

# **The experience of Self-harming behaviours that inflict external injuries to the body in UK-based Bangladeshi, Indian and Pakistani females: An Interpretative Phenomenological Analysis**

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## **Abstract**

Previous studies carried out on self-harm have consistently reported a higher level of self-harm among South-Asian women. They have shown that these women are also least likely to seek professional support from mental health professionals. However, previous studies have clustered the large ethnic group together, regardless of the differences between them, looked at all types of self-harming behaviours as similar and predominantly carried out quantitative studies. Therefore, the present study investigated the experience of self-harming behaviour that inflicts external injuries to the body in Indian, Pakistani, and Bangladeshi females.

A total of eight participants were recruited via purposive sampling and semi-structured interviews were carried out. The interviews were analysed from an Interpretative Phenomenological Analysis (IPA). Analyses were carried out on an individual and group level and four super-ordinate themes, and eleven sub-ordinate themes emerged. The superordinate themes were: 'Powerlessness' ('Entrapment', 'Internalised Negativity' & 'Abused by my Environment'), 'Mitigation' ('Releasing my Overwhelming Emotions', 'Connecting to my Pain' & 'Addicted to Self-harm') and 'Self-harm is Wrong' ('It must be Hidden', 'What have I done to myself?' & 'My Self-harm is Sinful'). The analyses revealed what appears to be novel insights on the impact and importance of the South-Asian cultural values and beliefs on the experience of self-harm in South-Asian women. The findings have been discussed relative to previous studies of this phenomenon. Also discussed are the strengths and limits of the study, clinical recommendations, and future research areas.

## **Abbreviations**

BPS: British Psychological Society

IPA: Interpretative Phenomenological Analysis

NICE: National Institute of Health and Care Excellence

NHS: National Health Service

UEL: University of East London

UK: United Kingdom

CoP: Counselling Psychology



## **CHAPTER ONE: LITERATURE REVIEW**

### **1.1 Chapter Summary**

This thesis is based on the experience of South-Asian (Bangladeshi, Indian and Pakistani) females who have inflicted external injuries to their body (e.g., via cutting, burning etc.). This chapter will commence by introducing self-harm and the prevalence in South-Asian females. It will also critically appraise the existing literature on self-harm among South-Asian women, highlight gaps in the current literature and outline the rationale for the current study. The chapter will end with a discussion on the relevance of the study to Counselling Psychology (CoP) as well as highlight its novelty.

### **1.2 Search Strategy**

It is noteworthy that many studies discussed in this literature review are now a little old, this reflects the lack of recent interest in the topic. Several databases were searched when conducting the literature review using EBSCO Host platform: 'PubMed', 'Science Direct', 'Sage Journals', and 'Psych Net'. The keywords used for the search included: 'self-harm', 'self-mutilation', 'self-injury', 'self-violence', 'self-injurious behaviour', 'self-inflicted harm', 'non-suicidal self-injury', 'South-Asian', 'Bangladeshi', 'Indian', 'Pakistani'. These keywords were combined using 'OR' and 'AND' to narrow down the results and display the most relevant studies for this research.

### **1.3 Introduction**

Self-harm has a variety of meanings in the literature (Sutton, 2009). The National Institute of Health and Care Excellence (NICE) defines self-harm as “any act of non-fatal self-injury carried out by a person, irrespective of their motivation” (NICE, 2013, p6). The National Health Service (NHS) states that self-harm can include cutting or burning the skin, punching, or hitting self, self-poisoning with tablets or toxic chemical, misusing drugs or alcohol, excessive exercising or deliberately starving oneself. Furthermore, it has been reported that these behaviours can be considered as self-harm irrespective of suicidal intent (Skegg, 2005) and can be a “one-off” or repetitive behaviour (Owens et al., 2002). The definition proposed by NICE (2013) has been selected for the present study for various reasons. Firstly, the comprehensive nature of the definition is in line with the exploratory nature of this research. Secondly, NICE

is a nationally recognised organisation with relevance to current practices on mental health in the United Kingdom (UK). Other terms used in the literature consist of deliberate self-harm, self-mutilation, self-cutting and self-injurious behaviour. Nevertheless, as 'self-harm' appears to be the most used term (Messer & Fremouw, 2007), it will be used in the present thesis.

Though statistics show that 5.5% of the adults engage in self-harm in their lifetime (Swannel et al., 2014), this figure is likely to be higher as many instances go unreported (Cooper et al., 2006). Statistics also indicate that 16.7% of females engage in self-harm compared to a comparably lower rate of 4.8% in males (The British Psychological Society and The Royal College of Psychiatrists, 2012), suggesting either gender differences or rates of disclosures in self-harm. More importantly, it has been found that the repetition of self-harm has been linked to suicide attempts (Turecki & Brent, 2016), which highlights that self-harm could be an indication of fatality. Furthermore, it has been estimated that one in twenty-five patients who visit the Accident and Emergency (A&E) services for self-harm will complete suicide in the next twenty-five years (Carroll et al., 2014). Consequently, 804,000 suicide completions are carried out each year, making suicide an immense cause of death worldwide (Swannel et al., 2014). Furthermore, external events have also been found to be linked to self-harming behaviours. For example, Low et al. (2000) investigated the link between childhood trauma and deliberate self-harm in a sample of women who were detained in a high secure setting. They found that self-harm was linked to childhood trauma and childhood sexual abuse and concluded that childhood traumas were an antecedent in self-harm. This highlighted the importance of thinking about the history of individuals when exploring self-injurious behaviour.

### **1.3.1 Theories of Self-harm**

Before reviewing the existing research, it is important to understand the conceptualisation of self-harm by researchers and clinicians. The differences in the way that self-harm has been defined is also reflected in the differences in the way in which self-harm has been conceptualised in the existing literature. The diverse range of behaviours defined as self-harm, create a level of difficulty on a theoretical level, nonetheless, there are a number of different models which aim to explain the function of self-harm (Skegg, 2005). The major theories are discussed below.

The Affect Regulation Model suggests that self-harm enables the management of unbearable feelings, which cannot be communicated verbally, thus individuals turn to self-harm as a control over difficult emotions (Chapman, Gratz & Brown, 2006). Studies have found that various emotions that had not been expressed have been present before acts of self-harm such as anxiety, anger, shame and tension (Crouch & Wright, 2004). This model has received the most support, as studies have found that these ideas resonated with therapists' clients who had self-harmed (Suyemoto & MacDonald, 1995). Furthermore, previous studies have found that some individuals were unable to express themselves to others and therefore resorted to self-harm, suggesting that self-harm enabled them to regulate their emotions (Bhardwaj, 2001).

Psychodynamic models view self-harm as a manifestation of life, death and sexual drives. For example, The Anti-Suicide Model interprets self-harm as a coping mechanism, as it is viewed as a negotiation between life and death (Klonsky, 2007). It states that the individual repeats self-harm as it enables them to act out their destructive impulses yet avoid suicide (Klonsky, 2007). Another psychodynamic model, The Sexual Model, states that self-harm is an act of punishment to prevent sexual feelings, thoughts or behaviours. It suggests that this link between sexual behaviours and self-harm is due to the non-existence of self-harm prior to puberty (Daldin, 1988). Although this is a criticised view in the literature due to its focus on sex (Suyemoto, 1998), the ideas related to internalised anger have been influential in explaining self-harm (Nixon, Cloutier & Aggarwal, 2002). Studies to support this model arise from single case studies of hospitalised patients. For example, a 17-year-old patient who had repetitively and ritualistically used razor blades to cut areas in her body including her abdomen, arms, breast and thighs (Parfitt, 2005). The author described the patients wish to punish herself due to disgust from sexual thoughts she had and suggested that the aggression felt had been internalised towards the self (Parfitt, 2005).

However, Parfitt's (2005) study did not randomly select the participant, therefore, it is not representative of all explanations of self-harm. While the epistemological stance of the methods used (case study) fits in with the Counselling Psychology ethos of exploring subjective experiences, it can be described as lacking external validity, in essence the degree to which these findings reflect the reasons for self-harm across different individuals. Furthermore, the evidence to support these models varies from single case to large empirical studies and

therefore can lack credibility. Although the strongest evidence was found for The Affect Regulation Model (Suyemoto & MacDonald, 1995), Messer and Fremouw (2008) state that ideas from several models should be taken into account to fully understand the explanations for self-harm. Furthermore, cultural, ethnic and gender differences in theories in the explanations of self-harm have not been explored; therefore, there is a lack of understanding as to how these models would apply to other cultures and ethnicities, such as South Asian individuals.

One model that could explain the reasons for self-harm in South-Asian individuals is known as the Environmental Model. This model links the environment to the individual where self-harm occurs, more specifically it states that self-harm is carried out due to external gain from the environment or due to release of negative feelings (Messer & Fremouw, 2008). Therefore, self-harm enables a distraction from unpleasant feelings deriving from family issues as the focus is on the pain (Suyemoto, 1998). This model suggests that the individual's behaviour needs to be contextualised within the framework of the environment that the individual is in (Babiker & Arnold, 1997). For example, homosexual men internalised the negative emotions associated with society's disapproval of homosexuality, and to deal with this some have self-harmed (Babiker & Arnold, 1997). This highlights the role of the broader socio-political context when considering self-harm, especially with individuals from a UK-based BIP background. However, the majority of the studies used to support these theories were carried out over twenty years ago, therefore, updated studies are required to corroborate the validity of this theory. Although the theories have attempted to provide an explanation for self-harm, it is important to acknowledge that no one theory will capture the reason for this injurious behaviour in all individuals. Counselling Psychology highlights the subjective experiences of individuals; thus, the subjective experience should be considered as opposed to fitting an individual into a given theory.

### **1.3.2 Precipitants of Self-harm**

These models of self-harm correspond to the idea that there are different reasons why individuals self-harm. Other precipitants of self-harm discussed in the literature include sexual, physical, and emotional abuse, pressures from school, bullying, interpersonal difficulties, low self-esteem, and difficult emotions such as anxiety, depression, anger, etc.

Gomez et al. (2015) explored history of abuse as a predictor of self-harm in three hundred and ninety-seven undergraduate students in exchange for course credits. They used The Brief Betrayal Trauma Survey-Modified self-reported questionnaire to assess emotional, physical, and sexual abuse. Their findings supported their hypothesis that historical abuse predicted self-injurious behaviour. Other studies have also echoed similar findings whereby child sexual abuse and child physical abuse were found to be linked to repeated episodes of self-harm (Yates et al. 2008).

Another precipitant of self-harm has been found to be bullying, as supported by research. Heerde and Hemphill (2018) carried out a meta-analysis on bullying and its link to deliberate self-harm in 156,284 adolescents (11-19 years old). They carried out a systematic review and a few meta-analyses using the random effects model. The results showed statistically significant links between traditional bullying, victimisation, cyber-bullying, and deliberate self-harm; thus, the authors highlighted that exposure to bullying can be a predictor for self-harming behaviour.

Eyuboglu et al. (2021) explored the prevalence of bullying and its link to mental health problems in a sample of 6202 students (aged 11-18 years old). They assessed bullying, self-harming behaviour, anxiety, depression, and psychosocial difficulties using a self-reported questionnaire. They found that bullying related to anxiety, depression, psychosocial difficulties, and self-harming behaviour. These findings can also indicate a link between mental health difficulties and self-harming behaviour.

Alongside bullying, research has also shown that interpersonal difficulties can act as a precipitant for self-harm. Skegg (2005) highlights that maladaptive parenting and childhood maltreatment can heighten the likelihood of self-harm as these adversities have been found to be linked to “severe” interpersonal difficulties. As such, an adverse life experience involving interpersonal difficulties, or a relationship breakdown could trigger self-harm in an individual.

Further, Wadman et al. (2018) explored the experience of self-harm in fourteen young women (13-18 years old) in the context of interpersonal stressors. They carried out semi-structured interviews and then analysed the results using interpretative phenomenological analysis. They identified several themes, including arguments and worries about family breakdown, Unhelpful

parental response to self-harm and emotions shaped by others. The authors therefore concluded that the themes highlight the complexity of self-harm which is experienced in the context of interpersonal difficulties.

Additionally, Fliege et al. (2009) carried out a systematic review on the risk factors associated with self-harming behaviours. They searched Medline, PsychINFO, Psynindex and reference lists for risk factors of non-suicidal self-injury. They found fifty-nine original studies that met the criteria and found that adolescents and adults that self-harmed had experienced negative emotions more frequently. These negative emotions were found to be anxiety, depression, and low self-esteem. This indicated that there may be an association between self-harming behaviours and negative emotions.

Although it is important to explore the precipitants of self-harm, it is also critical to think about the repetitive nature of self-harming behaviour. Davis and Lewis (2019) examined discussions on self-harm on message boards on the internet and searched for themes that related to self-harm as an addiction. They found five-hundred online postings from four online forums, which were then analysed to explore whether self-harm was viewed to have an addictive element. These posts were then analysed using content analysis, resulting in six themes – Urge/Obsession, Relapse, Can't/Don't want to stop, Coping Mechanism, Hiding/Shame and Getting worse/Not enough. Davis and Lewis (2019) utilised this finding to demonstrate that the repetitive nature of self-harm appears to have an addictive element.

Overall, it appears that there are a variety of different life difficulties. This is seen in the research by Townsend et al. (2015) whereby they investigated the difficulties experienced by those who had sought support at hospitals for self-harm. The data from the Multicentre Study of self-harm in England in 2000-2010 was used to examine life tribulations linked to self-harming behaviour. The study included the exploration of 24,598 patients including 36,431 episodes of self-harm. They found that those who reported a repetition of self-harming behaviour were more likely to also report difficulties with accommodation, mental health, and historical abuse. This led to the conclusion that self-harm typically happens in the context of numerous life troubles.

### **1.3.3 Ethnic differences in Self-harm**

Alongside the gender differences in self-harm, research has also found that the ethnicity of an individual plays a significant role in self-harming behaviours. Ethnicity, considered as separate from race, can be defined as a social group of people who share similarities related to nation, history, language, society, religion, or culture (Bhugra, 2004). An individual's ethnic background can give rise to their values, behaviours, and practices. However, it is important to note that ethnicity is not constant and therefore, over a period, there may be changes (Senior & Bhopal, 1994). As there is a link between self-defined ethnicity and identity, with our identity being informed by an individual's ethnic background, the literature will discuss identity using Erikson's theory. According to Erikson, identity, referring to the philosophical question of "who am I," is developed through the process of trialing out different versions of ourselves in various situations before deciding on an identity. Identity is made up of an individual's beliefs and values they think they should live in accordance with (Erikson, et al., 1959). Erikson suggested that adolescents may take on the beliefs, values, and morals of their parents, particularly if the individual has parents with traditional cultures (Erikson, 1968). Interestingly, research investigating self-harm and ethnicity have found ethnic differences in the rates of self-harming behaviours. It has commonly been found that self-harm is higher in South-Asian females than in other ethnic groups (Cooper et al., 2006; Marshall & Yazdani, 1999). Before discussing self-harm within the context of South-Asian ethnicity, it is important to consider the features of the South-Asian background.

Research has indicated that South Asians predominantly and historically espouse what is known as 'collectivist' culture, which relates to respecting the needs of the wider group as opposed to the individual's personal wishes and desires (Pilington et al., 2012). Another shared understanding of South Asians adopting a collectivist culture is adhering to conventional gender roles and respecting older family members and making decisions based on what is best for the family or wider community rather than the individual (Fayer, et al., 2002). Research has shown that there are various aspects that generate conflict in the values and beliefs (cultural conflict) of South-Asian women, including the clash between individualistic and collectivist culture, gender role expectations, marriage, and religion. These conflicts arise when South-Asian women are required by their family members or community to orient their behaviours towards the community as opposed to behave in the way that they wish to (Pilington et al., 2012). The next section will discuss the conflicting values that may lead many South-Asian

individuals to experience psychological distress, which can then be translated into self-harming behaviours to cope (Hussain & Cochrane, 2003; Bhardwaj, 2001). It will also highlight why there is a need to further study this area.

#### **1.3.4 South-Asian Culture**

The South-Asian culture has been viewed as different from the western culture in various ways. This section will argue that there are elements in South-Asian culture which contribute towards idiosyncratic distinctions in South-Asian females by exploring gender inequality, marital difficulties, and religion. These factors have been found to have an impact on South-Asian women's wellbeing.

##### **Gender roles**

An important aspect that needs to be considered for South-Asian women is the clearly defined gender role expectations (Rahman & Witenstein, 2013). Traditionally, men were viewed as the head of the household, whilst women were expected to be the primary caregivers of the family (Varghese and Jenkins, 2009). However, in more recent years, women have been required to maintain a career whilst also attending to the primary caregiving role for the family (Dasgupta 1999; Kallivayalil 2004). Consequently, South-Asian women were given a dual role of providing for the family whilst also involved in the caregiving roles, resulting in a demanding responsibility (Rahman & Witenstein, 2013).

A study by Dwyer (2000) explored cultural identity and the experience of gender inequalities in South-Asian women in the UK, aged 16 to 18. Dwyer carried out individual interviews and group discussions with forty-nine participants. These discussions were transcribed and analysed, though the author did not specify which analytic method was utilised. Dwyer (2000) reported finding "strong" gendered expectations of young women as the protectors of cultural and religious honour. These expectations were reported to have reinforced gender roles whereby women were expected to uphold the family's integrity. In other words, this meant that they were examined by others in their ability to follow a specific way of behaving and their attire, particularly when they were in "public places". Dwyer (2000) found that this was because a woman's dress was viewed as an indication of a woman's propriety, whereby if she



was wearing clothes associated with the western culture then she would be deemed rebellious or sexually active and therefore thought of as a threat to ethnic purity. Consequently, they are judged negatively by the wider South-Asian community for wearing clothes associated with the Western culture (Dwyer, 1999b). Dwyer (2000) indicated that this meant that young South-Asian women experienced scrutiny from others in their community, resulting to pressures on this group of women and their wellbeing.

Other studies have explored the dynamics that are present in South-Asian marriage. Bhugra and Desai (2002) carried out a review on suicide attempts in South-Asian women and found that females aged 18-24 were at an increased level of stress. They suggested that this could be due to the pressures of gender-role expectations from marriage, which can consequently contribute to self-harm. These studies suggest that males have a greater freedom culturally and in relationships, which could perhaps explain the lower levels of mental health difficulties, and particularly self-harming behaviours, in South-Asian men in comparison to South-Asian women (Gilbert et al., 2004; Niaz, 2003). Therefore, this study indicated that the lack of freedom generated a higher level of stress in South-Asian women, which resulted to the use of self-harm to manage this experience. It highlights that there are certain gender specific cultural values, beliefs and norms in the South-Asian culture which contribute to the self-harming experience of South-Asian women.

### **Marriage in South-Asian culture**

Another factor that is important in South-Asian culture but also with limited research is marriage. It appears that South Asians are more likely to get married at an earlier age and live with in laws compared to white individuals (Goodwin & Cramer, 2000). Yet these sociocultural factors (i.e., marriage, family disagreements over marriage, marital conflicts and in-law disputes) generate high levels of distress and can even lead to suicidal behaviours among South-Asian women (Raleigh & Balarajan, 1992). While individualistic cultures may view marriage as the linking of two individuals, collectivist cultures view marriage as the process of linking two families, thus there is a focus on satisfying the expectations of both families (Triandis, 1989). It has also been described by Ghuman (1994) that the common belief associated with arranged marriage is that 'love comes after marriage' and individual beliefs, feelings and love are subordinate to the wider interests of the family. Further, although arranged

marriages were found to be the norm in South-Asian communities in the past, more recent research has shown that younger South-Asian individuals contested this view and prefer their individual choices to be considered (Ghuman, 1994).

A study by Merrill and Owens (1986) compared the traits of individuals who had been admitted into hospital in Birmingham (UK) following an episode of self-poisoning. They found that South-Asian women disclosed more marital difficulties and these difficulties were culturally dependent. For example, several women in the study disclosed that their husband “demanded” that they dress in a less westernised manner. It was also commonly reported that their mother in laws had interfered in their lives and marriage. These South-Asian women reported these culturally specific factors placed pressure on them and thus a precipitating factor for self-harming behaviour. Importantly, they found that these South-Asian women were three times more likely to attempt suicide, which indicates self-harms link to fatality, thus further highlighting the importance of studying this group. However, Merrill and Owens were white male researchers and therefore they acknowledged that they may have missed important information during the analysis of the study. Thus, as the present study will be conducted by a South-Asian female researcher, it may provide different insights due to the shared understanding of the culture. Additionally, the use of reflexivity will be paramount to the present study to ensure fewer biases are present and thus increase the rigor of the study.

More specifically, Gilbert et al. (2004) described the sense of hierarchy in families, which create power dynamics between the husband, wife and in laws. Furthermore, males were seen as more powerful and had control over their wives, which created a sense of powerlessness and low self-esteem, and in some cases, this resulted to self-harm (Niaz, 2003). Gilbert et al. (2004) also reported that these power differences can often lead to mental health difficulties including self-harm and suicidal ideation. Some women reported that self-harm and suicide was preferred over seeking help and jeopardising the family ‘izzat’ (honour and respect for the family reputation) (Gilbert et al., 2004). This highlighted the link between South-Asian cultural values and beliefs and self-harm; therefore, it is crucial to study this group of women.

### **Religion within the South-Asian Community:**

Closely linked to culture, religion is usually an important aspect in the South-Asian community. Religion can be thought of as theories related to the cause, nature, and purpose of the universe, consisting of beliefs and ideas about the ways of behaving. Religious and cultural beliefs can become merged, with cultural practices becoming considered a religious aspect and a way of behaving and vice versa. The main religion in the South-Asian community includes Islam, Hinduism, and Sikhism, with Indian individuals consisting of Hindu, Sikh, and Muslims, with some Indian individuals identifying with the Christian religion ("South Asians, Minority Rights Group", 2021). Whereas, Pakistani and Bangladeshi individuals tend to identify as predominantly Muslim ("South Asians, Minority Rights Group", 2021).

The research on the connection between religion on self-harm have shown interesting findings. Borrill et al. (2011) explored the methods of self-harming behaviour across different genders, religions, and ethnic groups in a non-clinical population. They recruited 617 university students to complete a questionnaire on whether they had self-harmed, their self-harming method and frequency. They found that participants with a sense of religious belonging were less likely to present with repeated experiences of self-harm. They also reported lower levels of self-harm were associated with the Hindu religion, while participants with no sense of religious belonging reported an increased level of repetitive self-harming experience. However, due to the mixed findings, further research is required in this area to further inform our understanding. Further, participants from a Hindu and Sikh religious background were smaller in numbers compared to participants from a Muslim background, therefore, the numbers were too small to analyse such differences in a meaningful way. Perhaps, future studies with larger numbers of participants are required to generate a meaningful analysis. Additionally, participants were only asked which religious group they associate with, not the level of connection they felt with the religious beliefs associated with that religion. Thus, to understand the association between self-harm and religion, future research could explore the religious association that participants felt to their religion.

### **1.3.5 Rationale for Self-harming behaviour among South-Asian Females**

This is a crucial area to research as epidemiological studies have shown an evident rise in self-harm in the U.K, particularly among individuals from a South-Asian ethnicity (Marshall &

Yazdani, 1999). More specifically, it has been reported that South-Asian women are 1.5 times more likely to engage in self-harming behaviours than white women (Cooper et al., 2006). South Asians make up 4.9% of the total UK population and are made up of Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri-Lanka. The three largest South-Asian sub-groups consist of Indians (2.3%, 1.4 million individuals), Pakistanis (1.9%, 1.1 million individuals) and Bangladeshis (0.7%, 0.4 million individuals) (ONS, 2011). According to the recent census, the U.K has seen an increase in ethnic diversity within the last 20 years, with the largest increase in numbers by the South-Asian group by approximately 0.4million people from Indian and Pakistani ethnicity (ONS, 2011). Therefore, the likely trend is that the U.K will become more ethnically diverse with more South Asians as the years progress. Despite their numbers, little research has been carried out on this group and therefore there is a need for further research (Katbamna et al., 2004).

Self-harm appears to be higher among South-Asian females (Marshall & Yazdani, 1999); however, these conclusions have been made predominantly from quantitative studies, which adopt a positivist approach, therefore, the essence of the experience is overlooked, limiting our understanding of the meanings of experiences. Further, these studies have studied 'South Asian' as one homogenous group, but it is important to note that there are differences (i.e., cultural clash, gender role expectations, marriage, religion) between the groups and behaviours, thus the sample may not be homogenous. Additionally, existing studies have investigated 'self-harm' which encompasses a variety of behaviours. However, it can be argued that skin cutting, and misusing substances may be experienced differently from one another, therefore, researchers may not be examining the same phenomenon as they claim to be.

Given the current dilemmas within the literature, this thesis suggests studying the experience of self-harm that inflicts external injuries to the body in Indian, Pakistani, and Bangladeshi females specifically via Interpretative Phenomenological Analysis. This appears to be a novel research idea as Indians, Bangladeshis and Pakistanis have not been investigated via an Interpretative Phenomenological Analysis, which can help CoPs to understand the meaning of self-harming experience in South-Asian women. This knowledge could be used to promote cultural sensitivity when working with individuals from this background. The literature review will discuss how the current dilemmas in the existing literature have led to this research title in further detail.

## 1.4 Literature Review

This literature review will explore the differences in South-Asian culture which contribute towards the idiosyncratic differences in South-Asian females. Firstly, the initial migration of South-Asian individuals to the UK will be discussed, followed by their ethnic identity and cultural conflict. Then, existing literature related to self-harm among South-Asian women will be critically appraised, highlighting the gaps in the literature and areas for further research. Next, the South-Asian cultural values and beliefs that generate pressures for South-Asian women will be discussed before stating the details of the present research.

Before exploring the research on self-harm among South-Asian women, it is important to understand the initial migration of South-Asian individuals to the UK. During the 1950s and 1960s, men from South-Asia were recruited for manual labour to help rebuild Britain after the Second World War (Peach, 2006). Often, they were not able to speak English, lived in groups and were also employed in groups (Peach, 2006). Through their employment, they were able to send remittances to their families back home. After the Commonwealth Immigration Act in 1962, they had two options: to bring their wives to Britain to join them or return to their home country (Peach, 2006). Indian men were the first to bring their families to Britain, and although Pakistani and Bangladeshi men were more reluctant to bring their families and involve them in British values, they joined later (Peach, 2006). When their families (wives and children) joined them in Britain, which continued to the 1970s and 1980s, it led to the increase in the number of South-Asians in Britain (*South Asians—Minority Rights Group*, n.d.). Due to this migration, they settled into the UK, marking the start of a new life in a different context (Anwar, 1998). Despite the migration, South-Asian individuals were reported to have retained their cultural heritage, indicative of the diaspora residents (Peach, 2006). It was reported that the new generation of South-Asians (i.e., offspring of the South-Asian men who became residents of the UK) had a different stance on their ethnicity as they also held British heritage, thus, their understanding of their culture, values, behaviours, and practices differed to that of their parents (Hussain, 2017). The second-generation South-Asians were exposed to collectivist beliefs and practices which were gained from preceding generations, the community and family members whilst living in a western country (Faver, et al., 2002). Consequently, the second-generation of South-Asians in the U.K faced difficulties with their cultural and ethnic identity (Preece, 2006).

An individual's cultural identity can be thought of as beliefs, values, and practices that they adopt (Bhugra, 2004). A model to understand cultural identity is Berry's (1997) Model of Acculturation. This model suggests categories for those who encounter two contradictory cultural backgrounds. Acculturation refers to the modification of cultural identity by individuals who adapt to the cultural beliefs and values to their country of residence. Berry introduced four categories: integrated identity (individual able to take on both values, beliefs, and practices of both cultures), assimilated identity (individual takes on values, beliefs, and practices from new culture), marginalised (individual dismisses ideas from both cultures) and traditionalism (individual takes on beliefs, values, and practices from their country of origin over the country they originally reside). Research has indicated that there are various aspects that generate conflict in the values and beliefs (cultural conflict) of South-Asian women, some of which will be discussed later, including gender role expectations, marriage, and religion.

Studies investigating the link between cultural identity and mental wellbeing have found that an integrated cultural identity is related with improved psychological wellbeing outcomes, whereas a marginalised identity is associated with lower levels of mental health outcomes (Berry, 1997; Bhui et al., 2005). Research has also suggested that cultural conflict can be a risk indicator for self-harm (Biswas, 1990), however, prior to reviewing the research on self-harm among South-Asian women, the ideas around cultural identity will be explored further.

The clash between individualistic and collectivist culture will be discussed. The literature on South-Asian culture has commonly shown that the idea of collectivism (collectivist culture) is valued over the interests of the individual (individualistic culture) (Pilington et al., 2012). Therefore, South-Asian individuals are encouraged to adhere to the interdependence to the family and wider community. The characteristics of collectivist culture could include being respectful to elder members of family, listening to parents' wishes over that of their own in relation to personal decisions (e.g., career path, romantic relationships) (Faver et al., 2002).

Difficulties and conflicts can arise when the second-generation South-Asians are required by their family members or community to orient their behaviour towards the community as opposed to behave in the way that they wish to (Pilington et al., 2012). From an early age, usually childhood, South-Asian parents are often involved in the important decision making

related to school and career paths (Rahman & Witenstein, 2013). This parental influence has been described to be authoritarian and primarily focused on academic achievement and the prioritization of the familial 'solidarity' (Farver et al., 2007; Inman et al., 2007). This could mean that children needed to make close consultations with parents prior to making these decisions.

However, one aspect that has been raised is the conflict and tension that is often encountered by South-Asian individuals when negotiating their two ethnic identities. For example, it has been found that it can be problematic to hold two cultural identities when the two cultural norms are not compatible with each other, whereby abiding by one cultural value would directly prevent the obedience of the other (Dwyer, 2000). For example, the western culture could promote freedom of choice for the individual to choose a career path that an individual wishes to partake in, while their South-Asian parents may expect them to pursue a career path they want their child to, which could lead to an internal conflict between what they want to do versus what their parents expect from them (Ngo, 2006).

Due to these divergences, one of the difficulties that second-generation South-Asians faced was related to the development of their own cultural identity. This was due to the mismatch between the values of the South-Asian culture with those of the British western culture (Babiker & Arnold, 1997), referred to as 'cultural conflict'. The challenge for South-Asians living in the UK can be viewed as a conflict between the collectivist culture of their parents and wider community versus the western culture related to individualism (Triandis, 1989). This can generate difficulties with their decision to act either in line with the beliefs and values expected from their South-Asian community or that of the wider western culture. However, it can be argued that further studies are required on South-Asian women to comprehensively understand this cultural conflict which tends to reappear in different studies. Perhaps qualitative studies, and particularly semi-structured interviews, could provide further insight into the nuance's experienced by South-Asian women and the impact of these experiences.

## **Research on Self-harm among South-Asian Women**

This section will critically appraise the existing literature on self-harm among South-Asian women. The limitations of the studies will be stated, highlighting the gaps and areas for further research. This will lead to the discussion of how the present study may address these limitations and gaps in the existing literature.

There is limited research carried out on self-harm among South-Asian individuals, however, the common finding suggests that South-Asian females are at a higher risk of self-harm in comparison to individuals from other ethnic backgrounds. For example, Al-Sharifi et al. (2015) systematically reviewed ten articles on the rates of self-harm, clinical characteristics, method of self-harm and risk factors among different ethnic groups. They concluded that ethnicity should be taken into consideration when treating individuals due to the evident differences from cultural pressures. Further, it was found that factors that may protect or predispose the individual to self-harm (i.e., religion, mental health, coping styles) also differ between groups, therefore, the authors recommended that ethnicity be taken into consideration when self-harm is concerned (Al-Sharifi et al., 2015). Further, due to such differences in culture, heritage, language, and practices, it is argued that it is useful to investigate the ethnic differences in self-harm, which can provide insightful information, to inform the understanding for services, particularly as London consists of a diverse population (Peach, 2006). This form of cultural competence is also encouraged in CoP (BPS, 2005). However, while self-harm and suicide are distinguishable, this review investigated suicide and self-harm articles in conjunction. Therefore, future research specifically on self-harm is necessary to understand the phenomena more closely. Furthermore, the samples in this study were different, for example some studies explored levels of attendance to emergency departments, some looked at methods of self-harm, while others included participants that were young people, university students and hospital patients. These differences prevented the study from being a meta-analysis. Additionally, the studies investigated in this systematic review consisted of potentially diverse ethnic groups, which may not account for the cultural differences between ethnicities. Consequently, future studies could explore a specific ethnic group to allow for more confident interpretations to be made from the data and thus provide more focused conclusions. Nonetheless, the present study will be addressing these limitations by looking specifically at self-harming behaviours in South-Asian women.



Additionally, Biswas (1990) carried out a retrospective study, investigating the case notes of 38 Asian patients and 34 white patients. The participants were aged between 13 to 17 years and had attended Accident and Emergency (A&E) department in Bradford after an episode of self-poisoning. Although she found that the gender ratios of both samples were alike, she also found that 36% of South-Asian participants reported experiencing a cultural clash, whereby there was a conflict between the western and South-Asian cultural expectations as a precipitating factor prior to self-harming. These cultural clashes related to conflict over traditional customs from the South-Asian culture as a reason for self-poisoning (Biswas, 1990). Therefore, she concluded that culture and cultural clash plays an important role in self-harming behaviours in South-Asian women.

Moreover, Husain et al. (2006) carried out a review on the occurrence of self-harm in British South-Asian women and the issues that add to these rates of self-harm. They found that 16–24-year-old South-Asian women were more likely self-harm than white women. They also found that the rates of self-harm were higher in South-Asian women than South-Asian men in all age groups. When explored further they found that the South-Asian women that self-harmed were generally younger, more likely to be married and less likely to be employed. They also reported more interpersonal difficulties with family members. The authors highlighted that majority of the studies they reviewed did not consider the diversity that prevails in the South-Asian community, which could mean that the specific needs of each South-Asian group had not been considered and thus mental health services cannot be appropriately tailored to this overlooked group. The present study aims to acknowledge these differences and look at specific South-Asian groups that are homogenous and thus the findings can be used to tailor treatment for South-Asian women.

Furthermore, Bhugra et al. (1999) wanted to explore the link between culture and self-harm in South-Asian women. They used the Asian Cultural Identity Schedule (ACIS), which included 106 questions on cultural identity. The ACIS was created after a discussion with leaders from the local community and were piloted on 12 students from an Asian background. The 106 questions measured 12 areas of acculturation and cultural identity: religion, language, marriage, living with a white individual, decision making at home, joint decision making,

marital decision making, work, children's behaviours, social contact employment outside the house, leisure, food shopping and aspirations. This scale was used to interview 22 South-Asian adolescents who self-harmed and their parents, and 54 South-Asian women who had also self-harmed. Half of each group were in the control group, while the other half were cases. The scores from the ACIS were then compared among the groups. They found that women who had engaged in self-harming behaviours were less traditional (scored lower on the ACIS) in comparison to that of the control group. Additionally, they found that South-Asian women who had self-harmed were less likely to have traditional values, and more likely to experience family conflict and interracial relationships compared to matched controls. While the authors concluded that the ACIS was successful in highlighting the role of cultural identity and acculturation in self-harming behaviours, this study has several limitations.

One limitation of the study could relate to the fact that the ACIS interview captured the attitudes towards cultural identity as opposed to how participants chose to behave. Therefore, while understanding the attitudes towards South-Asian culture is important, the ACIS interview does not aid in our understanding of how South-Asian women chose to behave given the conflicting values and beliefs they are presented with by the South-Asian culture and the western society that they were living in. Additionally, the sample was made up of those in crisis, therefore only those who had sought professional support were included in the sample and thus the sample may not capture the self-harming behaviours of those that do not seek professional help for their self-harm. This may be problematic as it reduces our understanding of South-Asian women who self-harm but do not seek psychological support and thus there could be various barriers preventing South-Asian women from seeking professional help.

Research suggests that the act of self-harm may correspond with the struggle to discuss the difficulty in more healthy methods (Chew-graham et al., 2002). Further, South-Asian women reported 'izzat' (honour and respect for the family reputation) as huge repellent in seeking help when in psychological distress (Chew-Graham, et al., 2002). South-Asian women have reported that the concept of izzat was given high importance and placed above their own happiness and were taught that they could not behave in a way that would bring shame to the family, therefore, they would not seek help when they were in distress (Chew-Graham et al., 2002). Perhaps the present study will be able to highlight the experiences of South-Asian

women who have not sought psychological support. This can be achieved through recruitment via purposive sampling, which would be inclusive of participants who have not sought support in the past as well as those who have. Therefore, this would enable our understanding of this understudied group to understand their concerns about psychological services to implement changes and increase psychological engagement.

Furthermore, the use of the ACIS scale meant that participants responses were limited to the items deemed important by the scale. For example, the ACIS scale does not include attitudes on gender role expectations or living with in-laws which could also generate tensions in cultural identity. Therefore, important nuances that exist in South-Asian culture may not have been captured by the ACIS, thus this limits our knowledge and ability to support these South-Asian women. One way that the present study will address this limitation is through the use of a semi-structured interviews, enabling the flexibility of the responses from participants and encapsulating their subjective experiences. Therefore, this provides an opportunity for new information to be discussed by participants, which would add to our understanding of this group which in turn can be utilised to support this group further. The above studies can allude to ideas indicative of self-harm in South-Asian women occurs in the cultural context. As South-Asian females have been found to be at an increased risk of self-harm and culture can be seen to play a role in self-harming behaviours, the following paragraphs will explore the literature that has investigated self-harm in South Asians.

Quantitative studies have commonly shown that South-Asian women have higher rates of psychological difficulties compared to South-Asian males. These gender differences have been highlighted by Cooper et al. (2006). Cooper et al. (2006) compared age and gender differences in reported self-harm in 7158 participants. Participants were recruited via four A&E departments around Manchester (UK). Clinicians at the A&E department completed a psycho-social assessment form following the participants incident of self-harm. The form was predominantly dichotomous, including socio-demographic information, psychiatric history, details of self-harm, precipitating events, method of self-harm, mental state, and a risk assessment. Cooper and colleagues found that South-Asian females were five times more likely to self-harm compared to South-Asian males (Cooper et al., 2006). They also found that South-Asian females had the highest rate of self-harm in comparison to white females. Although the

reason for this was not clear, the authors concluded that this increase was due to interpersonal problems with family members which were culturally influenced.

The reason for the higher prevalence in self-harm of females could be that males are more likely to externalise their difficulty whereas females tend to internalise (Crick & Zahn-Waxler, 2003). Therefore, females are more likely to internalise their emotions and harm themselves intentionally (Laye-Gindhu & Schonert-Reichl, 2005). Also, one explanation of gender differences in self-harm is that Eastern sociocultural expectations create restrictions on opportunities for females and decrease their ability to have a “voice” (Laye-Gindhu & Schonert-Reichl, 2005; Shaw 2002). Thus, one of the reasons that South-Asian women experience an increased level of distress and difficulty could be due to the pressures placed from the families and communities perhaps (Cooper et al., 2006). Due to this, it is important to study self-harm among South-Asian women.

However, Cooper et al., and numerous other researchers, have clustered various South-Asian groups (i.e., Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri-Lanka) together, which suggests that the differences between the groups have not been acknowledged. The differences between Bangladesh, India and Pakistani versus Afghanistan, Bhutan, Maldives, Nepal, and Sri-Lanka can be thought of as geographical and historical. For instance, the latter countries were not referred to as one country before the partition of India and did not share the same colonial history by the British Raj in the Indian subcontinent between 1858 to 1947 (Rajan, 1969). This impacted the Indian subcontinent, leading to a decline in income, facing poverty and experienced racist attitudes from British ruling (Habib, 1975). These similarities generate a shared sense of history and identity, which is not shared by Afghanistan, Bhutan, Maldives, Nepal and Sri-Lanka. These differences between each ethnic groups could mean that the data gathered does not capture the differences that appear in the different groups.

Therefore, the authors may not have gathered valid data and thus future studies could potentially look at self-harm in the three largest South-Asian groups - Indian, Pakistani, and Bangladeshi individuals. They can be considered as a homogenous group, as the three groups

were originally known as India prior to the partition in 1947 and they share many characteristics (Butalia, 2017). These groups share cultural similarities related to arranged marriage with high marriage rates usually at an early age and gender role expectations where the women typically bear children and males provide for the family (Dale & Ahmed, 2011). Further, the appraisal of mental health is similar in these groups, as they tend to disclose somatic rather than psychological symptoms (Hussain & Cochrane, 2004). Additionally, they share common experiences with the mental health services as they feel that they cannot share their difficulties (Bowl, 2007). Further studies have found that these groups deal with their mental health difficulties in a similar way, such as normalising their symptoms, relating it to life events and finding meaning for their difficulties through religion (Anand & Cochrane, 2005). Finally, it has been found that coping strategies for mental health difficulties are similar, in essence it was found that they used religion, prayer, talking, crying and self-harm to cope (Hussain & Cochrane, 2003). Therefore, it can be assumed that Indians, Pakistanis, and Bangladeshis are similar and thus future in-depth studies are required to understand this group further.

Furthermore, Borrill et al. (2011) also investigated ethnic differences in self-harm by administering questionnaires to 617 students in two London universities. They found that 29.4% of the Asian females had reported engaging in self-harm. Interestingly, they also found that 53% of participants who had reported self-harm also reported scratching and 46% reported cutting, suggesting that external injuries to the body are the most common form of self-harming behaviours. The use of a quantitative methodology in these studies enabled the researchers to draw conclusions from a large sample of participants and thus it can be argued that this allows for generalisability. However, it does not enable the researcher to grasp the full complexity of the human experience of self-harm that inflicts external injuries to the body (e.g., cutting/scratching or burning the skin). Further, as it was a quantitative study, there was limited scope to explore the meaning of this method of self-harm. This means that there was a limited scope for understanding the full complexity of this behaviour. For this reason, qualitative research is perhaps ideal, as it has been suggested to be an effective way to understand and unravel the full intricacies of experiences (Reinharz & Davidman, 1992). This is perhaps why Borrill et al. (2011) also recommended the need for further qualitative research to understand the phenomena in depth particularly when diverse communities are involved. Perhaps the present study will be able to address these limitations by exploring the meaning given to self-harming behaviours that inflict external injuries to South-Asian women's bodies. This could

add further insight to the literature and expand our understanding of this specific behaviour in this specific group.

In contrast to quantitative studies, qualitative studies looking at self-harm in South-Asian individuals have also been conducted. Qualitative studies use a smaller number of participants and are focused on the subjectivity of participant's experiences of self-harm in South Asians (Willig, 2013). A qualitative research by Bhardwaj (2001) acknowledged the need for focusing on the experiences of self-harm in South-Asian women as current literature had focused on quantitative studies. Bhardwaj (2001) explored the reasons as to why South-Asian women self-harmed through interviews and guided focus groups. One common theme that emerged was that many females reported using self-harm (e.g., cutting, burning, overdosing) to 'cope' with distress. They explained that self-harm was particularly used when they felt they could not articulate their distress towards others. One concept that emerged was the idea of power and control. For example, they felt that they had no control over their lives but the one thing that they could control and had power over was their own body, thus self-harming enabled them to regain control (Bhardwaj, 2001). The researcher ended with a recommendation of a need for culturally competent services and raising awareness, especially in London, where the study was carried out. Particularly as London is one of the most multi-cultural places in the UK with over 18.5% of individuals identifying with the Asian ethnicity (Gov.uk, 2019). This recommendation was made because the authors had seen that the source of distress for these women which then resulted to self-harming behaviour was due to psychological distress around "parental, family and community related oppressions", whereby issues related to 'izzat' and 'honour' generated burden for these South-Asian women. Further, they described that the gender inequalities placed on them by their parents acted as a contributory factor to self-harm. This highlighted that the unattainable standards and expectations that South-Asian women were expected to live up to generated emotional distress and thus these women self-harmed to cope with it. Therefore, their recommendation made an emphasis on the need for mental health professionals to be aware of such nuances that are experienced by these women. However, the authors did not state the basic details of the study such as the number of participants or the exact methodology used for analysis. Therefore, readers are unable to understand the process used and thus the themes and conclusions made become somewhat questionable. The present research will ensure to state the full details in the methodology chapter to ensure that readers can assess the quality and rigor of the study.

Another qualitative study by Chew-Graham et al. (2002) looked at the experience of psychological distress and self-harm in South-Asian women, through four focus groups with five to twelve women each. The researchers took notes during the focus group discussions and analysed the data in accordance with the codes of Framework Analysis, based on Richie and Spencer. Upon analysis, the researchers found three themes: '*Izzat*', Community grapevine and Racism. *Izzat*, meaning the honour and respect for their family reputation, was placed at a high position, over their happiness and wellbeing in South-Asian women. They stated that it played a role in coercing them to remain silent about their psychological distress, refraining from seeking psychological help as this would look bad on the family reputation and therefore, they had found other forms of maladaptive coping strategies such as self-harm. The second theme, the role of the community's involvement, meant that South-Asian females had limited privacy. They explained that if they had been seen to be "behaving inappropriately" then this was spread around the community. They felt that this led to a sense of isolation, as they did not have any appropriate services to seek support. Finally, they felt that mental health professionals saw them as being lesser than their white counterparts; therefore, they were reluctant to access mainstream services. These combined contributed to psychological distress and self-harm as a result (Chew-graham et al., 2002). This indicated the significance of exploring the individual's broader context and culture on understanding self-harm, as culture in South Asians played a crucial role in self-injurious behaviour (Chew-graham et al., 2002).

It is however questionable whether the use of group discussions as opposed to individual interviews prohibited participants from sharing their honest opinions. Participants could have been swayed by the opinions of others, thus limiting new perspectives. This argument is based on The Asch Effect (Asch, 1955) from social psychology research whereby 76% of participants had answered incorrectly to an obvious question in front of confederates who had previously chosen the incorrect answer. This suggests the possibility of an individual's judgement being influenced by the majority group, particularly when responses had to be given in public such as that in a focus group.

Further to this, the use of group interviews utilised a less idiographic standpoint as the data were analysed as a whole rather than each individual participant (Willig, 2013). This could

mean that certain themes may be underrepresented or even overlooked due to the data being analysed as a whole. Perhaps conducting individual interviews which looks specifically at self-harm in South-Asian females would provide a deeper understanding of the lived experiences as this would mean that each participant is being analysed ideographically. This ensures that important themes that arise in each participant will be considered prior to analysis as a group. Therefore, the present study will address this by carrying out individual interviews with South-Asian females to gather valid data for qualitative analysis.

Furthermore, it is also important to note that one group made up of the Bangladeshi Women's Project (BWP), including twelve women, required the use of an interpreter as they were unable to speak English. As language is not always interchangeable and words in one language may not necessarily exist in another (Tribe & Morrissey, 2004), meanings of certain experiences may have been lost in translation. More specifically, the analysis showed that a large portion of their difficulties were described as not being able to communicate with health professionals and other relevant teams, therefore, had these women been able to speak English, perhaps their difficulty with communication would not have been reported to the extent that it was. Therefore, it is questionable whether the same analyses would appear if individual interviews were carried out with Bangladeshi women who were able to speak English and were able to communicate with mental health professionals.

A benefit of the use of Framework Analysis enabled the researchers to produce recommendations in relation to the issues being studied, which they referred to as "lessons", for NHS trusts (Chew-Graham et al., 2002). However, this does not focus on extrapolating the meaning of the discussed experiences, and they are simply a description of the patterns observed within the transcript and has been argued that simply looking for themes in data are not useful in understanding the lived experiences of the participants under investigation (Braun & Clarke, 2006), therefore, further research is required.

Additionally, Marshall and Yazdani (1999) carried out another qualitative analysis of self-harm among South-Asian women with an aim to develop and improve services in London. They interviewed seven South-Asian women with a history of self-harm and eight service providers,



with a focus exploring the meanings given to self-harm by South-Asian women. They also discussed the broader environment within which participants located their self-harming behaviour, which included broader discussions of whether and how self-harm related to factors of the South-Asian culture. They analysed the data via discursive analysis which held the assumption that self-harm and culture are created through language, which draws on pre-existing socio-cultural narratives to construct experiences (Marshall & Yazdani, 1999). Marshall and Yazdani (1999) found four meanings of self-harm: a release from distress, ending it all, effecting change and taking control. Firstly, a release from distress was associated with emotional pain relief, whereby emotional distress was released. For these participants, self-harm was viewed as a coping strategy to enable “day-to-day” survival. Secondly, ending it all referred to suicide attempts which focused on the self and thus allowing the body to ‘escape’ from the desperate situation. Thirdly, effecting change referred to self-harm as an act of expression of disclosure, and thus communicates a message to others (e.g., family members) for ‘outside’ support. Finally, taking control referred to where a participant experienced a perceived lack of control and viewed cutting or overdosing to regain this control. The authors concluded that clinicians working with South-Asian women should prioritise their meaning and the needs which may be located within the socio-cultural environments.

This study provided a deeper understanding of the experience and meaning that South-Asian women attributed towards their self-harming experience. However, the participants method of self-harm varied from cutting, to not eating, etc. which could question the homogeneity of the sample. This means that the small number of participants studied were not particularly similar in their method of self-harm. For example, it is difficult to see how a participant who engaged in self-harm via cutting would share a lived experience with a participant who had been restricting their eating for long periods of time. This could question the validity of the research, particularly the rigour (Yardley, 2000). This lack of similarity may have made it difficult to examine convergences and divergences in detail during the analysis stage.

Perhaps the present study could address this limitation by studying self-harming behaviours that inflict external injuries to the body (e.g., cutting, scratching, burning the skin). This is because Borrill et al. (2011) found that 53% of participants had reported engaging in self-harm by scratching their body and 46% had reported cutting, which can indicate that external injuries

to the body are the most common forms of self-harming behaviour in South-Asian women. As studies have not previously made this distinction, it is important to consider the differences in the types of self-harming behaviour to further add to our understanding of the complexity of this phenomenon. This would ensure that participants are describing and making meaning of a similar phenomenon. The authors also note that the definition of self-harm used in the study did not include behaviours such as substance misuse, excessive exercising or overworking, which may be equally harmful to the individual. Thus, future study could potentially explore these unconventional methods of self-harm.

Additionally, one element that is important in qualitative research and is missing from Marshall and Yazdani's study is reflexivity. Reflexivity refers to the assessment of the researchers' beliefs and judgement about the study and a reflection on how these may have impacted the research (Finlay, 1998), thus readers can assess whether the data and interpretations were influenced by these beliefs and judgements. This is an aspect that will be addressed in the present study by including a section on reflexivity which will state the researchers' positioning, beliefs and judgement. Moreover, another limitation of this study was that the participants consisted of those who had been in 'crisis', therefore this study did not include women who had engaged in self-harm but had not sought professional support. Consequently, the sample is not inclusive of these overlooked individuals and thus our understanding of this group is limited. The present study may aid in the understanding of this group by utilising purposive sampling whereby participants who express an interest and meet the selection criteria will be interviewed. This ensures that niche groups of participants can be recruited.

However, it is also important to remember, as Marshall and Yazdani (1999) have highlighted, that there are diverse narratives of the ways in which young Asian women perceive and engage with their culture. For example, there may be differences in the view that South-Asian culture generates a 'clash' as an explanation of self-harm and may reject notions of South-Asian culture as pathogenic. Thus, this emphasises the understanding that South-Asian culture is complex and can be experienced in diverse and perhaps contradictory ways by South-Asian individuals. Therefore, there is a need for further culturally sensitive training, emphasising that there is no cultural template when working with South-Asian women who self-harm. Marshall and Yazdani (1999) also recommend that this could be achieved by accepting culture as

complex and relational and through open discussions with service users about each individual meaning of self-harm.

Also, as suggested by numerous studies above, South-Asian women have a higher risk towards self-harming behaviours to cope with the psychological distress they experience. Although, the existing literature on self-harm among South-Asian women has been evaluated, we know very little about these women. Many studies have suggested that South-Asian women do not seek help for their self-harming but rather seek help at crisis point. Therefore, the following section will aim to discuss the reasons for non-disclosures, help-seeking, and coping methods (including traditional interventions) used to cope with distress by South-Asian women.

Irrespective of the fact that self-harming behaviours that inflict damage to the body externally (e.g., cutting, burning, scratching, etc.) could leave physical marks or scars, self-harm is often a behaviour that is carried out in secret and goes undisclosed. Disclosure of self-harm could include telling another person about the injury or the injury being seen by another person. It has been suggested that one of the biggest barriers to disclosing the difficulties that an individual may face is the discomfort that comes with talking about this topic (Vogel & Wester, 2003). A study to explore this further was carried out by Chew-Graham et al. (2002).

Chew-Graham et al. (2002) found that due to a “community grapevine”, if South-Asian women were seen to be behaving in a way that was perceived as ‘bad’ by the community then word would spread, therefore, they preferred not to disclose personal matters such as self-harm and preferred to deal with it themselves. The authors found that ‘izzat’ (i.e., honour) was prioritised over their own wishes, which resulted in coercing these women to remain silent about their psychological difficulties and refraining from seeking psychological support. It is also noteworthy that there are currently no studies directly exploring the disclosure of self-harming behaviours in South-Asian females, therefore further research is required to understand this phenomenon in depth.

Closely connected to disclosures of self-harm are difficulties surrounding help-seeking following engagement in self-harming behaviours. Help-seeking refers to the act of requesting support or assistance with self-harming behaviour. Borrill, et al. (2011) looked at the coping styles and self-harm in a range of ethnic groups. They found that Asian participants reported the highest level of avoidance coping methods than other ethnic groups. Thus, this group may be more likely to use avoidance as a coping strategy and less likely to seek help. However, Borrill and colleagues looked at 'Asian' group as a whole, it would be interesting to see whether findings would differ if the Asian group was categorised into subgroups. The present study may be addressing this limitation by ensuring that smaller subgroups (i.e., Bangladeshi, Indian and Pakistani) individuals are studied, thus ensuring a homogenous sample.

Further, it has been reported that South-Asian women use traditional methods to cope when in distress. Research by Dien and Sembhi (2001), using a mixed methodology, explored traditional healing strategies in 25 South-Asian psychiatric patients. They found that 28% of the patients used a traditional healer when they were in distress, which included going to seek advice from a religious leader or eating or drinking specific foods. They also examined 5 case studies and found that patients had turned to traditional healing methods in conjunction with western interventions. Participants reported that one aspect they liked about traditional methods was the inclusion of their family members, whereas western treatment excluded the family in the interventions, thus they preferred traditional over western methods. This highlights the importance of systemic interventions for South-Asian individuals (Dien & Sembhi, 2001). However, this was explored for the psychiatric and physical illnesses, further research is required on the use of traditional methods of treatment for psychological distress, particularly self-harm. Furthermore, the extent to which involving family members for the treatment of self-harm in South-Asian women is questionable, particularly as South-Asian women would prefer to not disclose their self-harming behaviours to family members.

Additionally, Gilbert et al. (2004) carried out a qualitative research using three focus groups with women who identified as being 'Asian'. They were presented with four different scenarios which the researchers believed would tap into the issues related to izzat, shame, subordination, and entrapment, and they were asked questions to generate conversation around the scenarios. Gilbert et al. (2004) found that some women reported that self-harm and suicide was preferred

over seeking help and jeopardising the family 'izzat' (honour and respect for the family reputation). This highlighted the importance of concealing any information that could endanger the family reputation. It also alluded to ideas around shame and loss of izzat as key reasons for South-Asian women not utilising mental health services. This means that further research is required to understand how these issues about shame and izzat can be overcome so that South-Asian women are able to seek psychological support for their self-harming behaviour and they are not just waiting for crisis point to seek professional help.

Although studies have shown that South-Asian females are at a higher risk of self-harm, less likely to seek professional support (Cooper et al., 2006), it has also been reported that South-Asian women would only seek help at the point of crisis, therefore early intervention opportunities are missed (Chew-Graham, et al., 2002). The following paragraphs will explore the perceived barriers towards accessing mainstream mental health services by South-Asian females.

When South-Asian women were asked about the reasons for their avoidance of mainstream mental health services, they mentioned a lack of trust in services, as they feared that the professionals from their culture would breach confidentiality and then word would spread within their community that they had been using mental health services. Gilbert et al. (2004) linked the emotion shame as one of the barriers against seeking psychological help, as this would jeopardise the 'izzat' of their family. Furthermore, their spouse may be a factor in preventing help seeking behaviour as they feel a sense of shame to seek outside help as it reflects badly on their spouse, which exerts undue pressure on themselves as a result (Anand & Cochrane, 2005). Additionally, a literature review by Anand and Cochrane (2005) exploring the beliefs around mental health noticed a high level of stigma surrounding mental health within the South-Asian community than by white communities. It was reported that the South-Asian community attributed mental health difficulties as 'incurable' which would then impact reputation and marriage prospects, thus inhibited South-Asian women from seeking help. These factors highlight that South-Asian women feel pressure to cope with distress by themselves. Further, Husain et al. (2006) also found that South-Asian women were less likely to seek professional support, as they believe that their needs are not met by mainstream services, which will now be explored.

Despite the excellence that is offered by mental health professionals, it is important to consider that South-Asian women have complained that mental health professionals lacked basic empathy, did not inform them of their rights, with some even breaching confidentiality (Chew-Graham, et al., 2002). Therefore, further investigation is required to examine the phenomenon that results in a breach of ethics and a lack of basic counselling skills (Hussain & Cochrane, 2004). Only when we know the reasons for the lack of care and approachability of the mental health services will we be able to find appropriate solutions. One way to raise awareness within the mental health team could be to offer more training on cultural competency and psychoeducation on these factors. Perhaps this would reduce any stereotypes or prejudices resulting to negative treatment of these women. Previous studies have shown clear differences between the ways in which South-Asian women are treated in comparison to their white neighbours. For example, Cooper et al. (2006) have reported that South-Asian females are more likely to be seen by General Professionals as opposed to mental health professionals compared to white females. Additionally, professionals appeared to rate South-Asian females as lower risk and refer them back to their General Practitioner rather than referring them on to specialist services despite the high rates of self-harm in South-Asian females (Cooper et al., 2006). The reasons for these trends are still unclear, therefore further studies are required.

The existing literature on self-harm among South-Asian women has been evaluated. The current literature cannot explain the full complexities of this phenomenon in this group and studies on help-seeking and disclosures have shown that these women do not seek psychological support for self-harm. Having discussed the impact of cultural elements on South-Asian women's experience of self-harm, it can be inferred that there are cultural factors that influence their wellbeing, which is linked to self-harm. In essence, South-Asian women experience pressures from their culture, which then has an impact on their wellbeing and can be linked to self-harming behaviour. Therefore, the next section will discuss the aspects specific to the South-Asian culture that the literature has shown can generate pressures on South-Asian women.

This literature review has explored the idiosyncratic characteristics that South-Asian women attribute that generate a homogenous group. It has also discussed that they experience

psychological difficulties due to the South-Asian cultural values and beliefs they are expected to abide by whilst living in the UK and being exposed to western values. Therefore, further studies are required specifically on this group to explore the impact of South-Asian culture and psychological distress, particularly self-harm.

In sum, this review has highlighted that South-Asian women have idiosyncratic characteristics (i.e., gender inequalities, pressure from culture, marital difficulties) that play a role in lower levels of wellbeing and consequently their self-harming experience. Further, the evaluation of existing studies on self-harm among South-Asian women cannot explain the full complexities due to the limitations in the research. Furthermore, it is worth noting that many studies in this review are dated, which is indicative of the lack of up-to-date research. These reasons further emphasise the need for the present research.

## **1.5 Present Research**

The present literature review has discussed the existing research on self-harm in South-Asian females. The limitations in the previous studies have highlighted the need for further research in this area. The literature has predominantly used quantitative research and of the limited qualitative studies carried out, they have not acknowledged the meaning of the experiences of self-harm. Furthermore, it has clustered larger ethnic groups together regardless of the differences between them, therefore, this research aims to look at Bangladeshi, Indian and Pakistani females who are more similar to one another and form a homogenous group as stated earlier. Finally, current studies have looked at all types of self-harming behaviours as similar, and therefore this research aims to look at self-harming behaviours that inflict external injuries to the body such as cutting, burning, and scratching the skin. Narrowing these factors down increases the homogeneity of the study.

### **1.5.1 Research Aim**

The aim of the current research is to carry out a qualitative study, from an interpretative phenomenological perspective exploring the experience of self-harming behaviour that inflicts external injuries to Bangladeshi, Indian and Pakistani females. More specifically, it is looking at the meaning given to this experience. Previous research has explored this topic

predominantly through a quantitative lens; thus, this research aims to provide a deeper insight into the experiences which has been neglected in the past.

### **1.5.2 Research Question**

What is the Experience of Self-harming Behaviours that inflicts external injuries to the body in Indian, Pakistani and Bangladeshi Females?

### **1.5.3 Novelty and Relevance to Counselling Psychology**

The present research aims to study the experience of self-harming behaviour that inflicts external injuries to the body in Bangladeshi, Indian and Pakistani females. This understanding would enable CoPs to understand the meaning of self-harming behaviour in South-Asian women. In doing so, the focus would be on the accounts given by the participants of their subjective experience to highlight the participants understanding of their experience and how this has shaped the decisions they have made (Daher et al., 2017). Thus, the data, and accordingly analyses, produced are viewed as vivid, rich, and accurate, consequently meeting the requirements for rigour in qualitative research (Daher et al., 2017). Additionally, focusing on the meaning of self-harm enables CoPs to further understand this under-researched topic so that assessment, formulation, and treatment can be tailored to this group of women. Further, it provides CoPs with an up-to-date understanding of how self-harm is subjectively lived, it can generate new meanings and can enhance our knowledge of how self-harm among South-Asian women is currently understood (Laverty, 2003). This is particularly important given the limited up-to-date research available. This is an area that requires further research especially as previous research has established that these females are not utilising the services available to them due to the lack of trust and understanding received from mental health professionals (Chew-Graham et al., 2002). These elements have not previously been considered by the studies in the existing literature and therefore this would be a novel research.

This study is relevant to CoP as it focuses on investigating the individual experiences, which is held closely to this profession (BPS, 2005). Furthermore, the research is focused on culture and diversity, which CoP values and encourages the awareness of (BPS, 2005). Perhaps this would help reduce the occurrence of self-harm if these females had support available from professionals who understood their experiences and were sensitive to their cultural factors and



thus increase the chance of meeting the target set by The Five Year Forward View of Mental Health to reduce self-harm by 10% by the year 2021 (Independent Mental Health Taskforce, 2016).

## **CHAPTER TWO: METHODOLOGY**

### **SECTION 1: METHOD**

#### **2.1 Chapter Summary**

Moving on from the literature review, this chapter will begin by reflecting on my epistemological position and the chosen methodology to address the research question (RQ). It will also provide a rationale for IPA. The practical aspects (i.e., recruitment, sampling, data collection, data analysis, ethics) will be outlined. The participant's demographic details will then be detailed, and the stages of IPA analysis will be outlined. The chapter will end with a discussion on methodological reflexivity. The use of first person in this chapter highlights my immersion in the research process and my engagement in reflexivity.

#### **2.2 Research Aims**

The aim is to explore the experience of self-harming behaviour that inflicts external injuries to Bangladeshi, Indian and Pakistani females. Previous research has explored this predominantly through a quantitative lens; therefore, this research aims to provide a deeper insight into such experiences via an IPA methodology.

#### **2.3 Research Question**

What is the Experience of Self-harming Behaviours that inflicts external injuries to the body in Indian, Pakistani and Bangladeshi Females?

#### **2.4 Research Paradigm**

A research paradigm is a set of beliefs that shape the research, with different research paradigms adopting different beliefs. However, researchers use different terms to describe the theory of knowledge (ontology), how it is produced (epistemology) and the role of the researcher in the scientific process (axiology) (Ponterotto, 2005). Nonetheless, I have chosen to focus on the understanding of Ponterotto (2005) and Willig (2013) as it has facilitated my understanding.

Pressurised by the need for scientific enquiry to be observable and measurable, conventional research in Psychology took predominantly a positivist stance. This can be considered as the ontology of realism, which dictates that there is one true reality, that can be observed, measured, and apprehended (Camic, et al., 2003). It proposes that experience and behaviours can be objectively measured, via quantitative methodology, to establish a confirmable phenomenon (Blair, 2010). The positivist position and thus quantitative methodology was evident in my literature review of South-Asian females and self-harm (Cooper et al., 2006). However, the positivist paradigm has been critiqued as advocates for relativism have argued that we can never fully grasp ‘true’ reality (Willig, 2013). Additionally, it has failed to acknowledge the subjective experiences and the meaning of these experiences. These tensions have resulted in embracing different paradigms.

On the opposite end lies the social constructionist stance. Its ontological position of relativism assumes that reality is shaped by the views derived by gender, ethnic, cultural, political, and social factors, with an emphasis on power relations (Ponterotto, 2005). Therefore, there is an understanding that human experiences are mediated linguistically, culturally, and historically (Willig, 2013). It emphasises that the researcher and the participant are in a two-way interaction that aims to empower and liberate those ‘oppressed’ (Willig, 2013), particularly groups that lack a “voice”.

Noticing these tensions makes space for the critical realist ontology, a position I align myself with. It is the belief that there are multiple equally valid realities that are co-constructed by individuals within their environment (Willig, 2013; Ponterotto, 2005). Thus, I acknowledge that there is an independently existing world, which is separate from my theories, however, I can construct my reality through observation and my own beliefs, perception, and analysis (Maxwell, 2012). My ontological position would be in line with an interpretative phenomenologist. Interpretative phenomenology aims to understand the meaning of the experience by reflecting upon the wider meaning of the data related to the psychological, social, and cultural context (Willig, 2013). This would deliver a critical way of portraying the participants meaning making (Willig, 2013).

Axiologically, there are two tensions regarding whether it is possible to ‘bracket’ beliefs, values, and experiences in research by two philosophers, Hurssel and Heidegger. Hurssel believes that researchers should bracket their values, beliefs, and experiences, while Heidegger suggests that it is impossible to position ourselves outside the phenomena under investigation (Landridge, 2007). I would position myself with the understanding of Heidegger, as I believe that our views shape the research process, thus I will acknowledge my values, beliefs and experiences and reflect upon them to understand the phenomenon under investigation. Consequently, my ontological and epistemological positions are in line with my CoP identity and scientist-practitioner, as the field of CoP values idiography and subjectivity.

## **2.5 Rationale for IPA and its underlying perspective**

Having considered which methodology would be best suited to address my RQ (‘What is the experience of self-harming behaviour that inflicts external injuries to the body in Bangladeshi, Indian and Pakistani females?’), I chose IPA as this would enable the exploration of the lived experiences of my participants, whilst also looking at the meaning of such experiences.

Thematic Analysis (TA) and Grounded theory (GT) were considered for studying the experience of self-harm in South-Asian females. TA was considered as it focuses on patterns (also called themes) in the data to describe the phenomenon (Braun & Clarke, 2012). This appeared relevant because it would help describe the phenomena of the experience of self-harming behaviours in South-Asian females. I thought TA was a good option as it was a relatively ‘easy’ methodology (Braun & Clarke, 2006), particularly as I was a novice qualitative researcher. I reflected upon using TA to generate themes of the experience of self-harm in South-Asian females. However, TA does not focus on the meaning of the experiences and was therefore disregarded.

Another approach I considered was GT, which uses an inductive process to collect detailed data and creates a theory (Strauss & Corbin, 1994). GT would offer an explanatory framework to understand self-harming behaviours among South-Asian females, which would be free of associations to any pre-existing theories and enable the production of novel information to be used in practice. However, it did not fit with my RQ as GT focuses on generating explanatory

frameworks, while the RQ was focused on a deep understanding of idiographic experiences. Therefore, GT was also disregarded.

I considered that IPA was best suited for this study as it aims to understand the meaning given to the phenomena under investigation (Smith, 1996) and in this research I wanted to explore the meaning of self-harm in Indian, Pakistani, and Bangladeshi females. IPA is governed by phenomenology (study of experience), hermeneutics (theory of interpretation) and idiography (Pietkiewicz & Smith, 2014). Phenomenology is focused on the way individuals make sense of their experiences (Pietkiewicz & Smith, 2014). It is based on inter-subjectivity suggested by Heidegger, referring to the interaction between the world and individuals (Smith, et al., 2009). This links to my RQ as I am not only looking at the lived experiences of self-harming behaviour in South Asian females but also the meaning and interpretation of them. More specifically, this understanding would add to the knowledge base of Counselling Psychology and could potentially make further input to the existing literature. This could enable further clinical recommendations and mental health interventions for South-Asian women who have self-harmed.

IPA also uses a double hermeneutic where the researcher is making interpretations of the participant making sense of their experiences (Smith, et al., 2009). As it relies on the interpretations made by the researcher, Heidegger stated that one cannot fully 'bracket' themselves away from their own beliefs and assumptions, but rather should be aware of these assumptions and biases and utilise them to progress understanding of the phenomena (Landridge, 2007; Smith et al., 2009). Consequently, the analysis of self-harm within South-Asian females would be the product of the rapport between the data and myself. These features are in line with my RQ as well as my ontological stance of critical realist and epistemological stance as an interpretative phenomenologist.

IPA also adopts a concept known as idiography, which refers to the analysis of every case within a given context before producing general statements (Smith, et al., 1995). Therefore, it conducts an analysis of each case studied and then identifies common themes (Pietkiewicz & Smith, 2014). This concept of idiography is in line with the RQ where the aim is to gain a deep

understanding of the meaning of experiences of self-harming behaviour by South-Asian females. This is also in line with CoP values, where the unique perspectives of individuals are valued over large general conclusions. Due to these characteristics, IPA was deemed a well-suited methodology for my RQ.

Despite IPA's growing popularity within qualitative research, it also has its limitations. It has been critiqued for the lack of acknowledgement of language when participants make sense of their experiences (Tuffour, 2017). However, others have argued that the importance of language is considered when meaning-making is derived from the analysis of the participant's narratives (Tuffour, 2017). Also, IPA has been appraised as only appropriate for those who are articulate and can provide rich data for analysis. But this critique can be considered as 'elitist' as it proposes that individuals with the desired level of fluency can articulate their experiences (Tuffour, 2017).

## **2.6 Assessing Quality**

According to Yardley (2000), there are four areas for assessing the quality of qualitative research: Sensitivity to Context, Commitment and Rigor, Transparency and Coherence and Impact and Importance. The following paragraphs will outline how the present research has addressed these factors.

### **2.6.1 Sensitivity to Context**

One way sensitivity to context has been considered is through careful consideration of ethical guidelines. Participants were aware that ethical approval was gained from the university, confirming that procedures were in place to ensure their security. Additionally, participants were able to choose the day and time of the interview to ensure that it was most suitable for them. The interviews were carried out in a relaxed and quiet environment to show sensitivity towards the difficult experiences' participants were sharing. During the interview, sensitivity was portrayed using open-ended questions, allowing flexibility in the information participants chose to share. Further, the analysis chapter includes direct verbatim quotes from the interviews; so, the participant's voices are heard. This means that rather than imposing the pre-existing themes and ideas in the literature, there was a careful consideration of the participant's

data. Further, reflexivity promoted the careful consideration of meanings generated by the participants themselves and has been at the forefront when collecting and analysing data.

### **2.6.2 Commitment and Rigor**

Yardley (2000) suggests that commitment and rigour can be displayed through a comprehensive engagement of the topic area and research methods. I have attended lectures on self-harm, carried out extensive reading on self-harm among the South-Asian community, completed literature reviews and a research proposal. Further, I have been a part of an IPA research group, attended lectures and workshops on IPA, data collection and data analysis. I have also completed and passed a Research Integrity and Ethics module at UEL. I argue that this suggests an extensive commitment towards the research area. As a novice qualitative researcher, I carried out extensive reading on analysis (discussed in section 2) and peer support groups for IPA. Further, I worked closely with my research supervisor, particularly with my first transcript, to ensure that the analytic steps were carried out at an appropriate level before moving on to the next stage. Further, the use of verbatim quotes from the interviews to promote the themes in the analysis suggests the rigour of the study. Additionally, an in-depth description of the methodological and personal reflexivity also contributes to the rigour of the study.

### **2.6.3 Transparency and Coherence**

I have increased the quality of my study by being transparent with all relevant aspects of the research process. Transparency refers to the full disclosure of the research process whereby the reader can follow the process from data collection to data analysis (Yardley, 2000). I also detailed all the relevant information related to this research as well as being aware of the impact of this. For example, several participant interviews were carried out face-to-face, while others were carried out online. This is an important detail as being face-to-face versus online may have had a different impact on the participant concerning how they feel and what they share about their experiences. IPA emphasises that our beliefs, assumptions, intentions, and behaviours shape our experience of the world, which places reflexivity at the forefront of research. Therefore, Yardley has argued that there is a need for researchers to reflect on how their values, beliefs, experiences, and assumptions have impacted the research. Therefore, reflexivity was given high importance and has been discussed in terms of methodological and

personal reflexivity. Thus, transparency and coherence were considered and adhered to improve the quality of this research.

#### **2.6.4 Impact and Importance**

This research aimed to enhance our understanding of the experience of self-harming behaviour that inflicts external injuries to the body among South-Asian females (i.e., Bangladeshi, Indian and Pakistani). The current literature contains research predominantly investigated via a quantitative lens; thus, this qualitative study facilitated a deeper understanding of self-harming behaviours among South-Asian females. Previous studies have grouped a large ethnic group regardless of the differences between them, therefore, this research looked at Bangladeshi, Indian and Pakistani females who are more similar to one another. Additionally, previous studies have looked at all types of self-harming behaviours as similar and therefore this research looked at self-harming behaviours that inflict external injuries (e.g., cutting, burning, scratching) to the body. This generated novel data for the RQ to understand the meaning of the experiences of self-harm and thus addressed the gaps in the literature. Additionally, I hope that this research will highlight our understanding of self-harming behaviour among South-Asian females to help facilitate conversations, such as in therapy.

#### **2.7 Participant Inclusion and Exclusion Criteria**

Alongside the quality of the research, it is also crucial to carefully choose the inclusion and exclusion criteria to ensure homogeneity. Homogeneity, central to IPA, is when the chosen participants have experienced a similar phenomenon (Smith & Shinebourne, 2012). This was ensured through strict inclusion and exclusion criteria. The inclusion criteria were that participants must have had an experience (at least one year ago) of self-harm that caused external injuries (e.g., cutting, scratching, burning) to the body. They needed to identify as Indian, Pakistani, or Bangladeshi. They also needed to identify as female as these are the characteristics under investigation. The participant must also be over the age of eighteen years old. There was no maximum age restriction (e.g., must be eighteen to 45 years old) as the experience of self-harm was not viewed as age dependent. Participants must also be able to speak English at a proficient level to talk in-depth about their experience and discuss the meaning they attribute towards their self-harming experiences.



The exclusion criteria were participants currently self-harming, being clinically treated for self-harm, under eighteen years old, experiencing suicidal ideation and symptoms of psychosis. A questionnaire (see Appendix A) was administered to screen for risks such as current self-harm, suicidal ideation, and psychosis. If participants were excluded from the study, time was taken to explain the reasons for this to address possible feelings of rejection. Participants who reported currently self-harming were excluded from the study as current self-harm could be an indicator of risk and engaging in deep discussions about their experience could potentially re-trigger their self-injurious behaviour. They could also potentially be re-traumatised if they are talking about their experience of self-harm in a research setting without the provision of therapeutic intervention in place. Further, it would be unethical to be conducting research on individuals who are currently self-harming due to the potential harm involved and therefore it was an exclusion criterion for this study.

## **2.8 Recruitment Strategy**

Due to the idiographic nature of IPA, a small number of participants were recruited via purposive and opportunistic sampling, where participants who expressed an interest and met the selection criteria were selected. The research poster (see Appendix B) was posted on social media, such as Twitter, Instagram, and Facebook pages. Further, friends and family were asked to circulate the poster among their friends and family. As it is a sensitive topic to discuss, plenty of time was allocated for recruitment.

## **2.9 Sample Size**

According to the guidelines by Smith et al. (2012), 4-10 participants are required for professional doctorate studies to gather rich data for analysis. Onwuegbuzie and Leech (2005) suggest that the sample size should be enough to tell a rich story but not too much that it prevents deep, complex engagement with the data in the time available. Therefore, eight participants were recruited for this research.

## **2.10 Data Collection**

Once participants had expressed an interest, a telephone call was arranged to provide further information on the study and ensure that inclusion criteria were met and that the exclusion

criteria did not apply via the screening questionnaire (see Appendix A). If they were happy to continue, then a date, time and location were agreed. Upon meeting, the participant was given an information sheet (see Appendix C) including the aims, procedure, confidentiality and its limits and the protocol and data analysis method. Finally, a written informed consent was gained before starting the interview (see Appendix D).

### **2.11 Semi-Structured interviews**

As IPA requires rich and detailed data for analysis (Smith & Shinebourne, 2012); a semi-structured interview style was adopted as it is based on asking open-ended questions which elicit deep exploration of the participant's experiences (Smith, et al., 2009). While this was difficult if not impossible, I aimed to set aside my thoughts, beliefs, and judgements on self-harm within the South Asian community. This is based on Heidegger's understanding that we cannot fully bracket our thoughts, feelings, and judgements as they ultimately shape our research (Landridge, 2007). Heidegger argues that we should remain reflexive and utilise these thoughts, feelings, and judgements in our research (Landridge, 2007). Consequently, I hope my transparency about my personal beliefs, feelings and judgements can allow readers to appreciate the co-construction of the knowledge derived from the data.

During the interview, a listener-narrator style of conversation was adopted, with the utilisation of verbal encouragers (e.g., 'mm') to help the participants engage, feel valued as well as show empathy (Robertson, 2005). The interviews were carried out in UEL meeting rooms or via Microsoft Teams. They lasted between 48-108 minutes per participant and were audio recorded. The audios were transcribed verbatim, anonymised, and then analysed using the steps suggested by Smith et al. (2009). It began with a warm-up question to allow the participant to ease into the interview process (i.e., motivation to participate). The rationale for this was based on the recommendation by Smith et al. (2009) who suggested that this allows the participant to answer their question in description, before asking analytical questions. I thought this helped build rapport before asking sensitive questions related to their self-harming experience.

Prior to carrying out the interviews, my interview schedule was trialled with research peers to ensure that the questions derive detailed data (Smith et al., 2009). The first participant acted as

a pilot and was discussed with my research supervisor for feedback. This enabled me to test out my interview schedule to ensure that it was fulfilling its aim of enabling deep exploration of participants self-harming experience.

## **2.12 Interview Schedule**

I created an interview schedule and used it in each interview (see Appendix E). The questions used in the interview were aimed at initiating explorative discussions about the participants experience of self-harm. Therefore, the questions used were open questions as this allows the participants to offer potentially new and unexpected insights with more details as opposed to closed questions. The schedule was made up of an initial warm up question related to the participants reason for wanting to participate in this study to ease the participant into the nature of the interview style. Next, ethnicity was introduced through an open question by asking participants how they would describe their ethnicity.

Subsequently, the topic of self-harm was introduced through asking about their first involvement in self-harming behaviour, before asking “Has your ethnic origin in any way shaped/contributed towards your self-harming behaviour/experience? If so, how?”. My rationale for including this closed question initially was to explore the participants’ perception of whether they thought that the environment that they have grown up in may have impacted on their self-harming experience. Although this appears to be a closed question initially or could be viewed as leading, participants were able to agree or disagree. Once their positioning was stated, further exploration of their view could be carried out. During the practice and pilot study, this question provided rich and detailed information about the position of culture for each participant on self-harm, particularly if they had not touched on this topic yet. It also provided a focal point for discussions surrounding self-harm and culture to derive rich data for the analysis of IPA. Then, the participants’ experiences were discussed further, with questions related to their thoughts, feelings, and impact of self-harming behaviour. Finally, the interview closed by asking how they felt speaking to someone from a similar background about their experiences, before asking if there was anything else they would like to add.

### **2.13 Ethical considerations**

As individuals who have self-harmed can be considered a ‘vulnerable’ group, careful ethical consideration was required. Ethical approval was sought from the University of East London Ethics Committee before conducting the research (see Appendix F). The ethical guidelines provided by the University of East London's Code of Practice for Ethical Research (UEL, 2013) and British Psychological Society (BPS, 2018) were strictly adhered to to ensure the wellbeing of participants. Careful consideration to the BPS Code of Ethics and Conduct was given, particularly to the requirement of protecting participants from psychological and physical harm and protecting their dignity, rights, confidentiality, and anonymity (BPS, 2018).

Each participant was given a written informed consent form (see Appendix D) and an information sheet (see Appendix C) before the interview, this ensured that participants could make an informed decision for their participation (BPS, 2018). This met the BPS guideline of ‘Respect for autonomy and dignity of persons’ (BPS, 2018). The information sheet also outlined the participants’ rights, such as the ability to withdraw from the study at any point (BPS, 2018) until analysis had begun. Participants were informed that the data were anonymised before analysis and pseudonyms were used to protect their identity (BPS, 2018). Any physical documents were kept in a secure locked cabinet and electronic documents were password-protected to ensure data protection (BPS, 2018). They were informed that once the research and ethical obligations were fulfilled, the documents will be destroyed. Further, during the interview, if participants looked distressed, then the interview was paused, and I initiated a discussion about how the participant was feeling and then further action was agreed upon collectively between the researcher and the participant. At the end of the interview, participants were debriefed (see Appendix J), and counselling support and helpline contact details (see Appendix K) were provided. Debrief took longer for those that disclosed sexual assault to ensure that participants had support networks in place and could contact support helplines for further support.

As self-harm can be linked to risk (Carroll et al., 2014), risk was carefully assessed. Participants were made aware of the limits to confidentiality, for example, if they revealed information of risk to themselves then confidentiality will be broken. Furthermore, if a disclosure was made about the risk to others, then the police will be informed, but they will be discussed with the

research supervisor before acting where possible. I also considered the possible presence of power dynamics, I may have been perceived as the person of power and therefore the participant felt obliged to sign the consent form and participate (BPS, 2018). To combat this, I ensured that there was at least a one-week gap between participants agreeing to participate and the interview so that they did not feel rushed and had enough time to consider the implications of participating.

One potential issue was that the interview questions may have been anxiety-provoking, as participants were asked to recall past difficult experiences, which may have been traumatic. Therefore, I kept a close eye on the participants' verbal and non-verbal communication for signs of anxiety (e.g., participant looked distressed, inability to articulate their experience, or were stuttering). I was not involved therapeutically at any point, but if these signs were noticed, the interview was paused, and I asked how they were doing and whether they would like to terminate the interview as they had a right to withdraw (BPS, 2018). Nonetheless, Biddle et al. (2013) found that 50-70% of participants who took part in a qualitative study of self-harm reported an increase in wellbeing, therefore I hoped that the distress experienced was minimal.

Furthermore, the UEL code of Ethics (UEL, 2013) recommends that trainees should consider the wider considerations of the research and try to maximise the benefits of the proposed research from the individuals researched to the wider society. The present research aims to be beneficial, as previous studies have shown that South-Asian females do not voice their concerns regarding their psychological distress and therefore they self-harm, this research gave my participants a voice. It may have enabled them to speak about their difficulties and seek support when required in the future. Additionally, reflecting on their experiences may have prompted participants to reflect upon the reasons for the increased instances of self-harm in South-Asian females. Although the aim of the research was not to find generalisable recommendations, the themes that have emerged can be used to inform service provisions, particularly in areas with a high number of South-Asians (e.g., Newham). It is also worth noting that these themes are tentative and therefore, they will not apply to everyone and thus the individual needs to be considered. Moreover, the benefits could be maximised through presenting the topic in psychological conferences as well as events held by South-Asian charities.

## **2.14 Ethical Amendments**

Originally, ethical approval was gained for face-to-face interviews. However, I had several participants outside of London who were interested but were unable to come to London and I was unable to find a suitable location to conduct the interview. Therefore, the ethical amendment was gained to conduct interviews via a secure online platform, Microsoft Teams video call (see Appendix G). Although participants lived in another part of the UK, they met the inclusion and exclusion criteria thus sharing a similar experience to explore the same phenomena. As they were video call interviews, I was still able to observe verbal and non-verbal cues, which was not a detriment to face-to-face interviews. Further, ethical amendment was gained to reflect the change of the research title from the working title (see Appendix H). This reflected the research and the inclusion and exclusion criteria of the research as participants did not need to identify as ‘British Bangladeshi, Indian or Pakistani’. The final ethical amendment (see Appendix I) gained was another change to the research title to include “UK-based” to reflect the sample under investigation as the inclusion criteria for the study required the participants to be based in the UK. This also provided better clarity of the sample in the title for readers.

## **SECTION 2: METHOD – The Research Process**

### **2.14 Participant selection**

I received responses via email from potential participants. We arranged a telephone call to discuss the details of the study further and assess the suitability for the research via the pre-screening questionnaire (see Appendix A). If they met the criteria, they were invited to an interview. Several participants who had come forward were excluded, due to reasons related to current self-harm, recent self-harm, self-harm via overdosing, or were not Bangladeshi, Indian, or Pakistani. The reason for the exclusion was explained. They were then emailed contact details for further support should they need it (see Appendix K). The participants that had met the inclusion and exclusion criteria were given additional details of the study and were given an opportunity to ask further questions. We also agreed on a date and time for the interview based on our availabilities. They were told that the interviews would be carried out at the university interview rooms (face-to-face) or via Microsoft Teams video call. An email to confirm the interview details were sent, detailing the date, time, and location.

### **2.15 The Eight Participants**

During recruitment, eight participants agreed to participate and met the inclusion and exclusion criteria. They were all female, had self-harmed via external injuries to their body at least one year ago, and in their 20s. They were also either UK-based Bangladeshi, Indian, or Pakistani. These similarities appeared to meet the requirement of a homogeneous sample, as recommended by Smith et al. (2009). The participant's demographic information is outlined below.

**Table 1***Participant Demographic Information*

	1	2	3	4	5	6	7	8
<b>Name</b> (pseudonym)	Uzm a	Zahira	Fateha	Sidrah	Laiba	Anisa	Zainab	Jasvinde r
<b>Age</b>	20	23	28	25	25	21	21	26
<b>Gender</b>	Fem ale	Female	Female	Femal e	Female	Female	Female	Female
<b>Ethnicity</b>	Paki stani	Bangla deshi	Bangla deshi	Paki stani	Paki stani	Bangla deshi	Pakistan i	Indian Punjabi
<b>Self-harming experience</b>	Cutti ng	Cutting	Cutting arm	Cuttin g & scratc hing	Cutting arms & legs	Cutting arms	Cutting	Cutting wrists & legs
<b>Last time they self- harmed</b>	“6 years ago”	“Dec 2018 – two years ago”	“2009 - 10 years ago”	“9 years ago”	“6 years ago”	“3 years ago”	“About 5 years ago (2015)”	“Late 2018”

**2.16 The Interviews**

A pilot study, also called ‘feasibility study,’ was used to test the interview schedule to ensure that the questions had elicited data pertinent to the RQ. During the pilot, I asked the questions on my interview schedule, whilst audio recording this. I then transcribed and discussed it with my supervisor. I found that, although the interview schedule was useful in eliciting relevant material, I could have explored the experiences described in more detail. For example, I could have asked further questions on the meaning of an experience described. This allowed me to



think about how I could develop my interview technique. I did further reading around qualitative interviewing techniques and then carried out practice interviews with my peers. Therefore, carrying out a pilot study allowed me to develop my interview skills further. The first interview provided rich data and therefore it was included in the main analysis. Although the questions did not change from the pilot study, my interview technique was different as I asked for more detail from the participants about their feelings and experiences. All other interviews followed this format.

## **2.17 Transcriptions**

The interviews were transcribed verbatim by me. After the initial transcription, I went over the recording and transcript again to ensure its accuracy as well as enforce anonymity by changing any names to pseudonyms. Additionally, any personal information was changed or removed to further ensure the protection of participants. There have been discussions around whether the data should be tidied up, in essence excluding any ‘um,’ pauses, false starts, laughter, sighs, and semantic details (Landridge, 2007). To help me decide on this, I considered the methodology of the study. Smith and Osborne (2013) argue that when carrying out IPA analysis, the transcription should be at a semantic level (e.g., false starts, pauses, laughter, sighs) as it may be meaningful in analysis.

If I had not included this detail, I may have missed or not understood the meaning of this experience. Consequently, it would have reduced the richness of the data, therefore, I thought that it was necessary to include them in the transcript. However, I may remove the ‘um’ and ‘er’ if they were not relevant to the meaning in the analysis chapter for ease of reading. The format of the transcript includes a table with three rows, the middle row included the verbatim transcript while the left row was for exploratory comments and the right row was for emergent themes.

## **2.18 Analytic Strategy and Procedure**

Interpretative phenomenological Analysis (IPA) was used to analyse the data, utilising the six-stage guideline provided by Smith et al. (2009). However, these steps were used as a guide

rather than a prescription, as recommended by Smith et al. (2009). The six stages of IPA will now be outlined and discussed concerning my experience.

### **2.18.1 Stage 1: Reading and re-reading**

To immerse myself with the data, I listened to the audio while following the transcript. This was because listening to the audio helps with imagining the participant's voice while carrying out the later stages of analysis and facilitates a "more complete analysis" (Smith et al., 2009, p. 82). It was also helpful to read my reflections from the interview itself to remind myself of my own beliefs and assumptions. The transcript was then read and re-read to fully immerse me in the data to facilitate my understanding of my participant's experiences. Further, as reading potentially distressing content could impact my wellbeing (Warr, 2004), personal therapy was in place to utilise when required.

### **2.18.2 Stage 2: Initial noting**

Stage 2 is described to be the most detailed and time-consuming stage as it engages the semantic data and the utilisation of language at an exploratory level. During this stage, I held an open mind and kept a note of anything that came up, specifically the way that the participant narrates, comprehends, and thinks about a particular aspect (Smith et al., 2009). The fact that there are no rules or expectations about what is commented on during analysis left me feeling anxious as a novice qualitative researcher, however, I followed the guidelines provided. The aim for this stage was to generate notes and comments of observation based on the data, which were written on the left-hand margin. Smith et al. (2009) suggest that to avoid surface-level analysis of the data (i.e., commenting on what I expect to find), there needs to be a close analysis of the data. The notes I made included descriptive (green ink), linguistic (blue ink) or conceptual (red ink) comments. Descriptive comments are related to relationships, locations, occasions, principles, and processes. Linguistic comments are related to how and why the participant is concerned with the descriptive comments. These include metaphors, laughter, pauses, speed of speech or hesitance. Conceptual notes are interpretative comments which aimed to conceptualise the participants broader understanding of their experiences. These comments involve double hermeneutics whereby I made sense of the participant making sense of their experiences; therefore, it relied on my interaction with the data. Once I had done this,

I went over the transcript again after some time to see if any new comments had emerged (see Appendix L).

### **2.18.3 Stage 3: Developing emergent themes**

The aim during this stage was to reduce the amount of detail while still preserving the complexity. This can include working with the notes made as opposed to the transcript itself. The task was to develop emergent themes (noted on the right-hand side), which represent sections of the transcript (Smith et al., 2009). This also involved breaking up and re-arranging the narrative flow of the data, which contained my interpretation of the data. Thus, the analysis became an outcome of the participant's experiences and my interpretations (Smith et al., 2009).

### **2.18.4 Stage 4: Searching for connections across emergent themes**

This step involves the organisation of the themes and how they fit together. To keep a note, I printed out a list of the themes, cut them out and re-arranged them on my desk. This allowed me to explore the suitability of how emergent themes relate to each other. It helped me to place similar themes together. The suggestions to help with finding the links included abstraction, polarisation, subsumption, and contextualisation. Abstraction was carried out when common themes were attributed a new label, while polarisation occurred when conflicting themes were clustered. When one theme was assumed as having a higher position and turning into a new label to join themes together was called subsumption. Finally, contextualisation enabled a connection of themes through cultural and narrative qualities. These techniques were particularly helpful for me to utilise as a novice qualitative researcher. Through this process, I found that some themes were disregarded when they were already covered by another theme and would not lose meaning. These decisions were recorded to keep track of the analysis process. For the first participant, 8 major themes were identified with between 2 to 4 emergent themes each. This was where the analysis was complete for the first participant, and I created a table of themes for this participant (see Appendix M).

### **2.18.5 Stage 5: Moving to the next case**

I repeated the above steps for the remaining participants. During this stage, it was crucial to bracket the themes that had emerged from the first interview to preserve its idiosyncrasy.

Although there will inevitably be an influence from the previous interview, Smith et al. (2009) argue that it is fundamental to allow new themes to emerge with each interview and following these steps will aid in achieving this. The number of major themes that emerged ranged between 8 and 11.

#### **2.18.6 Stage 6: Looking for patterns across cases**

This step involved searching for commonalities among all eight participants. Here, I laid each table (colour coded with one colour per participant) on the floor and looked for connections between them. The colour code enabled me to see how many, and which participants were linked together. As recommended by Smith et al. (2009) I asked myself the following questions to support me with this stage, for example, what associations are there across the interviews? What does a theme in one interview help enlighten a different interview? And which themes are the most powerful? It may also lead to a reorganisation or re-labelling of a theme. Initially, I identified 12 super-ordinate themes but reduced these to 3 using abstraction and subsumption. The super-ordinate themes consisted of 3 sub-ordinate each. A word document containing the quotes for each super and sub-ordinate theme, with the participant and line numbers was created (see Appendix N). This step enabled me to track the quotes for the themes during the write-up of my analysis. The result was presented in a table of themes in the analysis chapter.

Two sub-ordinate themes ('Abused by my Environment & 'Self-harm is Sinful') in the study were constructed around four participants, out of the eight under investigation. It can be argued that at least 50% of the participants are believed to be sufficient to support a commonality of themes. It could also be argued that IPA favours idiography and individual subjective experiences and thus if these themes were not included then these experiences would be lost, thus it was important to include the insights and experiences of the 4 participants.

### **2.19 Reflexivity**

IPA places the researcher at the forefront as interpretations made by the researcher influence the analysis (Willig, 2013), therefore, reflexivity is imperative. Reflexivity is the awareness of how the researcher's feelings, assumptions and motivations impact the research and analysis (Landridge, 2007). The next section will discuss my methodological and personal reflexivity so that the reader can be aware of my own experiences, beliefs, assumptions, values and to what extent they may have influenced the research and analysis.

### **2.19.1 Methodological Reflexivity**

My background as a UK-based Bangladeshi woman may have benefited or hindered the recruitment process. It has benefited me because I found it simple to communicate and relate to my potential participants as they were from a similar background to me, particularly because I had also grown up in Newham and Redbridge within a community with a high percentage of BIP individuals. However, it could have hindered my participants from participating as research suggests that there is shame, stigma and a lack of trust related to discussing mental health difficulties, particularly with BIP professionals (Chew-Graham et al., 2002). Alternatively, my background could have benefitted the participants, as they described that it was helpful speaking to someone from a similar background because they felt there was a shared understanding of cultural factors.

Furthermore, conducting semi-structured interviews was a new skill for me, and I was worried I was not going to be able to explore the experience in-depth as a novice qualitative researcher. I knew that if I had not developed my interviewing skills then I would not be able to explore my participant's experiences in depth which would limit the data that is available for analysis. Therefore, my supervisor and I had agreed I would carry out one interview, transcribe it and then he would give me feedback on how I can improve. This was beneficial for my development as a researcher as it highlighted areas for improvement and enabled me to practice before carrying out further interviews on participants.

Additionally, I noticed that I had felt a level of discomfort during the start of my interviews. I felt guilty for asking such sensitive questions, particularly as the interviews were voluntary and they were not reimbursed for their time. However, a few minutes into the interview, I realised that my participants were quite open and wanted to engage with the discussion and this reduced my guilt.

### **2.19.2 Personal Reflexivity**

In terms of my personal life, I am a British-Bangladeshi Muslim woman in my mid-twenties. Growing up in a traditional household whilst being exposed to Western culture generated a

sense of dichotomy on the ‘right thing to do,’ resulting in an internal conflict about my identity. I found this was a common experience among friends and this made me think about whether it was also the case for my participants. Further, in secondary school, talking to my BIP peers, I realised that they experienced a clash between what they wanted to do versus what their parents had expected of them, resulting in internal conflict and thus they used self-harm to cope. This contributed to my beliefs that a reason why UK-based BIP women self-harm is due to the cultural conflict they experience.

Potentially, these beliefs could have led me to be more inclined to explore and analyse experiences common with mine. Although IPA understands that the researcher cannot be fully impartial to the analysis stage (Landridge, 2007), I have taken necessary measures such as reflective journal, personal therapy, and research supervision, to limit these biases (Smith et al., 2009). This ensured that my personal beliefs did not supersede the themes that were present in the data by remaining reflexive during the analysis process. I hoped that this enabled me to be reflexive and transparent throughout the research process, and thus identify and limit my assumptions biasing the research process (Kasket, 2013).

## **CHAPTER THREE: ANALYSIS**

### **3.1 Chapter Summary**

As explored in chapter one, the purpose of this research was to explore the experience of self-harming behaviours that inflicted external injuries to the body in South-Asian women. This chapter will present the themes that have emerged from the interviews with eight South-Asian women via Interpretative Phenomenological Analysis (IPA).

Prior to the analysis, it is important to understand the key features of IPA and reflexivity. As IPA involves the co-construction between the participant and the researcher of the meaning of subjective experiences (Smith, et al., 2009), another researcher may have made a different selection of themes. Therefore, due to the subjective nature of the research, the suggestions made by Yardley (2000) was followed, as described in the methodology chapter. One important element in maintaining the quality of the analysis was to remain reflexive. To promote this, notes on my thoughts and reflections in response to the participants data and how this contributed to the analysis process during the data collection and data analysis was written down. These reflections will also be highlighted throughout the analysis chapter. The rationale for this is to add depth to the participant's quotes and for the reader to assess the quality of the study. As the focus of this chapter is on the participants' words, the links between the themes and psychological theories, research and practice were made in the discussion chapter.

### **3.2 Summary of Analysis**

The IPA analysis in this study produced three super-ordinate themes and nine sub-ordinate themes (see table 2), which highlight the captured themes for the experience of self-harming behaviour that inflicted external injuries on UK-based Bangladeshi, Indian and Pakistani women. The themes have been organised in a way that is indicative of a narrative style to ensure that it can be coherently followed as a process. It begins with the influences and triggers of self-harm and then leads to the idea of using self-harm to cope, before exploring the complex presentation of self-harm. Thus, the order of the themes does not necessarily reflect the order that the participants spoke about their experiences.

The first super-ordinate theme, 'Powerless, captured how the demands related to the values and beliefs of South-Asian culture perhaps contributed towards self-harming behaviour. The sub-ordinate themes ('Entrapment', 'Internalised Negativity' & 'Abused by my Environment') will

discuss the gender-based inequality experienced by these women and the inability to be their true selves due to expectations from others. It also includes the factors that led to the self-harming behaviours such as mental health difficulties, internalised anger and hatred and traumatic events (e.g., bullying, and sexual assault).

The second super-ordinate theme, called ‘Mitigation’, included how self-harm aided in the management of psychological distress. The subordinate themes explore the way self-harm was used to release and regulate emotions, connect to the psychological pain felt by experiencing the physical pain of self-harm. Further, it includes the conceptualisation of self-harm as an addiction whereby participants felt they became dependent on this self-injurious behaviour.

The third super-ordinate theme, ‘Self-harm is Wrong’, captured the secretive nature of self-harm and the regret associated with self-harming. It also explores how self-harm was conceptualised via religion as ‘sinful’. All of which combined aim to illuminate the meaning given to the experience of self-harming behaviour in South-Asian women. Appendix O shows a theme recurrence table, including which participants’ interview had supported the sub-themes.

### **Keys for participants’ quotes**

To remain consistent with IPA, the participant's quotes will be central to this chapter. The participant's quotes will be italicised and will include the participant pseudonym and the line number corresponding to the interview. For example, [Jasvinder, 457-459] represents Jasvinder and lines 457 to 459 in the corresponding transcript. There are instances where I have added words in square brackets to make the quote more understandable and clearer. Ellipsis (i.e., ...) have been used to indicate short pauses in the participant's speech. Furthermore, words that were emphasised during the interview are underlined. Finally, words that were not completed (i.e., partial words) are specified using a dash (e.g., comp-). Finally, square brackets (i.e. [...]) indicates deletion of words or phrases that were considered as not relevant to the extract and interpretation while not changing the meaning.



### 3.3 Table 2 Summary of Themes

Table 2 shows the final super-ordinate and sub-ordinate themes related to the research question.

Super-ordinate Themes	Subordinate Themes
Powerless	<i>Entrapment</i>
	<i>Internalised Negativity</i>
	<i>Harmed by my Environment</i>
Mitigation	<i>Releasing my Overwhelming Emotions</i>
	<i>Connecting to my Pain</i>
	<i>Addicted to Self-harm</i>
Self-harm is Wrong	<i>It must be Hidden</i>
	<i>What have I done to myself?</i>
	<i>My Self-harm is Sinful</i>

### **3.4 Super-ordinate Theme One: Powerless**

This theme explores the impact of the pressures associated with the South-Asian culture on self-harming behaviour and the feelings of powerlessness as a result. Although each participant discussed different idiosyncratic ways in which they experienced self-harm, they linked their self-harming behaviour to the values and expectations related to their South-Asian culture which left them feeling powerless and hopeless. There are three sub-ordinate themes ('Entrapment', 'Internalised Negativity' and 'Abused by my Environment').

#### **3.4.1 Sub-ordinate Theme One: Entrapment**

This subordinate theme explores the inequalities participants faced due to the values and expectations in the South-Asian culture. Participants indicated a link between gender inequality and self-harm. Further, this sub-theme also explores the views held by those from the South-Asian culture, which often contradicted the participants' values and beliefs. More specifically, this disparity was described to have generated an internal conflict and led to the questioning of South-Asian values and beliefs. The participants described that these pressures restricted them from being themselves and that in turn this was linked to their self-harming behaviour.

*"there's been lots of times when we have dinner as a family, and then it was either mum or dad would be like girls need to clean up after everyone. But I've got brothers as well and I feel like they should help out too, it's only picking up a few plates (yeah) but then they say oh they're little and they're boys, they don't need to and it's just wrong"*

[Zainab, 131-134]

Zainab's account suggested that she may have been socialised into accepting gender roles from a young age. This extract suggests an unquestionable expectation about the role of UK-based Bangladeshi, Indian and Pakistani women and gender inequalities. It is noteworthy that the gender inequalities were enforced by both mum and dad, which could indicate a level of internalised patriarchy by her mum, who is of the preceding generation. This can allude to the ideas of generational differences in the women of this culture, whereby her mother agreed with and enforced the gender roles, while Zainab did not agree with it and felt it was unfair and unjust to enforce them onto her. The tone and language (i.e., *"it's just wrong"*) used by Zainab could indicate that she not only disagreed with these inequalities but perhaps also wishes that

these gender inequalities did not exist. Further, Fateha also described experiencing gender inequality and gender role expectations.

*“in our culture, a lot of... like-obviously we’re the lady of the house we’re just expected to do certain things. Which is really to maintain the house, provide like you know clean and like look after the house and to be the happy one in the house. To give everyone understanding to like be, to play a certain role in the house so to have to like... keep our thoughts and feelings inside and if we have kids you know make sure they’re happy, make sure that they’ve got you know, they’re alright. And then erm... our feelings would get blocked out or hidden away and then just carry on with life really”*

[Fateha, 89-95]

Fateha described the importance of UK-based Bangladeshi, Indian and Pakistani women in their household, whereby women were central to its maintenance both physically and psychologically, irrespective of their own needs. This is indicative of a set of rules being prescribed to these women without their agreement, according to which they were expected to put others’ needs above their own. It can be argued that UK-based Bangladeshi, Indian and Pakistani women had limited control in leading their lives in the way that they wished. Furthermore, Fateha describes her way of managing these expectations as to “block” or “hide away” her feelings and “carry on with life.” It appears that by attempting to consistently fulfil the gender role expectations, there is a constant need to replace her desires with that of the demands of others. Additionally, the pauses in between her speech and the monotonous tone can be indicative of a sense of resignation, as though she had given up and adhered to these expectations placed on her. Jasvinder also reported these rules as gender specific.

*“it was very traditional things, girls don’t leave home, girls don’t move home and live in houses without their parents and stuff like that. Like what if there’s boys like what are you gonna you know all this kind of stuff. So, I was very much like I have to really prove myself I have to really prove, and that was a lot of pressure. And that I think is culturally specific especially the whole kind of girls don’t leave home. Girls stay at home until their parents you know get them married off so that was very culturally specific”*

[Jasvinder, 634-637]

Jasvinder discussed the application of a different set of rules and expectations for girls and boys in her culture. She explained the presence of a lack of trust in UK-based Bangladeshi, Indian and Pakistani girls which resulted in placing restrictions on her (i.e., "*what if there's boys*"). The tone and repetition of "*there was a lot of pressure*" indicated the desperation and pressure Jasvinder felt to prove herself to do what her male counterparts would automatically be allowed to do. It seems that these restrictions played a role in Jasvinder feeling controlled by gender rules and thus there was a requirement to sacrifice her desires from a young age. These restrictions placed upon Jasvinder were later discussed to have had "*a massive effect*" on her "*wanting to self-harm*" [Jasvinder, 653-654], which highlighted the enormity of the impact of gender role expectations on self-harming behaviour. Jasvinder also exclaimed that these pressures from her culture "*made [her] want to hurt [herself] and so [she] did*" [Jasvinder, 625-626], indicating that she believed that there was a direct link between gender inequalities and self-harming behaviour. Furthermore, Jasvinder's description highlighted the power differences between a parent and daughter in UK-based Bangladeshi, Indian and Pakistani families, where parents appear to have power and control over their daughters' lives. Additionally, Laiba also spoke about gender inequality as a contributor to self-harm.

*"I think when it comes to particularly how women are treated and me observing and hearing about those kind of things I've always felt helpless like there's no way out erm kind of thing and erm even with like the norms of how you treat your elders and not being able to answer back to comments that are being made either from like family or cousins or things like that, that kind of had like I feel like it might be encouraged and pushed me towards that side [self-harm]. Whereas had I not hurt- had I been able to stick up for myself and not seen such things happen to like family and things like that I think I would've had a very different reality, and not felt so helpless"*

[Laiba, 625-632]

Laiba discussed the treatment of women in her culture as a causal factor to her self-harming behaviour. The cultural norms linked to the treatment of women perhaps left her feeling trapped, which she stated had encouraged her to self-harm to cope. It can be argued that Laiba was required to passively tolerate unjust and upsetting comments made towards her, leaving her feeling powerless and a sense of lack of control. This resulted in a sense of feeling trapped ("*no way out*") and stuck and perhaps silenced by the restrictions and expectations from her

culture. Further, the expectation of not being able to “*answer back*” or “*stick up for [herself]*” and remaining silent was indicative of a sign of respect for elders, highlighted the role age also plays in the roles, expectations, and values in the Bangladeshi, Indian and Pakistani culture. It can also indicate a chain of power or hierarchy of power in these families. This pressure to remain silent, rather than defend herself, seemed to have influenced her need to self-harm. This opens the question as to whether Laiba used self-harm to not deviate from her cultural expectations, whilst addressing the helplessness she experienced from the inequalities via self-harm. These gender inequalities were reported to lead to feelings of powerlessness, a sense of feeling trapped and a lack of control. which resulted in self-harming behaviour as a way of coping with the feelings of helplessness and powerlessness.

*“I just wanted to fit in with my friends really badly, the way they were dressing, the way they would go out to places, not like even like late at night, just go out shopping and stuff I wasn’t allowed to do that, (M’hm) going to the cinema wasn’t allowed, I wasn’t allowed to talk about it. It was difficult I was just being left out and my parents didn’t see that”*

*[Zainab, 176-179]*

When exploring Zainab’s triggers of self-harming behaviour [Zainab, 169-170], she described the restrictions placed on her by her parents, highlighting a lack of freedom to do what she wanted to do. She explained that this resulted in an inability to “*fit in*” with her friends and thus it can be assumed that it prevented her from being herself and left her feeling excluded. This can be indicative of the pressure Zainab felt to conform to both cultures, Eastern and Western, leaving her feeling conflicted. Perhaps this restricted her development of personal identity and freedom of expression at a pivotal age. Zainab indicated that this was a “*difficult*” experience for her, and this possibly renders the thought of difficulty managing the expectations from her culture with her personal desires. Furthermore, there is a repetition of “*wasn’t allowed*” which could indicate the continuous restrictions that she faced in comparison to her friends. This inability to be herself was dealt with by self-harming by Zainab, but also expressed by Anisa.

*“There was a lot going on at that moment like my mum was saying stuff to me I think and other people saying stuff to me and it just like like they wanted me to be someone who I’m not I just thought what should I do if they don’t listen to me”*

[Anisa, 757-759]

Anisa's account indicates that by being expected to conform to others' expectations, she was not allowed to develop her own identity. Anisa's mention of "*what should I do if they don't listen to me*" highlighted a sense of helplessness related to her wishes about who she wanted to be, and it also indicated a sense of uncertainty on how to manage this. This struggle for developing her own identity and the lack of agency and autonomy was further highlighted when she noted:

*"They'd be like you can't do this; you can't do that because people will say something in the Asian community. Like it's all Bengalis so everyone knows who I am and it's just like bad mouthing basically to my mother. So, I can't really do anything when I go out"*

[Anisa, 148-151]

Her frustrated tone of voice also indicates that she perhaps wishes that this was not the case and that she had the freedom to behave as she wanted to. It can be assumed that these restrictions had an impact on Anisa's identity formation, whereby she was unable to and discouraged from being her true self in public in case people will talk negatively about her mum. This could have led to a sacrifice of her sense of self to abide by her mum's expectations. Consequently, these restrictions could be viewed as leading to a poor sense of identity. Furthermore, it appears that these pressures from the Bangladeshi, Indian and Pakistani culture had a negative impact on their psychological wellbeing and were linked to self-harming behaviour, as described below by Jasvinder.

*"there were things in being South-Asian, being Sikh being Punjabi that had a massive effect on me wanting to self-harm, because a lot of the time whenever I'd say-especially when I'd say to my dad like no, I wanna achieve my dreams, I want to go to the creative like no, I want to do this so then he would be like but we don't do this. We don't do this in our culture, people don't allow us to do this, this is not what we do. I didn't come to the country for you to do that and so those feelings and cause it was like arguing with a brick wall you can't win no matter what. I just kind of put those feelings out on myself"*

[Jasvinder, 652-658]

Jasvinder's description highlighted the substantial impact of her culture on self-harming behaviour. There was a repetition of "*we don't do this*" in her narrative which conveyed the

pressure that can be put on these women, leading to a sense of lack of control over her own life. Jasvinder's attempts at regaining control were met with a lack of response from her father (i.e., "*arguing with a brick wall*"), suggesting a sense of futility. Therefore, she feels it is pointless trying to regain control, possibly generating internal and external conflict in managing her dad's expectations of her and her wishes. She also stated that these restrictions had an impact on her wanting to self-harm, thus an inability to have control over her life due to the pressures from her culture can result in self-harming behaviour. The experiences described indicate that the pressures from her culture contributed towards self-harming behaviour.

### **3.4.2 Sub-ordinate Theme Two: Internalised Negativity**

Each participant had diverse experiences of what they felt had triggered their self-harming behaviour. All women described negative thoughts, feelings and self-loathing tendencies that were associated with their self-injurious behaviour. For example, they expressed difficulties with their body image, low self-esteem, and internalised anger due to comments from family members, which then resulted in cutting themselves.

*"Before I self-harmed, I was really low. I... was so down, I was so depressed, I was just so like miserable"*

[Fateha, 377-378]

Fateha's accounts described her experience of numerous and strong negative emotions before self-harming. The repetition of depression can portray the recurrence and the severity of this experience. Her account suggests a link between mental health difficulties and self-harm. Furthermore, the brief pause by Fateha indicates that she is still finding it difficult to talk about her mental health difficulties which contributed to her self-harming experiences. Similarly, the link between low self-esteem and self-harm was also discussed by Uzma.

*"I just remembered one of the main reasons I used to self-harm it was just self-esteem problems"*

[Uzma, 80-81]

*“with the low self-esteem its cause, I think how I must’ve been 14 at the time so sort of on social media and even the school environment everyone has this sort of idea of... I don’t know the perfect body and how people are supposed to look and so for me, sort of thinking oh I don’t look like that, why don’t I look like that and erm... just at the time I just had really low confidence, low self-esteem, and I think it’s just the whole sort of looks thing was triggering erm my low self-esteem”*

[Uzma, 235-240]

Uzma explicitly stated that the questioning of her appearance was a trigger for her self-harming behaviour. These questions perhaps caused her upset and confusion as to why she did not match societal expectations. The comparisons she made between herself and what she would see on social media and at school perhaps left her feeling less than everyone else in comparison. This perhaps caused tension as her true self did not match her desired self, generating internal conflict and thus low self-esteem. Her experience of low self-esteem appears to be painful to manage and therefore, Uzma used self-harm to cope with these difficult emotions. Similarly, Laiba described body image difficulties.

*“it’s now people that are like the elders of the family now saying like stuff to me and then that really really got me bothered and really upset. And so I used to look at my body, ever since I was like a young child even and I’d like pick certain parts of my body that I didn’t like and I started cutting those parts that I didn’t like.”*

[Laiba, 342-345]

Laiba discussed her use of self-harm to manage her body image difficulties, explicitly stating this as a trigger for self-harm. It can be assumed that the comments from her relatives about her weight and size resulted in her being self-conscious about her body, which then led to hatred for her body and thus she self-harmed to deal with this hatred. These comments could have stemmed from the beliefs in her culture, whereby men were expected to look “strong” while women were expected to be “dainty” [Laiba, 576]. These expectations combined with the negative comments about her weight could have contributed to the body image difficulties and low self-esteem and thus she used self-harm to deal with the distress. This highlighted the role that BIP cultural expectations have on women to look a certain way which can lead to psychological distress and self-harm. Further, a common emotion described by the participants



was anger. Five participants (out of the eight) explained that a strong feeling of anger was present before they had self-harmed.

*“It was just extreme anger [...] So, like not being able to go out and arguing parents made me really angry. And I remember cutting my arm”*

[Laiba, 797-801]

Laiba discussed how the restrictions placed on her resulted in feelings of “extreme anger”. It seems that there was a clash between what she wanted to do and what her parents wanted. These restrictions perhaps led to a lack of agency and autonomy, resulting in feelings of anger. Laiba experienced this anger as an uncomfortable strong emotional state in response to the threat to her autonomy and seemed to use self-harm as a coping mechanism. Correspondingly, Jasvinder also explained the presence of anger related to her self-harming behaviour.

*“Anger was probably one. Myself which is why I was like carving like fuck up and bitch on my leg cause I was like angry at myself”*

[Jasvinder, 847-848]

*“it was probably anger or anger nobody wanted to be my friend, anger that I wasn’t able to achieve anything, anger that I wasn’t able to get a good work life balance in or that I wasn’t achieving the grades, honestly it just goes down to anger.”*

[Jasvinder, 859-862]

The repetition of “*anger*” by Jasvinder indicated the frequent presence of anger in self-harming behaviour. Jasvinder attributed the anger to herself for not being “*good enough*” and achieving her goals. The numerous items on her list of things she did not have perhaps suggests that she felt she was not “*good enough*” or competent to achieve them. It could be that Jasvinder was unable to see any positive aspects in her life, which is perhaps linked to the feelings of “*depression*” she had described earlier [Jasvinder, 849]. This anger she felt towards herself for not being good enough was translated or expressed as self-harm whereby she carved the words “*fuck up*” and “*bitch*” on her leg. It can also be interpreted that she is blaming herself for not achieving her desires. Jasvinder may have thought she was unable to voice her anger about this to her dad (“*it was like arguing with a brick wall*” [Jasvinder, 657] and therefore, she found

self-harm to manage her inability to express her anger. Furthermore, Jasvinder has simplified the complex behaviour of self-harm into one emotion, anger, when she stated that “*it all comes down to anger*”, perhaps highlighting the enormity of the role anger plays in self-harm. Zahira also discussed the presence of anger, particularly the lack of control of anger, in her self-harming behaviour.

*“I’m really rubbish at controlling my hurt and anger like when a situation happens I will just try block it out but then as time goes along I start getting worse and worse and it starts building up and that’s when the self-harming comes out so I struggle with controlling my anger [...] I’m not an angry person, I don’t like being angry at all but when I am angry I ain’t the nicest person to be around so anger for me is like a forbidden ”*

[Zahira, 829-835]

Zahira discussed strong feelings related to wanting to control (not express) her anger. Due to the negative impact of this emotion (e.g., shouting, swearing), Zahira has seen the adverse impact on her relationships. Therefore, she puts strong effects into blocking out her anger, which ultimately gets built up and seems to trigger self-harm. Zahira also explored the ideas related to controlling anger, whereby self-harm occurs as a result of no longer being able to suppress her anger. This further highlighted anger as a trigger for self-harm.

### **3.4.3 Sub-ordinate Theme Three: Harmed by my Environment**

There are several external events that the participants described which were linked to their triggers of self-harm. For example, the pressure placed on them to achieve good grades, witnessing violence at home, bullying and relationship breakdown.

*“a lot of it comes from school cause I went to a grammar school and they literally push you so much to get like 100% in everything and it’s like if you got 99 that’s not good enough you have to have 100. It was that mentality, so I think coupled together with the whole like cultural element it was yeah (laughs) I think that’s also why my self-harm started when I was in school just cause it was very much like a way to be that perfect person ”*

[Sidrah, 233-238]

Sidrah explained that the pressures from her grammar school fuelled the idea of striving for perfection, whereby achieving less than 100% was not good enough. It could be argued that there was a judgement from the environment to meet certain criterion and thus achieve perfection. Similar to a punishment, Sidrah would reinforce perfection via self-harm, whereby she would self-harm if she did not achieve 100% [Sidrah, 243-244]. It seems self-harm enabled Sidrah to meet the unrealistic expectations put on her by her school and her culture. This indicated that the environment in which these women grew up in can generate pressure to excel in different areas of their lives which was achieved by using self-harm. Aside from pressures at school, other participants explored the exposure to an abusive home environment and linked this to self-harming behaviour.

*“unfortunately I grew up in a abusive violent household like I have, there was some physical violence dotted about here or there- a couple of times here or there but it was a lot of controlling behaviours, a lot of erm shouting arguing a lot of just violent attitudes and tendencies [...] and so maybe there was that”*

[Jasvinder, 504-510]

When asked about what led Jasvinder to begin self-harming, one trigger she mentioned for her self-harming behaviour was the common exposure to an abusive home environment. It could be assumed that the physical, verbal and mental abuse and controlling behaviour that she witnessed and perhaps experienced to a degree had set the standard and had normalised these behaviours. Perhaps repetitive exposure to such abusive environments had also given her the idea that she could also abuse herself by self-harming. Perhaps these early experiences modelled the idea of violence to Jasvinder. Additionally, Jasvinder suggests that she was not entirely sure whether the abusive home environment alone had triggered her self-harm. Perhaps it was a combination of different factors as she also discussed experiences of being bullied that could have contributed to this behaviour.

*“But I really don’t know, apparently, I was bullied in school, in primary school. I remember vague bits of it of having kids say racist things to me and having them put a erm like a snot and saliva on the back of my school jumper. I remember that being an issue, I remember*

*making up like rhymes about killing my family and stuff and so I remember those things and bullying and stuff like that.”*

[Jasvinder, page 485-489]

*“I think not having friends and being in a violent household just really, the two together was just probably the two things that was the tipping point.”*

[Jasvinder, 528-529]

Jasvinder discussed her experience of bullying and racism in a monotonous tone and in a rather matter of fact way with a lack of emotional engagement. This perhaps serves to distance herself from the pain associated with these painful memories. Jasvinder’s account indicated that perhaps she was singled out and made to feel like an outcast due to her BIP background, as she went to a school with predominantly white students. The rhymes about killing her family could have felt threatening and instilled fear in Jasvinder. Whilst she was speaking, I noticed myself taking time to breathe as I felt overwhelmed by hearing the abusive home environment and bullying she experienced. I wonder how she managed these feelings of fear and intimidation from peers. Furthermore, not having any friends meant that she was perhaps lonely and there was a lack of social interaction with people her age. This alluded to the idea that harmful environments with a lack of social support can have an impact or perhaps even trigger self-harming behaviour. Aside from bullying, Fateha reported that she experienced sexual assault which triggered her self-harming behaviour.

*“the assault... I felt disgusted of myself I felt like urgh (laughs) I felt erm like- I just felt like I didn’t have no one to turn to. I felt really ashamed of myself I felt really disgusted, I just wanted to go to another place. In my mind as well, I just thought about self-harming”*

[Fateha, 200-202]

When Fateha was asked about what triggered self-harm, she had an immediate short and sharp response, which can be indicative of a clear trigger for her self-harming behaviour. Her use of “*disgusted*” and “*ashamed*” could indicate that she attributed a level of responsibility towards herself for the sexual assault as opposed to her perpetrators. This highlighted that this external event had been internalised as strong feelings of disapproval and shame towards herself. Further, her statement of “*no one to turn to*” suggested that there was a lack of support available

and highlighted the importance and desire for support after a traumatic experience. This highlighted that sexual assault, an external event, and the lack of support available had triggered her self-harming behaviour.

### **3.5 Super-ordinate Theme Two: Mitigation**

This super-ordinate theme explores the use of self-harm as a means of emotional regulation. It focuses on the use of self-harm to manage participants' psychological difficulties and the meaning given to self-harm. It includes three sub-ordinate themes: 'Releasing my Overwhelming Emotions', 'Connecting to my Pain' and 'Addicted to Self-harm.'

#### **3.5.1 Sub-ordinate Theme One: Releasing my Overwhelming Emotions**

This sub-ordinate theme looks at how self-harm was used to regulate emotions after experiencing strong feelings of distress. Participants described the use of self-harm as an escape, distraction, and a release from the emotional difficulties they had experienced.

*“And I remember cutting my arm erm and I just felt like all these like all the like bullying and all these experiences rushing through my mind and like the comments people made the fact that I like didn't like the way I looked in the mirror erm feeling helpless like cause seeing my parents argue and like family and friends and stuff all of those thoughts would be in my mind and I feel like I needed a release erm and so I just concentrate on the cutting and when the blood came out I feel like it's just a release of tension [...] and that was a release like I continue wanting”*

[Laiba, 801-809]

Laiba's description indicated that her experiences of bullying, family difficulties, and body image issues were managed through self-harm. All these difficulties being experienced at the same time perhaps resulted in overlapping thoughts that felt overwhelming to manage all at the same time. Therefore, self-harm seemed to have provided her with a distraction from these overwhelming thoughts and emotions. It can be assumed that self-harm was a compromise, enabling Laiba to express her built-up emotions without deviating from the expectations of the family (i.e., by keeping silent) and not causing further conflict. Further, self-harm numbed

Laiba's emotions, experiences and psychological distress and therefore enabled her to manage this difficult period. Also, self-harm could have been reinforced due to the release of tension and distress and thus this could have promoted the repetition and maintenance of this self-injurious behaviour. Other participants, such as Zahira, also discussed self-harm as a release.

*“Towards the end of our breakup I started to do it a lot more I started cutting myself a lot more because one day I thought to myself, the feeling that I had when I first cut myself and the feelings before as well every time like I started to feel like very anxious and hysterical there's a lot of hurt built up inside me and anger I realised that the pain used to somewhat feel better after like I could see the pain and I could make the pain visible to me”*

[Zahira, 563-568]

Zahira's expression of unseen pain after her relationship breakdown could indicate that it was important for Zahira to translate her psychological pain (distress associated with relationship breakdown) into physical pain (cutting). Perhaps, this enabled her to see the pain associated with the loss of a relationship, as opposed to just experiencing the feeling. This may have made her pain more tangible and thus more real, highlighting a further release of thoughts and emotions. She also discussed self-harm as a way to eliminate experiencing her emotions.

*“it felt really very very relieving like I felt like a weight off my shoulder it felt like hurt that I could see and that's why I was very very happy that I could get it out [...]. Cause once it was done and I would stop feeling pain, tears would stop like I would stop crying instantly”*

[Zahira, 805-808]

This further corroborated that she used self-harm to manage her emotions. It can be argued that self-harm enabled her to release her distressing feelings related to the relationship breakdown and thus provided a way to manage these emotions. Furthermore, other participants, such as Jasvinder, also described their use of self-harm to manage distressing thoughts.

*“it turned into I need this [self-harm] to sustain myself. But at the same time I still was doing it the other way which was the I feel upset, I'm a fuck up and I need to express this and I'm*

*gonna express it on myself because it's easier to express it on myself and push it down rather than to actually seek professional help"*

[Jasvinder, 926-929]

Similar to other participants, Jasvinder repeatedly mentioned language that related to feelings of self-loathing and self-hatred, in response to expectations set by herself and by others. Further, there was a tendency to internalise these expectations, leading to thoughts such as *"I'm not good enough"* [Jasvinder, 270]. Perhaps the repetitive and self-loathing nature of these experiences generated overwhelming feelings of distress. It appeared to be easier to express these negative feelings by transferring them into physical harm than seeking professional help. This in turn could have enabled Jasvinder to take control over herself and her body and enabled her to achieve a sense of control, power, and agency. Self-harming was viewed as an easier option because seeking help would perhaps generate more conflict with her parents disapproving of seeking mental health support. Further, as she was already experiencing difficulties with her dad, she perhaps did not want to exacerbate this. Therefore, it was perhaps easier to self-harm to manage these feelings of distress without repercussions from family members. Anisa also elaborated on self-harm as a release.

*"I couldn't get my anger out to anyone or like try and say to someone when I cut myself it's just like my thoughts are coming out when I'm cutting"*

[Anisa, 820-821]

Anisa explained her suppression of anger and her inability to speak to anyone about her unmanageable feelings. Therefore, she perhaps internalised her anger and was able to release it via self-harm. The compelling aspect of this extract is that she believed self-harming was perhaps the only appropriate way to release her built-up anger. It could be associated with feelings of hopelessness due to not having other ways to manage this difficult feeling. This could highlight that self-harm was used to release emotions as other options (i.e., talking) was deemed as not possible.

### 3.5.2 Sub-ordinate Theme Two: Connecting to my Pain

Alongside the idea that self-harm was used to manage difficult emotions, the experience of self-harm was reported to be a way of relating to psychological pain, resulting in a psychological and physical experience of self-harm.

*“I think it was just feeling really hot and like I was crying crying crying like erm there’s like a cry that you have that’s like surface, but this was a different crying from like inside and like really really painful cry”*

[Laiba, 855-857]

Laiba described a “*deeper*” more painful level of crying, which can be assumed that a more profound level of emotions was evoked during self-harm, highlighting that self-harm generates an intensely emotional experience. This could mean that self-harm is an all-consuming experience whereby it allowed her to connect to a “*deeper*” level of pain. She also highlighted that the cry during self-harm is different to that of a normal cry, indicating that it was more painful or complex perhaps. Further, Laiba described feeling hot, which indicated that there was both a psychological and physical experience during self-harm. This could portray that self-harm provided a way to connect to psychological and physical pain. Other participants, such as Jasvinder, also discussed using self-harm to connect to physical pain.

*“it’s quite fucked up but after I self-harmed, I’d go to the gym and then try and run on the treadmill for about 15-20 minutes so I could really feel the pain because your stretching your skin your stretching your legs. You’re going at speed your sweating and the material of your leggings is really kind of rubbing against the scars, and so that physical pain and reinforcing that pain”*

[Jasvinder, 877-881]

Jasvinder highlighted that feeling pain was a sensation sought after, to the point where she generated more pain even after self-harming. It can be assumed that this was due to the belief that she deserved the pain and therefore wanted to punish herself. This is supported by her discussion earlier whereby she said “*and then inflicting pain on yourself. Because that’s what you think you deserve*” [Jasvinder, 835]. This can be assumed to highlight the idea that self-



harm was a physical manifestation of her psychological pain of “*not being good enough*” and thus “*deserving pain*”. Furthermore, Jasvinder’s use of “*fucked up*” to describe her use of self-harm to inflict further physical pain upon herself can be argued that she found it strange, wrong, confusing or it did not make sense to her. The use of profanity may perhaps indicate her verbal aggression towards this decision now in retrospect. It is also noteworthy that participants also made the purpose of self-harm to connect to their pain apparent, such as Sidrah.

*“I stayed away from anything that drew too much blood erm not because I was scared of blood but just cause I needed the pain and not necessarily the I need to end my life kind of thing.”*

[Sidrah, 810-812]

It can be assumed, based on this quote, that self-harm did not involve suicidal ideation but rather a connection to physical pain due to the psychological distress Sidrah had experienced. It can also be argued that Sidrah made calculated decisions to ensure that her purpose of self-harm (i.e., connect to her pain) was fulfilled. Thus, she perhaps spent time to think about and consider which tools would be ideal to ensure she felt the pain but did not experience damage to her vital functioning to end her life. She also refers to the pain as needed, which suggests that feeling the pain associated with self-harm was a necessity. This idea was also supported by Laiba, who utilised calculated decisions to fulfil the purpose of self-harm.

*“it never got to the point where I cut a major vein or something but there were times where I would try and cut as much as I could until it got really painful...”*

[Laiba, 882-883]

It can be argued that Laiba knew the limits of what she can and cannot do when self-harming. Similar to Sidrah, this also alluded to the idea of a calculated and thought-out process before self-harming for it to serve the purpose of instigating physical pain. Furthermore, Laiba also stated that she would cut until it got “really painful,” which could portray the idea of boundaries and limits related to self-harming behaviour. It could also highlight a sense of control she was able to regain in her life, which she was unable to have in her personal life.

### 3.5.3 Sub-ordinate Theme Three: Addicted to Self-harm

Participants also described self-harm as an addiction, a behaviour that they knew was bad for them but could not refrain from engaging in. Others described self-harm as a “*must*”, which they repeated and became dependant on. This sub-theme will explore self-harm as an addiction.

*“I remember at the time thinking like this is addictive but it’s so bad for me like I can’t keep doing this so erm from being sort of addicted to it to cause obviously addictions are addictions you can’t stop”*

[Uzma, 369-371]

Uzma explicitly stated that her repetition of self-harm meant she was addicted to it, which can be assumed that she experienced a physiological need for self-harm that characterised self-harm as obsessive. The repetition of “*addiction*” can indicate that she felt strongly about her use of self-harm being addictive. Further, her use of “*can’t stop*” points to her inability to refrain from self-harm, thus she experienced a reduced sense of control over her self-harming behaviours perhaps. This could highlight her dependence on self-harming behaviour. This interpretation is further supported by an earlier extract from Uzma where she says “*I at some point became dependent on it*” [Uzma, 343]. Other participants also explicitly referred to the experience of self-harm as an addiction.

*“I would define my self-harming in 2 separate ways. One of them is the way that I mentioned which is almost the addiction side of it. Which is the it’s something like I can’t cope with the stress right now, I can’t cope with this work load I know what’s gonna help me refocus my mind. I’m gonna go I’m gonna self-harm that will refocus me, that will bring me back to its this horrible pseudo feeling of strength and stamina and will power like I’m rebuilding it again like I’m self-harming”*

[Jasvinder, 818-823]

Jasvinder also explicitly discussed self-harm as an addiction, which indicated the need and repetition of self-injurious behaviour. It can be interpreted that self-harm provided a short-term strength for Jasvinder as she states constantly using self-harm to build her strength and consistently needing self-harm to enable her to deal with her difficulties. This perhaps meant

that self-harm was a source of resilience for Jasvinder as the repetition of self-injury enabled her to manage her worries. It can also be assumed that she was constantly thinking about self-harm, which became habitual. Sidrah also discussed her repetition of self-harming behaviour.

*“...during like the part where I did it the most it was pretty much every day or multiple times a day...”*

[Sidrah, 797-798]

*“sometimes I got a bit like I think I don’t know if it’s mania but just you know when your just in that moment and you have to do it multiple times”*

[Sidrah, 740-741]

*“I used a safety pin and I scratched myself with a safety pin like a couple of times and then it sort of goes red and then a little bit of blood comes out and then later it just got a bit deeper and that was it it was like later it got deeper and then also multiple yeah”*

[Sidrah, 330-332]

Sidrah described building tolerance, by gradually increasing the severity of her self-harming behaviour. This build-up of tolerance towards the pain and severity of self-harm, thus requiring further engagement to it, can also indicate an addiction to this behaviour. Sidrah’s use of “*mania*” can be assumed that she experienced phases of high excitement or euphoria perhaps. This could also be viewed as an obsession or an addiction particularly as she described an excessive need to engage in self-harm. This idea of “needing” to engage in self-harm was also explored by Anisa.

*“...when I kept doing it, it just felt like I had to do it.” [Anisa, 787-788]*

*“...so, I start hurting myself and it just got to a place where I couldn’t stop.”*

[Anisa, 328-329]

It sounded as though Anisa thought she had no choice but to self-harm and thus she possibly believed, at the time, that self-harm was the solution to her difficulties. However, she also indicated conflicted feelings of not wanting to engage in self-harm, but she was not able to stop. This could be interpreted as a perceived lack of control over her behaviours, which can

also link to addictive behaviours. This could highlight that she knew self-harm was bad for her and that she should not engage in it but thought this was the only way to release her emotions (i.e., anger).

### **3.6 Superordinate Theme Three: Self-harm is Wrong**

The final theme explores the participant's views of self-harming behaviour as wrong. The three sub-themes that will be discussed are: 'It must be Hidden,' 'What have I done to myself?' and 'Self-harm is Sinful'. This super-ordinate theme highlights the disappointment and remorse experienced after self-harming.

#### **3.6.1 Subordinate Theme One: It must be Hidden**

Self-harm was described as a hidden behaviour that participants said they did not want to disclose to others. They mentioned that the reason they had to keep their self-harming behaviour a secret was due to cultural beliefs and values. This subtheme illustrates how participants kept their self-harming behaviour a secret.

*“it’s a part of my past [...] so to avoid questions and avoid judgment I feel like that probably the best thing to do, to just cover it up...”*

[Zahira, 1051-1053]

*“when its summer and you wanna wear a t-shirt and you can’t, it’s not something that I’m doing because I want to do it, I feel like I have to do it now. Because I don’t want people to see the scars or see what I’ve done. [...] I’m a private person”*

[Zahira, 1053-1055]

Zahira revealed that self-harm determined the clothes she wore, indicating that her past self-harm had impacted aspects of her life in the present. This resulted in her taking precautions to hide her scars, which highlighted that despite her experience of self-harm being in the past, she still needed to think about it and conceal it accordingly. Further, taking precautions to be questioned and judged suggested that she thought people would perceive her negatively due to her self-harm. This could indicate that there is shame and embarrassment linked to this self-injurious behaviour. Furthermore, it could be interpreted that by hiding it, she has maintained

control over her body and her behaviour. Her use of “*it’s a part of my past*” could be indicative of the idea that she does not believe that it defines her despite self-harm being wrong. This idea of concealing self-harm was also seen in other participants.

*“I didn’t want to do it that bad where I’d have to get help and then everybody would find out. [...] but I guess as I got used to it, I realised that I can’t go that deep that I would need help.”*

[Zainab, 728-730]

Zainab's extract suggests that there was a conscious decision-making related to the severity of her self-harm to ensure that no one found out about her self-injurious behaviour. This perhaps highlighted a negotiation between engaging with it enough for it to serve the purpose she intended it to but not too severe that she needed professional help as “*everybody*” would find out. It could be argued that Zainab feared that her engagement in self-harming behaviour would become public knowledge. Perhaps she also pre-empted how difficult it would be to deal with everyone finding out. This interpretation is supported by her earlier quote “*it’s just easier to just pretend things are not happening, and things are not there*” [Zainab, 38]. She further elaborated on the idea of self-harm being a taboo.

*“in our community it’s like a taboo.”*

[Zainab, 29]

This highlighted that there was a shared understanding that self-harm was a prohibited behaviour in society. It can therefore be inferred that self-harm was not accepted or even spoken about openly and thus it was associated with negative connotations and beliefs. Due to the idea of self-harm as a taboo, Zainab perhaps had an implicit understanding that she should not be engaging in self-injurious behaviours, however, she managed this conflict by engaging in it but hiding it from other people. Therefore, by concealing it, she was able to do what she wanted to do without letting people know that she had deviated from her cultural norms. Other participants, such as Sidrah, also shared her experience of self-harm as a hidden behaviour.

*“ten years ago it was a completely different society [...] all of that stuff that didn’t exist so it’s really difficult to I think that’s also why I found it difficult to talk about cause everyone*

*was like why didn't you just talk to someone or why didn't you tell us and there was no conversation for it"*

[Sidrah, 320-325]

Sidrah discussed the understanding of self-harm and mental health, which she believed was dependent on the cultural understanding of that time. This can indicate that the perception of self-harm is dependent on societal values and beliefs at the time and that perceptions of self-harm have changed with societal changes. She alluded to the idea that there was a lack of acceptance and understanding of self-harm during the time she was self-harming and thus this resulted in her finding it difficult to talk about her experiences of self-harm and perhaps even seek help. This perhaps encouraged her to keep her self-harm hidden, which highlights that South-Asian values and beliefs played a role in Sidrah keeping her self-harm hidden. Furthermore, Sidrah may have experienced an internal conflict with others questioning why she did not talk to someone, yet she thought that she was not provided with the space to discuss mental health difficulties at the time. Perhaps this left her feeling confused and somewhat frustrated.

### **3.6.2 Subordinate Theme Two: What have I done to myself?**

This subtheme explores the common feeling of regret after self-harming. Participants confirmed that they realised it was not a behaviour that they should be engaging in as it did not benefit them, yet they still engaged in it. This also highlighted the conflicting response to self-harm, such as aiding in the management of emotions yet regretting it.

*"And then it starts to feel a bit regretful."*

[Zainab, 476-477]

It could be argued that Zainab felt sad, repentant, or even disappointed that she had self-harmed. This idea of regret after self-harming was also expressed by other participants.

*"then I thought why I've done this like it's not worth it like why am I doing this to myself"*

[Zahira, 916-917]

The use of questioning can be interpreted as Zahira having doubts about her decision to self-harm, indicating that she lacked confidence in her decision. It also highlighted that she was evaluating her behaviour after she had engaged in it, which could suggest that she negatively appraised self-harm. Uzma also shared a similar experience.

*“I remember crying and letting it all out and then erm thinking I’m never gonna do this again”*

[Uzma, 55-56]

It can be argued that initially Uzma saw self-harm as a good option to release her emotions but afterwards she appraised it as a bad decision. This appraisal of self-harm could have led to her prohibiting herself from doing it again and attempt to utilise this as a learning experience perhaps. This idea of regret was also expressed by Sidrah.

*“I wouldn’t do it again and I think about it and I’m like what why did I do that that sounds really weird”*

[Sidrah, 287-288]

Sidrah’s use of “weird” to describe her self-harming behaviour could indicate that in retrospect it does not make sense to her as it may not be the norm. It could also be a way of distancing herself away from the behaviour, which could also highlight that self-harm was perhaps not a socially acceptable behaviour in the South-Asian community, as discussed in the previous subtheme. This interpretation can be supported by Zainab’s extract.

*“it’s not regret of actually doing the cutting, it’s regret that it’s going to leave a mark like a scar and you just don’t know when that’s scars gonna go.”*

[Zainab, 484-485]

Zainab’s discussion of her thoughts around remorse that other people may see her self-harm scars can be interpreted as a lack of uncertainty about the long-term impact of self-harm. The repetition of “mark” and “scar” could indicate Zainab’s worry about the permanent reminder of self-harm on her body. Perhaps, she wishes it had not left a scar. Further, it also highlighted

her fears about other people potentially seeing her scars and what the impact of this would be. Other participants, such as Uzma, also elaborated on this shared experience of regret.

*“you look at yourself and you think w-what have I done, like why did I do that and erm yeah and I think that was erm the last time that I did self-harm because like seeing the things I did to myself, I was like I can’t keep doing this like why am I doing this to myself”*

[Uzma, 219-221]

Uzma highlighted the repetition of questioning herself, which can indicate her lack of knowledge about why she had self-harmed. This could also highlight that Uzma experienced self-doubt and uncertainty in her decision to engage in self-mutilation. It could also be argued that there is a lack of confidence in her engagement in self-harm, which could advocate for the idea that she perhaps knew that self-harm was wrong. This could highlight that self-harm was not thoroughly thought about before cutting herself. Further, Uzma talks about the cyclical nature of the regret associated with self-harm.

*“But after a while, it’s the same again. It was just realising obviously that it was stupid, and I shouldn’t be doing stuff like that”*

[Uzma, 105-106]

The repetition of this cycle could mean that self-harm served a purpose and was important for Uzma that she continued despite regretting it and knowing it was not good for her. It also highlighted that self-harm was a behaviour that was being maintained and had a cyclical process of regret and then engagement and then regret again. Aside from cultural values and beliefs, one participant rationalised her regret towards self-harm using her religion.

*“I do regret it because I don’t know what I’m gonna answer when I die”*

[Fateha, 543]

Fateha's extract suggested that feelings of regret were associated with self-harm due to the teachings of her religion. This could indicate that Fateha regretted her self-harming behaviour due to the sense of being held accountable for her actions which are prohibited in her religion



(Islam). There is also a sense of taking responsibility for her actions. The importance of religion in the meaning-making of self-harm is further discussed in the next sub-ordinate theme.

### **3.6.3 Subordinate Theme Three: My Self-harm is Sinful**

As culture and religion often get “*mixed*” [Jasvinder, 100], the values and beliefs of each are frequently intertwined. One common theme that was repeated, and will be explored via this sub-ordinate theme, was the meaning-making of self-harm as sinful via religion.

*“in the Islamic religion you’re not supposed to inflict any harm on your body it’s like a sort of promise that you make with God. Your body’s like a promise and you have to return it in a proper state”*

[Laiba, 58-60]

Laiba perhaps used the term “*proper*” to refer to her body as unharmed, healthy and in the state that God gave it to her. This indicated that self-harming behaviours are against the teachings in her religion and therefore a behaviour she should not engage in. She also discussed that it is a “*promise*” she has made with God, indicative of an unspoken agreement with God. This was repeated twice, which perhaps highlights the importance of religion in the conceptualisation of the values and beliefs in the BIP culture but also self-harming behaviour. This perhaps left Laiba in a state of conflict whereby she needed to cut her body to manage her difficult emotions, yet her religion was advocating for her to look after her body as it does not belong to her. This idea was also echoed by Fateha.

*“Religion comes into it. Like in Islam were meant to look after our body, not hurt it, it’s not ours to have like it came to it after erm self-harm”*

[Fateha, 381-383]

Fateha explained that although religion and culture are two different concepts, religion played a huge role in the values and beliefs in the South-Asian culture. Her understanding that her body belonged to her temporarily can be interpreted as an internal conflict related to self-harm as there was an internal desire to self-harm, however, the teachings of her religion required her to look after her body and not harm it. There were perhaps feelings of guilt or even regret

related to her decision to self-harm when she knows she should not be. These ideas were also explored by Laiba.

*“because a lot of with religion as well comes into it it’s kind of like looked down upon if you do inflict harm on yourself”*

[Laiba, 21-22]

Laiba stated that it is “*looked down upon*,” indicating a level of judgement from others in the community towards those that self-harm. Perhaps, she thought that she would be perceived negatively by anyone that finds out. It could be that there was a level of shame or embarrassment involved if people found out that she had deviated from her religious expectations. This can also be seen in Uzma’s discussion about religion and self-harm.

*“she started talking about religion and how she was like don’t you know its haram to self-harm urm how’s God gonna feel, like something about being punished I can’t remember”*

[Uzma, 557-558]

Uzma’s extract highlighted that there was a strong belief that she should not engage in self-harm due to religious reasons. Her vague narrative on being punished and her lack of recall could be thought of as a way to distance herself from the distressing thought that self-harm is sinful and punishable. Therefore, it can be interpreted that to avoid the distress associated with this thought, she perhaps did not want to think or talk about it. Maybe, this was Uzma’s way of managing the difficulties associated with going against the religious expectations related to self-harm.

### **3.7 Summary**

The analysis in the present study sought to explore the experience of eight UK-based Bangladeshi, Indian and Pakistani (BIP) women who have engaged in self-harming behaviour. Three super-ordinate and 9 sub-ordinate themes emerged from the exploration of their experiences which provided an in-depth understanding of what it was like to self-harm and what the triggers and impacts were for them. More importantly, the analysis focused on the ways in which these women conceptualised their experience. The sub-ordinate themes, among

three super-ordinate themes, generated a rich and detailed perspective of their lived experience and the meanings attributed to this experience.

## **CHAPTER FOUR: DISCUSSION**

### **4.1 Chapter Overview**

The present study aimed to explore the experience of self-harm that inflicts external injuries to the body in UK-based Bangladeshi, Indian and Pakistani women. Three super-ordinate themes emerged: 'Powerless', 'Mitigation' and 'Self-harm is wrong'. This chapter summarises this study's main findings with links to previous research. It will also outline the study's potential implications to the knowledge base and contribution to Counselling Psychology. Further, a methodological appraisal will be included, with suggestions for future research, before ending the chapter with a summary of the research and final conclusions.

### **4.2 Understanding the findings in the context of Self-harm among South-Asian women**

One of the primary aims of interpretative phenomenology is to understand the meaning of experiences through an interpretative process that makes meaning of an individual's relationship to the world (Landridge, 2007). More specifically, this would mean that there is a reflection upon the wider meaning of the data related to the psychological, social, and cultural context (Willig, 2013) that implies the way individuals view their lives. Due to this understanding, the main research findings are explored in the context of self-harming behaviours of BIP women in the UK, as their accounts could be conceptualised as experiences consequential of their social setting to a degree. The meaning given to self-harm was discussed during the interviews. The analyses showed findings that were similar to the existing literature whilst also highlighting novel ideas that were not found by previous research.

One theme that was prominently expressed and similar to existing literature was the 'Entrapment'. The participants explored the idea of gender-based inequalities in the roles and responsibilities of women due to BIP cultural values and beliefs. These inequalities were described to have led to psychological distress and consequently, self-harm was used to manage the distress. Similar ideas were found by Bhardwaj (2001) whereby gender inequalities enforced by parents and the wider society generated distress and were found to be a contributory factor in self-harm. More specifically, the participants in the present study disclosed roles and responsibilities that were assigned to them based on their gender (i.e., cleaning up after others, taking care of the family). These concepts were also discussed by

Bhardwaj (2001) stating that there were rigidly defined matrimonial roles and the duties of women. Additionally, Husain et al. (2006) also found that interpersonal difficulties with family were a contributory factor in self-harming behaviour. Perhaps these societal gender inequalities generated interpersonal difficulties with family members resulting in self-harm. Another aspect that was highlighted in the present study and by Bhardwaj (2001) was the idea of a lack of freedom for UK-based BIP women experienced in comparison to their male counterparts, emphasising the gender inequalities experienced and how these inequalities resulted in self-harming behaviours.

In line with previous literature, participants mentioned that they were unable to be themselves due to the expectations imposed on them by their families and society. One participant described that her parents wanted her to be someone she was not, resulting in psychological distress and particularly self-harm to manage this distress. This was also seen in Gilbert et al's. (2004) study whereby results suggested that UK-based BIP women felt controlled by the cultural values and traditions, and this then impacted their psychological health. This also links with their identity and sense of self, which has been previously discussed by Chew-Graham et al. (2002).

More specifically, in this study, the analysis suggested that cultural pressures on how participants should behave had an impact on their identity formation, whereby they were unable and discouraged from being their true selves due to how others in the community would perceive them and thus self-harm was used to regain control. These ideas related to the challenge of holding two different identities was found by Triandis (1989) where South-Asian women expressed experiencing a conflict between the collectivist culture of their parents and the individualistic western culture. This was found to have generated an internal conflict between how they wanted to behave and how their parents expected them to behave, resulting in psychological distress and self-harming behaviours. This finding was also supported by other studies (Dwyer, 2000; Babikar & Arnold, 1997).

These concepts related to cultural conflict and a struggle for identity development was a recurrent theme in this research. The pressures experienced from their culture and family were

reported to have an impact on their identity formation and limited their sense of self. These ideas also relate to Berry's (1997) Model of Acculturation whereby participants may be in the assimilated identity (individual takes on values, beliefs, and practices from new culture) or perhaps marginalised (individual dismisses ideas from both cultures). However, one aspect that this model did not account for that was highlighted in this research was the desire for participants to take on the values and traditions of the country that they reside in but experiencing pressures from parents to take on more traditional values and beliefs. This could perhaps be explained by Erikson (1968) who suggested that adolescents take on values, beliefs, and morals from their parents, particularly if individuals had parents with traditional values. Thus, this phenomenon may have occurred with the participants in this study too.

Alongside the pressures from the BIP culture, the participants spoke about their triggers of self-harm. In line with existing literature (Al-Sharifi et al., 2015; Bhardwaj, 2001), all the participants in this research described a form of psychological distress that triggered their self-harming behaviour, such as low self-esteem and body image difficulties. These psychological difficulties were described to be intense feelings that they were unable to escape from and thus seemed as though self-harm was the only viable way to manage these difficulties at the time.

Existing literature has linked self-harm to negative emotions such as depression, anxiety and low self-esteem in adolescents and adults in the general population (Fliege et al., 2009). While the present study found that negative thoughts, feelings, and self-loathing tendencies were associated with self-injurious behaviour in UK-based BIP women. Furthermore, previous studies have suggested that women are more likely to internalise their difficulties in comparison to males (Crick & Zahn-Waxler, 2003). However, this study may provide novel insights concerning internalised anger that does not appear to have been investigated in UK-based BIP women specifically. More specifically, internalised anger as a trigger for self-harm in UK-based BIP women does not appear to have been explored in the existing literature. This study suggested internalised anger as a reason for their distress and subsequent self-harming behaviours, which appeared to be linked to ideas surrounding control. More specifically, participants explored feeling angry about their perceived lack of control (i.e., not being able to do what they wanted to do) as well as not being able to eliminate their feelings of anger. The desire to eliminate feelings of anger could be because expressing anger is often not culturally

sanctioned as participants described. Therefore, this resulted in self-harm when they felt they were unable to control their anger. This theme suggested that there is a connection between anger, control, and self-harm in UK-based BIP women.

Furthermore, existing literature has commonly found that deliberate self-harm was linked to a history of sexual and physical abuse in the general population (Low et al., 2000). Further, studies have also shown that sexual and physical abuse is a predictor of self-harm (Gomez, et al, 2015; Yates et al., 2008). It has found links between sexual assault and self-harm in South-Asian women (Low et al., 2000). Additionally, the existing literature has shown that bullying can contribute towards self-harming behaviours in the general population (Heerde & Hemphill, 2018; Eyuboglu et al., 2021). The participants in this study also expressed bullying, toxic home environment and relationship breakdown as triggers of self-harm in BIP women. Therefore, although these triggers were not explored specifically in women of UK-based BIP heritage, this study has emphasised the significance of traumatic experiences and past adversities as a link to self-harm in UK-based BIP women. Therefore, self-harm to manage traumatic events in UK-based BIP women can be viewed as a novel insight from the present study.

One recurrent theme discussed by participants was the use of self-harm as a coping strategy. Firstly, they discussed that self-harm was a way to connect to their psychological pain. This was a common finding in the existing literature also, whereby engaging in self-harm provided UK-based BIP women with an ability to connect to psychological difficulties, resulting in a psychological and physical experience of self-harm. This highlighted the complex and multifaceted experience associated with self-harm. This was also found by Marshall and Yazdani (1999) whereby self-harm was used to manage difficult and painful emotions and focusing on the physical sensations of self-harm provided a sense of relief.

Further, research from the existing literature indicated that self-harm was a response to psychological distress (Chew-Graham et al., 2002; Bhardwaj, 2001; Marshall & Yazdani, 1999). Similarly, the participants in this study also viewed self-harm as a coping strategy to release their difficult to manage emotions. More specifically, they described self-harm to regulate their emotions by releasing them. Parallel to previous research, participants described

the use of self-harm as an escape, distraction, and a release from the overwhelming emotions they experienced (Marshall & Yazdani, 1999).

Previous studies have explored the notion of self-harm as an addiction in the general population (Davis & Lewis, 2019), whereby a clear demonstration of the repetitive nature of self-harm can be seen. However, the present study highlighted this idea in UK-based BIP women. For example, several participants in this study self-defined this behaviour as an addiction while others also described their self-harming experience as repetitive, a behaviour that they had become dependent on and had built up a tolerance to. More specifically, self-harm was described as a behaviour that they had used as a coping mechanism to manage difficult emotions. Further, they described knowing that self-harm was not good for them but could not refrain from engaging in it, highlighting a sense of addiction towards self-harm. Perhaps this links to the idea of control in self-harming behaviours. More specifically, previous literature has highlighted that South-Asian women expressed a lack of control over their lives; therefore, perhaps self-harm had also become a behaviour they could not control.

Although participants reported using self-harm to cope, they also described regret towards their self-harming behaviour. For example, participants expressed shame, guilt, and regret after they had self-harmed. This theme was prominent in the present study, with a focus on participants questioning themselves for their engagement in self-harm. This was also found by Sinha et al. (2013) who found that most participants had strong feelings of regret about their engagement in this behaviour, indicative of the idea that self-harming behaviours can be impulsive. However, there appears to be no studies at present that have found regret associated with self-harm in BIP women specifically. This highlighted that participant's conflicting perceptions (desire to engage in self-harm and then regret) of their self-harming behaviour was more prominent in this study than seen in the qualitative studies from the existing literature.

This regret and questioning of engagement to self-harm could be associated with the conceptualisation of self-harm in the BIP culture and those in the BIP community. For example, the theme related to 'It must be hidden' whereby participants expressed that they did not wish to disclose their self-harm to others, particularly due to the cultural values and beliefs



surrounding self-harm, which encouraged them to keep their self-harm a secret. These ideas can be related to the existing literature whereby Gilbert et al. (2004) discussed shame and izzat (family honour) playing a role in not seeking support for their self-harm as this could endanger the family reputation. Further, the occurrence of this theme in other studies, such as Chew-Graham et al. (2002), highlighted the importance of family reputation in keeping self-harm a secret.

Further, the participants' exploration in the present study revealed that it was difficult to talk about their distress or self-harm, which was also reflected in the findings by Hussain and Cochrane (2002) who argued that the inability to discuss these difficulties led to feelings of isolation which played a role in the causation and maintenance of psychological distress in South-Asian women. Further, despite participants explaining a distaste towards the idea of izzat and family reputation, they still felt the need to comply with these values. Thus, this links in with previous research by Chew-Graham et al. (2002) who found that izzat was internally and outwardly enforced. Therefore, despite not agreeing with these expectations, they perhaps adhered to them due to their family values.

Although existing literature has explored the link between religion and self-harm to an extent (Borrill, et al., 2011), this research provided novel information on the conceptualisation of self-harm via religion. Existing literature has suggested a connection between religious belonging and fewer repeated incidents of self-harm (Borrill, et al., 2011). However, this study revealed that participants used religion to conceptualise self-harm as wrong and sinful. They explored that self-harm was prohibited in their religion (e.g., Islam) and was against the teachings of their religion. This emphasised that religion may have been viewed as a protective factor against self-harm by UK-based BIP women.

The findings from the present study have highlighted how the wider culture that UK-based BIP women are from may impact the meaning of their experiences of self-harm. This emphasises the importance of understanding the individual's broader context and what this means for them. This may be particularly relevant for UK-based BIP women, in understanding the full intricacies of self-harming behaviour.

### **4.3 Implications of the findings for Counselling Psychology**

Moving away from the emphasis on psychopathology, Counselling Psychology focuses on an individual's subjective experience and the meaning given to them (BPS, 2005). This encourages the conceptualisation of individuals as unique beings, highlighting idiography, which can promote empowerment and increase wellbeing (BPS, 2005). Further, the discipline is focused equally on enhancing scientific understanding while also developing practical implications for counselling and therapy (Strawbridge & Woolfe, 2010). Combined, the two areas generate the scientist-practitioner model for the discipline of Counselling Psychology (Strawbridge & Woolfe, 2010). Consequently, there is an emphasis on the application of psychological knowledge from research to be transferred into therapeutic practice. Therefore, there is a need to highlight the findings from the present research to inform clinical practice for UK-based BIP women who self-harm.

#### **4.3.1 Contributions to the Knowledge and evidence base of the Profession**

This research was motivated by the apparent lack of qualitative studies in the existing literature (see literature review) on UK-based BIP women's experience of self-harm. As stated above, the findings appear to have expanded on previous research on self-harm among UK-based BIP women. This research has facilitated a phenomenological approach, favouring meaning and idiography, which may provide a more distinct and up-to-date knowledge for the utilisation in the Counselling Psychology discipline.

#### **4.3.2 Informing Clinical Practice**

The recommendations by NICE (2004) state that practitioners working with individuals who self-harm are given training on how to support these individuals, illustrative of the idea that those who self-harm may require specialist understanding and treatment. This means that the understanding and training of those working with self-harm should be carefully considered. Thus, the present research has aimed to add to existing literature and inform clinical practice.

Based on this research, it appeared that there are cultural nuances that have an impact on UK-based BIP women's psychological wellbeing and subsequently self-harming behaviour. This

research has highlighted the importance of considering these cultural factors when working with UK-based BIP women in a therapeutic context. It appears that although these are sensitive issues, BIP women were able to discuss them in a safe environment (i.e., research setting). Perhaps this means that given that confidentiality is enforced, participants will be able to discuss the cultural elements that may play a role in their psychological distress and self-harming behaviour. This highlighted that when given the opportunity, BIP women are willing to discuss the cultural aspects that impact their identity and psychological wellbeing. Thus, the idea of a safe and secure environment when working with BIP women who self-harm in a clinical setting should be provided to facilitate this exploration when these women engage in therapy. Further, clinicians could openly acknowledge cultural differences and explicitly state their willingness to discuss issues related to culture, ethnicity, and identity to facilitate these conversations if UK-based BIP women would like to.

As mentioned above, this research appears to have provided novel information, such as self-harm as an addiction, regret associated with self-harm, self-harm conceptualised as sinful and anger at self in UK-based BIP women. This knowledge can be added to the literature to expand our knowledge on UK-based BIP women's experience of self-harm. This could enable clinicians to have a better idea of the experience of UK-based BIP women who self-harm and provide further in-depth information on the nuances involved. Further, it could help to tailor the treatment towards this group, for example, offer intervention on the management of internalised anger and discuss how to manage difficulties associated with engaging in "sinful" behaviour. Although each participant would inevitably differ concerning their subjective experience of self-harm, it could provide clinicians with a framework to understand the distress that this specific group experience better. Thus, perhaps this study can offer information for the understanding of how UK-based BIP women may deal with distress. However, it is important to note that these are findings based on a sample of eight participants and tentative and therefore will not apply to all UK-based BIP women who self-harm, thus each client's subjective experience will need to be considered.

Further, many UK-based BIP women reported not being able to seek support when they had self-harmed, particularly due to the lack of awareness and stigma related to mental health in the community. Perhaps there could be more services available that enable BIP women to

access support more discretely such as via internet-based support systems. For example, some participants mentioned that when they went out, they would be worried about being perceived negatively by the community, and they were required by their parents to be ‘on their best behaviour’ by adhering to cultural norms and expectations. Perhaps offering more internet-based support (such as online sessions) would increase access to psychological support as they would not physically need to go to the location to receive the support. This may help reduce the fear of judgement and thus encourage access to psychological support for self-harm.

Furthermore, there is an urgent need for the stigma related to mental health difficulties to be addressed in the BIP community, as the stigma reduces the likelihood for UK-based BIP women seeking support for mental health difficulties. This research has suggested that culture and religion can get intertwined, therefore, perhaps mental health services can collaborate with places of worship (e.g., Mosque, Temple, Gurdwara) to support this group of women. Although this is currently being offered, perhaps further collaboration can be encouraged between mental health services and the community to raise further awareness of mental health and normalise these difficulties. It can also be used to encourage UK-based BIP women to seek support if they are engaging in self-harm. This increase in awareness may help reduce the stigma associated with mental health and encourage UK-based BIP women to seek psychological support. If psychological distress is normalised via awareness, then it could help tackle the issues related to izzat and family reputation that is otherwise emphasised in the BIP community. Further, this collaboration may not be available UK-wide, therefore, it is important to widen the access to availability to different areas in the UK.

#### **4.4 Limitations and suggestions for Future Research**

In the literature review, it was discussed how the term ‘South-Asian’ does not distinguish between the differences that exist in the South-Asian communities therefore, this study narrowed the category down to the three largest South-Asian groups resident in the UK: UK-based Bangladeshi, Indian and Pakistani (BIP) women. Although some may argue that the sample is not homogenous, this research argues that there are many similarities in the three groups to form a homogenous sample for the analysis of IPA. As outlined in the literature review the three groups were all one country before the partition of India in 1947, share colonial history (Butalia, 2014) and share cultural values and beliefs related to gender roles, marriage,

religion, and education. For example, the values related to marriage are similar with higher marriage rates usually at an early age and gender role expectations where the women typically bear children and males provide for the family (Dale & Ahmed, 2011). Furthermore, previous research has found that the appraisal of mental health is similar in these groups as they are more likely to somatise their psychological distress (Hussain & Cochrane, 2004). Additionally, research has suggested that these groups respond to mental health difficulties in a similar way such as somatising experiences, normalising symptoms, relating it to life events and conceptualising their distress via religion (Anand & Cochrane, 2005). Lastly, the coping strategies used by UK-based BIP women were found to be similar, whereby they used religion, prayer, talking and self-harm to cope with their distress (Hussain & Cochrane, 2003). Consequently, the present research argues that UK-based Indian, Pakistani, and Bangladeshi women are similar and thus can generate a homogenous sample.

If the sample was reduced to one group alone (i.e., UK-based Bangladeshi, Indian or Pakistani), this may mean that recruitment would be far too restrictive, and it may not have been possible to conduct this study within the time limit available. This is because the stigma attached to mental health in the BIP community may have prevented BIP women from volunteering for the study and resulted in difficulty during the recruitment stage. Therefore, thinking about one group alone would have resulted in recruitment being more difficult than it already was. Thus, using UK-based Indian Pakistani and Bangladeshi participants widens the pool of participants available for this study.

Perhaps as time goes on and the stigma towards mental health reduces, future research could carry out a study on the experience of self-harm in these groups individually. This is based on the understanding that the current stigma towards mental health reduces the likelihood of UK-based BIP women seeking support for self-harm (Chew-Graham et al., 2002) and thus they would be less likely to engage in psychological research too. Based on this understanding, if there is a reduction in stigma related to UK-based BIP women, then perhaps UK-based BIP women would be more likely to seek support and volunteer to participate in research to discuss their experience of psychological distress. Future research could also distinguish between the different religions in the cultures and look at a specific religion (for example, Muslim UK-based BIP women) as religion was deemed to be an important aspect in these women's lives.

Further, it may also be important to consider the implications of the data being influenced by the ethnicity of the researcher and how the participant perceived this. In essence, some participants may have found it easier to explore their experiences with a UK-based BIP researcher while other participants may have found this difficult. This could impact the information shared and some participants' exploration and therefore is an aspect to be aware of. For example, some participants may not have shared criticisms or differences in views of the BIP culture in the fear of how the researcher would have perceived this. Perhaps future studies could think about this factor and ask such questions during the screening calls and match researcher and participants preferred ethnicity to promote the richness of the data retrieved. It is also possible that the ethnicity of the researcher could have impacted the interpretations made during the analysis due to the shared experience and exposure to BIP cultural values and beliefs; however, as discussed in the methodology chapter the researcher remained reflexive and aware of these issues so that these biases were reduced.

Furthermore, due to the use of the inclusion and exclusion criteria, the sample in the present study represented a sub-sample of the group under investigation. For example, although there were inclusion and exclusion criteria, there will be some individuals who met the criteria but did not wish to volunteer for the study. Therefore, the study does not encompass the whole UK-based BIP group. Additionally, this data is not generalisable to all UK-based BIP women who have self-harmed due to the sample size. However, it is important to remember that the aim of qualitative research is 'theoretical transferability'. The understanding is that the analyses made from the data gathered are context-dependent, detailed data that enable others to assess the ability to transfer the analyses made to individuals in similar situations (Smith et al., 2009). Thus, readers are required to consider the individual differences that will be present when applying the findings from this study to other UK-based BIP women who self-harm. Additionally, the sample size of the present study is adequate as 4-10 participants are recommended for the qualitative analyses of IPA (Smith et al., 2012).

As this research included semi-structured interviews, there is a high level of involvement of the researcher in the data that is retrieved. Therefore, careful consideration was taken during the development of the interview schedule to ensure that ideas were not being imposed on the

participants. The researcher ensured that the interview schedule included open-ended questions and was not leading towards a specific idea or experience. This rule was also implemented for follow up questions based on the participant's answers. This allowed the participant to respond to the question in any direction they had wished. The researcher also found that some participants required more prompting than others, to retrieve rich data.

To ensure that themes from one participant were not biasing the themes analysed in the next participant, different techniques were used. The ideographic nature of IPA, one technique that was used was analysing one participant at a time and creating a table of themes for that participant before moving on to the next. Further, the researcher took short breaks before moving on to the next participant. This facilitated emergence of different themes to develop without one theme from one participant biasing the other and preserved the idiosyncrasy of each participant and reduced biases during the analysis stage.

Given the lack of research on self-harm among UK-based BIP women, there is a need for future research on this area to better understand the phenomenon of self-harming behaviours that inflict external injuries to the body in UK-based BIP women. As mentioned above, future research could focus on each UK-based BIP group separately to ensure a more homogeneous sample. Further, the present research highlighted the role religion played in the conceptualisation of participants experiences and therefore, perhaps future studies could explore the experience of self-harm by UK-based BIP women of a specific religious background. This would provide a better understanding of this experience that cannot be understood by the existing literature. Furthermore, the present research highlighted the importance of traumatic experiences on self-harming behaviour. Thus, future research could carry out a study on the experience of external traumatic events such as sexual assault, physical or psychological abuse on self-harm in UK-based BIP women.

The secretive nature of self-harm was a recurrent topic as found in this research. Therefore, perhaps future research could explore the views of friends and family members of UK-based BIP women who self-harm, to raise awareness and increase our understanding of how to support these women within the BIP community. In doing so, this would allow for

'triangulation' a concept where information from different sources can be used to provide a more in-depth understanding (Heale & Forbes, 2013).

#### **4.5 Summary and Conclusion**

In this research, the experiences and the meaning given to self-harming behaviour that inflicted external injuries to the body by UK-based BIP women were explored. A total of eight participants were recruited and interviewed. These interviews were analysed via interpretative phenomenological analysis (IPA). The analysis revealed three super-ordinate themes and nine sub-ordinate themes: 'Powerless' ('Entrapment', 'Internalised Negativity' & 'Abused by my Environment'), 'Mitigation' (Releasing my Overwhelming Emotions', 'Connecting to my Pain' & 'Addicted to Self-harm') and 'Self-harm is Wrong' ('It must be Hidden', 'What have I done to myself' & 'My Self-harm is Sinful').

These themes from this study offered different meanings of self-harm, some of which were similar to those described in the existing literature (Bhardwaj, 2001; Husain et al., 2006; Chew-Graham et al., 2002; Al-Sharifi et al., 2015). However, there appears to be novel information that had emerged from this study such as self-harm conceptualised as an addiction, regret associated with self-harm, and self-harm as sinful. This information can perhaps add novel knowledge to the literature of the experience of UK-based BIP women who self-harm and may help inform clinical interventions when working with this group.

There are also strengths and limitations to the present study. The limitations could be the grouping of three large ethnic groups, which could be argued as reduced homogeneity of the sample. Further, the ethnicity of the researcher could have had an impact on the information that the participants were willing to share. Some may argue that the sample size is not large enough for the data to be generalisable however qualitative research is focused on 'theoretical transferability'. On the other hand, the strengths of the study include the rich and detailed data derived from semi-structured interviews to inform our understanding of this phenomenon. This information then potentially enables the application to clinical practice when working with UK-based BIP women who self-harm. Another strength included the use of reflexivity to ensure



that the researchers own feelings, assumptions and motivations do not impact the research process and analysis.

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## Appendices

### **Appendix A: Pre-Screening Questionnaire**

#### **Pre-Screening Questionnaire:**

**Working title of research:** The Experience of Self-harming Behaviour that inflicts external injuries to the body in Bangladeshi, Indian and Pakistani Females: An Interpretative Phenomenological Analysis.

This form is gather information about you (e.g. age, gender, ethnicity, etc.) to assess the suitability. The reason for gathering this information is to show the readers of my thesis that I have gathered the views of the relevant participants. This information will be kept confidential and will not be used to identify you.

1. What is your gender?

Male

Female

Other

2. How old are you?

..... Years old

3. How would you describe your ethnicity?

Bangladeshi

Indian

Pakistani

Other. If other please specify here

.....

4. Have you self-harmed in the past?

Yes

No

5. Which behaviour did you engage in? How long ago was this? Please provide details about what you did.

.....  
.....  
.....

6. When was the last time you self-harmed?

.....  
.....  
.....

7. Are you currently self-harming?

.....  
.....  
.....

8. Are you currently being clinical treated for self-harm?

.....  
.....  
.....

9. In the past two weeks, have you felt that things were so bad that it was not worth carrying on?

.....  
.....  
.....

10. Do you have any clinical diagnoses?

.....  
.....  
.....

# **PARTICIPANTS NEEDED!**

**Are you a British Bangladeshi,  
Indian or Pakistani female who  
has self-harmed in the past?**

Would you be interested in talking to  
me about your experiences?

I am carrying out a research on the  
meaning given to self-harming  
behaviour by South Asian women.

For further details or to participate,  
please contact me on

Thank you!

## Appendix C: Information Sheet

### Information Sheet:

**Working title of research:** The Experience of Self-harming Behaviour that inflicts external injuries to the body in Bangladeshi, Indian and Pakistani Females: An Interpretative Phenomenological Analysis.

The purpose of this information sheet is to inform you about the reason for this study so that you can decide whether or not you would like to participate. If you are unclear about anything or you would like further information on something, please contact me on the details at the bottom of this sheet.

Many thanks,

Sharmin Aktar

Counselling Psychologist trainee

School of Psychology

University of East London

Water Lane

Stratford, London

E15 4LZ

The research is carried out under the direction of University of East London. It is supervised by Dr Stelios Gkouskos.



**What is the purpose of the study?**

I am looking for Bangladeshi, Indian or Pakistani women who have previously engaged in self-harming behaviours that inflict external injuries to the body. I hope to carry out an interview to discuss the meaning of the experiences.

**What does the interview involve?**

The interview involves me asking you several questions to promote a discussion about your experience of self-harm. Our conversation will be informal and you can tell me as much or as little as you want. The interview itself lasts between an hour to an hour and half but we can stop for breaks if you would like to. You are free to stop the interview at any point and do not need to give a reason.

**Who will carry out the interview?**

I am a Bangladeshi woman and I am studying Counselling Psychology at University of East London to be a Counselling Psychologist. When qualifying, I hope to work with the South Asian community and I am interested in the experiences of these women who have self-harmed.

**What are the benefits of taking part?**

The benefit of participating in this study is related to improving the knowledge of Counselling Psychologists and other health professionals on the experiences of self-harm on Bangladeshi, Indian and Pakistani women.

**What are the risks of taking part?**

I understand that this is a sensitive topic to discuss and I will provide you with details of support organisations at the end of our discussion if you require further support.

**Will my response be confidential?**

Yes, all information you share will be strictly confidential. I will audio record our conversation to help me remember what you have said. Our discussion will remain strictly confidential and we will keep this in a locked cabinet with no reference to your personal details. Any information that could identify you as an individual will be removed. The tapes and original documents will be destroyed once the report is complete.

**Can I withdraw from the study?**

Yes, you can withdraw at any point during the study. Your data will be destroyed and will not be included in my research.

You can also withdraw up until 4 weeks after the interview.

How long is data kept?

The names and contact details of the participants will be kept in a secure computer in a folder that is password protected. This will ensure that only I have access to these details.

The real names and identifying references will be changed to a pseudonym in the thesis and transcript to ensure that it does not lead to identification and ensures confidentiality.

The data will be kept for two years after the study in case I wanted to publish the study at a later date. The data will be kept on a secure computer in a folder that is password protected.

Regardless of keeping the data, the names and contact details of participants will be destroyed.

### **Do I have to take part?**

Not at all. It is up to you whether or not you would like to participate.

### **I am interested, what do I do now?**

If after reading this information sheet you feel that you would like to ask a question, clarify something or you would like to participate, please email me on

If you do not wish to participate, you do not need to contact me to say you are not interested.

### **What will happen next if I take part?**

Once you have contacted me:

1. I will call you to answer any questions that you may have and discuss a suitable time and place for us to meet
2. I will send you a form for you to sign saying that you agree to participate which you bring with you when we meet.
3. We will meet at the agreed date, location and time. I will audio record our conversation to help me remember what you have said. Our discussion will remain strictly confidential and we will keep this in a locked cabinet with no reference to your personal details. Once the report is complete, the tapes and original documents will be destroyed.

### **Further details**

If you have any concerns about the way that this research is/was carried out, you are free to share this with The Chair of Ethics Committee, School of Psychology, University of East London, Water Lane, Stratford, E15 4LZ.

**Thank you for taking your time to read this. Please feel free to keep this information sheet for your records.**

## Appendix D: Consent Form

### Consent form:

**Working title of research:** The Experience of Self-harming Behaviour that inflicts external injuries to the body in Bangladeshi, Indian and Pakistani Females: An Interpretative Phenomenological Analysis.

Statement	Please tick if you agree
I have read the information sheet for this study.	
I have had the chance to ask questions and discuss the study and am happy with the responses to my questions, therefore, I have enough information about this study.	
I understand that my participation is voluntary, and I can withdraw at any point during the interview without providing a reason.  I understand that I can withdraw up till 4 weeks after the interview has taken place.	
I agree to audio-recording this interview.	
I understand that quotes from what I have said may be used as part of the research thesis, but my personal details will be removed so that there is no possibility of personal identification.	
I understand that all material will be kept confidential unless I am at harm to myself or others.	
I agree to take part in this study.	

Participant Name:.....

Participant Signature:.....

Date:.....

Researcher name: .....

Researcher signature: .....

Date: .....

**Thank you for your time!**

## **Appendix E: Interview Schedule**

### **Interview Schedule:**

Research Question: What is the experience of self-harming behaviour that inflicts external injuries to the body in Bangladeshi, Indian and Pakistani females?

1. Can you tell me what made you decide to take part in my research?
2. As you know, I am interested in understanding the experience of Bangladeshi, Indian and Pakistani females. How would you describe your ethnicity?
3. Can you tell me about when you first started self-harming?
4. From your understanding, why do you think you started self-harming?
5. Has your ethnic origin in any way shaped/contributed to your self-harming behaviour/experience? If so, how?
6. Think about a time you self-harmed, can you tell me how you felt before, during and after you self-harmed?
7. What kind of thoughts went through your mind when self-harming?
8. What was the physical experience when you were self-harming?
9. Can you tell me about the frequency, method, and severity of your self-harm?
10. In the context of external injuries to your body, how would you describe your relationship with your body now?
11. Have you spoken about your experiences with anyone else in the past?
12. How does your history of self-harm impact you now?
13. As I am someone from a similar background to you, how did you feel about speaking to me?
14. Is there anything else you would like to add that we haven't already discussed?

## Appendix F: Ethics Form

### School of Psychology Research Ethics Committee

#### NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

**REVIEWER:** Ian Wells

**SUPERVISOR:** Stelios Gkouskos

**STUDENT:** Sharmin Aktar

**Course:** Professional Doctorate in Counselling Psychology

**Title of proposed study:** The experience of self-harming behaviour that inflicts external injuries to the body in British Bangladeshi, Indian and Pakistani females: An Interpretative Phenomenological Analysis

#### DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.
2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

**DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY**

*(Please indicate the decision according to one of the 3 options above)*

**APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

**Minor amendments required** *(for reviewer):*

Supervisor to confirm the following :

- 1) That it is acceptable to limit the right of withdraw to a four week period
- 2) The organisations suggested for support for participants are appropriate to the materials being discussed

**Major amendments required** *(for reviewer):*

**Confirmation of making the above minor amendments** *(for students):*

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):* Sharmin Aktar

Student number:

Date: 28.09.2019

*(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)*

**ASSESSMENT OF RISK TO RESEACHER** *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐

HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐

MEDIUM (Please approve but with appropriate recommendations)

☒

LOW

Reviewer comments in relation to researcher risk (if any).

**Reviewer** (*Typed name to act as signature*): Ian Wells

**Date:** 23/8/19

*This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee*



**RESEARCHER PLEASE NOTE:**

For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard

## Appendix G: Ethics Amendment Form – Online interviews

### UNIVERSITY OF EAST LONDON

#### School of Psychology

#### REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

**Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.**

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Tim Lomas (Chair of the School Research Ethics Committee. [t.lomas@uel.ac.uk](mailto:t.lomas@uel.ac.uk)).

#### HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. When submitting this request form, ensure that all necessary documents are attached (see below).
4. Using your UEL email address, email the completed request form along with associated documents to: Dr Tim Lomas at [t.lomas@uel.ac.uk](mailto:t.lomas@uel.ac.uk)
5. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
6. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.
- 7.

#### REQUIRED DOCUMENTS

1. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
2. Copies of updated documents that may relate to your proposed amendment(s). For example, an updated recruitment notice, updated participant information letter, updated consent form etc.
3. A copy of the approval of your initial ethics application.

**Name of applicant: Sharmin Aktar**

**Programme of study: Professional Doctorate of Counselling Psychology**

**Title of research: the experience of self-harming behaviour that inflicts external injuries to the body in Bangladeshi, Indian and Pakistani females: An Interpretative Phenomenological Analysis.**

**Name of supervisor: Dr Stelios Gkouskos**

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
<p>In the original ethics application, the researcher wanted to meet all participants face to face for the interview.</p> <p>However, the researcher is now proposing ethical amendments to carry out interviews online via a secure video platform called Microsoft Teams.</p>	<p>The reason for this amendment is due to reaching participants from outside London, who may not be able to travel to London for the interview. As long as participants meet the inclusion criteria the geographical location should not be a barrier to the participation.</p> <p>Although, participants may be living in another part of the UK (e.g. Leicester), they would all be required to meet the inclusion criteria thus sharing a similar experience in order to explore the same phenomena.</p> <p>An online interview may also ease the anxieties of the process for participation process as they will be in an environment where they are comfortable and trust. It will also be easier for them to withdraw or end the interview if they feel uncomfortable.</p> <p>As it will be a video interview, I will be able to pick up on verbal and non-verbal cues, which would not be a detriment to face-to-face interviews.</p> <p>Risk issues will be followed as described in my original ethics application.</p>

Please tick	YES	NO
-------------	-----	----

Is your supervisor aware of your proposed amendment(s) and agree to them?	x	
---	---	--

Student's signature (please type your name): Sharmin Aktar

Date: 20.02.2020

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	Yes	
Comments		

Reviewer: Tim Lomas

Date: 20.2.20

## Appendix H: Ethics Amendment Form - Title



# University of East London

## Psychology

### REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

#### FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed title change to an ethics application that has been approved by the School of Psychology.

By applying for a change of title request you confirm that in doing so the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed then you are required to complete an Ethics Amendments Form.

#### HOW TO COMPLETE & SUBMIT THE REQUEST

Complete the request form electronically and accurately.

Type your name in the 'student's signature' section (page 2).

Using your UEL email address, email the completed request form along with associated documents to: [Psychology.Ethics@uel.ac.uk](mailto:Psychology.Ethics@uel.ac.uk)

Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

#### REQUIRED DOCUMENTS

A copy of the approval of your initial ethics application.

Name of applicant: Sharmin Aktar

Programme of study: Professional Doctorate in Counselling Psychology

Name of supervisor: Dr Stelios Gkouskos

Briefly outline the nature of your proposed title change in the boxes below

Proposed amendment	Rationale
<b>Old Title:</b>  The Experience of Self-harming behaviour that inflicts external injuries to the body in British Bangladeshi, Indian and Pakistani females: An Interpretative Phenomenological Analysis	I have taken out 'British' from my title as my participants did not necessarily need to identify as British.  As participants did not need to identify as 'British Bangladeshi, etc', they were able to identify as 'Bangladeshi' only.  As long as they were living in the UK, the identification of 'British' was not a relevant criterion to my study.
<b>New Title:</b>  The Experience of Self-harming behaviour that inflicts external injuries to the body in Bangladeshi, Indian and Pakistani females: An Interpretative Phenomenological Analysis	

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	YES	
Does your change of title impact the process of how you collected your data/conducted your research?		NO

Student's signature (please type your name): Sharmin Aktar

Date: 31/05/2021

<b>TO BE COMPLETED BY REVIEWER</b>		

**APPROVED**

Reviewer: Glen Rooney

Date: 17/06/2021

## **Appendix I: Ethics Amendment Form – Title to include “UK-based”**



REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

**Please complete this form if you are requesting approval for proposed title change to an ethics application that has been approved by the School of Psychology.**

By applying for a change of title request you confirm that in doing so the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed then you are required to complete an Ethics Amendments Form.

### **HOW TO COMPLETE & SUBMIT THE REQUEST**

1. Complete the request form electronically and accurately.
2. Type your name in the ‘student’s signature’ section (page 2).
3. Using your UEL email address, email the completed request form along with associated documents to: [Psychology.Ethics@uel.ac.uk](mailto:Psychology.Ethics@uel.ac.uk)
4. Your request form will be returned to you via your UEL email address with reviewer’s response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.

### **REQUIRED DOCUMENTS**

1. A copy of the approval of your initial ethics application.

**Name of applicant: Sharmin Aktar**

**Programme of study: Professional Doctorate in Counselling Psychology**

**Name of supervisor: Professor Rachel Tribe**



Briefly outline the nature of your proposed title change in the boxes below

Proposed amendment	Rationale
<b>Old Title:</b>  The Experience of Self-harming behaviour that inflicts external injuries to the body in Bangladeshi, Indian and Pakistani females: An Interpretative Phenomenological Analysis	<ul style="list-style-type: none"> <li>- I have added 'UK-based' to the title to better represent the sample under investigation as the inclusion criteria for the study required the participants to be based in the UK.</li> <li>- Adding UK-based to the title provides better clarity of the study for readers.</li> <li>- Adding UK-based to the title was a recommended amendment post viva.</li> </ul>
<b>New Title:</b>  The Experience of Self-harming behaviour that inflicts external injuries to the body in UK-based Bangladeshi, Indian and Pakistani females: An Interpretative Phenomenological Analysis	

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	YES	
Does your change of title impact the process of how you collected your data/conducted your research?		NO

Student's signature (please type your name): Sharmin Aktar

Date: 02.10.2021

<b>TO BE COMPLETED BY REVIEWER</b>		

APPROVED

Reviewer: Glen Rooney

Date: 01/11/2021

## **Debrief Sheet:**

**Working title of research:** The Experience of Self-harming Behaviour that inflicts external injuries to the body in Bangladeshi, Indian and Pakistani Females: An Interpretative Phenomenological Analysis.

Thank you for your participation in my research on the experiences of South Asian (Bangladeshi, Indian and Pakistani) females experience of self-harming behaviours that cause external injuries to the body. The purpose of this study is to find out the meaning of the experiences of South Asian women who have self-harmed in the past. This will also create awareness for Counselling Psychologists as well as other health professionals. If there are any concerns or questions regarding your participation in this research, then please do not hesitate to get in touch with myself or my supervisor using the contact details below.

### **Researcher**

Sharmin Aktar  
University of East London  
School of Psychology  
Water Lane  
Stratford London  
E15 4LZ

### **Supervisor**

Dr Stelios Gkouskos  
1.24 Arthur Edwards Building  
University of East London  
School of Psychology  
Water Lane  
Stratford London  
E15 4LZ  
Contact number: +44 (0)20 8223 4993  
Email: [s.gkouskos@uel.ac.uk](mailto:s.gkouskos@uel.ac.uk)

**Thank you for your time**

## Appendix K: Further Support

### **Further support:**

Below are contact details for organisations you can contact should you need further support.

Service	Contact details
<b>Samaritans Helpline</b>	Contact number: 08457909090 Email: <a href="mailto:jo@samaritians.org">jo@samaritians.org</a> Nearest Branch: Leyton, 663 Lea Bridge Road, Leyton, E10 6AL
<b>Mind</b>	Contact number: 020 8519 2122 Email: <a href="mailto:supporterrelations@mind.org.uk">supporterrelations@mind.org.uk</a> Location: 15-19 Broadway, Stratford, London E15 4BQ
<b>East London Asian Family Counselling</b>	Contact number: 02077395058 Email: <a href="mailto:afcs@btconnect.com">afcs@btconnect.com</a> Location: Oxford House Bethnal Green, Derbyshire St, London E2 6HG
<b>Nafsiyat</b>	Contact number: 02072636947 & 07436532872 Email: <a href="mailto:admin@nafsiyat.org.uk">admin@nafsiyat.org.uk</a> Location: Nafsiyat Intercultural Therapy Centre, Unit 4 Lysander Mews, Lysander Grove, London N19 3QP
<b>Forest Therapeutic Counselling Agency</b>	Contact number: 02085024674 Location: Horn Cottage, Holcombe Hill, London NW7 4ES
<b>Relate (London, Hackney)</b>	Contact number: 01708 441722 Email: <a href="mailto:enquiries@relatelnene.org.uk">enquiries@relatelnene.org.uk</a> Location: London Hackney (Picture House) Relate, Community Rooms, Hackney Picture House, 270 Mare Street, London, E8 1HE

**Thank you for your participation!**

## Appendix L: Example of transcript analysed – Participant 4

<p><u>Descriptive:</u> really difficult to manage expectations          Couldn't talk to parents about difficulties</p> <p><u>Linguistic:</u> you don't (laughs) talk to your parents"          → it's a norm that she didn't speak to her parents about her difficulties</p> <p><u>Conceptual:</u>          Difficult to manage school and family expectations          Unable to speak to parents about difficulties          'caged in' → trapped/restricted/no freedom</p>	<p>P: <b>It was really difficult</b>, and I think it was like another cultural thing. I didn't think I can talk to my parents about most things like <b>I couldn't talk to my parents about school or my friends or homework</b> or anything just <b>because you don't (laughs) you don't talk to your parents about that</b> like you talk to your parents about like I don't know what are we going to have for dinner or what's happening on the weekend. Erm so I don't know that's that's kind of why I didn't like being at home as well <b>cause I didn't have anyone to talk to</b> I just felt like <b>I was very much like caged in</b> and yeah</p>	<p><b>Difficult to manage school and family expectations</b></p> <p><b>Unable to speak to parents about difficulties</b></p> <p><b>'caged in' – lack of freedom</b></p>
<p><u>Descriptive:</u> wasn't allowed to use public transport on her own  <u>Linguistic:</u> laugh as a way of managing being trapped  <u>Conceptual:</u>          More restriction for eldest female          Lack of freedom for eldest female          Self-comparison to others her age</p>	<p>I: caged in?          P: yeah like <b>I couldn't leave (laughs)</b> so I think at the time as well <b>I wasn't allowed to get public transport on my own</b> like 14 which I don't know, I know 14 year olds that take train and the bus all the time so it's like yeah cause <b>I'm the oldest it's like a lot more restrictions on me so literally couldn't leave</b></p>	<p><b>More restrictions for eldest female</b></p> <p><b>Self-comparison to others her age</b></p>
<p><u>Descriptive:</u>          Gender based restrictions – gender inequality          First child who had grown up in the UK – first to go through life here – so there were more restrictions  <u>Linguistic:</u>  <u>Conceptual:</u>          Teenagers aren't trustworthy so not allowed freedom</p>	<p>I: why do you think there's this restriction on you cause you're the eldest          P: <b>because I'm a girl</b>, because they haven't seen anyone else so I think because second I think generation, basically my grandparents came and then my dad grew up in Pakistan. So, he was born here, and he grew up in Pakistan and came back so he hasn't grown up in the UK. And so, <b>1</b>. Erm yeah.</p>	<p><b>Gender inequality</b></p> <p><b>Lack of trust from family</b></p>

## Appendix M: Participant 8 Table of Major themes

Major theme	Emergent Themes
Self-harm as a coping strategy	<ul style="list-style-type: none"> <li>• Self-harm to resolve difficulties</li> <li>• Self-harm as a release</li> <li>• Self-harm as an expression of thoughts and feelings</li> </ul>
Triggers of self-harm	<ul style="list-style-type: none"> <li>• Mental health difficulties linked to self-harm</li> <li>• Self-worth linked to self-harm</li> <li>• Bullying as a trigger for self-harm</li> </ul>
Cultural conflict	<ul style="list-style-type: none"> <li>• Internal conflict about ethnic identity</li> <li>• Pressure from South-Asian culture</li> <li>• Gender inequality</li> <li>• South-Asian culture as suppressive</li> </ul>
Overcoming Self-harm	<ul style="list-style-type: none"> <li>• Support system</li> <li>• Medical and psychological interventions required</li> <li>• Access to mental health as a barrier</li> <li>• Lack of South-Asian therapists</li> </ul>
Characteristics of self-harm	<ul style="list-style-type: none"> <li>• Self-harm as sporadic</li> <li>• Self-harm as painful</li> <li>• Self-harm as addictive</li> <li>• Self-harm as hidden</li> </ul>
Self-harm is not understood	<ul style="list-style-type: none"> <li>• Understanding of self-harm varies across generations</li> <li>• Fear of self-harm being misunderstood</li> </ul>
Explanations of self-harm	<ul style="list-style-type: none"> <li>• Self-harm as innate</li> <li>• Self-harm as deserving pain</li> </ul>
Lack of awareness	<ul style="list-style-type: none"> <li>• Lack of recollection of self-harm</li> <li>• No knowledge of why self-harm was used</li> </ul>

## Appendix N: Clustered themes with extracts

<p><b>Self-harm as a way of coping with difficulties:</b></p> <ul style="list-style-type: none"> <li>• Self-harm to cope with difficulties</li> <li>• Self-harm as a way of coping with distress</li> <li>• Self-harm as a coping strategy in life</li> <li>• Self-harm to cope with stress and feeling overwhelmed</li> <li>• Self-harm reduced pressure</li> </ul>	<ul style="list-style-type: none"> <li>- I can't remember what but something must've been like oh is <b>this the way that people cope</b> and <b>some people did it</b> and <b>I was like okay this is what you do this is how you get through things....</b></li> <li>- ...I think what happened was like <b>I felt a lot of relief and a lot of pressure go away and I felt like this is something that I can do again.</b></li> <li>- <b>I do remember at one point, I did think it would never stop doing it, I would- I was just like envisioned myself as an adult like who's gonna you know who's gonna be with someone who's got scared arms and stuff like that...</b></li> <li>- <b>the stress and everything bubbling up</b> and just knowing that <b>if I cut it will make me feel better.</b></li> <li>- ...So I think what happened was like <b>I felt a lot of relief and a lot of pressure go away and I felt like this is something that I can do again</b></li> </ul>	<p>Participant 4</p> <p>Page 11</p> <p>Page 19</p> <p>Page 26</p> <p>Page 28</p> <p>Page 19</p>
<ul style="list-style-type: none"> <li>• <b>Self-harm as a crutch</b></li> </ul>	<ul style="list-style-type: none"> <li>- at the time and in the moment it was definitely <b>something like a crutch almost to help me feel better yeah</b></li> </ul>	<p>Participant 4</p> <p>Page 11</p>
<p><b>Regret after self-harm:</b></p> <ul style="list-style-type: none"> <li>• Regret after self-harm</li> <li>• Questions why she self-harmed</li> </ul>	<ul style="list-style-type: none"> <li>- ... <b>I wouldn't do it again</b> and I think about it and I'm like what why did I do that that sounds really weird...</li> <li>- <b>Why did I do that...</b></li> </ul>	<p>Participant 4</p> <p>Page 11</p> <p>Page 34</p>
<p><b>Self-harm as a hidden behaviour:</b></p> <ul style="list-style-type: none"> <li>• Self-harm as a secret/hidden behaviour</li> <li>• Self-harm as hidden so others don't judge</li> <li>• Self-harm as a secret behaviour</li> </ul>	<ul style="list-style-type: none"> <li>- ...my <b>arms</b> and my little bit one my <b>chest</b> just cause no one like saw those areas yeah</li> <li>- ... like ten years ago oh my god she's walking down the street with boys even if she's friends with them, <b>oh my god she's got friends who are boys</b> that like <b>everyone's like zoomed in on you.</b> You can't do certain things so if it's like <b>simple things like walking down the street with a guy friend from uni that's bad.</b> Imagine how bad like a self-harm scar would look.</li> </ul>	<p>Participant 4</p> <p>Page 16</p> <p>Page 16</p> <p>Page 20</p> <p>Page 16</p> <p>Page 20</p> <p>Page 21</p>

<ul style="list-style-type: none"> <li>• She felt she had to hide her self-harm</li> <li>• Self-harm is not talked about</li> <li>• Added pressure of not being able to speak about self-harm</li> </ul>	<ul style="list-style-type: none"> <li>- I think it has but I think it has in the sense but that it has to be a lot more secretive than normal like I couldn't like I mentioned I couldn't talk to my parents about it like I literally couldn't talk to anyone about it.</li> <li>- ...there's an element of me being brown and wearing hijab at the time where I didn't feel like I could show scars at all like not that I would now but just it's more easy if you're a white woman to be self-harming I got some issues don't talk to me about it as opposed to being brown and having self-harm scars.</li> <li>- ....I couldn't talk to my parents about it like I literally couldn't talk to anyone about it...</li> <li>- ... a lot of pressure because I can't talk about it but also I feel like no one should know cause then I'll be like seen in a different way...</li> </ul>	
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## Appendix O: Theme recurrence Table

This table shows the recurrence of the super-ordinate and sub-ordinate themes, and which participants interview had supported it.

Super-Ordinate Themes	Sub-ordinate Theme	1 Uz	2 Zah	3 Fat	4 Sid	5 Lai	6 Zai	7 Ani	8 Jas
Super-ordinate Theme One	<b>Sub-ordinate Theme One:</b> <i>The Patriarchal Script for South-Asian women</i>	✓	✓	✓	✓	✓	✓	✓	✓
	<b>Sub-ordinate Theme Two:</b> <i>You cannot be Yourself</i>		✓		✓	✓	✓	✓	✓
Super-ordinate Theme Two	<b>Sub-ordinate Theme One:</b> <i>Feeling Negative about Myself</i>	✓	✓	✓	✓	✓	✓	✓	✓
	<b>Sub-ordinate Theme Two:</b> <i>Angry at Myself</i>		✓			✓	✓	✓	✓
	<b>Sub-ordinate Theme Three:</b> <i>Abused by my Environment</i>			✓	✓	✓			✓
Super-ordinate Theme Three	<b>Sub-ordinate Theme One:</b> <i>Releasing my Overwhelming Emotions</i>	✓	✓	✓	✓	✓	✓	✓	✓
	<b>Sub-ordinate Theme Two:</b> <i>Connecting to my Pain</i>	✓	✓	✓	✓	✓	✓	✓	✓
	<b>Sub-ordinate Theme Three:</b> <i>Addicted to Self-harm</i>	✓	✓		✓			✓	✓
	<b>Sub-ordinate Theme One:</b>	✓	✓		✓		✓	✓	✓

<b>Super-ordinate Theme Four</b>	<i>It must be Hidden</i>								
	<b>Sub-ordinate Theme Two:</b> <i>What have I done to myself?</i>	✓	✓	✓	✓		✓		
	<b>Sub-ordinate Theme Three:</b> <i>My Self-harm is Sinful</i>	✓		✓		✓			✓