regarding criteria for rigour one of these assumption is that the findings are not presented to the reader as *the* truth, but rather *a* truth, which is linked to the participants and me in our respective times and places. When seeking truth in a narrative study, one seeks the truth of the experience, rather than the truth of the thing (Glover, 2003). In other words a truth is located in experience, not outside of it. This standpoint means that knowledge is thus accepted as contested, temporal and relational, but through rigorous argument, defensible. Such truths are generative and should not be viewed as any sort of authority to explain or solve a problem (Frank, 2004). This study and its thesis are therefore only one of a number of possible ways of thinking about self-injury in gay men.

Study limitations

The value of a narrative inquiry informed by postmodern assumptions perhaps lies in the way it can call us to want to cultivate a sense of community with others (Huber, Clandinin, & Huber, 2006) rather than to find out truths about them. A well crafted and rigorous piece of narrative research might be understood as something that has the potential to build connections between people, like nurses and people who self-injure, or straight people and gay men, without homogenising or essentialising. Engaging in research that finds and illustrates defensible new ways of thinking about old problems (Williams et al., 2003) can break social deadlocks and develop sites for dialogue. As such, a rigorous narrative inquiry can be individually and socially transformative and possess a moral and aesthetic quality (Dodge et al., 2005).

Getting to this point, however, means that some narrative studies are lengthy and both narrator and researcher come to rely to some degree on memory that may be aided by field texts, notes and other aides-memoires (Clandinin & Connelly, 2000; Riley & Hawe, 2005). Furthermore, stories can be told in a variety of different ways (Carson, 2001) creating findings that are tentative and partial. While this may be a limitation, in so far as it compromises claims to "truth", narrative inquiry instead seeks to offer faithful insights into phenomena. Such a venture is achieved in this thesis, using the criteria for rigour outlined above, resulting in a thesis that may be judged as generative rather than generaliseable.

In order to avoid the risks of over and under-interpretation described earlier in this chapter, I have shown how data are used (Clandinin & Connelly, 2000) and I return to data to embed analysis and interpretation. As critical points emerge in narratives, I also return to the literature to enable a robust discussion of individual experience in the context of what is known. As participants' narratives are further discussed in Chapter 5, their voices remain a constant feature in the discussion, as they engage with the literature.

Because narrative inquiry needs an acknowledgement of researcher presence, a declaration of interest and statement of researcher's background and involvement is needed. This has elicited criticisms of solipsism (Berger & Quinney, 2005a; Clandinin & Connelly, 2000). Some argue that research is not about the researcher and unless carefully executed, research can appear to be self-centred (Harden, 2000).

Therefore, while I am present in this study and attempt to make transparent my influence on the process and research product, I have also described how the analysis and interpretation foregrounds the stories of the men who self-inure and attempts fidelity to their voices.

This thesis and the stories contained within it are one of a number of possible stories about self-injury in gay men. While this thesis addresses a significant issue, it fills only a small gap and only for a short time. Other stories are needed to add to these and to advance the discussion of self-injury in the context of same-sex attraction.

Conclusion

This chapter has outlined the theoretical underpinnings and practical procedures of this study. The epistemological foundations of narrative inquiry provided a context for the narrative method used in this study. The strengths and limitations of this approach have been outlined to further provide a conceptual boundary around the knowledge claims made in this study. In the following chapter, the research method is deployed and the stories of five gay men who self-injure are told.

CHAPTER FOUR

FIVE SHORT STORIES OF SELF-INJURY

Introduction

You are about to enter the worlds of five men who provided rich insights into their lives with self-injury. The purpose here is to give each man his own voice: to tell his story unencumbered and uninterrupted.

Each man's story unfolds within the three-dimensional narrative inquiry space (Clandinin & Connelly, 2000), a space that is personal and social and locates the storyteller in the past, present and future. Each story stands alone and in this chapter no attempt is made to deconstruct the story. Instead, I allow the stories to emerge as a means of witness to each man's experience (Frank, 1995). My voice, as researcher, is present in each story to provide signposts that mark each participant's journey through his story.

Arun: Not showing, not telling

I am twenty-seven years old.

I live and work around the city and I have been here for nearly five years. I work in an organisation that supports young people who are having emotional difficulties and who do not have parental or other support.

I live alone.

> I started self-injuring with razor blades on my arms and it was so easy. It didn't leave any scars. I have friends from college who have horrific scars and I never realised what it was at the time. Now I do it I understand what it was and I don't want to look like that so I try not to be scarred. I am also quite wary because of my work; people will say I need help and I don't want to be tarred with that brush, I want to deal with it myself. I can't access any services because of work, plus I don't trust them. There's only one place that could help that's gay specific and I do think it is related to my sexuality.
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> For me, self-injury is a release and a coping mechanism. It is a way to use the physical to release emotionally. It's all about locus of evaluation as well. My locus of evaluation is all over there somewhere so I can't talk to others, I have to rely on myself continuously and when I need help or need to do something about my problems it is a sort of immediate release that is satisfying and a way to say "that's an end to it now", so it's also a completion and ending—that kind of thing.

His perception of how others see him influences his self-injury:

> It's about being able to deal with it on my own and not having to rely on anyone else… To be strong enough because everybody thinks… you want to be able to prove yourself because everybody thinks oh gay people are just all emotional and they're just out for sex and you really can't share anything about yourself so much to heterosexuals or anything like that. You can't be who you want to be. You can't make yourself vulnerable to your parents or trust your parents or speak to your friends and family and say, look I'm having a really tough time or

> this person I really liked and thought I was getting on with said they wanted something different. They just say, "Ah well, gay relationships don't really last". I don't want to be able to prove them right in that respect. People put your sexuality first and any problems you have are to do with your sexuality because that's all you are and I am so much more than my sexuality. Well… it's a huge part of my life and it's the bit that's the problem. Well, I have a problem with it because most other people have problems with it.

The real or imagined judgement of others establishes his self-injury as both internally motivated and also as something that mediates his presence in and relationship with his social world.

Arun uses a temporal vantage point to narrate how he had learned at an early age how he should conduct himself:

> I have a twin brother who was abused when he was younger and he was sectioned[3] from self-harming and doing lots of things. He did risky sex and went on downward spirals. Now he has his own house and stuff and I've got to be seen to be able to cope with things. The trouble is, once you've bought into that kind of ideal, is being able to keep it up. So it's about being able to deal with it on my own; about not having to rely on anyone else, because everybody says you have to cope with things yourself. You've got to grow up and deal with it yourself and so I'm reluctant to get help from friends or tell friends about it because that is relying on other people. I don't want to put it on anyone else. I suppose it is sort of selfish in a way. Friends sometimes say, if I'm feeling bad to phone them, but I don't want to let them into that. I don't want them to see this positive person who's got this

[3] This term refers to the formal detention of a person in inpatient mental health care in the United Kingdom under a section of the Mental Health Act 1983.

> little problem with blades and stuff. It's not a pride thing, rather I'm trying to show a confident strong person to the world.
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> I play tennis with a friend of mine who is a psychotherapist once a week and I make sure he can't see that I have hurt myself. If I know we are going to play I sometimes use the soles of my feet so that he can't tell. It kills but nobody can see the bottom of my feet and it's a great way to deal with it because, and it sounds so gratuitous and gratifying, but I can actually feel it with every step and be reminded that I am coping with it. I am proud of doing it, because it is me taking responsibility to do it and it is something that I do well. This is something that I have complete control over and I am proud that I can do this to myself and not involve anybody else or rely on anybody else to help with it.

A vulnerable yet proud man, Arun uses his self-injury to manage his distress. To this point his story is one of emotional pain, but it is also one of coping:

> I did speak to a mate on Friday and I said to him, "Don't shout at me, but something's happened in the last week and I just needed a release". I didn't want to cut but I didn't know who to turn to or what else to do so I went back to what I know. It's a silly thing to do and I shouldn't do it, but it's how I cope.

Coping/hurting in the face of bad experiences is his experience:

> I've been assaulted, mugged and beaten because of my sexuality, just by walking down the street. I'm waiting for something to go to court actually. I was walking down the street and this girl asked me for money and cigarettes. This was on a lunch break from work. I said no and this girl calls me a fucking faggot bastard. I told her to fuck off and she followed me across the road,

grabbed my arm and spat in my face. I got scrape marks on my wrist and I thought bugger this and I was really quite pissed off, because she wouldn't do that to just anybody.

Then, one night, around the corner from my house I was walking home through the park and there were these guys who had lit a bonfire. The last time that happened it set fire to a tree that then set fire to a neighbour's shed. I went to phone the fire brigade to get them to come and put it out. I wasn't going to confront them myself because they looked as rough as hell. Basically, this guy saw me on the phone and he came over and asked what I was doing. I said nothing and walked away but he followed me giving me mouth. He said, "You're only a fucking poof anyway" I said, "Yes I am, and your problem is"? And he said he didn't have one, I think because he was shorter than me. I started to walk away but his mate joined him and then I had seven bunches of shit kicked out of me. It's not nice, but there's nothing you can do. I self-harmed a lot from that incident, because the police could have done something about it, but they really couldn't give a fuck. Nothing's ever been done about it. It's probably partly my fault as well but I think well fuck you, I'm dealing with this myself. The worst thing about it was thinking am I that obvious? There's a sort of self-hatred in there, thinking am I so obviously gay? And if I am, what's so wrong with it?

Arun elaborates on the relationship between his self-injury and relationships:

Most of my self-harming comes from relationship stuff. It's the reason why I haven't done it for about a month and why the most recent one is this week. It was about somebody I had just met and who was really nice and really into me. He asked me out, which was a tremendous ego boost. My own personal values, which I guess have a kind of heterosexist bias, say you meet someone and settle down

> and have a closed monogamous relationship and you're happy. This other guy thought I was great and it was an affirmation for me and I was so pleased. My locus of evaluation is quite far away—I need validation.

Lack of validation leads to coping/hurting as he tells:

> Anyway, on Sunday night, we had finished having sex and he says, "I'm not too sure I want to keep doing this". I said, "What do you mean" and he said he wanted to be able to sow his wild oats. I said, "Well that's fine", trying to be the affable and amiable person I want to be. So I sat there, but I was also angry and pissed off and I couldn't be arsed talking about it. I thought well that's fine, that's his decision, but why am I left feeling like this? My values about relationships were being compromised. He wanted to see other people and I was lying there wishing he hadn't told me and just went and did it behind my back so I wouldn't know. So I went down to the car. I said I was going out for a fag and I sat in the car and thought, now what do I do? And I thought the only thing I know how to do to deal with this just now, because I can't cry, I can't get angry, is to go and do something about it. It was late, and I didn't want to be seen to be running away so I thought the only thing I can do is wait for tomorrow and deal with it. He sent me a text to say come back upstairs, that it was cold in bed without me and I resented that, because it felt like he just wanted me for sex and not for me, for what else I had to offer. The next day I got up, drove him to work and then spent the day at work feeling deceived and worthless, wondering what's wrong with me?

The consequences are enacted in a methodical, ordered way:

> I went home that night after tennis had a cup of tea and then tidied up the kitchen. I put a CD on, went upstairs

> and rinsed my tennis gear and then thought okay, now it's time to deal with it and I got the razor blade out. I keep them in the top cupboard of my kitchen. Because I am tall, nobody else can see them. Nobody can reach up and grab them or say, "Oh, there's razor blades up there". So I grabbed them and some tissues, sat on the sofa and happily hacked away. Well actually I don't hack. I run the blade slowly across my arm so I can feel it running across. Then I got upset, thinking why am I doing this again? It was like a form of self-pity and depression, wondering why I can't rely on other people and then resenting other people for why I do need them.

As Arun unfolds his story of a brief relationship with another man, he reveals a tapestry of emotion that, he had learned, cannot have voice. Instead, Arun's hurt speaks, in secret, through self-injury when he is alone:

> The anger is like the crying thing. I think it was when my brother was abused when we were little and we got taken to the police station. I got interviewed and stuff and I got really upset and the police lady stopped it. There were so many questions and things like that but my mum took me away from it because I was so upset. And I thought well that's obviously a sign of weakness, crying too much and I was only eight or nine at the time, probably eight and it started from then, not being able to cry and show vulnerability again to other people—showing that side of me that needs looking after and being validated and nurtured and stuff. After we found out my brother had been abused it was me who was the strong one, me it didn't happen to. So I became the strong one. It was like, "We'll let him be okay and we'll look after [my twin brother] Simon" and it's been like that ever since. Simon's been the one they've always been worried about—who's looking after him and coping for him and things. And then I've got a big brother as well but he's registered blind, whereas for me it's "well he's… got his

own home, got a good job” and so I’m the one who’s able to do things. It’s not a responsibility but it’s a hell of an act to keep going though, the self-reliance and being able to do these things and stuff. It’s a tough charade to show I’m the strong one still and I’m the one who’s got all of this

and I haven’t got that much really.

Brian: Journey through life

It took me over an hour and a half to get here on the blasted train; they get worse and worse these days.

I live in a small village just over the border and I love it, it's really homely and Dan likes it there too. The only trouble is that it is a bit far away from work. You see, I've just started seeing people for sessions in Manchester, so I travel down there once a week.

I do it because I like to help, although I'm a bit old for it all really!

It happened on my forty-eighth birthday. Everything was going brilliant that evening. Carl my ex-lover was home and my mum and aunt were there too. I went across the road for a church leaders meeting at a friend's house and when I got back mum and Carl had had a hell of a row. It really stressed me out such a lot. It was one more in a series of really bad arguments that had been going on for a while. Carl was on edge and the house was in total chaos so Carl and I left the house to go to his mum's place. We drank some rum on the way, but not a lot. It was strange because we didn't usually drink rum but we did that night.

We went to a nightclub and Carl flirted with some girls. He was bisexual you see. Anyway, I got angry about it and I hit him and he hit me back. In the end the police were called and Carl was nearly arrested. He got taken to the police van. As for me, the police just said, "Get out of town old man". I can laugh at that now, but I think I was just so stressed with the problems with Mum and home that at the time I just snapped. So I drove at quite a speed into this huge tree and tried to kill myself. I broke my arm, knee and ankle and when I came round I got a real fright, because I realised I had self-harmed. I also had a black eye from Carl. I tried telling the nurse but she didn't listen. I actually told another patient first and then got the courage to tell the nurse that I had actually self-harmed. They thought I had just had too much to drink and were worried that I had punctured a lung. They were worried about me; and their concern made me feel like I wanted to fight for all I was worth to recover.

Brian elaborates on his concerns and stressors at that time:

When mother came to visit, I said to her, "Look what you have driven me to now". Carl came too and he was

> shattered when he saw me. I gave him my bankcard because he said that while I was in hospital he would have nowhere to live. I was a fool to do it and I told a friend, I said, “Mike, I’m an idiot. Tomorrow is my pay day and I’ve given Carl my bankcard, he’ll take everything”. Mike cancelled my card and I didn’t see Carl for weeks. Then Mike actually did something. He didn’t like Carl and so went to see him and told him that I never wanted to see him again in my life. It was another five weeks after that before I saw him again. It was a long time. It was a long hard process and Mum wasn’t that good either. She was in her seventies and it was hard for her to come to the hospital. I had a phone line installed at her place so I could ring her as much as I wanted.

Carl and Brian’s Mother are central to Brian’s narrative. They are sources of pride, love, purpose and stress:

> I had told mum ten years before that I was gay and she seemed to accept it. But when I met Carl and he came to live with me there was trouble. There would be fight after fight after fight and if I went out she would attack Carl. It went on and on and mother started gossiping about my sexuality. She told the maid and the people at Church, which meant I had to contend with them as well. I was quite high up in the church at the time; I was a layman, a member of the Parish and regional councils and a warden. They made a new rule that you could only serve was a warden for a two-year period. I think the Priest wanted me out, but I had already stepped down at that point. I kept going to church and in a way they continued to support me.
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> Anyway, Carl was far from perfect. He tried with Mother but she just didn’t like him and everything he did was wrong. He tried to be good to her, but I think it was her religious outlook. Mum had also seen a psychologist

though and the psychologist told me the problem was that my mother was in love with me. I didn't know what to do about that. I mean, how do you treat an eighty-something year old with psychotherapy? I don't think she realised she was sexually in love with me and saw Carl as a threat. It all made sense and explained why she used to like to see me naked and do things like come into the bathroom when I was showering. After a while I remember I started locking the door. Mother always used to protest though whenever she saw Carl naked. He was quite a liberated guy and would undress in front of her quite often!

As Brian tells this story he does so with some amusement. Once he establishes the tension between his mother and Carl, Brian then goes on to explain how this tension is finally resolved:

Letting Mother come to live with me was the biggest mistake I have ever made. At one point, I had Mother and the Aunt, both in their eighties and Carl to contend with. One would play up, I'd sort them out and then the other would play up and that is how it went. There was terrible stress in the house at that time and I just totally flipped that night with the car. About a year later things got worse again. I graduated with my doctorate after a friend pushed me to get back to my studying and it was at this point that Mother told me that her job was done and she wanted to die. I think she actually gave up the will to live and I remember the priest telling me that my Mother was dying.

The year before she died, I was in the bath and I heard this scream from my Mum. Her hip had just broken. She didn't fall, she was just walking down the hall and it broke. It was the beginning of a lot of troubles. When she came out of hospital she couldn't shop or cook. I had to get a full-time maid and then she declined quickly.

The night before she died we had a barbeque at home. We were all there. Carl was there and it was his current girlfriend's birthday. We all had a lovely barbeque out the back. Carl's brother was in town playing in a band somewhere and I took Mother some food at around half past ten that night. Later, I went with Carl to fetch his brother and when we came back Mother had fallen out of bed. Carl picked her up and put her back in bed and stayed with her. He stroked her hand and I think that was good. He made his peace with her in a way that night.

The next day, I phoned the doctor because Mum was still not right. At first they found nothing, but when they x-rayed her lungs they found pneumonia. I knew from her face that she would die that night. I told the family she was dying. We have seen a lot of death in our family from cancer, so I know the colour of death.

The call came later that day to say she had gone.

With his attachments breaking down, Brian experiences the impetus to move to another town:

After Mother died, Carl left the house and started with another girlfriend. I'm totally gay but he was bisexual and always flirting around with some girl or another. He wanted to move in with this girl and he told me he had found the "right one". I was fuming and I told him to fuck off, that I'd had enough and to just fuck off. So he left the house after my Mother died. I told Carl and all the others that I was moving away. I'd had enough of that bloody community. I saw Carl a few more times but there was just one girl after another. One evening I went home to get changed and when I arrived back there was a woman

there. I just walked out the door and that was the final time.

I moved right out of town to a new place and eventually made friends with Dan. At the time he seemed like a bit of a loner. We met at the local pub and got chatting. He came past the house one day and asked if I needed someone to walk my dog. I told him no, but that I needed a hand fixing my fence. He wasn't working and spent a bit of time helping me sort the house out. When I moved in 2003, he came with me. Dan isn't gay. Well, actually, I don't think he knows what he is. He had a short fling, but that was a while ago now. He told me once that he wants to dress as a woman so I think he's probably a transvestite or something like that.

Dan helps me in a way, because I see myself as emotionally weaker now, after the accident all those years ago. I'm psychologically weaker, because to this day I sometimes still have a suicidal thought. I have been through lots of stress and I'll be honest that from time to time I do think it, but then I also think, "No, pull yourself together". I know when it is happening more now.

Having evoked a man who is weaker for his experience of self-injury, Brian brings himself into the here and now to give an example.

What happened was that bloody boss of mine;

she was a wicked little witch.

She called me in and she said to me one day, "Oh I want to talk to you". The supervisor was there and she said, "I'm just not prepared to recommend that you be registered as a social worker in England". So I asked her why and she said, "Because you are a bit behind with your recordings". There was only one child protection report that she had to

help me with because I hadn't been trained to do it. So she said "I had to help you with that" and also you were a bit late with some of those reports for the children's reporter". She knew that I was late because I had already told her there was a whole lot that was held up for the children's reporter, but she had made up her mind that she was getting rid of me and I think it was my sexuality. She was getting rid of me and when she said it to me, well, I just went to bits. And I remember then, it was immediately after that I walked out. I was shattered, I was totally shattered, because it meant my whole career in social work was finished in this country. And then I came up and I said to the other social worker that was there, I said, "Sally, I feel like committing suicide".

There, that flash.

So I thought Oh god, here it goes, back to that again. So then I came home, I was devastated when I came home. But I had enough sense not to go home straight away. I phoned this one lady from from the Church and said "Janet, I'm in a terrible state, I need to talk to somebody" so I went straight from my office to her place.

Brian reflects on what helps him resist the urge to self-injure:

Dan keeps me going because I think if I ended up doing something to myself, what would happen to him? I've also got three animals to think about. I met a guy the other week who seems quite vulnerable and he's an atheist, so what holds him together I don't know. I found I could help him though because he is going though what I went through and helping him has helped me.

Brian does not end his story neatly:

I stay in touch with Carl and the others through Dan. Once when Dan went back he took presents for them, but it took Carl three weeks to bother to go and get them. I realised that it has taken me ten years to understand that my Mother was right and that Carl had used me. I don't know why it's taken so long, but it makes me cross. It's taken me ten years to realise that even though Mother was over-protective she was right. I understand, I was her only kid. She was right. I mean he did use me. I loved him but I would never go back to that relationship again and put up with all that nonsense womanising. No, I couldn't put up with that. Not when I'm sixty!

Justin: Finding value in the moment

I've just started here at the local university. I came to it late, but at twenty-eight I still fit in with the others. I'm studying geography.

I think I would like to teach it one day.

For me, it is about being able to blank out or step out of real life and not have to deal with whatever is going on at the time and escaping a low mood. It helps me to blank off from feelings and build up walls that can't be broken down that easily. It is like a protective cocoon, or even like I'm stepping outside of my own existence to some extent. It becomes a focus and that is very important, for instance with the binge eating. The whole process of deciding to do it and then going out, deciding what food to buy, when it is going to be eaten. It is a distinct, focused process. The binge eating comes after a lot of casual sex, that's a pattern I see there. It is a way of blanking out stuff that doesn't make me feel good, which was also a way of blanking out other stuff, so it's quite convoluted in some ways. It is quite ritualistic and planned as well. For example, with the sex, it is about where I am going to go, how long I am going to stay there, whether I have planned it for a few days and so on.

The self-injury is about making my feelings physical. It externalises my feelings and become something I can hurt myself with. Food is a physical way of hurting myself really. The sex involves a physical risk and having sex with people I don't find attractive is another way of hurting myself and it leaves me with feelings that were less painful than those that were there beforehand—the feelings that I am worthless and valueless.

I'm in a pretty good place now, compared to where I was beforehand. When I was younger I would eat and make myself sick, which was scary and was a road I didn't really want to go down. Now, I accept where I'm at and the eating and sex is a part of it and it will change in its own time. I'm just waiting for the right time to tackle it.

In Justin's story, ego, sexual practices and self-injury merge. He reflects on his needs and childhood experiences as focal points:

> I get into this cycle of thoughts about being worthless and valueless and inadequate and I am quite solitary and isolated—that that's not going to change, no matter what attempts I make to address it – I am always going to fall flat on my arse. That cycle of thoughts can be triggered by something somebody says, something I've set myself up to do and not managed or done badly so it's all low self-esteem and it's all connected to not being visible. Even though I think friends should be able to pick up on how I'm feeling just by spending time with me, they don't. There is very little empathy there and it leaves the sense that I'm not seen and not heard.
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> I know all of this stems back to those feelings from my early childhood when my parents separated and I stayed with my Dad and that was quite a difficult time in lots of ways. I was incredibly angry at that time and I tried to express that, but my Dad broke me of that. Not through violence, but through mental work on me.
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> Dad taught me not to be angry externally, but that then became internal and the rage is inside and directed at me and the hatred is always against myself and not against anyone outside of me. I don't express anger externally really, although in the last few years I have started to feel it more. I'm seen as the peacemaker and the quiet, calm person. You know, it doesn't have feelings, it doesn't get upset by things because I can't express them in a way that other people understand. Everything gets stuck, here in my chest, and I lose my voice and I am more likely just to close down completely and become limp and exhausted. I can become completely unable to communicate or hold a train of thought or conversation in a

confrontation situation. It feels like I can't win and comes back to the relationship with my Father, where I could never win a fight or a discussion with him. He was always right and those feelings just kick back in at that time—that my anger is unjustified—that I'm just not right, so I don't have a leg to stand on.

Justin pauses briefly and then continues.

I had a discussion with a friend the other day about how many sexual partners we have had. I said I had about five hundred or more and he thought I was joking. I mean not all of those are full sex it can vary. Often it is cottaging[4], but it used to be cruising grounds a lot. I lived in London for a while and went to Hampstead heath—saunas as well. They were the main ways. When I was younger it used to be bars.

I always have a kind of pre-thought, that I'm gonna do that later in the day and the relief kicks in because I know that it's coming. I've allowed myself to do it and so I automatically start to feel better in a way. Then the process of actually going cottaging means I get caught up in the chase and that's where the blankness comes in, particularly in a cruising ground where it can go on for hours.

Another aspect that kicks in is the unsafe sex element. How much I want to hurt myself dictates the risks I will consider taking. It's also a way of testing my own boundaries, to see how far I'll go in blanking something out. When the opportunity for unsafe sex arises, something else kicks in, like, 'How much do I hate myself today'? And it's a real tug of the scales. On a day that wasn't the worst scenario, I wouldn't receive anal sex

[4] Cottaging is a British colloquial term that describes the practice of frequenting public toilets with the aim of engaging in sexual acts with other men.

> unprotected, but it would be in the scales as to whether I screwed someone without a condom. It would be in the scales of, do I take the risk and get the escapism and blank-out that comes with that, or do I step back?

Justin explains that there is more to the act:

> It's all tied in with what the other person wants as well. It's become quite difficult because so many guys don't want me to use condoms when they ask me to screw them. On a really bad day I would consider doing it without a condom, but it would be in the balance. Even on a normal day there are risks, you know? If I had mouth ulcers or bleeding gums would I suck someone off? I would normally manage to dismiss the risk in that situation and go with escapism. Of course it also depends on how turned on I am as well.
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> I don't fully understand it. And with the food, partly with both things actually, I am happier now I've become more settled where I'm living and that's made a big difference. I don't know quite how I got to that place but I've been in and out of counseling for years since I was eighteen. I'm twenty-eight now. So it's been a lot of different stages of enlightenments that have come. For example, my brother abused me when I was quite young and those memories are coming back over time. That actually helps because it explains why I feel the way I do. Having reasons is helping. And now, with the casual sex there's an element of it being about sex equaling affection as well, tied into that, tied into the abuse. For me, it's also about feeling loved and close to someone. It's about harming myself and getting affection at the same time—a bit of a head fuck really.

He elaborates:

There have been times when the casual sex has led to talking to someone about why we are both there, doing what we are doing. Sometimes that has been really helpful. Recently I met with someone and he came back to my place and we started talking quite a lot. He disclosed that he suffered quite badly with depression and was medicated quite heavily for it. In a way, I was able to talk quite openly about myself. It was quite a cathartic experience in that sense. Even though I'm feeling quite happy at the moment, I don't have anyone I can talk to on that level, so it was a very positive experience.

It's rarely the sex that is positive; it's the connecting with someone. I think I have come to recognise that a good percentage of the guys out there are doing it for exactly similar reasons. For me, it's like once the blankness of the hunt and the sex is out of the way, then that whole process is followed through and depending on how I'm feeling at the end of that I'll often go and binge. But if there is a connection with someone I've hooked up with, they are someone I can talk to, then maybe I will talk. It doesn't happen often, but it does on occasion. Partly because I don't feel able to put my feelings forward because I don't feel worthwhile or that they are of any interest to anyone. But it's that they wanted to have sex with me and that led to talking that makes me feel there was some level of enjoyment in it for them, otherwise they wouldn't want to talk. Therefore, I've been able to give them something. It's a kind of affirmation that I have value for that moment.

Matt: Weeds in the garden

I'm thirty-two years old and I can't say I achieve all that much on my own.

I know I said I'd meet you on Thursday,

but I don't want to now.

I want to meet you on Monday.

It's just that I've thought of something else I'd rather do that day

and I don't get out and do much.

> The first time was at high school during year eight. I didn't really have a great, well-developed social confidence and I found it very difficult. I didn't associate or relate with other students and I didn't really have any friends. It wasn't brilliant with my parents either. There was no tender emotion or positive emotion—there was a lot of coldness and therefore I think that's kind of affected me. Anyhow, one time, I can't really remember the motivation anymore, but it would probably have been some problem or some nonsense thing with my father, so I decided I would leave life. So I took this bottle of stuff that said "poison", so I took that, you know, quite literally. It was stuff for ears or eyes, I can't quite remember and it because it said poison I thought I would die from it, so I took it to school and poisoned my little cordial bottle and drank some of it in the toilet. Apart from tasting rather awful actually it did have an odour and made my bottle smell. Other than tasting awful there was no reaction from it. Because the bottle smelled my parents found out and the only thing my father did was to be abusive and rude. I think it was only a problem for them at that time, because they thought it was a phase.

Matt brings his story into the present by evaluating his current situation:

> There really wasn't anything I tried until more recent times. Even though I am not self-harming every day it's quite a bit of effort to think about what to do or whether I can do anything. Therefore, I am willing some other force that I have no control of to do it for me[5] and that takes away the pressure. I also have problems: being hindered, that life could be happier than it is in so far as employment or social deficiency and that I haven't been

[5] Matt later elaborates on this idea

> able to follow a career path or decide, "this is what I want to do" or find something and stick with it, or even have a personality that at least would… you know. It affects the degree of personal relationships that I am able or want to have with people. I've been diagnosed with anxiety and depression and I've had speech therapy. It was then discovered that I have a condition called Aspergers Syndrome. I feel like if a plant wasn't doing very well in the garden you weed it out. If something isn't healthy you take it out and that prevents it doing harm to the rest of the garden and so that's fine, that's my analogy.

In the coming story Matt locates his self-injury in a web of tension, frustration and shame experienced through his work and relationship with his parents:

> Some years ago, during my last full-time job, things seemed to be going okay. It was a fairly simple sort of job where I was delivering parts. I didn't have to have knowledge about car parts or sell stuff or anything and it was for a local business around here. Anyway, all of a sudden I started making a few mistakes for no reason. Well possibly it came out of the fact that my mother made some ridiculous rule because I was living with them until March this year. It felt like I had a full-time job but was still there so I had to be regarded as a child that had no thought of his own. They were able to dominate me completely and it was something about how they were still treating me as though I was at school.
>
> Well, what I'm leading up to say is that there were terrible memories of things in the past, you know, behaviours and things[6]. Well they invade my mind and it is pretty much all the time, even if I am at a rock concert

[6] Matt makes no further reference to these "terrible things" in his story; however, they provide the background for some of his sense of social failure, because they invade his thoughts and prevent him from functioning in a way he finds acceptable.

> or a movie or something, it will invade me there. Anyway there was a lot of time sitting in the car and the thoughts would take over and I made costly errors, not that I crashed the car but I made a few mistakes. I can't remember whether I did the thing or not, I can't recall it but it was in the three month trial period and so that was it. I didn't take it very well because it was my last opportunity that didn't require much qualification except a driving license. I didn't take it very well and I didn't want to say that I had failed again, particularly after a month or so, so I went and gassed myself. I didn't want to harm a child or anyone else so I waited around all day to go to some location on the other side of town. I used a barbeque gas cylinder in the car as I thought it would do the same thing as carbon monoxide.

In keeping with Matt's evolving narrative, he then provides context for his most recent episodes of self-injury:

> In more recent times I think I have discovered that, well, as I see it, I am not achieving very much in life and so I've been quite into self-harm as some sort of damage to myself so I wouldn't have to look for work because it's too much—the emotional energy that's required is why I haven't been able to do anything like studying or whatever it is. I haven't been able to achieve it. So I've been willing other things like a car accident or whatever or electrocution or coming across a brown snake or something like that. But then, I've also been going out in the middle of the day to mow the lawn to get terrible sunburn. To get sores all over me and hopefully one day that will turn into something. I've also inhaled rum and hydrochloric acid. Sometimes I get into thinking about doing things but I don't because I'm not in situations where I can do it properly, you know like I wouldn't do it outside because the acid stuff is dangerous and it might affect the dogs, it might harm them.

> I also tried to drink some bleach but I didn't really gain anything from it. At other times instead, I've just soaked my hands in it and all that does is make them sting a little bit, nothing really—all very silly and ineffectual in itself but I wonder whether because of it something will eventually happen. Some of the motivations for doing it are because I didn't want to face going to work again, which for me will be working at Coles supermarket collecting bloody trolleys because I don't have any qualifications. At that level maybe its my ego or something that tells me that is a job I should have been having when I left school not because it is the only one I can have and that means they can pay me less. Even living here is through public housing not through my own means, which would show there was a point to life.

There are further complications that Matt reveals:

> When I discovered I was same-sex attracted I never thought of myself as wrong or unnatural or that sort of stuff. It would be a part of my dissatisfaction with life to a certain degree, but again I've been handicapped in social ability. But I guess sometimes there is an aspect of my sexuality that causes problems and I'm actually talking about being attracted to under age persons, alright? For me, it's not a choice where I woke up one day and thought, "Oh, I know, I'm gonna be into children" or, you know, "I'm gonna be attracted to be people who are underage". It is something I think I had an idea of when I was a child myself. I didn't find people older than myself or in my class attractive but I was always attracted to people who were a few years younger than myself—and sexually, you know, not just a social kind of thing.
>
> I can talk to my GP about it, you know without prejudice or anything, but there's no more than that. A while ago

there were sites on the internet that related to or dealt with it, you know discussion forums where you could go. It wasn't pornography or anything but anyway. It's not about being a dirty old man or wanting to interfere sexually with young people, that's not something I would be able to do. I don't have any delusions that I should expect a person much younger than myself to be attracted to me but I do agree, accept and understand that abuses have happened to younger people and there's a reason why there's such a, you know, concern. Abuse to me is vile, or rape or manipulation, which I guess is a harder one to define.

I wish quite honestly that I didn't have the attraction but it isn't something I have chosen. There have been some books that talked about it as well as the film Mysterious Skin, which was going to be banned in this country and there was a Dutch film too. In that way I've found something to relate to. I really am quite unhappy that in Australia I can't even speak about it because here there is no distinction between people who do it and someone who is just attracted, both are pretty much in the same boat.

Paul: Living with the dance

I'm fifty-two years old now and I don't need that much in my life any more.

I get the odd bit of work here and there but I travel around a lot.

I just need my van and a place to kip.

> Leading up to it, for the great majority of my life I was in denial about my sexuality. I was spending time with my younger mates and the upshot of that was that I starved myself for four days and went to work, came straight home, went to work again and on the fourth day I nearly passed out. I don't know what was going on in my brain then but that was a sort of self-harm thing. I think I was trying to punish myself. I was trying not to feel the way I did. I'm dyslexic—I don't want to be dyslexic—I'd love to be able to spell but it's just the way I am so I have to accept that. And for me, having to accept the fact that I'm attracted to men and trying to change myself when I have unwanted feelings was hard when I wanted a normal wife and to be a normal dad and all that sort of stuff.

Paul establishes how what he wanted for his life was at odds with his feelings and desires:

> I needed to be punished because I was different to everyone else. I was eight years old, in my third class at school, so we're talking around nineteen-sixty something. The teacher said, "We are having half yearly exams for spelling and anyone who gets less than fifty percent will be punished". I sat the exam like everyone else in the class and after the results were in he walked up to me, grabbed hold of my hair and marched me up the front of the class and asked me if I remembered what he had said about people who got below fifty percent; that they would be punished. I said, "Yes sir". Then he pointed to me and said, "This man has got twelve percent, put your hand out" and he caned me. Not only did he embarrass and humiliate me in front of the class but also he physically caned me, as an eight year old.

> My feeling at the time was that I had tried my very very best and I had still failed, so why bother trying? By the time I was about twelve or thirteen, I was illiterate. My parents subsequently put me in and I started kindergarten stuff again and now I can read. I am still a hopeless speller, but at least I can read. You tried your best and you tried and tried and tried and you get punished because you're not up to standard. And it is the same with my sexuality. I've tried and tried to suppress it. I've tried and tried to push it down but it just keeps coming back. If you break the law, or the rules, you are punished, so I self-harmed.
>
> It's like I tried my best but did not come up to standard so I got punished for it, it's as simple as that. It's the logical outcome. If somebody else doesn't punish you then you punish yourself. So I tried my best and my best wasn't good enough so I punished myself. The logic behind it was that I shouldn't feel this way, you know, that's not good enough and when you're not good enough you're punished in an effort to make it better.

The next segment of Paul's story establishes the rules of conduct to which he was exposed.

> I think fundamentally I was also trying to deny what I felt. Physical contact between two guys was quite common when you missed out on a chick on a Friday night. You'd do it and nobody would mention it in the morning kind of thing. That was the physical side of it, but the emotional side was a different kettle of fish for me and it was something I was really scared about because it wasn't something that I thought was going to happen. It just happened and all of a sudden I realised I was basically in love with a guy and I didn't want that. Even though the physical act was quite common you would absolutely die if someone outed you, but it wasn't the

physical side that was a problem, it was the emotional side that was the problem.

Paul then ties the emotional repercussions of this realisation of same-sex attraction to his self-injury.

The cutting of the chest happened when I was about twenty years old. I fell in love with a mate and a work colleague and that just tore the legs plain out from under me and shocked me, you know, the way I felt about him. So I just took a carving knife to myself, which was probably a silly thing to do. Well, I suppose all self-harm is probably silly.

Anyway, this was the seventies. Things were a little freer then and there was a fair bit of promiscuity going round although nobody ever admitted to it. There was a younger mate that I had at work and we would spend eight hours a day together, socialising together seven days a week and um, when you spend that much time with somebody you care about a lot to start with, the friendship can only go down two tracks and one is to feel like chokin' 'em and the other is to feel like huggin' 'em. Yeah, it was a bit of a revelation at the time. The interesting part is that he came from a large family and I had actually been with his older brother who was the same age as me and his younger brother as well, but I never got the one I wanted!

He knew I liked him. We'd been away camping for long weekends, we'd slept in the same tent together but the slightest form of physical contact was shunned. So, we were great mates, had a great laugh together but there was no touching. He knew if he wanted I would take him as far as he wanted to go and I wouldn't step over the line. It was extremely frustrating on the one hand, but I was also punishing myself because I knew I shouldn't feel that way

in the first place. So I shunned him and didn't go back camping because I didn't want to have mixed emotions. Thinking back I did some terrible things to push him away. In hindsight maybe he realised that, but he was still there you know, because he was a mate.

Paul also talks about his other relationships over time.

I had girlfriends during my growing years as well. I got married, have a couple of kids and grandkids but it was always there, I have always had the feeling. My wife claims she didn't know, but she always did know because there was an incident before we were married with this guy who would have made a great gay guy. He was Roman Catholic and he married early. He came into the bedroom while me and my then girlfriend were having sex and he cradled my balls in his hand while I was rooting my wife, well, my girlfriend as she was then. If she didn't know then, well... He subsequently killed himself at twenty-five. I mean if you're talking about self-harm, that's the ultimate isn't it?

Yeah, so I got married and had kids and a mortgage and I always had a little mate on the side, but I wasn't cheating on my wife then cos I wasn't having sex with other women. I had one little mate who I thought was sixteen in about 1985 or 1986. In 1999 I got arrested and charged with sexual assault.

The guy was born in 1970 and I maintain the events happened in 1986, which would have made him sixteen, which was still against the law as the age of consent was eighteen. The law changed in 1985. For events that occurred prior to 1985, when he claimed they happened, I could use consent as a mitigating factor. After 1985 the law changed in this State and I could no longer use consent as a mitigating factor. So, I was in a catch

twenty-two. If I maintained it happened in 1986 when he was older I couldn't use consent. If I agreed with the timing of the prosecution then I could use consent, although it would have meant that he was younger than what he was at the time.

It made me look like a paedophile and after eleven court appearances and all the goings on, there is only so much you can take so I pleaded guilty and fell on my sword. Maybe in hindsight that was silly, but there you go. So you've found the strength to survive the ordeal and you've found the strength to survive nine months in jail and the rest is easy after that, to be honest with you.

When I came out of jail my wife left me and I lived in a small country town where everybody knew what I had been to jail for so I thought… well, here I am. That's why I don't have to punish myself anymore. The system has done it for me. I don't self-harm any more; I don't need to.

There are lasting consequences of his imprisonment:

The system is still there. I have a bill from victims' compensation; I've lost my wife, my kids, my town. I'm on the child protection register, so I have to let the police know where I am going. I went to Tasmania and I let them know, three days later I got the sack from the place I was working at.

Another time, I got sacked from the coast, from one of the resorts there. I got dragged into the office, I had been there for two weeks and I got dragged in and sacked on the spot with no explanation, they didn't give me a reason but just said that I was not a suitable employee. It was forty or fifty kilometers to the next town and I drove out on me own and there was a road train on the other side of the road and I thought it would be so easy to turn that

wheel, but no the bastards aren't going to beat me. I'll put up with it and go and do something else. You do have some doubts sometimes about your capability to carry on. I don't have any self-doubts about the fact that this is the system; this is what I've got to live with, this dance you know?

No, I don't have to self-harm because the system is doing it quite adequately for me. I will use the analogy of the Cronulla riots[7]. If you think of the Aussies and the Lebanese and they are there throwing bottles at one another right? That's what's going on inside me. It's one half fighting the other half. But if you take those Lebanese and Australians and Australia is in the world cup against New Zealand they will all be arms in arms around one another waving Aussie flags to combine their forces against a common opposition.

There are these two halves in me, arguing with one another whether I am a good person or not or whether I should feel this way or not, but then they combine in me because I know I am a good person and I know the world is a better place because I've been here. And they combine together because there is another oppressor and that's the system that keeps hounding me down and dumping shit on me, so you've got to find the strength in you to keep standing up all the time otherwise there is no other option. Well there's only one other option when you keep getting dumped on and that is to give up. To roll up into a ball and die and I am not ready to do that yet.

I now have the strength to help other guys who have had problems. It is a powerful experience to be able to talk to someone who says, "You don't know what it feels like to have a bad temper or a bad experience—you don't know what

[7] The Cronulla riots were a a series of ethnically motivated confrontations between white Australians and immigrants of Middle Eastern origin

it feels like to self-harm" and so I show them the slash marks on my wrists and I rip my shirt open and say, "Tell me I don't know about self-harm. Now… let's talk about your problems". And so you know, they see you can have empathy because you have been there and they respect that. And in a small way you try and help and that's one of the reasons I am here today. It is interesting to think about where my life would be today if I hadn't had the experiences that I have had in prison and stuff like that.

He continues:

There were plenty of guys in there who were dealing with those issues. There was one young guy who I sat in the sun with for two hours. He was twenty-five years old and was talking about how much of a mess he had made of his life. He was in for eighteen months I think. So I sat with him and I told him you know the positive things in his life and what he had to look forward to and all that and that night, he filled his sink with water and slashed his wrist with razor blades. Well he ended up in the psychiatric section, where they lock you in a room with no clothes on and put you under twenty-four-hour surveillance.

A month later he came back to the exercise yard and he saw me and was calling "Paul, Paul". I said to him, "don't you talk to me. I spent all that time sitting in the sun with you and you go and do something like that that night. I feel like I've wasted my time, I've failed". He said, "oh, I'm sorry Paul mate". I haven't seen him since jail, but I hope that talking to him did help. But then you talk and he goes and does something like that and it does make me think that I've failed. I don't know if a psychologist would have done it any differently but that was how I dealt with it. But I felt like I failed. I've said to people if you want to study psychology get dressed

> in a prison uniform and go and spend a month there. You will see the worst that human beings can be, but you'll also see the absolute best of people as well.
>
> I got kicked and bashed and I had boiling water poured over me for what people assumed I was in there for. In the end they came back to apologise and I never had any other problems. Sometimes they come into your cell and punch you to the ground and you have to get up again. You don't lie on the ground and let them kick you to death, you know, every time you get knocked down you get up again—you do what you do in life. The sun is going to shine tomorrow and it's another day.

Even so, Paul's tomorrows are not always easy:

> Me and my wife are still mates, but she just doesn't want to live with me anymore because she is a Catholic too and she's got the mother-in-law in the background. My sexuality just doesn't sit well, you know, and me being out about it and open. My daughter's getting married in a while, so I'm working to be able to give her a few dollars but I've reached the stage of my life where I don't really need any assets. Regarding the property settlement down on the coast, I said to my wife, "Look", I said, "You keep it now for the family". She said, "Well you might get married" and I said to her, "Don't be stupid woman, I'm single" and also I was staying in the shed at the time. I went to the pub and there was one particular woman there who was taken with me and wanted to come round for sex and I said, "Well that's fine but ring me first and make an appointment, because I might have a guy in my bed" and I don't have to pretend about that shit any more, whereas I always had to pretend prior to that.

Paul's rejection of pretence also extends to the marks left by his self-injury.

> I knew my self-harm would be visible for the rest of my life. It seems for me that now's the time to explain some of the reasons behind them. Even though I explain them away to some people like, "It was a good party" or, "I walked into a barbed wire fence" for others it shows that I have more than sympathy, I've got empathy. It wasn't a conscious thing at the time and it's not that I'm proud of them but I am not embarrassed about them either. They are about a part of my life that I went through and I've survived and come out the other end.

As he concludes his story, Paul counts his blessings:

> I'm more comfortable with how I am now. I don't have self-doubt or questions. I just get a bit disillusioned sometimes when something crops up and gives you the nark every now and again, but that happens to everyone. To be honest with you, at my age I've still got both parents alive, I've never lost anyone in a car accident, I've got twenty-one cousins and everybody is healthy and alive. I've never been to hospital for instance. When I think of all the positive things, the experiences I've had with the courts and being in prison and everything probably there is a reason for that and that's why I think I have been able to help some people and without it I wouldn't have been able to have an influence in their life. So, that's where it goes and who knows what is coming next week?

Weaving a thread through the stories

Even though the men's experiences are different, their accounts of their self-injury share some similarities that are difficult to ignore. The second stage of the analysis and interpretation incorporates Frank's (1997b) notion of illness narratives: the idea that bodies are given voice and speak in certain ways through stories of illnesses (Sinclair & Green, 2005). I do this in order to show how the experiences of the men in this study can contribute to social and disciplinary discourses of self-injury.

There is merit in allowing stories to speak for themselves, but some meanings are more accessible or obvious than others, and so a further analytic reading offers an opportunity to develop different and coherent ways of thinking about self-injury. Discussion of the stories presented in chapter four can lead down several paths. One of these paths is a conventional reading of self-injury, which emphasises method, motivation and concurrent distress. The purpose of such a reading would be to find a way to treat or respond to the disordered or unwell individual in society. The purpose of this study, however, is to explore different understandings of self-injury.

At the conclusion of the interpretation, I reveal how one particular element of self-injury, present in each man's account, links his story of self-injury into a collective and hitherto untheorised voice. Such a practice has the potential to offer strength and support to each man's account of his self-injury (Bazylak, 2002). This final level of interpretation might best be understood as weaving a thread amongst the stories, showing the points at which they intersect and share commonalities, while retaining their individual character and difference. This latter stage of theorising forms the basis for recommendations made in the concluding chapter.

Using more than one method of analysis is a means of generating new and novel insights (Hunter et al., 2002). This furthers the agenda of this research in so far as it can generate useful ideas for practice and insights into issues of identity and social practices (Clews & Newman, 2005) which may be useful for therapeutic working with gay men who self-injure.

CHAPTER FIVE

HARM, INTERRUPTED: SELF-INJURY, THEORY AND PRACTICE

The purpose of this study was to explore different experiences and understandings of self-injury. In this chapter I argue that while there are elements of the accounts of these men's self-injury that are consistent with much of the existing self-injury knowledge, there are fundamental social features of the men's stories that warrant further explication and discussion. In this chapter, I present an analysis that substantiates the central argument of this thesis. This argument is that two narratives feature in the men's stories of self-injury. The first is the harm narrative, which is shaped by prevailing discourse about self-injury. The second narrative is a moral narrative of self-injury. In order to frame and develop this argument I draw upon the descriptions of self-injury and circumstance told by the men in their stories, particularly with attention to focal points in their accounts of life and self-injury. In order to elucidate the moral narrative I contrast these accounts with existing understanding of self-injury, drawing attention to differences, silences and marginal readings (McAllister, 2001; Roof, 1993) that are present across the three-dimensional narrative inquiry space.

The harm narrative

What arises from this analysis is a reading of self-injury that transcends what, for the purposes of this study, I will call the harm narrative. The harm narrative is the storyline that underpins current self-injury knowledge and practice. The harm narrative should not be mistaken as a discourse that is just about self-injury. To understand it in this way is to adopt a reductionist position that makes the self-injury central to the inquiry at hand, furthering individualised readings of self-injury. The harm narrative is a moral judgment and implicit within this judgment are rules for thinking about and acting upon self-injury.

How the harm narrative constructs self-injury

There are a number of ways that the harm narrative operates in self-injury stories that make it influential and difficult to see past. At a basic level, the harm narrative of self-injury is about the way self-injury is predominantly seen as harmful and is therefore not to be validated as a reasonable practice. It informs understandings about the way reasonable people are expected to conduct themselves and the expectations of the responses of individuals and communities when they do not. Because of the focus on conduct and behaviour, the harm narrative is concerned primarily with the individual.

The harm narrative embeds and is embedded by certain injunctions: for example, "the reasonable person self-cares, they do not self-injure"; "the reasonable person safeguards their physical integrity, they do not cut or burn their skin". The harm narrative assumes that people who self-injure cannot be reasonable people. The harm narrative is informed in part by virtue ethics that means if people who self-injure demonstrate faulty reason (and because they self-injure how can they not?), they cannot be good or moral people (Kant, 1949, 2002) . This requires others to contain or control and ameliorate that which is unreasonable, immoral and thus harmful.

The harm narrative is deployed in different social mechanisms that enable societies to place limits on the exercise of individual will (Gaita, 2004). Self-injury discourse, or the way language is used to describe the phenomenon of self-injury, is one of these mechanisms. Another is the discourse/practice of medicine or psychiatry, which, through treatment, offers the reassurance of containment or even hope of a cure, if enough can be found out about dysfunction through the use of reason. With medicine playing a central defining role in the social construction of ill health, it is not difficult to understand how the harm narrative becomes concerned with self-injury as the central point of interest. Because of the dominance of these institutions and practices, the harm narrative becomes learned as a culturally appropriate narrative to describe experiences of self-injury (Frank, 1995).

The harm narrative is important to the argument in this thesis because considering different narratives is one way that self-injury is able to take on different meanings. Here I draw upon Frank's notion that a narrative represents "a general story-line that can be recognised underlying the plot and tensions of particular stories" (Frank, 1995, p.75). The purpose of discussing the harm narrative and revealing new narratives is not to create another unifying view of self-injury, but to enable readers to attend more closely to the stories that people who self-injure tell.

People both think in stories and tell stories. Interpretation of these stories is important for accessing culturally held meanings. This is important because it can bring health carers closer to meaningful philosophising about the experience of being someone who self-injures. Analysis of these stories can reveal narratives that underpin the way that experience is related (Frank, 2000; Riley & Hawe, 2005). This is important, because even though people tell stories, they may not be able to articulate or give voice to the particular narrative that shapes it. In Frank's (1995) exploration of the ways that people tell illness stories, people changed between drawing on different types of narrative that were made culturally available. In the present study it is possible to identify how the men used the harm narrative to account for their experience of self-injury.

Through the ongoing contribution of individuals' experiences the harm narrative encapsulates many stories about what it means to live as a person in a social world. The idea of harm is central to constructions of good living, in that avoiding harm is considered to be a worthwhile and indeed healthy and adaptive stance. The harm narrative therefore contributes to understanding healthy and pro-social behaviour, because it also defines that which should be resisted.

Where the harm narrative intersects with self-injury, it is possible to see how self-injurious acts are therefore taken to be unhealthy, expressions of pathology or even as evidence of social deviance. This perspective creates and legitimates a role for medicine. Medicine is concerned primarily with the treatment of individuals and as such tends towards focusing on what is wrong and restoring health, in so much as it can be restored.

In a clinical as well as social sense, then, the harm narrative is instructive, in that it partially constructs bodies as agents of wrongdoing, either to self or others (Don, 2005). For example, the harm narrative implies an internal chaos and impulsivity to the act of cutting. The harm narrative, through its reliance upon psychopathology as an explanation of the need to self-injure and its association with medicine, means that the person who self-injures must have disordered motives for their self-injury. Either way, the harm narrative means that self-injury is difficult to understand as something other than hurtful and contrary to living a good, healthy life.

Because self-injury is taken to resist good living it becomes synonymous with pathology or deviance. The harm narrative is also instructive in that it calls upon clinicians to treat the person to stop, or at least contain, the harm being done, thus creating a logical progression to the harm narrative: something is wrong, it can be fixed, attempts to fix it are made and outcomes are observed and reported.

The discourse and practice of medicine, central to the dominance of the harm narrative and partly shaped by discourses of efficiency, effectives and outcomes (Estefan et al., 2004) requires improvement in health (or reduction in harm) as a measure of progress or restitution of wellbeing. So central is this focus with the person who self-injures, and so common-sense has the reasonableness of it become that signs or indicators of goodness, wellbeing and adaptation within stories of self-injury, can be difficult to locate, even by those who self-injure.

This is illustrated in how participants in this study relied heavily on the harm narrative to tell their stories of self-injury. Paticipants were aware that they were engaging with me in this study because I was a nurse who wanted to know more about their self-injury. The storytelling relation (Frank, 2000) between the participants and myself brought forth the harm narrative as a way to organise the plot of their individual stories, illustrating how even those whose self-injury seems to take on a different meaning other than harm use the narrative to explain their experience.

One of the ways the harm narrative can be located in accounts of self-injury is through attention to the way that participants explain a false sense of unity of experience: for example, where cause and effect associations are made between bad

experiences and subsequent injurious behaviour. This is a form of Gilligan's (1982) ventriloquism, where men's voices reproduce, sustain and extend the harm narrative by drawing upon the voices of medicine and, in the case of this study, the heterosexual communities in which they live. Where common sense or unified explanations of self-injury are told it can provide a clue or marker that the ventriloquised harm narrative is operating.

Moving away from harm

Each man told a story that is undeniably about pain, suffering and injury. But they also told stories about living as social beings. It is easy to read harm into their circumstances and in many instances it would be correct to do so because physical harm to the body, at least, has occurred. What is important in this study, however, is to scrutinise and even trouble such a reading in order that the voices of the men in this study are not drowned out by conventional and dominant stories about what it means to self-injure. As I argued in Chapter 2, there is a need to go beyond risk-based perspectives to examine how people are living and find contexts (Adler & Adler, 2005; Gutierrez et al., 2001) that are subjugated by the harm narrative.

The harm narrative weaves through existing stories of self-injury as lived, told and retold in clinical contexts. A challenge for clinicians is to approach the harm narrative more tentatively and imaginatively (Barker & Buchanan-Barker, 2004). The literal damage done to the body in an act of self-injury has become so embedded in the memory and imagination of clinicians that damage is often all that is seen and an outcome of ultimate harm is assumed. That is not to say that self-injury is never damaging and harmful but to be able to grasp the salience of a moral narrative of self-injury it is important to understand that harm is not the only way that self-injury can be thought about.

If it is possible to acknowledge that self-injury is not always about an intention to harm, then clinicians need to be able to access and use other stories to interpret a client's actions and frame their own responses. There is value in finding new narratives that are used to account for experience (Frank, 1995). Being open to the

idea that self-injury may be something more than damage or harm, which says something about moral living, reconstitutes the body as a vehicle of good as well as possible harm and provides new stories to explore and develop in caring partnerships. Because such a way of thinking does not easily or fully enter clinicians' practice consciousness, the harm narrative remains dominant and lies behind the notion that the behaviour is a damaging one that needs to be eradicated.

In advancing a new perspective on self-injury that opens up possibilities for understanding and care, I contend that, in the case of this study, a general storyline of doing something good pervades each man's account of his self-injury. It is this storyline that I call the moral narrative. For the men in this study, being gay and self-injuring was tied to the need to show one's moral value in the public world: to show strength not weakness, to show capability and responsibility.

A moral narrative of self-injury

It was Iris Murdoch (1970) who said that people have a tendency to view themselves too seriously and stand outside of moral philosophy when instead it should be lived. This idea is key to the moral narrative—to consider how self-injury operates in a lived morality. In order to frame the moral narrative of self-injury and advance the argument in this thesis, there are a number of steps that need to be taken. The first of these is to establish what morality and moral conduct are taken to be for this study.

What it means to be a moral person

Morality is an abstraction that describes right and wrong and the characteristics of right and wrong behaviour (Meier, Sellbom, & Wygant, 2007). There are diverse moral positions that further shape what may be considered right and wrong or good and bad acts in particular circumstances and contexts. For example, in some instances, morality is constructed from absolutes where rules of right and wrong apply, while other types of morality focus on how moral behaviour evolves in specific contexts and in relationships between people (Abend, 2008). What is moral and what

is not is, however, a question of standpoint (Gensler, 2003) and as such open to debate and argument.

How morality features in illness narratives

There is a need to advance the study of morality as it is practised by bodies in social contexts (Abend, 2008). At a first and fundamental level, the sharing of a story of illness or pain is an ethical act because sharing a story with another is an act of caring and an example of where stories of "I" can be for the other (Frank, 1995). Stories about illness contain more than information about what is right and wrong, good or bad. Illness stories tell about harm as well as beneficial action.

Because they contain multiple layers, made up of that which is not functioning, perhaps wrong or deviant and involve suffering, illness stories are not easy to hear. Stories are told for a reason, however, and listening to them and being receptive to the messages contained in stories is an ethical act (Frank, 1995). When stories of illness are being told, the transaction between teller and listener creates a moral space because each is there in some way "for" the other.

In illness narratives it is important to attend to context in order to gain insights into moral behaviour. Attention to definitions or rules of right and wrong yields to embodied experience in the sometimes liminal and uncertain moments of illness. At these times rules of conduct do not always apply. Frank (1995, p.139) argues that illness creates a postmodern ethic that presents itself in "bits and pieces" located in personal everyday struggles, and it is there that evidence of a moral self-injury narrative might be found. It is the responsibility of the listener, and in the case of this study, the writer, to locate the fragments and put the pieces of the narratives of self-injury together.

An ethics of care

The idea that self-injury might be understood from within a postmodern ethics is both seductive and unsettling. The promise of uncovering another layer of meaning behind

self-injury must be tempered with the realisation that this meaning is situated, partial and temporal. It is for this reason that care, as a moral value and practice is helpful in understanding self-injury because care is well suited to narratives and context rather than abstraction or universality (Held, 2006). An ethics of care is a relational position that seeks to understand and respond to people in context.

An ethics of care is associated with feminist positions regarding relationships between self and other (Gilligan, 1982; Noddings, 2003), which lend some insights into how a relational component underpins moral self-injurious conduct in gay men. An ethics of care posits that, rather than being an objective truth, morality is a practice that revolves around people, relationships and responsibilities (Gilligan, 1982). Moral motivations and actions can arise from empathy for others (Slote, 2007) and so the moral narrative emphasises how empathy becomes action.

Care places emphasis on connection and how that connection is lived and experienced. From within a position of connectedness to others, care is about the "moral salience" of attending to and meeting the needs of particular others (Held, 2006, p.10) as well as finding meaning in actions (Gaita, 2004). Moral conduct that is informed by an ethics of care is thus relational.

The emotions that feature in the stories presented in this study mediate the relationship between morality and self-injury for the five men. The role of emotions in morality is open to interpretation, depending on moral standpoint and the overall relevance of emotions to moral action is a theoretically dense area (Oakley, 1992). Self-injury has much to teach us in the realms of moral conduct of the self. While Kant's (1949) ethics make sense of duty central and necessary to the moral conduct of the self, other moral philosophers believe that sensitivity to what is right is something that is cultivated through emotional experience (Sherman, 1990).

A study that points towards a moral narrative of self-injury must necessarily look beyond a Kantian view of moral conduct. While duty features in the narratives of some of the men in this study, it features within a narrative landscape that also includes profound states of emotion, which for Kant, had no place in morality. For example, Kant was sceptical of the moral capacities of women, due to the way women

use emotion to guide moral decisions (Held, 2006; Kant, 2002, 2007). Gay men are often equated with feminine characteristics, one of which is to be more emotional than straight men, yet in this study, some men made an effort to conceal emotionality to avoid being stereotyped. A Kantian moral account of gay men might therefore be unlikely to reveal useful knowledge about the relationship between gay men's experiences and moral conduct when they self-injure.

The men in this study provided rich and detailed accounts of their emotions as lived on their narrative landscapes. Attending to their emotional experiences has the potential to reveal how moral thought and action feature in their self-injury. Self-injury evolves as a feature of being for these men and thus necessitates a review of its relationship to life and living, self and other. Because self-injury for these men somehow mediates the relationships between self and other, a moral narrative of self-injury offers a new perspective of its role and function in a life lived.

Relational morality or an "ethics of care" potentially offers further insights into how moral thought may operate around issues of gay men's self-injury. An ethics of care views the duty that features in gay men's accounts of self-injury as relational and embedded. Rather than seeing the development of moral thinking and ethical conduct as a developmental stage, achieved through cognitive maturity (Kohlberg, 1976), coming to care is a narrative progression. That is, a sense of self and self-in-relation-to-other grows out of a lived experience. A moral narrative of self-injury, informed by an ethics of care emphasises interdependence and relatedness as features of social living that give rise to moral action (Gilligan, 1982; Held, 2006).

Drawing upon relational morality, or an ethics of care, the moral narratives of self-injury can be revealed through attending to the way that people conduct their bodies in social spaces and how this conduct is explained through language. Language provides insights into motivations and emotions and in a relational sense, emotions are relevant to moral conduct. The moral narrative that evolves from this perspective is not a "capital M" morality, but rather forms of moral conduct that shape self-injurious behaviour.

Broadly speaking then, the moral narrative operates in two ways. The first is by understanding particular self-injurious actions as having moral value. The second shows how self-injury creates moral spaces in which acts of "good" or caring for others occurs. While self-injury and its outcomes are different for each participant, the moral narrative emerges in each of their stories. The moral narrative of self-injury is a fluid concept that is local, particular, fragmented and discontinuous.

On being a moral person who self-injures

The view articulated above enables self-injury to be theorised from a moral perspective because right and wrong, good and bad cease to be absolutes tied to rule or context. Instead, moral conduct as it applies to self-injury emerges within a reflexive narrative space between people and can be accessed through told stories.

Discussion of moral narratives in self-injury is problematic, however, because self-injury transgresses medical and social rules about how a person should conduct their body. For this reason the notion of a moral dimension to self-injury is difficult. Morality as a topic is challenging because it provokes deep questioning about living well and the rules, mores and practices that shape such a life.

Bodies respond to more than rules and bodies in society do not function in isolation. A sociology of morality explicates the nature, causes, and consequences of ideas about what is good and right (Abend, 2008). This is an important discussion in the context of self-injury precisely because acts of self-injury are often interpreted as a challenge to social and clinical conventions of good or right conduct.

Much clinical and academic discussion privileges "knowing" self-injury over knowing more about the everyday lives of people that self-injure. One outcome of this is that once self-injury is known, people who self-injure can be separated from those who do not, through developing clearer and more precise understandings of pathology (Clapton, 2003). Research that attempts to understand more about the lives of people who self-injure makes it possible to show how even people who behave in conventionally amoral ways, such as by doing "bad things" to the self, possess

positive pro-social attributes that are also located within people who do not self-injure. To overcome the idea of self-injury as unequivocally bad, it is useful to adopt a position about what it is that is good. Key to understanding morality is to attempt to determine what is meant by good (Gensler, 2003).

In the context of self-injury, I argue that good is usually understood as that which is "not harm". This leads to a necessary question: What is good, or right, in the context of self-injury? If this question cannot be answered, then it will not be possible to theorise a moral dimension to self-injury. I have already stated that harm is present in self-injury. For example a cut harms the body. Self-injury also, however, subverts the harm narrative, in that many people self-injure as a way to be in control (Rayner & Warner, 2003) and resist a trajectory towards more serious damage (Duffin, 2006; Marusic & Goodwin, 2006). In this way self-injury might be thought of as having a function that is, at that level, good. If this function of self-injury can be thought of as good (in that it prevents greater harm), then it is feasible that other types of good might co-exist with self-injury. This good is not necessarily well understood when interest is directed only towards individuals and their pathology.

In this following section, I provide evidence for the premises argued above by examining the stories of self-injury from a moral perspective in order to bring forth a different narrative that featured in the men's accounts of their self-injury. In order to achieve this, two parts to the forthcoming discussion are set out. The first part, *Gay men's self-injury and an ethics of care*, examines self-injury and morality as a practice that reflects an ethics of care. This part reviews how some of the men were able to give and receive the experience of care through their self-injury. The second part, *The conduct of self-injury, metaphor and moral body practice* extends the ethics of care by considering how language, trope, metaphor and motif feature in the accounts of self-injury that lend to a postmodern moral narrative of self-injury.

Part One: Gay men's self-injury and an ethics of care

Arun's story provides the first insight into a moral narrative of self-injury. There are many layers to Arun's self-injury understood as a relational practice. Arun learned

early in life that he should not cry because it conveyed weakness. He knew he was the son with the responsibility to be strong. His relationships with his parents and his brother meant that he understood his role as the person who coped. In maintaining this position he cares for his parents and brother by not exposing them to his distress.

> So I became the strong one… It's not a responsibility but it's a hell of an act to keep going…

In his story, Arun narrates how, for him, the showing of emotion is equated with weakness. It was a lesson he learned at a young age and it is one that he carries with him today. As a child, crying betrayed his confusion and distress; as an adult, self-injury helps him to keep that distress contained in a place where it can be managed. Arun's account of his experience at the police station provides insights into the genesis of his need to conceal emotion.

Arun's experience of being the 'well' brother, who wasn't abused, meant that he needed to be seen to cope. The possibility of voicing distress was removed by his responsible position as the one who is "allowed to be well". Arun explained how he felt his parents "let" him be the "well one". In his story this is not Arun's choice, but a role he is given. As events unfold within Arun's story we were shown how he has internalised the well role, and must now cope.

The harm narrative constructs Arun as using a coping mechanism because physical self-injury can protect against greater emotional harm (Claes et al., 2005; Korner, Gerull, Stevenson, & Meares, 2007). The harm narrative is focused on individual action and individual need: Arun is hurting himself to try and stop the *other* hurt within himself.

Having claimed the role of the person who copes and who values stoicism, Arun elaborated upon the sense of responsibility that he feels to other gay men. Despite his involvement in the local gay community, Arun lives in a world that emphasises being proper man; he has learned he must be strong and he must not look gay. As such, Arun experiences a "betrayal of masculine virtues necessary for success" (Adam, 1996, p. 117). On the one hand, he partially reclaims these virtues through his self-

injury because it permits him to present a functioning face to his world and his self-injury affirms in him a kind of masculine strength.

This practice enables a moral practice of self-injury to be illuminated. There is a sacrificial feature of self-injury: eliminating (either metaphorically or literally) part of the body in order that another survives (Fenichel, 1945). Conventionally, this might be understood as sacrificing physicality, in order that coping is maintained (Rayner & Warner, 2003). That is, Arun is self-injuring so that he is not pushed to a greater harm by the cumulative stressors that he experiences. Other readings are possible, however.

The ethic of care extends the pertinence of the body beyond the self and propels it into a relational space with others. Therefore if the idea of "the body" is extended to include others, within a vague, yet felt system as experienced by Arun, the self-injury takes on a more moral meaning. He is sacrificing himself to protect others—the other part of the social body to which he belongs.

On the one hand, Arun is sensitive to being cast as deviant and as such he responds in a punished role that protects the sexual normalcy of the society in which he lives (McIntosh, 1996; Weeks, 1996). However, an ethics of care allows him to be read differently and transcend the punished role, albeit briefly. Thinking about Arun's self-injury in the framework of an ethics of care calls us to look at *how* his mostly hidden self-injurious actions function as a way to speak to others in his social world.

> …but I think well fuck you, I'm dealing with this myself.

At its extreme, ongoing social invalidation is one risk factor for gay men. The experience of feeling different and being treated negatively can mean that self-injury evolves as a way to cope with marginal status (Alexander & Clare, 2004), a feature that also emerged in this study. Self-injury can be a way of taking on the world for people who are same-sex attracted (Alexander & Clare, 2004), but Arun is taking on the world without showing the world that he is engaged in a battle with it. It is a silent war. His efforts to conceal his distress, however, have a purpose that goes beyond the need not to appear weak in front of others.

When Arun self-injures he is participating in hegemonic masculinity (Connell, 1995), while refusing to perpetuate the view of gay men as emotional and weak. This position reflects a sense of community that is embedded within an ethics of care . This view means that Arun's body becomes the site where attempts are made to protect others. The harm narrative emphasises what seems to be a strong internal locus of control. That is, Arun has become convinced that he is responsible for his deviance (Tulloch et al., 1997) and a relational solution is not accessible to him.

By acting upon himself, Arun also acts on society by preventing himself from being incorporated into discourses of instability and vulnerability in gay men. In this way, Arun is responding morally to his sense of marginality and the marginal status of other gay men. As a result, however, outlets other than self-injury for Arun's distress are blocked by his concern for both himself and others. This concern is that he will contribute to a stereotypical view of gay men.

Arun's internal, external and developmental experiences across time contribute to his sense of personal moral norms, or what is right for him as he interacts with others (Schwartz, 1973, 1977). Arun's altruistic intent to abstain from emotional expression occurs partly because he perceives that to express might create or contribute to conditions that will threaten other gay men. In Arun's situation, moral motivation can arise from a number of sources: his awareness of the potential consequences of his actions or inaction; his belief that he carries some responsibility towards other gay men; his sense that he knows how to prevent harm to others occurring (by avoiding self-expression); and his belief that he is capable of doing what is necessary to protect others (van Kesteren, Hospers, van Empelen, van Breukelen, & Kok, 2007), by actually physically cutting himself.

In uncovering more novel elements of Arun's self-injury, the notion of voice is important. The voice in the foreground of Arun's story is that of an injured gay man who needs to sustain a sense of coping. This is the voice present in the harm narrative. This voice, while powerful, seems to reflect Gilligan's (1982) notion of ventriloquism: it is Arun using the voice of hegemonic masculinity and psychiatry to explain himself.

Ironically, this seemingly maladaptive stance is one of the features of Arun's relational self-injury that forms the foundation for his ethic of care. Arun is aware of how gay sexuality is perceived within the society in which he lives. This awareness and knowledge adds to his sense of responsibility for other gay men. The voice that emerges through his body practice, however, tells a story of self-injury by someone who occupies a number of professional and social spaces. He has become and performs the role of a helper and his body is the means through which this help is enacted. Although he understands himself as damaged, Arun's body filters and transforms that injury through action into something more novel and rarely associated with self-injury.

Gay men tend to be viewed as somehow less than straight men. The view of gay men as a lesser version of the heterosexual is a product of the western cultural value placed on the masculine ideal. There are a number of ways that male bodies convey masculine codes, for example through cultivation of a masculine/muscular body type, dress or practices like tattooing (Atkinson, 2004; Connell, 1995). Arun is not immune to this cultural ideal and is thus subject to hegemonic masculine values.

> The worst thing about it was thinking am I that obvious? There's a sort of self-hatred in there, thinking, am I so obviously gay?

Arun assumed a responsibility for other gay men and he would not show vulnerability, lest it further the idea that gay men are weak. Arun assumed a role of rescuer of gay men in both work and personal facets of his life, reinforcing his identity as someone who can and must cope. He also made a contribution to a group of people to which he felt he belonged, by trying to control himself so that he did not contribute to pejorative constructions of gay men.

Arun's desire to show outward strength may be common to many people who self-injure, but in gay men it might be additionally motivated by the desire not to be viewed as stereotypically gay. Read in this way, self-injury might be one way that

Arun also remakes his masculinity (Ridge et al., 2006) because even though for him it is about hurting, he also seems aware that it positions him as the "strong, silent type".

On one level this is an issue of conformity. Arun is creating himself in the image of a "proper man". Self-injury can be a sign that a person is engaged in a form of moral conflict regarding their non-conformity (Kruger, 2003). For Arun, this moral conflict is complicated by his self-confessed heteronormative values, which exist in tension with his identification with and loyalty to other gay men. Arun's story tells of how this tension pervades most facets of his day-to-day living.

The harm narrative reduces Arun's self-injury to a form of morbid self-help (Favazza, 1998); a way to get by. A moral reading, however, advances understanding of his self-injury because the focus is on self-care and other care. He is tending to his body and, indirectly, the bodies of others within the limits imposed by a social world that does not legitimate him or others for whom he feels responsible.

There is a metaphor prevalent in the extant literature that seems to encapsulate some of Arun's experience. The silent scream (Pembroke, 1994) metaphor evokes trauma so overwhelming that it needs to be spoken despite barriers to speech. A silent scream can also occur where the repetitiveness of traumatic events becomes unmanageable (Mitchell & Dennis, 2007). The silent scream is thus a way to "express the inexpressible" (Reece, 2005, p.570): a way to have voice when one cannot, or is not permitted, to speak. Sometimes people cannot speak because their experience falls outside normative discourse and their body practices and motivations cannot be articulated outside the dominant paradigm.

Within a harm narrative the silent scream can be read as a way of creating a voice that can be heard by others. The harm narrative makes self-injury a voice on the skin or a way of speaking the unspeakable (Crowe, 1996; McLane, 1996) or even attention seeking (Pembroke, 1998; Rayner, Allen, & Johnson, 2005). A moral narrative can capture the way self-injury might be a dialogue rather than one-way communication and the moral objective of self-care means that this dialogue may be internal rather than externally focused. If a person is able to understand that they can listen to their

own self-injury it creates the possibility of healing (McLane, 1996), even if the act of bodily harm feels and "looks" bad.

Hearing one's own voice through self-injury might enable a person to interpret and understand their situation and responses as a means to resist ventriloquising dominant explanations. In this study, as the men told their stories, their voices are understood to arise from their embodied experiences and are filtered *through* their self-injury. That is, the men do not speak independent of their bodies. In this way, the silent scream becomes not just an expression of distress, something that tells of how bad things are. When it is not possible to speak of pain or experience to others, people may be pushed into dialogue with themselves as a form of self-reflection. Where voice can only be achieved through self-injury, it becomes a way to hear oneself into speech and presence (McAndrew & Warne, 2005). That is to say, a person might hear what they corporeally express before words can be found to describe the experience.

It cannot be assumed, however, that a person who self-injures possesses the ability to hear this voice as, like many other voices, its meaning can be obscured or drowned out by louder, more dominant voices. Clinicians therefore need to be open to different interpretations of self-injury.

Each participant in this study experienced constraints around their ability to speak, which means their self-injury might be too easy to read as a silent scream. In the case of the men in this study, however, it is more accurate and relevant to a moral narrative to say that their self-injury was more of a secret sound because, like others who self-injure, it was not always disclosed to those around them (Rodham et al., 2007). Each man's self-injury was, in some way, hidden but the act itself resonates both within the men and through the communities in which they lived.

Resolving the trauma of being gay

The pain of overwhelming trauma is one possible precursor to self-injury but it is not the only one. Self-injury is also a means of managing traumas that are neither

fantastic nor monolithic, but mundane and part of the course of living (Mitchell & Dennis, 2007). These small "t" traumas (Shapiro, 1995), or everyday life events are cumulative and can be relentless and deeply stressful, particularly where emotional and social support might be absent. This type of trauma is particularly well evoked by the participants in this study and further serves to illustrate the tensions that gay men experience in social living.

Arun gives an account of three traumatic experiences. Early in his story he signals that relationship difficulties play a large part in his self-injury. Since Arun wants to be seen as a calm and affable person, he defers his emotional response to relationship rejection and then self-injures when nobody can see. Arun's other two traumas relate to social living. He gives two accounts of difficult and homophobic encounters with strangers. The way Arun describes the abuse in these encounters helps to construct a picture of a man living with ongoing invalidation that he manages with self-injury.

While invalidation is a known trigger for self-injury (Linehan, 1993), the way this occurs for Arun and the other men in this study says something about the experience of being a gay man who self-injures. When an expression of emotional pain leads to the experience of not feeling understood or valued, it is possible that individuals will cease trying to express that pain (Pembroke, Shaw, & Thomas, 2007). In this case, a more overwhelming internal state might develop which ultimately leads to a more pronounced expression of distress.

In Arun's account of cutting his feet, he reveals a complexity to the secret sound his self-injury made. Because he went to efforts to ensure nobody saw his injury (Adler & Adler, 2008), there is only one person to listen to what it says and that is Arun. Arun's self-injury, as a concealed, secret sound, is dialogue with himself, in which he explores what it means to live in his circumstances. Arun's description of being able to feel the cuts when he walks evokes the image of the recitation of a mantra: "I am strong… I am strong". Arun explains in his story how cutting his feet hurts, but feeling that pain helps him to understand himself as a proud man and as someone who is able to cope. The pain that he feels from this serves as a reminder that he is coping with his emotional pain himself. Arun experiences pride as a result of his pain because it confirms to him that he is coping and he is coping well.

Arun's account of cutting his arm in his flat is a more reflective kind of dialogue that illustrates how the act of cutting enabled him to engage himself in questions like "why am I doing this again" and "why can't I rely on other people"? It is a moment of allowing an emotion like resentment to surface and be felt, before the amiable veneer returns. In this way, perhaps Arun is being true to himself, by more fully experiencing himself rather than suppressing emotions he finds difficult.

To summarise, Arun is both inward and outward looking when he self-injures. His inward focus centres on the distress that he feels and his outward focus relates to why his relationships with others leave him feeling the way he does, as well as the responsibilities he has to his wider community. Despite his injuries, Arun's is a story of community awareness, a degree of self-sacrifice and moral action.

Another element of the ethic of care as it relates to self-injury features in Justin's story. Justin's story is powerful and moving because of the way he narrates his past and present relationships. A prominent feature of the ethic of care is that it involves an emphasis on special relationships as a site for moral decision making (Gilligan, 1982; Held, 2006). In Justin's story, however, conventional close relationships, such as those with his father and friends, are fragile and problematic. Justin's story adds to the moral narrative by evoking the intimate element of relational self-injury. Where Arun's moral practice was community focused, Justin's was more dyadic.

Self-injury is one means of establishing the difference and creating physical and psychological space between self and other (Straker, 2006). For example, a young woman who hurts herself as a means of reclaiming her right to autonomy over her own body is establishing the difference between self-injury and harm by another as well as claiming control of the damage that is done to her body. Though it is founded in distress and even confusion about the boundaries between self and other, self-injury becomes a way for a person to know where they are in relation to others (McLane, 1996) and as such forms the foundations for a relational existence.

Discovering self in the other

Justin's harm narrative is inward focused and isolating. He is a young man with poor self-confidence and low self-esteem. The way he tells his story he is easily read as introverted and depressed. One of his self-injurious behaviours seems congruent with this psychological background, because his binge-eating was conducted alone and in private. But Justin also self-injured in another way that was much less isolative: he engaged in anonymous, risky sex.

For Justin, while self-injury was the way he hurt himself it also gave him a way of connecting to others and addressing unmet needs for affection resulting from his father's emotional neglect. Justin's self-injury was also a way of communicating something else that he found difficult to say. That is, that as an adult, he was a social and relational being. Self-injury was a way for Justin to express this inexpressible facet of himself. It was one that he himself found difficult to connect with.

Justin's experiences with his father led him to believe he had nothing worthwhile to say. Justin explains in his story that he feels invisible. He tells of how his friends do not notice when he is feeling low and he feels unseen and unheard. What is less obvious, but important, in Justin's narrative is that he also seems to be invisible to himself. Knowledge of and confidence in who he is, what he wants and what he believes have been submerged in the doubts that arise from a constraining and invalidating relationship with his father. Justin's sense of self as isolated and inward looking is a self that arises out of the harm narrative.

The sense Justin held of being unworthy, or less than he should have been might be understood as a form of disenchantment with the self (McAndrew & Warne, 2005). The disenchanted person emphasises self as problem in ongoing social troubles. So even though Justin characterises his father as cold and controlling, dictating what emotions it was acceptable for him to convey, he still assumes responsibility for how he lives in his world.

The absence of caring from a parent can increase the vulnerability of young gay people to self-destructive impulses (Eisenberg & Resnick, 2006). Both Justin and Arun experienced the absence of parental caring. For Justin, the experience was one of emotional abuse resulting in diminished self-confidence. Arun stories a childhood in which his needs were placed second to another sibling who was perceived to have greater needs. The harm narrative enables this sort of emotional neglect to be read as a possible trigger for self-injury (Gratz & Chapman, 2007).

Locating Justin's moral narrative is not easy. Instead of the harsh visual of a vivid cut, the language of Justin's self-injury, spoken through his body, is subtle, protracted and thus easy to overlook. Each time Justin seeks out and achieves a random sexual encounter, or binge-eats, he is expressing himself and giving a voice to his pain that is filtered through his body.

As Justin unfolds his story, however, he also reveals how, similarly to Arun, his self-injury is a dialogue with himself. Justin links his self-injury to being invisible and so when he hurts himself he gains the ability to start to questions his legitimacy and his worth. He asks himself questions, like "How much do I hate myself today"? The self-injury that is enacted occurs in proportion to his self-evaluation of being unworthy.

Despite the obvious distress contained within Justin's self-injury, the way he describes his preparation for and engagement in self-injury suggests that it might have another important function. Justin's self-injury usually follows a decision-making process about how he is going to self-injure and to what degree he will engage in self-injurious acts. This allows him to make decisions without the promise or reassurance of anybody else's validation.

Two important points emerge here. The first is that, like Arun, Justin is able to control his urge to self-injure and this is an important finding, because the harm narrative emphasises internal chaos and impulsivity in people who self-injure across a variety of contexts (Borrill, Snow, Medlicott, Teers, & Paton, 2005; Castillas & Clark, 2002; Hjelmeland & Grøholt, 2005; Kumar et al., 2004; Skegg, 2005). Even though he experiences an impetus towards a self-injurious act, Justin is able to control

the trajectory towards it. Whether his self-injury involves binge-eating or casual sex, Justin plans the event in a detailed, meticulous fashion.

> The whole process of deciding to do it and then going out deciding what food to buy, when it is going to be eaten. It is a distinct, focused process.

The second point to emerge is that within his self-injury context, Justin gets to experiment with testing out his own decision-making. For example, he decides what sort of self-injury to engage in. Justin's planning of his self-injury is done in a way that allows him to weigh up the pros and cons of engaging a particular form of self-injury.

This "cool, calm and collected" feature of Justin's moral narrative is interesting in another way. Object relations theory suggests that children who develop positive feeling about the self in childhood also learn how to self-soothe using external objects (Gallop, 2002). Justin seems not to have acquired this ability and his self-injury acts as a self-soothing substitute. If Justin's self-injury is thought of as self-soothing, then the controlled manner in which he goes about making decisions about how to self-injure and when take on the quality of a ritual, which enables him to locate the necessary external object required for self-soothing.

Justin used sex and eating, which incorporates his sexuality and body into a ritual of self-injury. It is almost as if self/body/injury/other cannot be separated for Justin—they are bound and their relationship morphs depending on his internal state. While I discuss the relationship around body/self-injury and other for Justin in a later section, the important notion here is the one of ritual that is enacted when self-injury is desired. The ritual acts in a soothing fashion for Justin and enables him to attain relief from his feelings.

> Then the process of actually going cottaging means I get caught up in the chase and that's where the blankness comes in, particularly in a cruising ground where it can go on for hours.

Rituals are rarely impulsive acts and self-injurious rituals can be thought through and used when the need arises. Some acts of self-injury can reflect a form of control of the body (Atkinson, 2003) rather than loss of control and where the need to self-injure is experienced, it is not always necessary to experience immediate gratification (Borrill et al., 2005), but rather to dissociate from emotional pain for a time. For some, the helpfulness of self-injury in effecting body management in this way means it is integrated as part of living (Rayner & Warner, 2003).

Discovering the other in the self

Interrogating the special relationships that Justin experiences reveals an interesting feature of his self-injury that contributes to the moral narrative. One dimension of the ethics of care is that in terms of special relationships, moral conduct is relational and that relationship contains unique features that are not replicated with others (Held, 2006). Justin tells a story that emphasises his experience as someone who stands apart from others and feels disconnected. Using a harm narrative he creates his trajectory towards harm that is grounded in his relationship with his father, which led to self-doubt and he describes how he now feels abandoned by friends. The story is one of a young man who is cut off from relationships that offer him a sense of worth, so he self-injures.

As Justin leads us through his social landscape, he offers interesting moral insights into his self-injury. Once he has discussed the ways that he self-injures, he reveals a benefit that he sees in the self-injury. Justin describes that when he self-injures through having sex with strangers he is able to take care of what the other man wants as well. It is reciprocal because it provides affirmation, even if transient, and it provides Justin with an otherwise elusive moment of worth.

> But it's that they wanted to have sex with me and that led to talking that makes me feel there was some level of enjoyment in it for them, otherwise they wouldn't want to talk. Therefore I've been able to give them something.

> It's a kind of affirmation that I have value for that moment.

The relational aspect of sex that occurs between men who have sex with men is virtually unacknowledged in the literature that seeks to explore motivations, practices and outcomes relating to unsafe sex (Adam et al., 2002; Fordham, 1998). The harm narrative is powerfully present here because it is easy to equate anonymous sex with an increased potential for antisocial behaviour. That is, a person may perpetrate or become victim to antisocial behaviour (Krahe et al., 2000) or engage in a sexual act that shows little regard for the physical wellbeing of another (Longfield et al., 2007). A harm reading empahsises how Justin was at risk in these encounters and also how he himself posed a risk to others through engaging in unsafe sex.

Justin's promiscuity might be read as displaced intimacy and an attempt to mitigate feelings of early rejection (Taylor, 2003). The literature review identified a link between gay identity, social distress and sexual risk taking (Crawford et al., 2002). From a harm perspective, Justin's sense of himself as weak constructs his self-injury as a way of managing the internal effects of not being quite the man he feels he should be.

Justin's further use of the harm narrative enables him to consider the physical risks he is prepared to take, balanced against how he feels. However, because it is preoccupied with the individual, the harm narrative is not able to account for the physical wellbeing of the other man. The moral narrative, however, shows how an act of apparent self-injury is also an act of building (albeit short-lived) relationships and caring for another, even in the presence of possible harm.

As Justin delves further into this experience towards the end of his story, it is possible to see how this relationship includes elements that Justin does not replicate with other people described in his story. Justin explains how his friends do not always notice that he is hurting emotionally, but he does not directly discuss his pain with them. Meeting a man for sex and connecting emotionally provides the context for Justin to be able to give voice to his pain while also attending to the pain of another.

> …he disclosed that he suffered quite badly with depression. In a way I was able to talk quite openly about myself

Congruent with a postmodern reading of Justin's narrative, it seems that rather than creating an enduring sense of being a worthwhile person, Justin rather has discovered that he might be able to experience a series of moments of worth. This emphasises the discontinuity of the moral narrative and illustrates one of the reasons why it might be difficult to locate. Justin's self-injury is relational, "in-the-moment". He is reflective and about what both he and the other man wanted but offers no assurance that these experiences serve to create an enduring sense of wellbeing.

Perhaps for this reason it is easy to continue to discount the moral and relational elements of Justin's story and to continue to read it as one of deviance. He himself points to the type of sex that he pursues as being dangerous and potentially life threatening. Any sexual culture produces beliefs about approved and disapproved forms of sexual relations in society (Herdt, 1997). On the surface this is antisocial sex, but the dominant view of what is acceptable sex obscures a fundamentally relational narrative underlying Justin's choice of self-injury.

During the moments of worth, the relational self-injury re-emerges as an important factor. In a traditional sense, self-injury might be thought of as relational insofar as it is a behavioural outcome of troubled, problematic or abusive relations. The act of self-injury can also be understood as relational in that it forms one of a number of ways of signalling to others that something is wrong. For Justin, as for other victims of childhood psychological abuse (McLane, 1996), self-injury was one way that he was able to legitimate his existence.

Caring for self, caring for the other

As Justin described reflecting in the moment of his self-injury, his self-focus diminished and he took on a broader sense of what was required based on what the other man wanted as well. He found that this brought something to the encounter and created an after product as well, a connection with another person who might also be

hurting. His self-injury thus became a vehicle that took him to a site of care for self and others.

As Justin tells of his encounter with the man who was heavily medicated for depression, he suggests that he recognises some of his own distress in this man, which leads to the ability to share his own experiences. At one level he could be thought of as taking an opportunity to vent his thoughts and feelings, but he also shows the other man that he is not alone. Justin will not take this risk with everyone and so it is a relationship that is unique to his harm context and one that allows him also to find worth.

Paul's story also captures the essence of the ethic of care and enables him to find worth. The special relationships that Paul describes in his story are those between himself and people he identifies as in need, or in some way suffering. The examples Paul provides in his story are young men who are hurting themselves. His wounds confer the authority to speak to others on issues of suffering (Frank, 1995) and he uses this authority to convey caring. He tells one story in depth, where he helped a young man in prison, but he implies that, over the course of his travels, there have been others.

> I knew my self-harm would be visible for the rest of my life. Even though I explain them away to some people like 'it was a good party" for others it shows that I have more than sympathy, I've got empathy.

Paul's account of his self-injury underplays the distress in his self-injury. Rather than emphasise the pain and uncertainty he experienced as a young man realising he was same-sex attracted, Paul uses a more stoic narrative that means his own self-injury is something very much in the past, that now serves as a lens through which he can understand and empathise with other people's experiences. At the time that he cut his chest with a carving knife though, he could not speak of his same-sex attraction as he can now. There was no explanation for his emotional attraction and no sympathetic other to whom he could voice his fear of more than physical involvement with other men—so he cut himself with a carving knife.

The stoicism in Paul's narrative reveals two things. The first pertains to how the harm narrative shapes his understanding that he must be strong and reject the relevance of the self-injury in his life, even though he uses it more than once.

> *[it] was probably a silly thing to do. Well, I suppose all self-harm is probably silly.*

The second important point is that Paul's story shows how he is not "there" for everybody. The part of him that has been injured and vulnerable and is now marked by this experience is reserved for those who will benefit from being exposed to this side of him. It is a side of his personality, part of his history and a way of knowing about the world that Paul shares with some and not others. If Paul identifies with the other person, or recognises a need for him to offer support or empathy, he explains he will do so. These are special relationships for Paul and while he is helping others he is also able to fulfil a need in himself to do something worthwhile.

Carving out identity

Constructing an identity is one way of gaining mastery over the environments in which people operate (Howson, 2004). When things change, understanding oneself in a certain way enables people to make meaning of events that otherwise might press at the boundaries of that which is tolerable or manageable. People also use experiences to make meaning about self. The harm narrative confers a particular identity that is not always helpful because it individualises and forecloses exploration of self as socially situated and adaptively relational. The moral narrative, by contrast, enables a postmodern self to emerge because self-injury can be reinterpreted as an act of meaning making, in which different identities might be accessed and used in differing circumstances.

Another relational element of Paul's self-injury questions the relevance of the harm narrative. Being a carer, or someone who will give of himself for others, is a way that Paul can attain a mastery over his experiences and current situations. Paul's "self as

carer" identity is one that, while fragmented, affords a certain continuity to Paul's experiences and it is an identity that grows out of his self-injury. The "self as carer" identity helps Paul to organise his experiences around a quest narrative that transforms him into a kind of peripatetic do-gooder.

Frank (1995) might characterise Paul's particular quest narrative as a "manifesto". In manifesto stories, people discover truths that lead to a need for social action. Manifestos are stories that foreground the responsibility that accompanies an illness. Paul's story, while an account of self-injury, is also a commentary on the sense of responsibility to others that has grown from his initial injury to himself.

As Paul narrates his experience, however, he vacillates between the notion that his story is something that constitutes social action and an account of his story as personal. Frank refers to this latter style as "automythology: a type of story that positions the body at the nexus of "microcosm, macrocosm and human potential" (Frank, 1995, p.126). So for Paul, his self-injury crosses into both political and personal landscapes. Politically, his self-injury arises from distress at the shame he felt at being same-sex attracted. Paul is moved to speak out to select others about his experience and give voice to their experience. Regardless of the political or personal motives for Paul's actions, his is a counter-story (Clapton, 2003) that challenges normative explanations of self-injury and people who enact it.

Paul occupies what can be thought of as transitional spaces for caring. The idea of transition implies changing from one thing to another or even moving from one place to another. The spaces where caring occurs for Paul are transitional because the encounters change him and the other men he meets, but the encounters also occur in the context of ongoing transitions between places.

At a personal level, Paul narrates his story in such a way that as his social and personal issues are played out, a new Paul emerges as the product of his experiences, which include his self-injury. Comparably to Frank's (1995) description of Audra Lorde's breast cancer, Paul suggests at the end of his story that these experiences were necessary because without them he might not be the complete version of what he always was—someone who is there for others.

> When I think of all the positive things, the experiences I've had with the courts and being in prison and everything probably there is a reason for that and that's why I think I have been able to help some people and without it I wouldn't have been able to have an influence in their life.

Even though altruism is present in Paul's encounters, it seems that his self-injury also helps to give meaning to an otherwise unstable and often unpredictable context. Paul seeks opportunities to care and behave in a moral fashion, but he tells of the limitations imposed by his past and by his need to change social settings. Paul's story is not about restitution (Frank, 1995). Even though he does not self-injure any more, his is not a story about eventually getting better or returning to the way things were. Instead it is about where he has ended up and how, despite the limitations of his situation, that sits well with him. As he ends his story he implies an uncertainty about what is to come.

Part two: The conduct of self-injury, metaphor and moral body practice

With the idea that self-injury can protect, or in some way safeguard esteem, comes the sense that even though restitution might not be possible, self-injury itself might in some way reflect a sense of hope, or a belief that things can at least get better (Lindgren, Wilstrand, Gilje, & Olofsson, 2004). When a person self-injures in order to cope, they are deferring the possibility that life can no longer be managed. Even though, as with Paul, what lies ahead is unknown, self-injury implies that it is at least possible.

This perspective makes Matt's self-injury interesting because he is both suicidal and self-injuring; vacillating between wanting to die and self-injuring for reasons that seem entirely more complex. Matt talks about his struggles to live in the world as someone with Asperger's Syndrome and an anxiety disorder. Matt's self-injury effectively takes him out of the world and enables him to escape the tension he

experiences when he feels challenged beyond his capacity. This does little to relieve his sense of failure, but it highlights how self-injury might protect him from further esteem-reducing experiences. The harm narrative reading of Matt's circumstances seems to be that he is using self-injury as a way of avoiding that which causes him distress (Andover, Pepper, & Gibb, 2007) and that he is, at best, surviving.

The moral narrative within Matt's story can be seen through an altruistic lens, although his altruistic modus operandi is difficult to locate. In order to be able to locate moral thought or practice, it is possible to turn to language, which can signal where moral thought or concepts are being employed. Metaphors are central to being able to apprehend and understand moral concepts (Murdoch, 1970). In the case of Matt's moral narrative, metaphor is central to its construction and transmission.

Matt's story opens with the image of a sad young boy of eleven, alone in a school toilet, drinking what he thought was poison, hoping it would kill him. A child's cordial bottle, meant to hold something sweet and refreshing, instead becomes a vehicle of intended death. It is a stark narrative and one that it is hard not to be moved by. Apart from this first experience of trying to end his life, Matt made another suicide attempt after being dismissed from his job when he tried to gas himself.

But Matt is also self-injuring in a different way, which, in a moral sense, is interesting. He is self-injuring using a variety of different methods, hoping, ultimately that this might result in death. In Matt's story, however, death might be a long way off. On the one hand, he is hoping that something might happen that will kill him; he is *willing* an accident to occur and this reflects a latent suicidality.

> …I've been willing other things like a car accident or whatever, or electrocution or coming across a brown snake or something like that…

But where he is active in his self-injury, the outcome of death is a long way off

> But then I've also been going out in the middle of the day to mow the lawn to get terrible sunburn. To get sores all over me and hopefully one day that will turn into something.

This "active" self-injury is interesting because it is more novel, insofar as it is possible to identify suicidal intent in Matt's account of his self-injury, but death, as an outcome, is deferred. Instead, where Matt is actively participating in his eventual death, he is also interestingly creating a space between the act of self-injury and eventual death. As readers of his story, we are drawn into what might potentially fill this space. The harm narrative fills this space with suffering and Matt evokes his conformity to the harm narrative very well.

At one level, Matt confirms that avoiding the world reduces the feelings of worthlessness that arise from social skills deficits and not being able to function at work. Matt's self-injury functions as a protective mechanism in that it enables him to withdraw to a place where he feels life is less anxiety provoking and therefore manageable. At least partially, then, the space between Matt's self-injury and his eventual, hoped for death, is filled with coping (Alexander & Clare, 2004; Suyemoto, 1998). Seeing Matt's self-injury as a form of coping is still a conventional harm reading of his self-injury, and it supports the pathogenic view of withdrawal and isolation as a symptom of a larger pathology.

Such an interpretation, however patent from a clinical perspective, fails to explore the moral nuances of Matt's story. It becomes possible to interrogate another purpose for Matt's self-injury by attending to his use of a garden metaphor. When this metaphor is explored more deeply in the context of his sexual orientation and isolative practices, it is possible to understand how the space between self-injury and eventual death is still filled with avoidance, but the avoidance in this different reading becomes the moral activity.

A first glance at Matt's garden metaphor seems to suggest he is talking about dying.

> I feel like if a plant wasn't doing very well in the garden you weed it out.

There is another level to this metaphor that reveals something else about how Matt thinks about his circumstances. Taking the plant out of the garden does not necessarily mean death, but because this statement is delivered after his stories of suicide attempts it is tempting to read it in this way. The question that arises here is not so much about the nature of the plant, that is, what is wrong with Matt, but rather what constitutes the garden.

Suffer not the little children

If the garden is understood to be life, then Matt's removal from it supports a conventional reading of a suicidal motive. If the garden is taken to be the social world in which life is lived, then Matt seems to be saying something about the relationships between him and those in his social setting.

> If something isn't healthy you take it out and it prevents it doing harm to the rest of the garden and so that's fine…

Put another way, Matt is self-injuring because it prevents harm to others. People sometimes self-injure because the alternative is to hurt someone else (Rayner & Warner, 2003). Rarely is this considered something that occurs within moral space. It seems that Matt has made a choice about how to deal with the perception that his sexuality might threaten his social world (garden) and his story suggests that while there is some support available, life has not offered him any other helpful alternative.

Discourses of paedophilia are an embedded part of the western cultural imagination. Matt is both an object of this imagination and a subject of it as well. The image of the inverted paedophile is in many ways comparable to that of the chemically castrated sex offender (Mac an Ghaill & Haywood, 2007). The image is one of contained danger, but the potential for emergence of threat requires constant vigilance. This image is one that Matt quite faithfully lives out through his self-injury because it

effectively precludes the possibility of contact with or attractiveness to young sexual partners.

As a participant in culture, Matt is exposed to a variety of social messages about his sexuality. One very powerful message is how society seeks to contain the known paedophile and (potential) sex offender. Matt has internalised this message and contains himself through his self-injury. Matt's body was something that he controlled through his self-injury. His acts of self-injury limited his involvement with his social world. Matt's body had the potential to engage in acts that he both desired but also feared and tried to contain. This tension seemed to leave him somewhat at war with a body that could cause him further problems (Young, 1992).

It is here, then, that the moral narrative emerges in Matt's story. Although Matt does not make any direct link between his attraction to young boys and his self-injury, his garden metaphor builds a conceptual bridge between the two. Matt's self-injury is a way for him to tend to the garden by extracting himself from it. Like Heurodis, in the poem *Sir Orfeo* (Caldwell, 2007), Matt disfigures himself to preserve his chastity. Although he continues to live and function within his diagnostic and social limitations, he actively tends to the other plants through his actions that cordon him off from life. Matt's self-injury functions as the constant vigilance: the watch he keeps over himself to minimise his threat.

When a social issue or in this case element of sexuality can be medicalised then it is possible to create a boundary between that which is sick and that which is well (Mac an Ghaill & Haywood, 2007). Matt uses the discipline of medicine, usually complicit in the harm narrative, to further his moral body practice. One of the ways that Matt was watchful over his sexuality was to use his general practitioner as someone with whom he was able to talk about his attraction. For Matt this was a non-judgemental and confidential space in which he could talk about his attraction.

This choice could be interpreted as an obligation to confess (Foucault, 1990) and although Matt's confession to his general practitioner might be likened to a form of coming out as a gay man it instead served a reverse function. Coming out is about newly emerging into the world (at least for a short while) as a gay man. This is, of

course, only good for as long as one socialises with people who were present for the original coming out. Living socially implies repeated coming out moments (Sedgewick, 1990) and new possibilities for shame and rejection.

Rather than "coming out" as being attracted to boys, Matt's confession helped him to stay where he was and avoid acting upon his desires. Matt's purpose seemed not to be to emerge into the world as a paedophile but to deploy a safety net. By talking to his general practitioner, Matt made a choice to declare his attraction to somebody who was in a position not only to support him but also to contain his behaviour if needed.

The medicalisation of his attraction served to help Matt to construct the attraction as sick. On one level this worked for Matt because it was one element of his garden metaphor and contributed to his identity. By managing his attraction through using his general practitioner he was able to be the sickness that could be removed from the garden. In other words, by medicalising his attraction he was more able to enact his moral narrative.

When Matt uses the garden metaphor he sets up a polemic between himself, who is disadvantaged, sick and unable to cope, and the garden, which is taken to be functional and well. While the metaphor reveals some of Matt's motivations for withdrawal it also reflects an assumption on his part and fails to acknowledge how Matt's world is sometimes hostile, silencing and infantilising. Matt uses the metaphor on the one hand to explain his deviance but also his metaphor works to negate the effects of the living in a hostile environment.

In a consumer culture, body work such as exercise or even surgery can increase appeal or desirability (Featherstone, 1993) and negate the effects of being present in an invalidating social world. The notion of bodywork enables Matt's self-injury to be thought of in a different way. If Matt's self-injury is taken to be a type of bodywork then in what way might it increase his appeal and what is its point? First, it might be that Matt is acting upon his social body, that which interacts and exists in tension with his surroundings. On one level his self-injury seems to detract from his desirability by causing physical injury and presenting his social world with a marker of damage. But his self-injury seems to also serve another purpose that is illuminated by his use

of the garden metaphor. By harming his body, Matt keeps it separate from the social world. He uses self-injury as a way to stand apart from others and in doing so he prevents his integration with and exposure to others.

Another metaphor that features in accounts of morality is where implicit associations are made between morality and vertical space (Meier et al., 2007). That is to say, moral thought or conduct is generally taken to be *higher* than immoral thought or conduct. Two of the participants in this study used spatial metaphors in their stories that allow access into their moral worlds and facilitate the emergence of a moral narrative in this study.

Making the best of bad situations

Paul's story, in many ways is also one of risk: risk of being someone who self-injured, the risks of being someone without domestic stability, and the risks of being a registered sex offender. Paul's narrative offers the most memorable use of the spatial metaphor to illustrate a moral underpinning to this self-injurious body/practice. Paul has spent his life trying to meet the standards that were expected of him and which he expected for himself. When he reflected on being caned at school for failing the spelling test he was aware that he had, somehow, done something wrong.

> It's like I tried my best but did not come up to standard so I got punished for it, it's as simple as that. It's the logical outcome.

The logic of pain as a consequence of failure is a feature of the harm narrative. Paul believed that punishment came from not succeeding and it was what helped him to try harder. His early experience paints a picture of a man who is striving to do better. But he is also a man who self-injures. The self-injury is tied into his dissatisfaction with how he has emotional feelings towards men that are difficult for him to express.

There is no clear point in Paul's story about when or how his self-injury takes on a moral quality in and of itself. He does not self-injure for noble reasons or because it

is considered to be right for same-sex attracted men to self-injure in his social context. Rather, it seems that Paul self-injured because he was distressed at feeling an emotional attraction to another man. That his self-injury is tied to his emotional response to his attraction does, however, seem significant to the way that he utilises his self-injury later in his story.

For many people who self-injure, emotional pain can be so intolerable that it needs to be replaced with something more tangible and manageable. Self-injury therefore functions as a means to focus nebulous emotional distress in the body (McAndrew & Warne, 2005). Before and during the times when Paul self-injured he was closeted and silenced. The self-injury can be viewed as a product of that tension and a way to punish himself for being gay.

In Arun's story it is possible to identify sexuality and specifically the way hegemonic masculinity shapes the experience of gay identity as implicated in self-injury through a harm narrative. That is, Arun was distressed about appearing gay and so he hurt himself so he didn't appear "typically" gay. Paul's story of emotional attraction to a man and how this led to self-injury enables the social element of sexuality to be thought about differently.

The notion of vertical space as metaphorically representing moral concepts is useful here. Even though Paul makes no specific reference to vertical space around this particular emotional issue, he does make reference to not being able to express the emotional attraction. Not talking about sexuality, either by choice or through social constraint is one way of being "in the closet" as a gay man. The idea that the "closet position" of gay men might also say something about moral position is perhaps worthy of further study.

Ultimately, though, Paul's self-injury seemed to produce a voice and it was the voice of someone with the capacity to help others. Once the self-injury punishment had been taken over by the state, his body (while contained within discourses of legal sexual conduct and behaviour was the subject of the state), became free to discover itself through mentoring those who also experienced similar kinds of distress.

There are two moments when Paul uses the spatial metaphor to illuminate his experience that are paradoxical, at least in a conventional sense. The first is when he has told of his trial for allegedly having sex with a minor. As he tells the story, Paul builds some tension around his legal choices, leaving the reader with the impression that he had little choice at all: he could be guilty or he could be guilty. Since he didn't have a choice, he was on a downward trajectory.

> …so I pleaded guilty and fell on my sword

The fall, or descent into guilt that was imposed upon Paul is something he seems to regret, yet his life-course impetus to "come up to standard" means that he located the intrapersonal resources that he needed to manage the experience. It is also possible to read his "fall" on his sword as an admission of guilt and a decision to take the punishment that he expected would accompany his act.

Fall to grace

This first example is paradoxical in that it is the downward trajectory that has moral currency. Paul's decision to offer a guilty plea exposed him to people who needed something from him. Perhaps he recognised people who were lower on the vertical space than he was, and he felt moved to respond to them. Paul's fall provided an opportunity to meet a "good person" standard that he set for himself.

Paul understands himself as now being the subject of a system that keeps him in a low position. He stories himself in a nomadic fashion, going from one place to another. On one hand, he feels he doesn't need very much now that his family is grown, but on the other he is being pursued by his past, when he is dismissed from jobs or has to report to police stations.

> I got dragged in and sacked on the spot with no explanation. The system… keep(s) hounding me down and dumping shit on me.

Paul uses a riot analogy to explain how he resolves some of the conflict associated with his circumstances and his self-injury. He refers to the Cronulla Riots and explains how there are two parts to him that fight with each other. Interestingly the warring parts argue about whether he is a good person or not and this concern belies an underlying moral concern about himself.

Rioting is one means of acting out fear (Lattas, 2007) and in the case of the Cronulla Riots the fear was related to an erosion of national identity. In Paul's case he seems to be describing a riot between the side of him he considers to be a good person and the side of him that has made decisions or acted in ways that have had negative consequences. He is illustrating that despite his "get on with life" mantra, his intellectual trajectory is not as simple as a blinkered forwards looking approach: his past decisions are as much in his present, shaping his actions, as something he decided upon yesterday.

Without the experience of being constrained by the system, it seems that Paul's altruistic side might not flourish. He extends the riot analogy to explain how it is the "hounding" of the system that allows his two rioting sides to unite, so that he has the strength to "stand up". He is also aware that without his history, he may not be credible as someone who is able to help others who are in need.

> And in a small way you try and help and that's one of the reasons I am here today. It is interesting to think about where my life would be today if I hadn't had the experiences I have had in prison and stuff like that.

The harm narrative continues to influence the reading of Paul's story, however, and an undertone of conventional self-injury pervades his account. When Paul is eventually released from prison, he explains how he no longer needs to self-injure because there are other punishments that are available to him: he has lost his wife and children and he is forced to live in a community which knows what he has done. Paul is able to convey how self-punishment is linked to self-injury for him as a same-sex attracted man (Taylor, 2003).

Even though Paul's self-injury is linked to self-punishment it is also one of the ways he works to construct himself as a good person. He no longer needs to enact harm upon himself because society fulfils that role and so the moral element to his self-injury is free to emerge. The system is punishing him, he last lost much and now has little but it is from this position that he is able to help others.

The act of helping others is one form of resistance to being "hounded down". Self-injury is the vehicle that allows Paul to accomplish this. When Paul sees others who are in pain, or who perhaps have even self-injured, he uses his experiences and scars to offer a listening ear, empathy, friendship and advice. These are likely to be luxuries for some gay men who do not have access to people with whom they can share their triumphs or traumas . As such, Paul's conduct and use of his body reflect a moral practice and concern for the other, similar to Arun's socially motivated action. Despite his oppression, Paul's self-injury has helped him to ascend within the moral spaces that were available to him and to make a contribution to his world. Making contributions and being worthwhile are important features of the moral narrative of self-injury. These motivations are elaborated on and clarified further in Brian's story.

Brian starts his story with an account of the stressors that were present in his home circumstance. He begins his story with the final events that pushed him to his breaking point, but later in the story he returns to describe how difficulties had started to build up. As such, Brian's self-injurious act provides a narrative footing (Faircloth, 1998) from which the moral dimension of his body practices can be considered. Brian's narrative is moral in that the life story he tells give shape to his experiences as things that have contributed to the person he is in the here and now. It helps therefore to read his story as it is told from the vantage point of today

Through the telling of his story, Brian constructs himself as a helper. When asked about self-injury Brian's response was to tell a story of his life. His narrative style is to use his life story to illustrate what he has learned from his experiences. This lifelong learning then translates into the position he is in as his story is told. The experiences he has had contribute to who he is now. Brian tells the story of an injured helper; someone who, like Paul, has had experience of adversity, albeit of a different kind, but who goes on to be with others in supportive ways.

Once Brian has told the story of his act of self-injury, he returns to his "coming out" and narrates his life story as it relates to his self-injury. It is perhaps easy at this point to read Brian's self-injury as an act that arises from anger towards his mother and Carl (Chapman & Dixon-Gordon, 2007). Leaving aside the individual emotional features emphasised by the harm narrative, it is possible to understand him differently. He first explains how he came out to his mother who then proceeded to gossip about him to others. This posed problems for Brian because he lived in a small community. Here, Brian's moral narrative starts to emerge through the spatial metaphor.

> I was quite high up in the Church at the time… I think the priest wanted me out, but I had already stepped down at that point.

Dignity is a necessary component of emotional wellbeing (Sayer, 2007) and in this part of Brian's story, he illustrates how his dignity was compromised by the actions of his mother and the response he received from the Church. Hence, he experienced a downward trajectory. Brian's control over his own moral direction was compromised and his esteemed suffered somewhat.

Interestingly, each time Brian narrates deterioration in his coping, and when he feels like committing suicide, this is linked to moments when his moral life-course is interrupted. The first time was the build-up of stressors at home tied in with how his relationship was compromised by his partner's actions. Later in the story he says that he felt suicidal again when his career in the helping professions was compromised by another social worker who wanted to block his application to join the professional register.

The notion of a moral life-course is further illustrated by Brian's account of being "high up" in the Church as one way that he was able to feel like he was making a contribution to his community and doing something good. While he does not expound upon the motives behind his Church involvement we are left to wonder whether he volunteers time to the Church to meet an altruistic need. From being high up in the Church, however, he then "stepped down": a lower point in vertical space

that implies a lower moral position as a result of the emergence of his sexual orientation into his social sphere through his mother's gossiping.

If Brian's mother's gossiping was one of the contributory factors to his "stepping down" in moral space, then his self-injury seems to be the ultimate expression of his dissatisfaction with occupying a lower moral position. Being high up in the Church might have helped Brian to experience himself as a moral person, but because he could no longer access this experience, his stressors compounded.

> At one point, I had Mother and the Aunt, both in their eighties and Carl to contend with. One would play up, I'd sort them out and then the other would play up and that is how it went. There was terrible stress in the house at that time…

It seems as though everyone important enough for Brian to mention in his story was "playing up" at that point. Brian adeptly narrates a building tension that results in his self-injury. What possible remedy would there be for such a tension? Perhaps an opportunity to engage in something Brian considered worthwhile would have helped. Brian's story suggests that he did try to assume a helping or caring role. Even though he laments the decision to allow his mother to live with him, caring for her seems to meet a need in Brian to be able to "look after".

Approximately one year after his car "accident" Brian's stressors began to increase again, culminating in the death of his mother and separation from Carl. Carl's bisexuality and his affairs with women offended Brian to the point that he could not continue the relationship. Staying with a moral narrative helps the reader to see how a move to another town reveals further insights into Brian's self-injury and life story.

The first significant character presented in Brian's new location is Dan. Dan becomes a central figure in the later part of Brian's story because he provides one foundation upon which Brian is able to rebuild his life. Rather than simply situating Brian as the altruist, however, the moral narrative means his story can be read as having a more relational quality in which Brian is comfortable to acknowledge his own needs

> Dan helps me in a way, because I see myself as emotionally weaker now, after the accident all those years ago.

Prior to this, Brian narrated his helping of others as one-way, with little in it for him at a personal level. There are, however, signs in his story that his needs for love and affection were also being met, although he does not acknowledge them: he extols the degree to which his Mother and Carl relied on him, but does not comment within the story upon the multitude of subtle (and not so subtle) clues that he is also very much dependent upon the relationship with both of these central figures in his story.

Like Paul, Brian did not self-injure as a moral act. In fact, Brian's act of self-injury ran contrary to his own beliefs about what is right conduct. The expression of frustration and the attempt that he made upon his own life remain deeply disturbing for him. Brian's self-injury can, however, be understood as an expression of frustration about not being able to exercise his need to live as a moral person. In this regard his story stands as an exemplar of how circumstance and the cumulative actions of others can become compounded inside a body, which then reacts to being a repository for social problems.

Brian's story reveals how his experience has moved from "I help them and it is stressing me" as with his Mother and Carl to "I help them and they help me" in regards to his relationship with Dan. It reflects a balanced view in which he still acknowledges his need for help but he is aware now that he has something to offer. The harm narrative tends to polarise sick and well. Brian is both vulnerable and able to care for others, reflecting a profoundly embodied dialectic.

The moral narrative, as it features in the men's stories of self-injury can be thought about in two ways. The first is that, for some men, their self-injury had moral value. Arun self-injured, in part, to avoid contributing to negative evaluations of gay men and Matt self-injured as a way to contain his attraction to boys. The second way that the moral narrative can be thought about is in how it shows how self-injury created spaces in which the men were able to give and receive care. Justin experienced a reciprocal caring in an unlikely space, Paul was able to care for others in many

different physical spaces and Brian's story revealed how thoughts of self-injury arose when his caring trajectory was thwarted.

Conclusion

This chapter has foregrounded two narratives that operated in the stories of self-injury given by the men in this study. The first was the harm narrative, which features strongly in existing social and clinical stories of self-injury. The harm narrative makes self-injury an individual problem and limits the potential of the person who self-injures to transcend pejorative constructions of vulnerability, emotionality and risk. This thesis questions the authority of the harm narrative to explain self-injury. Turning to experience as it was told within a three dimensional narrative inquiry space enabled a different narrative to be elucidated and theorised.

Attending to experience as it was storied meant the harm narrative was able to be theorised as a form of ventriloquism (Gilligan, 1982). That is, the men were drawing on a culturally validated narrative as they storied their experiences. Attending to how men lived and conducted their bodies (Frank, 1997a) meant that silences and gaps between the dominant harm narrative and their body practices emerged. Within this space, the moral narrative was located. The moral narrative is a marginal and fragmented feature of the self-injury stories told by the men in this study. The moral narrative reveals more than harm and shows how, for the men in this study, their self-injury enabled them to experience care for self and others and to engage in moral body practices.

CHAPTER SIX

LOOKING BACK, LOOKING FORWARD

This study asked three specific research questions that sought to explore how gay men experienced their self-injury. The first question asked was: How are gay men self-injuring? This study found that gay men are self-injuring in ways that are both similar to and different from other populations. For example, Arun and Paul cut themselves, but Justin used rituals of sex and eating to self-injure. Brian and Matt had both attempted suicide and Matt experienced both suicidal and self-injurious impulses. At an individual behavioural level there are significant commonalities between gay men and more established research populations. Answers to this first question can also be found by answering questions two and three.

The second question asked: What does this self-injury mean in the context of a life lived in relationship with others? This question set out to explore the social and relational aspects of self-injury in gay men that were hitherto poorly explored in the literature. A narrative approach meant that self-injury was examined through a concern with the story that each man told. This approach meant that self-injury was necessarily considered as a part of a larger storyline of life and as such the richness of each man's experience could be accounted for alongside the experience of self-injury.

Through attention to the stories it was possible to consider the meaning of self-injury for each man. Each man's story stood as a testament to the enduring notion that self-injury reflects something that is going wrong in life, whether that is something that happened in the past, or whether it is something that is currently being managed. Each man told a story that was shaped by what was termed the harm narrative. The harm narrative does not necessarily reflect the authentic voice of the teller. Instead, the harm narrative is learned through attention to other stories that are told at institutional and social levels. In this study the men ventriloquised a harm narrative as a valid, culturally sanctioned explanation of their self-injury. The effect of this

narrative is to foreclose other culturally relevant explanations, or at least make them difficult to locate or approach without suspicion.

The harm narrative features a plot line that embeds risk in each facet of the self-injury experience. For example, each man spoke about how his past had, in some fashion, generated a risk for distress that led to self-injury. Each man's internal experience was one of distress in some form and socially each man experienced tensions that put pressure upon him that led to self-injury. The harm narrative directs attention to what is wrong and, since the plot is institutionally crafted, how to fix it. The harm narrative therefore places the person who self-injures at the centre of interest to the self-injury experience and harm as the logical outcome of it.

The third question asked in this study was: What do gay men's voices say about self-injury that is different or not yet known? Through attending to men's voices as they told evocative stories of their lives, another narrative was present in their accounts of self-injury, although it was much more marginal.

A moral narrative featured in each account of self-injury. Whereas the plot line of the harm narrative embeds individual risk as a central feature of self-injury, the plot of the moral narrative grows out of the relationships that feature over time and context in stories of life as they are told. Listening to the accounts of relational experience and the complex interplay between person, time and place in the men's stories enabled two layers of the moral narrative to emerge. The first layer was in the moral value of some of the men's self-injurious actions. For example, Arun's decision to self-injure is presented as an attempt to avoid contributing to a pejorative discourse about gay men's emotional or unstable attributes. Another example is how Matt's use of a relational metaphor of being part of a garden illuminated his self-injury as a way to keep himself separate from a community to which he was aware he posed a danger.

The second layer of the moral narrative was in how self-injury created a moral space in which some of the men were able to both experience and offer caring to others. For example, Justin self-injured through sex but the act of seeking a man for anonymous sex meant, from time to time, that he was able to meet someone else's needs and also have his own met at the same time. For Paul, his past self-injury

meant that he was able to empathetically engage others who might need help or advice. Brian's account of feeling suicidal when his life trajectory as a helper/carer was interrupted revealed how his self-injury was a protest against not being able to care for others.

The harm narrative is dominant in the readings of self-injury and the moral narrative is marginal, discontinuous and fragmented. The apparent logic or common sense of the harm narrative is contrasted by the moral narrative, which locates some good in apparent harm. Both the harm narrative and the moral narrative are present in the men's stories of their self-injury. The men's stories illustrate how the harm narrative offers insights into the particular social stressors they face as gay men living socially as they described what was going wrong in their worlds that led them to self-injure.

The moral narrative shows how what looks like harm can also be something else. This something else is more than just coping; it is a way of living in the world that has moral value that has not yet been theorised or explored as a means of helping people who are experiencing emotional pain and who also self-injure. This way of living perhaps has the potential to be strengthened in a way that will let people let go of ongoing self-injury and this seems an important next step for clinical and social research. Certainly such research would, at least, stand to challenge the dominance of harm, as a means to explain and shape interventions that, to date, are not always helpful.

Three further interesting features emerge from this study. The first relates to how the findings of this study suggest the continuum theory of self-injury (Pearce & Martin, 1994; Stanley et al., 2001; Vermeiren et al., 2002) is deserving of more scrutiny. The notion that self-injury exists on a continuum of self-injurious thought to suicide was raised in the literature review. The idea of a continuum is appealing because it makes it easier to think about self-injury and assess risk. The idea of a continuum gives a sense of unity to self-injury: that it is organised on a trajectory of seriousness. The unity created by the continuum theory suggests it is part of the harm narrative because it is a continuum of risk. The idea of a moral narrative interrupts a continuum because the moral narrative liberates self-injury from notions of harm.

The second feature is that some of the men present a story of self-injury in which they are more controlled and measured about their self-injury than the harm narrative usually makes visible. Therefore, the calculated, precise and timely use of self-injury narrated in this study challenges some popular notions of the impulsive and out of control self-injurer who requires containment and control.

The third feature relates specifically to the way the men in this study storied their self-injury in relation to their sexual orientation and the tensions of living in a social world that did not always affirm. For the men in this study, self-injury seemed to work as a way to craft masculinity as well as a way to mitigate the effects of hegemonic masculinity. Three of the participants expressed values that are linked to a masculine ideal and narrated how their self-injury was deeply embedded in and by this context. For one, self-injury was a way to be more of a man and not appear gay; for another, stoicism was valued and self-injury played a role in constructing and leading a stoic life. For the final participant, self-injury was equated with a way of resisting the role of being weak—an identity he had taken on through a difficult relationship with his father. The stories told by the men in this study thus corroborate the extensive literature that highlights a social distance between gay men and the heterosexual society in which they live. If nurses are to provide supportive and empathetic care, they need to be prepared to get to know something of the lives and stories of the gay men for whom they care.

Suggestions for caring practices

These findings create further implications for practice because nurses and other health professionals cannot separate clients from their social contexts. That it is possible to draw upon narratives other than harm to give meaning to self-injury means that nurses need to be prepared to explore the possibility of different responses to people who present with self-injury as part of their clinical presentation. Derived from the findings of this study, here are three suggestions for practice that clinicians may like to consider when working with people who self-injure:

Listen first, then act. Not every episode of self-injury is a psychiatric emergency. One clear message that emerges from this study is that nurses need to attend to clients by finding ways to care that go beyond observing for signs of problems, containing and repairing injury. In the first instance doing less, rather than more, might be an appropriate endeavour for first encounters and beyond. As was found in this study, clients will perhaps tell stories of life, not just of self-injury. These stories can contain important messages for nurses about how people cope, manage and advance through life and trauma or distress. When these stories are listened to and heard, it is possible that new ways of working will emerge that increase nurses' sense of efficacy and help to minimise care as a possible risk factor to clients.

Care can be a risk factor for clients. Failing to acknowledge difference and not getting to know clients might mean that nurses are then forced to rely on practices that are embedded within the harm narrative. The current body of self-injury knowledge point to care as a potential risk factor, if nurses are not well informed or lack the skills to respond. Talking to professionals is not always a validating experience and can prompt negative feelings that can lead to further self-injury. As Arun, Justin, Matt and Paul demonstrated in their stories, self-injury can become established in the everyday where it is easier to hurt the self than to be able to talk about problems.

There is a challenge here for nurses who work with gay men. This study has shown how, for these men, their self-injury was linked to their sexuality and how their sexuality silenced them within their social worlds. Part of helpful nursing practice with this group is therefore to give voice to experience in a way that does not shame or further silence.

Self-injury is not always about vulnerability so try not to assume that it is. One way that nurses and other health professionals currently silence people who self-injure is through the enforced containment of self-injury. That is to say, when people self-injure, the voice on the skin, the silent scream or secret sound is interpreted as risk that must be managed. This study has shown that some of the men deferred their need to self-injure. For these men, control and precision are as present in their accounts of self-injury as chaos or impulsivity. Two of the men were more impulsive than the

others, and so nurses should assume neither vulnerability nor control, but be aware that a person need not necessarily be out of control.

Another assumption that is made by nurses and other health professionals is that self-injury reflects vulnerability and care is planned accordingly. The care that follows from this position may be unhelpful because it is does not take account of the client's epistemology. Each of the men in this study engaged in forms of self-injury that were about more than harm. If nurses were able to harness the moral motivations exhibited by clients, new interventions that focus on strengths rather than vulnerabilities might prove helpful.

Recommendations for Research

In order to augment practice and develop useful knowledge for working with different groups who self-injure, further research is warranted. Arising from the findings of this study, three areas for further research are highlighted:

- Studies that seek to explore the moral reasoning that features in people who self-injure may be useful. This focus may have the potential to develop the body of knowledge regarding the social and cultural significance of self-injury as well as to find ways to develop solution-focused working with people who self-injure.

- This study provides rich insights into the experiences of five men who self-injure. Additional research is required to explore aspects of self-injury such as health care preferences and provision that this study does not address.

- The mediating relationship between self-injury and masculinity is interesting and deserving of further research. The idea that men engage in self-injury as a way to express dissatisfaction with a body that betrays hegemonic masculine ideals is a relevant social critique that might benefit from further social inquiry.

Concluding comments

The findings of this study make both theoretical and practical contributions to working with people that self-injure. While there are likely to be a multitude more meanings of self-injury being lived and storied as this dissertation is being read, here I present one reading of self-injury told through the voices of five gay men. It is a new story of self-injury because it gives voice to gay men. It is one story in a history of stories that, as we move forward in care, concern and interest for others, may help to leave harm behind.

EPILOGUE

Now that this study has concluded, I am forced to reflect on how it has not turned out quite as I had expected. Almost five years ago, I proposed a study into how gay men were self-injuring and it was this that I expected would make the focus of my findings. While I hope that I have, to a large degree, achieved the aim of evoking something of the experience of being a gay man who self-injures, I am aware that the research says something about how self-injury is thought about in a more general sense.

This shift in focus brings me back to Daniel and his self-injury. I wonder whether his self-injury was saying something about his sense of his own moral value. The fact that he felt out on a limb and voiceless and wrong seems to resonate with me in a different way now. I never explored his self-injury with him in this way and I wish I had. For many reasons, Daniel will stay with me throughout my career. Writing this thesis has made me reflect on my own journey to find a sense of worth that lasts, even when the world implies there is something a little wrong with you.

A rich narrative landscape has shaped how the story of this thesis has been told. Once the last word is written I will walk away and the stories and challenges in this thesis will be read, met and reinterpreted by others. I myself will try and extend this research, because undertaking this study has renewed my professional and personal commitment to this field. So, whether it is through you, the reader, or through me, the author of this dissertation, these stories will form part of another story of self-injury and same-sex attraction that is yet to be told, but is already forming—somewhere in the back of your mind.

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APPENDIX ONE: ADVERTISMENT TO RECRUIT PARTICIPANTS IN PHASE ONE

A study is currently being conducted that examines self-injury in gay men in order for health professionals to try and find helpful ways to respond. Participation involves being interviewed for one to two hours. Any gay men who are interested in being involved in this research can contact Andrew Estefan on [researcher's telephone number] or by email at [reseacher's email address] for further details.

APPENDIX TWO: ADVERTISEMENT TO RECRUIT PARTICIPANTS IN PHASE TWO

A researcher at Griffith University is undertaking a PhD project that looks at self-injury in gay men. The purpose of the project is to find out more about how gay men self-injure and to find helpful ways for health professionals to respond. If you self-injure or have self-injured and would like to participate in an interview about your experiences call Andrew in confidence on [researchers telephone number].

APPENDIX THREE: INTERVIEW QUESTIONS

Question 1
Can you tell me about a time in the past when you have self-injured?

Question 2
What was that like?

Question 3
How do you remember feeling?

Question 4
What else did you do/what else was happening?

APPENDIX FOUR: REFLECTIVE FIELD NOTES (TRANSCRIBED)

1st October 2005

I am a bit unsure about where I go with the data collection now. I've had a couple of chats on the email with [Arun] and he seems relaxed and looking forward to his time off of work. He's had the transcript for about three weeks now but no mention of it in his emails. Haven't heard from the others so I'll hang on and see what happens. I want to think about more about what's there but I think wait. See what happens.

13th Octover 2005

I've not had replies from either of the other two men. I can't contact [Justin] at all and [Brian] has not returned my calls. I had to send another email to Arun today to chase up the review of the transcript.

18th November 2005

Nothing more from Arun now. Everything has gone quiet. I'm back in Australia in a month or so, so even though I can email it still feels more distant somehow. I will need to chat this over with Margaret and Jen to see where I go from here. I think there is interesting material in the transcripts.

17th January 2006

Out of the blue, I had an email from [Arun] today. He is coming to Australia to see a friend, so he said he thought he would contact me. His email was full of his plans and the excitement at coming out here. Not a mention of the research though. I don't think he's embarrassed because if he was I'm pretty sure he wouldn't have contacted me at all.

APPENDIX FIVE: INFORMATION FOR PARTICIPANTS FORM

Griffith Health
Nursing and Midwifery

Nathan Campus, Griffith University
170 Kessels Road
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Self-harm in Gay Men: A Study of Difference

INFORMATION FOR PARTICIPANTS

To be retained by participants

Who is conducting the research

Associate Professor Margaret McAllister
Contact: Tel: [telephone number] Email: [email address]

Dr Jennifer Rowe:
Contact: Tel: [telephone number] Email: [email address]

Mr Andrew Estefan:
Contact Tel: [telephone number] Email: [email address]

Postal Address: School of Nursing, Griffith University, Nathan Campus, Kessels Road, Nathan, Queensland 4111 Australia.

Why is this research being conducted

This study aims to find ways to think about self-harm that have not previously been considered in order that nurses and other health professionals can improve their care of people who self-harm. Current research into self-harm focuses on heterosexual populations and gay men are under-represented in the research literature. This study aims to address this deficit.

What you are being asked to do

Becoming involved in the study would mean that you would be interviewed for approximately one to one and a half hours. The interview would be audiotaped and then transcribed onto paper. During the interview you will be asked some questions about times when you might have self-harmed, what happened and how you understand your self-harm. Even though there are some questions, the interview will be more of a conversation between you and the researcher (Andrew).

Once the interview has been transcribed, the transcript will be returned to you, to read and delete any material with which you are uncomfortable. Alternatively you might have thought of something else to add, in which case you can do this too.

The expected benefits of the research

It is expected that this research will address the current gap in professional knowledge about self-harm in gay men. This research will enable nurses and other health professionals to become more aware of some of the issues faced by gay men who self-harm. It may be that talking about issues may provide a sense of relief for you and give an opportunity to be heard.

Risks to you

Talking about things like self-harm can sometimes be stressful. You might feel nervous or apprehensive about discussing a time when you have self-harmed. The researcher, an experienced mental health nurse, will make every effort to make you feel comfortable and at ease before starting the interview. If you become upset and would like to stop the interview, you can do so.

You should know that your wellbeing is our priority. If there are signs that you do become at risk of injury during the interview, the researcher will indicate concerns to you and arrange follow-up support with an expert counsellor.

Your confidentiality

You will not be identified in any written material produced from the interview. Because your experiences and words are important, these will be used but we will protect your privacy and anonymity. You will be asked to choose a name other than your own by which you will be known in the study. The names of locations, significant other people you mention or services used will be changed.

Your participation is voluntary

Your participation is voluntary and you do not need to answer any question during the interview unless you wish to do so. If you decide not to participate, this decision will not affect your involvement with [Agency name] in any way.

You are also free to withdraw from the study at any time and without explanation and there will be no penalty.

If you agree to participate, you can contact Andrew Estefan on [researcher's telephone number]. Andrew will call you straight back. Andrew will arrange a convenient date and time to meet with you.

Questions/further information

If you have any further questions you may contact Andrew on the telephone number or email address listed at the top of this information sheet.

The ethical conduct of this research

Griffith University conducts research in accordance with the National Statement on Ethical Conduct in Research Involving Humans. If participants have any concerns or complaints about the ethical conduct of the research project they should contact the Manager, Research Ethics on +61 (0)7 3875 5585 or research-ethics@griffith.edu.au

Your Privacy

The conduct of this research involves the collection, access and / or use of your identified personal information. The information collected is confidential and will not be disclosed to third parties without your consent, except to meet government, legal or other regulatory authority requirements. A de-identified copy of this data may be used for other research purposes. However, your anonymity will at all times be safeguarded. For further information consult the University's Privacy Plan at www.griffith.edu.au/ua/aa/vc/pp or telephone (07) 3875 5585.

Feedback to you

A written summary of the findings of the study will be made available to each participant. A written report of the study, outlining findings will be provided to [Agency name]. Research findings will be available upon conclusion of the study in August 2007.

The researchers and the University thank you for your assistance with this research project.

APPENDIX SIX: CONSENT FORM

Griffith Health
Nursing and Midwifery

Nathan Campus, Griffith University
170 Kessels Road
Nathan, Queensland 4111
Australia

Telephone: + 61 (0)7 3875 5406
Facsimile: +61 (0)7 3875 5431

www.griffith.edu.au

Self-harm in Gay Men: A Study of Difference

CONSENT FORM

Research Team

Associate Professor Margaret McAllister Tel: [telephone number]
Dr Jennifer Rowe: Tel: [telephone number]
Mr Andrew Estefan: Tel: [telephone number]

School of Nursing, Griffith University, Nathan Campus, Kessels Road, Nathan, Queensland 4111 Australia.

By signing below, I confirm that I have read and understood the information package and in particular have noted that:

- I understand that my involvement in the research will include participation in an in-depth interview that will last approximately one to one and a half hours;
- I have had any questions answered to my satisfaction;
- I understand the risks involved;
- I understand that the benefit may come from my interaction and discussion with the researcher;
- I understand that my participation is voluntary;
- I understand that if I have any additional questions I can contact the research team;
- I understand that I am free to withdraw at any time without comment or penalty;
- I understand that I can contact the Manager, Research Ethics at Griffith University Human Research Ethics Committee on +61 (0)7 3875 5585

(or research-ethics@griffith.edu.au) if I have any concerns about ethical conduct of this project, and;'

- I agree to participate in the project.

NAME_____

Signature_____

Date_____