

Deliberate self-harm among adolescents in South African children's homes

by

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TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION

1.1 DEFINITION OF CONCEPTS	1
1.2 RESEARCH QUESTIONS POSED BY THE CURRENT STUDY	3
1.3 JUSTIFICATION OF THE CURRENT STUDY	4
1.4 THEORETICAL FRAMEWORK FOR THE CURRENT STUDY	6
1.5 BRIEF OVERVIEW OF THE RESEARCH METHODOLOGY IN THE CURRENT STUDY	7
1.6 STRUCTURE OF THE CONTENT	9

CHAPTER 2: LITERATURE REVIEW

2.1 GENERAL OVERVIEW OF DELIBERATE SELF-HARM	11
2.2 FACTORS PREDISPOSING INDIVIDUALS TO DELIBERATE SELF-HARM	14
2.2.1 Environmental Factors	14
2.2.2 Biological Factors	16
2.2.3 Cognitive Factors	16
2.2.4 Affective Factors	17
2.2.5 Behavioural Factors	17
2.3 ANTECEDENTS AND CONSEQUENCES OF DELIBERATE SELF-HARM	18
2.3.1 Antecedents of Deliberate Self-Harm	18
2.3.2 Consequences of Deliberate Self-Harm	21
2.4 CONNECTION BETWEEN PSYCHOPATHOLOGY AND DELIBERATE SELF-HARM AND THE POSSIBLE INCLUSION IN THE DIAGNOSTIC AND STATISTICAL MANUAL	23

2.5 THE LINK BETWEEN DELIBERATE SELF-HARM AND SUICIDE	29
2.5.1 Intent of the Behaviour	29
2.5.2 Level of Physical Pain Caused by the Behaviour	30
2.5.3 Frequency of the Behaviour	31
2.5.4 Use of Multiple Methods	31
2.5.5 Level of Psychological Pain	32
2.5.6 Constriction of Cognition in Self-Harm Versus Suicide	32
2.5.7 Helplessness and Hopelessness	33
2.5.8 Psychological Aftermath of the Incident	33
2.5.9 The Core Problem Associated with the Behaviour	34
2.6 EXISTING LITERATURE ON DELIBERATE SELF-HARM AMONG ADOLESCENTS IN CHILDREN’S HOMES	34
2.7 EXISTING LITERATURE ON THE CONTAGION OF DELIBERATE SELF-HARM	36
CHAPTER 3: RESEARCH METHODOLOGY OF THE CURRENT STUDY	
3.1 RESEARCH DESIGN OF THE CURRENT STUDY	42
3.2 RESEARCH CONTEXT(S) OF THE CURRENT STUDY	43
3.3 PARTICIPANTS IN THE CURRENT STUDY	45
3.4 DATA COLLECTION PROCEDURES OF THE CURRENT STUDY	47
3.5 DATA ANALYSIS OF THE CURRENT STUDY	51
3.6 ETHICAL CONCERNS OF THE CURRENT STUDY	53
CHAPTER 4: FINDINGS OF THE CURRENT STUDY	
4.1 RESEARCH QUESTIONS POSED BY THE CURRENT STUDY	57

4.2 FINDINGS WITH REGARD TO THE PERCEPTIONS CONCERNING THE CONTAGION OF DELIBERATE SELF-HARM AMONG ADOLESCENTS IN SOUTH AFRICAN CHILDREN’S HOMES	58
4.2.1 Acquisition of Deliberate Self-Harm Through Contagion of Deliberate Self-Harm	59
4.2.1.1 Acquisition of Deliberate Self-Harm Outside the Children’s Home	59
4.2.1.2 Acquisition of Deliberate Self-Harm in the Children’s Home Setting	62
4.2.2 Episodes of Co-occurring Deliberate Self-Harm as Contagion of Deliberate Self-Harm	65
4.2.2.1 Episodes of Co-occurring Deliberate Self-Harm Outside the Children’s Home	66
4.2.2.2 Episodes of Co-occurring Deliberate Self-Harm in the Children’s Home Setting	68
4.3 FINDINGS WITH REGARD TO THE FREQUENCY, METHODS, DURATION, SEVERITY AND EMOTIONAL CONTEXT OF DELIBERATE SELF-HARM AMONG ADOLESCENTS IN SOUTH AFRICAN CHILDREN’S HOMES	72
4.3.1 Methods Employed in Deliberate Self-Harm	74
4.3.2 Tools Employed in Deliberate Self-Harm	75
4.3.3 Bodily Areas Commonly Targeted for Deliberate Self-Harm	76
4.3.4 The Number of Wounds Inflicted During an Episode of Deliberate Self-Harm	76
4.3.5 The Frequency of Deliberate Self-Harm	77
4.3.6 Discarding of Tools, as Opposed to Keeping Tools	77
4.3.7 Care of Wounds Following Deliberate Self-Harm	78
4.3.8 Methods Employed to Prevent Discovery of Deliberate Self-Harm	78
4.3.9 Emotional Context of Deliberate Self-Harm	79
4.4 FINDINGS WITH REGARD TO THE MOTIVATIONS OF DELIBERATE SELF-HARM AMONG ADOLESCENTS IN SOUTH AFRICAN CHILDREN’S HOMES	82

4.5 FINDINGS NOT SPECIFIED IN THE RESEARCH QUESTIONS FOR THE CURRENT STUDY	86
4.5.1 Psychological Intervention for the Deliberate Self-Harm of Participants	86
4.5.2 Findings Pertaining to the Personal Histories of Participants that Could Influence the Acquisition of Deliberate Self-Harm	88
4.5.2.1 The Observation or Experience of Physical Abuse Before Removal from Parental Care	89
4.5.2.2 The Observation of Parental or Guardian Alcoholism Before Removal from Parental Care	90
4.5.2.3 The Experience of Parental Unavailability Before Removal from Parental Care	92
4.5.2.4 The Experience of Sexual Abuse Before Removal from Parental Care	93
4.5.2.5 The Experience of Human Trafficking Before Removal from Parental Care	94
4.5.2.6 The Experience of Emotional Abuse Before Removal from Parental Care	95
4.5.3 Diagnosed Psychological Disorders that may have Influenced the Acquisition of Deliberate Self-Harm	96
4.5.4 Instances of Suicidal Ideation or Attempts	98
CHAPTER 5: CONCLUSION	
5.1 OVERVIEW OF THE FINDINGS OF THE CURRENT STUDY	100
5.2 EVALUATION OF THE CURRENT STUDY	106
5.2.1 Contributions of the Current Study	106
5.2.2 Limitations of the Current Study	109
5.3 IMPLICATIONS OF THE CURRENT STUDY	111
5.4 RECOMMENDATIONS WITH REGARD TO THE CURRENT STUDY	115
REFERENCE LIST	

Figure 1: Demographic Features of Participants

Figure 2: Summarised Results from the Deliberate Self-Harm Inventory (DSHI)

Figure 3: Summarised Results from the Functional Assessment of Self-Mutilation (FASM)

Abstract

The current study is motivated by the relative lack of research on the contagion of deliberate self-harm, research on self-harm among adolescents in children's homes, as well as South African research on self-harm. In this study, I explore three aspects concerning deliberate self-harm in the South African context: The perceptions of adolescents in children's homes concerning the possible contagion of self-harm; the frequency, methods, duration and severity of self-harm among adolescents in children's homes; and lastly, the motivations of adolescent self-harm in children's homes. I make use of both quantitative measures, being the Deliberate Self-Harm Inventory (DSHI) developed by Gratz (2001) and the Functional Assessment of Self-Mutilation (FASM) developed by Lloyd (1997), and qualitative measures, being the logbooks completed by participants and three semi-structured interviews conducted, to address these questions. The current study uses both the functional approach to deliberate self-harm, that classifies self-harm according to the four functions that produce and maintain such behaviour, and the environmental model that emphasises the situational influences on the contagion of deliberate self-harm. The findings of the study indicate that 10 of the 12 adolescent participants have experienced either the acquisition or episodes of co-occurrence of self-harm through contagion, both outside the children's homes and within the children's homes. The contagion of self-harm is influenced by the desensitisation and growing prevalence of self-harm, frequent observations of self-harm, close personal relationships between individuals who self-harm, and the influence of the visual media. With regard to the findings of the DSHI, the methods most commonly employed for self-harm in the study include cutting, carving words into the skin, as well as the breaking of bones; the majority of the methods had been employed by the participants within the last year; and the emotions present immediately prior to the episode of self-harm include anger, depression, sadness, frustration, anxiety and disappointment. Findings from the FASM indicate that the motivation for the majority of the adolescent participants' self-harm is 'to stop bad

feelings'. Furthermore, the findings of the study indicate that psychological intervention may be available to adolescents in several situations; that the personal histories of the adolescent participants include experiences of physical, emotional and sexual abuse, parental unavailability, the observation of parental alcoholism, as well as the experience of human trafficking; and suicide attempts have been made by the participants following instances of perceived ineffectiveness of self-harm. From the findings, it is evident that the contagion of self-harm is no longer a hypothetical phenomenon. Further implications of the study include the need for continued research on the methods reported by South African individuals who engage in self-harm that are not as prevalent in other research; and the influence of the study on the development and implementation of interventions to address self-harm in children's homes.

Key words: Deliberate self-harm, self-mutilation, self injury, contagion, children's home, adolescents, South Africa, trigger, episode, suicide.

CHAPTER 1: INTRODUCTION

The current study, entitled ‘Deliberate self-harm among adolescents in South African children’s homes’, explores several aspects with regard to the self-harm among adolescents that have been neglected in previous research endeavours. As such, the current study is the first exploration of the nature and perceptions of self-harm among adolescents in children’s homes – and specifically, in South African children’s homes – as well as the first South African study exploring the phenomenon of contagion of self-harm among adolescents. The data collection procedure for the current study include both quantitative and qualitative methods – being the completion of two questionnaires concerning the nature of the participants’ self-harm, with subsequent semi-structured interviews aimed at gaining an in-depth understanding of the perceptions of the adolescent participants with regard to their deliberate self-harm. In this chapter, the definition of concepts, the context of the study, as well as the questions posed by the researcher concerning self-harm among adolescents in children’s homes, are outlined in order to provide a framework for understanding the subsequent chapters.

1.1 DEFINITION OF CONCEPTS

For a comprehensive understanding of the current study, it is imperative that certain terms with regard to the study are defined and clarified. As such, concepts that are essential to the current study – such as deliberate self-harm, contagion of deliberate self-harm, adolescent, and children’s home – are defined in this section.

Firstly, several terms are used when describing and investigating deliberate self-harm – including self-mutilation (Suyemoto, 1998), nonsuicidal self-injurious behaviours or NSSI (Dyl, 2008; Gratz, 2007; Oliver, Hall & Murphy, 2005), and self-cutting behaviours (Yip, 2006). The current study employs the term deliberate self-harm – similar to authors such as Corcoran, Mewse and Babiker (2007); Gratz (2001); Poland (2008); Rayner, Allen and Johnson (2005); Swannell, Martin, Scott, Gibbons and Gifford (2008); Taiminen, Kallio-Soikainen, Nokso-Koivisto, Kaljonen and Helenius (1998); and Whotton (2002). Deliberate self-harm refers to “the deliberate, direct

destruction or alteration of body tissue without conscious suicidal intent, but resulting in injury severe enough for tissue damage to occur” (Gratz, 2001, p. 253).

Secondly, Walsh and Rosen (1985, p. 119) define the contagion of deliberate self-harm – the phenomenon the study mainly aims to explore – as the “sequence of events in which an individual inflicts deliberate self-harm and is imitated by others in the immediate environment”. The contagion of deliberate self-harm can therefore be considered to indicate two separate, but inter-related situations. Firstly, the contagion of deliberate self-harm can occur when an individual acquires self-harm through the observation of self-harm in another individual – supported by of the Social Learning Theory (Yates, 2004). Secondly, the contagion of self-harm can occur when an individual's deliberate self-harm triggers others who self-harm – resulting in episodes of co-occurring self-harm among individuals (Walsh & Rosen, 1985).

Thirdly, the current study considers any individual between the ages of 12 and 19 as an adolescent. Although most individuals would consider the developmental stage of adolescence to end at the age of 18, adolescents in children's homes who have already turned 18 remain at the facilities until the end of their final year of highschool. Adolescents that are 18 – but still reside at the children's home – are included in the current study.

Last, the new Child Care Act, 2005 (Act 38 of 2005) [as amended] employs the term child care facilities – which refers to any facility in which children are housed outside their parental home, and include schools of industry, foster care placements, places of safety, as well as children's homes. However, for the purposes of the current study, the term children's homes is employed – so as to specify the setting in which the study is conducted. As such, a children's home refers to “any facility... that is maintained for the admission, protection, care and education of more than six children away from their parents' homes” (Terminology Committee for Social Work, 1995, p. 25). The children placed in a children's home fall under the legal guardianship of the head of the children's home. Adolescents who self-harm while housed at the children's homes in the Pretoria area, Gauteng, serve as participants for the current study.

1.2 RESEARCH QUESTIONS POSED BY THE CURRENT STUDY

The study aims to provide in-depth understanding of the phenomenon of deliberate self-harm among adolescents. As such, the study attempts to answer three questions concerning self-harm that have been neglected in the South African context.

Firstly, the study aims to answer the question “What are the perceptions of adolescents in children’s homes who self-harm concerning the contagion of self-harm?” The perceptions of adolescents in children’s homes concerning the contagion of deliberate self-harm are addressed by employing the use of daily logbooks kept by the adolescent sample – an instrument which eliminates the reliance on retrospective reporting alone – as well as the use of three semi-structured interviews held with each individual participant.

The study secondly aims to answer the question “What are the frequency, methods, duration and severity of deliberate self-harm among adolescents in children’s homes?” Exploring these aspects of self-harm among adolescents will allow for greater understanding of the contagion of deliberate self-harm. Incorporating this research question in the current study could provide further empirical support for these aspects of deliberate self-harm (as reported in studies by Nock, 2009; Nock & Prinstein, 2004; Stanley, 2007; Walsh, 2006). These aspects of self-harm have, furthermore, generally been investigated in the international context – with few South African studies focusing on the frequency, methods, duration and severity of deliberate self-harm among adolescents. The current study therefore aims to provide empirical data on these aspects, as presented in the South African context. The frequency, methods, duration and severity of deliberate self-harm are aspects that are easily measured quantitatively; and as such, are addressed through the use of the Deliberate Self-Harm Inventory (DSHI), a questionnaire developed by Gratz (2001). The adolescent sample completes the questionnaire individually, after which the data gained is incorporated into the semi-structured interviews held with each participant.

Lastly, the study employs the use of the Functional Assessment of Self-Mutilation (FASM) developed by Lloyd (1997) in order to address the question “What are the motivations of adolescent self-harm in children’s homes?” The motivations of deliberate self-harm provide insight into the maintenance of the behaviour – a feature that could ultimately prove essential in developing treatment strategies for deliberate self-harm. The motivations of the self-harm among the adolescents in the study furthermore allows for the exploration of the contagion of deliberate self-harm in the children’s homes – as initial motivations may progress to involve the triggering of self-harming behaviour.

1.3 JUSTIFICATION OF THE CURRENT STUDY

The current study attempts to address several gaps in existing research concerning the phenomenon of deliberate self-harm, being the relative lack of research in the South African context, the predominant use of university or adult samples as opposed to adolescent samples, the investigation of self-harm as it presents itself in psychiatric settings as opposed to non-psychiatric environments, and the lack of research concerning the contagion of deliberate self-harm.

Firstly, although an abundance of research has investigated self-harm in the international context in recent years (for example Briere & Gil, 1998; Dyl, 2008; Nock & Prinstein, 2004; Stanley, 2007; Suyemoto, 1998); relatively little research has been conducted in South Africa in order to explore the contextual presentation of deliberate self-harm. Deliberate self-harm could feasibly present itself quite differently in the South African context, as the higher prevalence rates of HIV/AIDS, trauma and sexual abuse, as well as cultural factors could increase the occurrence of deliberate self-harm in South Africa. The current study therefore explores deliberate self-harm from a South African perspective.

Secondly, studies concerning deliberate self-harm often employ university or adult samples, although the prevalence rate for self-harm has been found to be significantly higher among adolescents (Briere & Gil, 1998; Dyl, 2008). It is further possible that the methods, frequency, duration and motivations for self-harm provided by adolescent

samples differ from those reported by university or adult samples – emphasising the need to employ adolescent samples in the study of deliberate self-harm.

Thirdly, although there is wide-spread interest in the prevalence, frequency, methods, duration, motivations, and severity of deliberate self-harm among psychiatric samples (Taiminen et al., 1998; Walsh & Rosen, 1985; Walsh & Rosen, 1988), community samples are often neglected in research concerning deliberate self-harm. The studies employing community samples furthermore typically fail to employ a sample of adolescents in foster care or children’s homes. According to Walsh and Rosen (1988), deliberate self-harm may be especially prevalent among children and adolescents in foster care or children’s homes – due to the often temporary and ambiguous separation from parents. Only two previous studies have investigated self-harm among adolescents in children’s homes – being the study by Walsh (1987), and the study by Stanley (2007) – however, there are two limitations evident in these studies: The self-harm among the adolescents in the children’s homes was not the main focus for either study, and the adolescents who engage in deliberate self-harm were not directly interviewed so as to explore their perceptions concerning self-harm. It is therefore imperative that research explores the phenomenon of deliberate self-harm in these settings, in order to further the understanding of the contextual features of self-harm in environments not often included in psychological research. The current study employs the use of an adolescent sample in the four children’s homes in the Pretoria area, Gauteng, so as to explore the adolescent participants’ perceptions concerning this psychological phenomenon.

Lastly, only two previous studies have attempted to investigate the possible contagion of deliberate self-harm – although an abundance of literature exists concerning the theoretical explanations for the occurrence of such episodes (Taiminen et al., 1998; Walsh & Rosen, 1985). Both previous studies employed the use of a psychiatric sample of adolescents, and were conducted in the United States of America and Finland, respectively. Only the study by Taiminen et al. (1998) interviewed the adolescent participants so as to gain their perceptions concerning the episodes in which contagion occur. The current study aims to explore the phenomenon of the contagion of deliberate self-harm from a South African perspective, employing a non-psychiatric sample of

adolescents – and will do so by exploring the personal perceptions of the adolescent participants through interviews conducted with the participants.

Thus, the current study attempts to address several gaps in existing knowledge concerning the phenomenon of deliberate self-harm; in that it employs the use of a non-psychiatric adolescent sample from the four children’s homes within the Pretoria area, Gauteng – in which interviews are conducted with the adolescents to explore their perceptions concerning the features of self-harm as well as the possible contagion of self-harm from a South African perspective.

1.4 THEORETICAL FRAMEWORK

Although several theoretical frameworks have been proposed with regard to deliberate self-harm, the current study employs two frameworks that are relevant to the focus of the study: The Functional Approach to Deliberate Self-Harm, and the Environmental Model of Deliberate Self-Harm. In this section, these two theoretical frameworks are discussed.

The Functional Approach to deliberate self-harm, originally proposed by Lloyd (1997) does not attempt to understand deliberate self-harm based on its symptoms and characteristics – typical of earlier approaches – and rather “classifies and treats behaviours according to the functional processes that produce and maintain them” (Nock & Prinstein, 2004, p. 885). The approach claims that there are two main categories of functions that maintain deliberate self-harm – contingencies and reinforcement – from which four main functions of deliberate self-harm emerge. Firstly, in automatic-negative reinforcement, an individual employs deliberate self-harm as a means to reduce negative emotions such as anger, isolation, internal pain, tension, depression or feelings of loneliness (Nock & Prinstein, 2004; Rissanen, Kylma, & Laukkanen, 2008). Secondly, automatic-positive reinforcement of self-harm refers to the generation of positive emotional states – or “to feel something, even if it is pain” (Nock & Prinstein, 2004, p. 886). Nock and Prinstein (2004, p. 886) define social-negative reinforcement, the third function, as the “use of [self-harming] behaviour to escape from

interpersonal task demands” – and is therefore heavily influenced by the responses of others. Lastly, social-positive reinforcement “involves gaining attention from others or gaining access to materials” (Nock & Prinstein, 2004, p. 886).

According to Suyemoto (1998), the Environmental Model emphasises the situational influences on self-harm. As such, this model assumes the contagion of deliberate self-harm to be caused by one of two reasons: Firstly, deliberate self-harm can be acquired through the observation of abuse and the subsequent association children make between care and deliberate self-harm; and secondly, self-harm can be acquired through “modeling and learning about the benefits of deliberate self-harm through vicarious reinforcement” (Suyemoto, 1998, p. 538). The Environmental Model is heavily influenced by the Social Learning Theory, as this model emphasises the learning and subsequent reinforcement of behaviour (Bandura, 1977; Suyemoto, 1998). According to Bandura (1977), behaviour is commonly reinforced by a combination of external reinforcement – in which the responses provided by significant others such as family and friends result in the continuation of the acquired behaviour – and self reinforcement – in which behaviour results in positive emotional outcomes for the individual and is therefore continued (Bandura, 1977). Bandura (1977) notes that observational learning can furthermore occur through the observation of models in the media. In accordance with this, Nock (2009, p. 14) notes that “messages about [deliberate self-harm] in the media may actually serve to increase the occurrence of this behaviour”, as the media may be increasingly referring to deliberate self-harm. The Environmental Model has been successfully applied to the contagion of deliberate self-harm in adolescents, as Walsh and Rosen (1988, p. 90) claim that support has been found for the influence of modeling on the “acquisition, instigation and maintenance of self-harming behaviour”.

1.5 BRIEF OVERVIEW OF THE RESEARCH METHODOLOGY

In this section, several aspects of the methodology employed in the current study – being the research design, and data collection procedures – are discussed. By doing so, the researcher explains and clarifies the research methodology of the current study – including clear motivations for the methodology selected in the study.

The current study employs both quantitative measures, for the measurement of the methods, frequency, severity and motivations of deliberate self-harm; and qualitative measures, which allows the researcher to explore the perceptions of the adolescent sample concerning the experience of deliberate self-harm and the two forms of contagion of self-harm. Here, these two designs are discussed in relation to the current study. Firstly, the current study assesses the differences in individual participants' self-harm – by assessing the severity, duration, frequency and motivations of self-harm through two self-report measures, being the DSHI developed by Gratz (2001) and the FASM developed by Lloyd (1997). The responses provided by participants on these questionnaires are compared in order to determine possible commonalities in self-harm among the adolescent sample (similar to the research conducted by Gratz, 2001). Secondly, the current study employs the use of qualitative measures to gain an in-depth understanding of the perceptions of the participants concerning several aspects of their deliberate self-harm, and explore the possible contagion of deliberate self-harm among adolescents in children's homes. As such, the three semi-structured interviews are conducted with the adolescent participants for three consecutive weeks, and are structured to focus on specific aspects concerning their deliberate self-harm.

In summary, the data collection procedures for the current study consist of two sections – allowing for the triangulation of methods: The first section of the data collection procedure in the study consists of the completion of the DSHI (Gratz, 2001) in order to assess the methods, frequency and severity of the participants' self-harm and the FASM (Lloyd, 1997) which is designed to assess the motivations underlying the participants' self-harm. The second section of the data collection consists of the completion of a logbook by each participant concerning their self-harming behaviour, as well as three semi-structured interviews with each individual participant, in order to gain greater insight into the perceptions, emotional context and experiences of adolescents who self-harm – with specific focus on instances in which contagion of deliberate self-harm might occur (as suggested by Dyer, 2006).

1.6 STRUCTURE OF THE CONTENT

The structure of the current study consists of five chapters – including the current chapter. Chapter two provides an extensive discussion of the existing literature concerning deliberate self-harm. As such, the chapter contains a general overview of the features of self-harm such as the prevalence, a discussion of the Biopsychosocial Model of Deliberate Self-Harm that outlines factors that may increase risk for later adoption of self-harming behaviour, the antecedents and consequences of deliberate self-harm, the connection between psychological diagnoses and deliberate self-harm, a discussion of the links and differences between deliberate self-harm and suicide, as well as a discussion of specific literature on the prevalence of self-harm among children in children's homes and the contagion of deliberate self-harm.

Chapter three focuses on the research methodology employed in the current study. Therefore, the chapter contains discussions on the research context(s) of the study, participants in the study, the research design, the data collection procedures and ethical concerns of the study. Clear motivations are furthermore provided in this chapter for the decision to employ these means of exploring the deliberate self-harm among adolescents in children's homes.

Chapter four consists of a comprehensive discussion of the findings of the current study. As such, the chapter is structured according to the research questions posed by the study – and contains a section on additional information gained from the participants during the semi-structured interviews not specified in the research questions. In the chapter, the findings pertaining to the contagion of self-harm are discussed with reference to both forms of contagion of self-harm; the findings with regard to the methods, frequency, severity and emotional context of the self-harm of the participants are addressed; the motivations provided by participants on the FASM are discussed; as well as the additional information not specified in the research questions are discussed. In the discussion of the findings of the current study, the researcher makes reference to the existing literature concerning self-harm, and how the findings of the current study either provides support for previous research or differs from previous conceptions.

The final chapter contains a brief overview of the findings of the current study, an evaluation of the contributions and limitations of the study, a discussion on the implications of the current study, as well as recommendations for future research that aims to explore similar topics as the current study.

From the above sections, it becomes evident that there are several gaps in existing knowledge concerning deliberate self-harm – most noteworthy, the lack of research in the South African context in which adolescents are requested to report their perceptions of their self-harm; and the relative lack of empirical support for the contagion of self-harm. This chapter further clarified the concepts employed in the current study, the research questions, the research context, the theoretical framework for the understanding of deliberate self-harm, a brief overview of the research methodology and the structure of the content – which are addressed in the following chapters.

CHAPTER 2: LITERATURE REVIEW

In this chapter, existing literature with regard to several aspects of deliberate self-harm is reviewed in order to provide a concise understanding of the information that has become available on this psychological phenomenon. As such, a general overview of deliberate self-harm; the Biopsychosocial Model of Deliberate Self-Harm; the antecedents and consequences of self-harm; the connection between psychopathology and self-harm; and the connection between deliberate self-harm and suicide are discussed in depth in this chapter – so as to provide a framework for the understanding of the topic of the current study – deliberate self-harm. Furthermore, existing literature that is specifically relevant to the current study – being the literature with regard to deliberate self-harm within children's homes, and literature concerning the contagion of deliberate self-harm – are discussed, which allows for the possible confirmation of previous research concerning these features of self-harm.

2.1 GENERAL OVERVIEW OF DELIBERATE SELF-HARM

Most research endeavours in recent years concerning deliberate self-harm have attempted to investigate the prevalence, methods, and motivations of self-harm. Here, some of the empirical evidence concerning deliberate self-harm in previous research endeavours is briefly discussed.

Briere and Gil (1998) and Dyl (2008) note an estimated prevalence of 4% of deliberate self-harm in the general adult population, 12-35% among tertiary education students, and 5-47% in the adolescent population. Research conducted by Nock and Prinstein (2004) however indicate a much higher prevalence of self-harm among adolescents – 50.6% of their community sample of adolescents reported up to 19 incidents of deliberate self-harm during a 12 month period. In the South African context, Pillay and Wassenaar (1997, p. 155) note “adolescents have been found to have substantially high risk for [self-harming] behaviours”. There are several possible reasons for the recent increase in the prevalence of self-harm among adolescents – including the high stress levels at schools; multitasking lifestyles; the lack of adequate self-soothing skills taught

to children; the lack of supervision and psychological availability of working parents; the portrayal of self-harm in both video and music media; the availability of websites dedicated to self-harm; the powerful communicative abilities of self-harm; and the sense of control that self-harm provides the adolescent (Walsh, 2006). Dyl (2008) and Walsh (2006) further claim that the prevalence rate of self-harm has increased over recent years – which may be due to a combination of both the actual increase of self-harm, as well as increased precision with which deliberate self-harm is recorded (Turner, 2002; Walsh, 2006). Determining the annual incidence or actual prevalence of deliberate self-harm is severely complicated, however, by the tendency of individuals who self-harm to treat their own injuries – and thus avoid emergency medical care (Suyemoto, 1998). Walsh and Rosen (1988) further note that the social stigmatisation and the deception of medical personnel could contribute to the underreporting of deliberate self-harm.

According to Yates (2004) deliberate self-harm can be sub-divided into two categories, being compulsive- and impulsive self-harm. Firstly, compulsive self-harm is typical of impulse control disorders – such as Trichotillomania, Autism, head banging and Pica – in which self-harm is seen to be purely repetitive as part of the disorder (Nock & Prinstein, 2004; Yates, 2004). Methods commonly found in compulsive self-harm include hair-pulling and compulsive scratching (Yates, 2004). Secondly, impulsive self-harm begins as an episodic behaviour – such as deliberate cutting, burning or hitting – and often becomes repetitive due to the reinforcement it provides (Yates, 2004). Cutting – through the use of razor blades, knives, scissors, glass, paper clips, fingernails or other sharp objects – is reported as the most common method for impulsive self-harm (Dyl, 2008; Stanley, 2007; Suyemoto, 1998). Other forms of deliberate self-harm include hitting, scraping, biting, inserting objects under the skin, tattooing the skin, burning, and erasing the skin to the point of drawing blood (Nock & Prinstein, 2004). Pillay and Wassenaar (1997) note a preference for the ingestion of poison and overdoses of medical substances as the methods most commonly employed by individuals in the South African context. The forearms and wrists are furthermore reported as the most common areas for impulsive deliberate self-harm (Ross & McKay, 1979).

The debate concerning the distribution of self-harm among males and females remains somewhat unresolved. As such, many authors note a greater prevalence of deliberate self-harm among females; whereas others argue for a more equal distribution in recent years. According to Plante (2007), the prevailing gender difference in the prevalence of self-harm – stipulating that more females than males self-harm – can be attributed to several factors. Firstly, males generally adopt an externalising pattern of behaviour. As such, males are more likely to resort to aggression, alcohol and substance abuse, and overtly defiant behaviours than women – who internalise aversive experiences (Plante, 2007). Secondly, males who have experienced trauma in childhood typically identify with the aggressor – resulting in self-destructive behaviour in later life. According to Plante (2007), males are more likely to express their emotions concerning the trauma in aggressive behaviours similar to those the individual experienced as a child – for example, the male victim of an alcoholic parent is more likely to become a violent alcoholic himself, as opposed to expressing his emotions concerning the victimisation through self-harm. Thirdly, males generally avoid situations of expressing weakness or pain (Plante, 2007). As such, males are less likely to report a history of self-harm or seek treatment if such behaviours do occur. Therefore, the self-harm among males may be underreported – resulting in inadequate estimates of self-harm among males. Females are, however, socialised to express their emotions and seek treatment for emotional disturbances – thus resulting in an increased possibility of an adequate estimated prevalence of self-harm among females (Plante, 2007). Fourth, Plante (2007) notes that the change of roles and expectations of females in Western societies in recent years could result in depression, anxiety, internalisation of the failure and fear of failure in such environmental circumstances, and ultimately self-destructive behaviour. As such, females are more likely to internalise the pressure of achieving success in modern society – resulting in aversive behaviour if the goals are not obtained (Plante, 2007). Males, on the other hand, have been exposed to this degree of pressure for a prolonged period – possibly indicating a greater degree of adaptation to the circumstances. The study by Briere and Gil (1998), however, emphasises the equal distribution of self-harm among male and female participants in both inpatient and community samples.

2.2 FACTORS PREDISPOSING INDIVIDUALS TO DELIBERATE SELF-HARM

There are several factors that could indicate a higher risk for deliberate self-harm in later life, including environmental, biological, cognitive, affective and behavioural factors – as stipulated in the Biopsychosocial Model for Deliberate Self-Harm (Walsh, 2006). These factors form part of the etiology – or causal factors – of deliberate self-harm. In this section, these factors that could contribute to the later development of self-harming behaviour are discussed, with relevant examples.

2.2.1 Environmental Factors

There are several environmental factors that could influence the later development of self-harm (Walsh, 2006). Environmental or contextual factors are those factors essentially ‘outside’ an individual that have an impact on the individual’s intrapersonal state. In this section, three of the important environmental factors that contribute to self-harm – being family historical events, client historical elements and current environmental elements – are discussed.

Firstly, family historical elements are those factors through which a child becomes either directly or indirectly influenced by the behaviour or actions of relatives (Walsh, 2006; Walsh & Rosen, 1988). In indirect influences on a child’s behaviour, the observation of a relative engaging in negative, self-destructive behaviour could result in the adoption of the behaviour by the child in later years – as the modeled behaviour includes the effects of the behaviour, such as a reduction in anxiety, anger, depression, frustration or contempt (Walsh, 2006). Examples of the negative modeled behaviour that could contribute to self-harm in later life include alcohol or substance abuse, mental illness, violence, self-destructive behaviour (such as self-harm), and suicide. Self-destructive behaviour appears to have a significant impact on the later behaviour of a child, as the behaviour models a belief that life is persistently painful, not worth living and that others cannot assist during difficult times (Walsh, 2006).

Secondly, client historical elements – such as the death or loss of a parent or caregiver; separation; divorce of parents; placement out of the home; experiences of neglect, physical, and sexual abuse – are those events directly experienced by the child throughout the childhood years (Walsh, 2006; Walsh & Rosen, 1988). Sexual abuse is one of the leading precipitating childhood conditions associated with self-harm in later life (Plante, 2007; Turner, 2002). As such, self-harm has been reported in both community and clinical samples of individuals who have been sexually abused (Briere & Gil, 1998). The reasons provided are closely related to the dissociation prevalent in deliberate self-harm; emotional or psychological distress; and symptoms of Posttraumatic Stress Disorder; depression, powerlessness, low self-esteem, body image disturbances, and self-destructive patterns following the sexual abuse (Briere & Gil, 1998; Plante, 2007; Walsh & Rosen, 1988). However, Plante (2007) notes that self-harm does not necessarily indicate a history of sexual abuse – as other victims of this particular form of trauma in early life do not develop self-destructive tendencies or resort to self-harm as a coping mechanism for the victimisation. The link between disrupted or inconsistent parental care in childhood and deliberate self-harm has further been investigated by many authors (Turner, 2002; Walsh, 2006; Walsh & Rosen, 1988). Turner (2002) notes that parental neglect could result in self-harm, in that neglect essentially contributes to psychological distress and symptoms similar to physical or sexual abuse. Parental neglect typically results in the social isolation of the child – for which self-harm is a common reaction (Turner, 2002). Consistent with this, Walsh (2006) notes that individuals who self-harm may become triggered by loneliness – and employ techniques of avoiding situations where loneliness is more likely to occur. As an extension of the above, Walsh (2006) argues that the lack of parental psychological availability – due to an increased demand on the abilities of the parents in their various roles – could result in a dramatic decrease in self-soothing skills among children and adolescents. The lack of self-soothing skills or coping mechanisms increases the possibility of self-harm profoundly.

Lastly, Walsh (2006) notes that invalidating families could contribute to the development of both Borderline Personality Disorder and self-harm. Invalidating families are characterised by indifference to the normal reactions of children to specific

situations – such as distress. In these situations, the normative or adaptive reaction of the child is ignored; and only responses at the extreme of the continuum are attended to (Walsh, 2006). This response to the reactions of a child could result in the reinforcement of maladaptive behaviour on the part of the child – in that the child manages any emotional state through self-destructive and maladaptive behaviour. Alternatively, the invalidating response provided by relatives could result in a cognitive schema for the child – in which all emotions are invalid and unworthy, and thus self-punishment in the form of self-harm could ensue (Walsh, 2006).

2.2.2 Biological Factors

There are several biological factors that could contribute to the later development of self-harm. Firstly, Walsh (2006) notes that the limbic system – responsible for the regulation of affective states – could contribute to self-harm, in that emotional dysregulation is commonly found in individuals who repetitively self-harm. Secondly, diminished levels of serotonin in an individual's brain have been linked with impulsivity, aggressiveness and deliberate self-harm (Walsh, 2006). Lastly, Walsh (2006) suggests that an increase of opioid activity could be conducive to self-harm – in that the act of self-harm releases opioids that serve to reduce negative emotional states and induce a sense of pleasure or lack of pain. This indicates the possible involvement of the endogenous opioid system in the development and maintenance of deliberate self-harm.

2.2.3 Cognitive Factors

Cognitive factors that could contribute to the later development of deliberate self-harm are two-part: Firstly, individuals who self-harm could be especially prone to forming negative interpretations of environmental events (Walsh, 2006). As such, individuals who self-harm typically develop self-defeating cognitive patterns following aversive events such as the loss or death of a parent; or neglect, physical or sexual abuse. Other examples of interpretations of environmental events could include a tendency toward perfectionism on the part of the individual (Walsh, 2006). In these instances, the self-

harming individual develops a belief-system that generates thoughts relating to perfectionism – such as “I must get full marks for this test” – that could result in self-harm as a form of self-punishment if not obtained. Secondly, pessimistic self-generated cognitions are typically found among individuals who self-harm (Walsh, 2006). As such, these individuals have persistent negative cognitions on a regular basis – although no aversive event occurred to prompt such pessimistic thought patterns. These self-generated cognitions are addressed in treatment; as the continuation of such thoughts reduce the possibility of successful treatment.

2.2.4 Affective Factors

According to Walsh (2006) and Walsh and Rosen (1988) self-harm centers on negative emotions such as anger, anxiety, frustration, depression, shame, and contempt. These emotions generally persist over a long period of time for the individual who self-harms; and precedes the episode of self-harm. Accordingly, it is essential for clinicians to determine which emotions are central to the self-harm of a particular individual – in order to address the motivations for these emotions (Walsh, 2006).

2.2.5 Behavioural Factors

Typical behavioural factors that influence the development of self-harm include the persistent sense of isolation from peers or relatives; conflicts with relatives; failure at activities; sexual behaviour; substance abuse; and the presence of eating disorders (Walsh, 2006). These behavioural events contribute to self-harm in that it promotes the negative self-defeating cognitive and affective states. The behavioural factors influencing self-harm further include those behaviours leading up to an episode of self-harm – such as preparing the environment, getting a tool for the self-harm and disposing of the tools following the self-harm (Walsh, 2006).

2.3 ANTECEDENTS AND CONSEQUENCES OF DELIBERATE SELF-HARM

Many studies have focused on the antecedents and consequences of deliberate self-harm. Antecedents of behaviour are those factors that contribute to the immediate behaviour at a specific time; whereas the etiology of the behaviour is those factors that in the long-term influence the behaviour – discussed in section 2.2. In this section, the antecedents of self-harm – as in the Biopsychosocial model advocated by Walsh (2006) – are discussed; followed by a comprehensive summary of the consequences of deliberate self-harm.

2.3.1 Antecedents of Deliberate Self-Harm

Many studies have attempted to investigate the antecedents of deliberate self-harm. The Biopsychosocial Model, advocated by Walsh (2006), includes five dimensions – environmental, biological, cognitive, behavioural and affective – and is considered the most comprehensive model for the understanding of the antecedents of self-harm. These antecedents of deliberate self-harm are those experiences at the current time that causes self-harm in an individual – due to the trigger provided by the experience.

Firstly, environmental antecedents of self-harm are “events or activities in the environment of the [individuals who self-harm] that trigger an episode” (Walsh, 2006, p. 58). These factors include the loss of relationships, interpersonal conflicts, performance pressure, frustrations, social isolation and neutral events that trigger memories of trauma. Of particular importance is the loss of a parent – as such occurrence in a child’s life is a profoundly traumatic event that has repercussions for adulthood (Walsh & Rosen, 1988). The loss of a parent could be either temporary (such as separation or placement of the child in a residential setting) or permanent (for example, the death of a parent). In a study to evaluate the types of loss most associated with the occurrence of self-harm in later life, Walsh and Rosen (1988) found that divorce of parents, placement in group care and placement in foster care have the most prominent influence on later self-harm. The reasons noted by the authors include the

“separation from a parent without permanent termination of the relationship” (Walsh & Rosen, 1988, p. 61). Rissanen et al. (2008) note that factors relating to familial relationships should be regarded as possible contributors to self-harm among adolescents in particular. As such, individuals who self-harm often report a sense of difference in their upbringing as opposed to siblings, a lack of care and concern regarding the mother, conflict within the family, as well as familial difficulties and abuse (Pillay & Wassenaar, 1997; Rissanen et al., 2008). The research by Pillay and Wassenaar (1997) specifically indicated that adolescents in South Africa who engage in self-harming behaviour experienced conflicts with their parents, siblings, peers, educators, or partners in romantic relationships in the 12 hours prior to instances of deliberate self-harm. Castille et al. (2007) and Suyemoto (1998) note that loneliness can further be considered a strong predictor of self-harm.

Secondly, biological antecedents of self-harm include emotional dysregulation, impulse control problems, and addiction – often due to the release of opioids following self-harm; and loss of sensitivity to physical pain (Walsh, 2006). In accordance with this, Dyl (2008) notes that the act of self-harm might allow the individual to “feel pain” as well as provides a sense of control over the situation. Dyl (2008) and Yates (2004) moreover recognise the addictive nature of deliberate self-harm in their studies; as self-harm is described as a highly addictive behaviour by those who engage in these behaviours, and that a wider variety of methods may be necessary to sustain the sensations it produces. The addictive nature of deliberate self-harm can also be seen in the increasing severity of deliberate self-harm (Dyl, 2008; Yates, 2004).

Third, Walsh (2006, p. 66) defines cognitive antecedents of deliberate self-harm as “thoughts and beliefs that trigger episodes of [deliberate self-harm]”. These include interpretations of events, thoughts that are automatically triggered, intermediate- and core beliefs, and cognitions related to past trauma. According to Deiter, Nicholls and Pearlman (2000), the past trauma in deliberate self-harm often involves childhood experiences of neglect and abuse – often sexual abuse.

Fourth, behavioural antecedents of deliberate self-harm refers to “observable actions by the [individual who self-harms] that trigger episodes of [deliberate self-harm]” (Walsh, 2006, p. 68). Typically, the behaviours that trigger deliberate self-harm are those that the individual perceives to be shameful and worthy of punishment (Walsh, 2006). Individuals who self-harm often experience dissociation – brought on by intense emotional arousal – which is ended by the act of deliberate self-harm (Suyemoto, 1998). Plante (2007, p. 18) defines dissociation as “a form of psychological distancing that helps the [individual] disconnect physically and emotionally from the experience as if in a dreamlike trance”. The inability to self-soothe behaviourally is further reported to be an important underlying factor for deliberate self-harm (Suyemoto, 1998). Chapman, Gratz and Brown (2006) further note that novelty seeking behaviour – which forms an integral part of behavioural inhibition – can be considered a temperamental characteristic, in which reinforcement strengthens the behaviour following the rewards for the behaviour. As such, the reinforcement of self-harm – in its avoidance of negative emotions – might implicate greater novelty seeking behaviour in individuals who self-harm. Thus, although Chapman et al. (2006) note that further research is needed, identifying novelty seeking behaviour in individuals who self-harm might be beneficial for the treatment of such behaviours.

Lastly, affective antecedents of deliberate self-harm include anxiety, tension and panic, anger, depression, shame, guilt, frustration and contempt (Walsh, 2006). These emotions can either be present for some time before the self-harm, or be of sudden onset. Empirical support has been found for tension, anxiety, fear, and anger as affective antecedents for deliberate self-harm (Dyl, 2008; Suyemoto, 1998). Fitting with the emotional antecedents of deliberate self-harm, Chapman et al. (2006) distinguish between heightened emotional arousal, lower tolerance for emotional arousal, and emotional dysregulation. Firstly, these authors note that individuals who self-harm might have significantly heightened physiological arousal to negative emotional occurrences – causing these individuals to experience all emotional arousal to greater intensity (Chapman et al., 2006). Flowing from this, individuals respond by avoiding the thoughts, emotions or internal sensations they have learned to associate with heightened arousal through self-harm – which reinforces the deliberate self-harm.

Secondly, Chapman et al. (2006, p. 378) propose that individuals who self-harm might have significantly lower tolerance for emotional arousal – which “increases the urge to eliminate the emotional arousal, thus increasing the likelihood of engaging in some form of experiential avoidance behaviour, such as [deliberate self-harm]”. Lastly, emotional dysregulation occurs when individuals fail to employ existing emotion regulation skills in situations of intense emotional arousal (Chapman et al., 2006). As such, individuals who self-harm might fail to respond adequately to the physiological, expressive, cognitive and behavioural components of emotional arousal – and therefore resort to self-harm. The reinforcement of self-harm might therefore cause this behaviour to be “regarded as an unusual but effective coping strategy for [emotional dysregulation]” (Sachsse, von der Heyde, & Huether, 2002, p. 1).

2.3.2 Consequences of Deliberate Self-Harm

Walsh (2006) provides a comprehensive summary of the consequences of deliberate self-harm. He notes six major consequences of self-harm, including psychological relief, the presence/absence of self-care, the presence/absence of excoriation after the deliberate self-harm, the demeanor of the individual who self-harms, and possible social reinforcement. In this section, these consequences are discussed – with brief examples to illustrate.

Firstly, the psychological relief experienced following self-harm typically involves the reduction of tension, anger, depression or frustration (Walsh, 2006). This psychological relief is not evidenced in suicidal individuals – as the permanence of the psychological pain prevents any attempts to reduce the emotions.

Secondly, individuals who self-harm can either take precautions to prevent infections and treat their wounds; or deliberately prevent the wounds from healing, thus extending the period of healing (Walsh, 2006). Individuals who attempt to treat their wounds following self-harm in order to prevent the development of infections are generally considered to have a lesser degree of severity of self-harm.

Third, excoriation of self-harm occurs when individuals purposefully reopen their wounds – which typically imply a greater severity of the deliberate self-harm (Walsh, 2006). Excoriation indicates a greater severity of self-harm in that it becomes more difficult for a clinician to assess the number of self-harm episodes; and it indicates a decreased level of fear for negative medical consequences due to physical damage.

Fourth, individuals who self-harm can either disclose the deliberate self-harm to others – such as peers, parents, caregivers and spouses – or keep their self-harm a private, secretive practice. According to Walsh (2006), those who disclose the information to others tend to self-harm for interpersonal reasons – in which the individual consciously or unconsciously self-harm in order to gain the attention, sympathy or reactions from others. Individuals who self-harm for interpersonal reasons are considered to be more susceptible to the contagion of self-harm, as the reactions of others in cases of contagion are typically extreme and may involve an increase of attention on those individuals involved in the episode of contagion (Walsh, 2006). Individuals who do not disclose their self-harm are considered to self-harm for more intrapersonal reasons – such as the reduction of tension, anger, contempt or frustration (Walsh, 2006). The self-harm of those individuals who do not disclose their injuries may be more severe – as the behaviour intensifies without notice throughout time.

Fifth, the demeanour or behaviours of the individual following the act of self-harm can often emphasise the outcomes of the deliberate self-harm (Walsh, 2006). Thus, individuals who express guilt concerning their self-harm are considered to have a better prognosis; whereas individuals that indicate indifference following self-harm are typically considered less cooperative in treatment, and therefore have higher relapse rates.

Lastly, Walsh (2006, p. 75) defines social reinforcement as “behaviour on the part of others that increases the likelihood of [self-harm] recurring”, and can be either intentional or unintentional. Walsh (2006) considers social reinforcement rarely to be the primary motivation for deliberate self-harm – contrary to popular conceptions – as

there are many alternative means through which individuals could gain the interpersonal attention that deliberate self-harm provides.

2.4 CONNECTION BETWEEN PSYCHOPATHOLOGY AND DELIBERATE SELF-HARM AND THE POSSIBLE INCLUSION IN THE DIAGNOSTIC AND STATISTICAL MANUAL (DSM)

Through extensive research, certain psychological diagnoses have come to be associated with deliberate self-harm. These include Borderline Personality Disorder (BPD), eating disorders such as Anorexia Nervosa and Bulimia Nervosa, Mood Disorders and Anxiety Disorders such as Posttraumatic Stress Disorder (Ross & McKay, 1979; Turner, 2002). Many authors have further debated the inclusion of deliberate self-harm in the Diagnostic and Statistical Manual (DSM) under the diagnosis of impulse control disorders (including Turner, 2002); whereas others contend that deliberate self-harm is merely a form of impulsive behaviour exhibited in distinct psychological disorders (as noted by Ross & McKay, 1979). In this section, the psychological co-morbidities and inclusion of self-harm in the DSM are discussed.

Firstly, Turner (2002) notes that there are several similarities between deliberate self-harm and eating disorders such as Anorexia Nervosa and Bulimia Nervosa: Both self-harm and eating disorders are more common among females – although the female-male ratio is currently diminishing in both; self-harm and eating disorders typically begin during early adolescence; both conditions are often marked by a history of abuse in childhood; the parents of both individuals with eating disorders and self-harm tend to be alcoholic, emotionally abusive or distant, or have emotional problems; both conditions are characterised by perfectionism and weak interpersonal relationships; and both eating disorders and self-harm are characterised by the attempts to control the environment (Plante, 2007; Turner, 2002). With regard to the concerns with control evident in both eating disorders and deliberate self-harm, Ross and McKay (1979, p. 20) note that “[adolescents] with eating disorders frequently express their torment through cutting in an effort to punish, purge, and take control of their bodies”. As both deliberate self-harm and eating disorders are characterised by these situational,

contextual and interpersonal difficulties; it is commonly found that the two conditions are co-morbid (Plante, 2007; Ross & McKay, 1979).

Secondly, Borderline Personality Disorder (BPD) is characterised by mood swings, melodramatic behaviour, interpersonal problems, emotional outbursts, impulsivity, boundary violations, provocation in conflict, manipulation, and intense fear of rejection or abandonment (Turner, 2002). Walsh and Rosen (1988, p. 95) note that “in the minds of clinicians, the diagnostic category most closely associated with the occurrence of [deliberate self-harm] is borderline personality disorder”. According to Turner (2002), deliberate self-harm is commonly found among patients diagnosed with BPD – as an externalising symptom of internal turmoil. Alternatively, individuals with deliberate self-harm are often diagnosed with BPD after obtaining treatment for the self-harm (Walsh & Rosen, 1988). Although Ross and McKay (1979, p. 21) warn against diagnosing especially adolescents who self-harm with BPD; the authors recognise that “many of its core features can be extremely useful in understanding and relating to [adolescents] who [self-harm]”. As such, individuals who self-harm have many features that are common in individuals with Borderline Personality Disorder (BPD): Firstly, both individuals with BPD and deliberate self-harm may have disturbances in their identities – which could result in contradictory behaviour, self-perceptions, and views of others; confusion with regard to sexual orientation, and self-image; as well as depression and feelings of loneliness (Ross & McKay, 1979; Walsh & Rosen, 1988). This disturbance in identity typically results in deliberate self-harm in individuals diagnosed with Borderline Personality Disorder (BPD) – with the motivation of alleviating those negative emotions, conveying their identity as an individual who self-harms to others, and providing punishment for the guilt or tension that patients with BPD often experience due to their identity disturbance. Secondly, both individuals with BPD and deliberate self-harm may have inadequate coping mechanisms in situations of increased discomfort (Ross & McKay, 1979). It has been proposed that self-harm serves as a coping mechanism for individuals who lack alternative means of responding to the environment and its demands (Sachsse et al., 2001). Third, Walsh and Rosen (1988) note that neither individuals with BPD nor individuals who self-harm, harm themselves with the intent to commit suicide. However, the authors warn that individuals with

Borderline Personality Disorder often do attempt to convince caregivers of their intent to die – even though the intent is often lacking (Walsh & Rosen, 1988). If lethal injuries occur in either individuals who self-harm or individuals with BPD, it is typically due to miscalculations or accidents. Fourth, both individuals who self-harm as well as patients with BPD have greater levels of impulsivity than the normal population (Walsh & Rosen, 1988). In patients with BPD, the impulsivity generally centers on sexual activity, alcohol abuse, shoplifting or reckless driving; while self-harm itself is seen as an impulsive act to restore negative emotional states (Walsh & Rosen, 1988). Lastly, individuals with BPD and deliberate self-harm typically have difficulty managing intense negative emotions such as guilt, anxiety, fear, and loneliness – and, due to the lack of effective coping mechanisms – resort to self-harm to alleviate the emotional state (Ross & McKay, 1979).

As a co-morbid condition, there seems to be a definite relationship between Posttraumatic Stress Disorder (PTSD) and deliberate self-harm. As such, the diagnosis of co-morbid PTSD and self-harm operates in two ways: The individual can firstly develop self-harm, and later be diagnosed with PTSD after initiating treatment; or may develop PTSD following a traumatic event, and consequently resort to deliberate self-harm. Firstly, many individuals who self-harm may exhibit symptoms that are characteristic of PTSD. With regard to this, Turner (2002, p. 95) notes that “because many [individuals who self-harm] were physically and/or sexually abused as children or raped as adults and often have the characteristic symptoms of Posttraumatic Stress Disorder, they are frequently given this diagnosis”. Alternatively, the symptom of numbing and dissociation commonly found in PTSD could result in desperation on the part of the individual to experience some sensation – which could, in turn, result in the use of deliberate self-harm (Turner, 2002). The self-harm may therefore serve the function of restoring the emotional numbing or dissociative state that the individual with PTSD experiences.

Fourth, Turner (2002) notes that several Anxiety Disorders – including Generalised Anxiety Disorder, Obsessive Compulsive Disorder and Panic Attacks – are commonly found to be co-morbid in individuals who self-harm, along with Posttraumatic Stress

Disorder (PTSD). In all of these Anxiety Disorders, an individual becomes preoccupied with certain aspects – such as perfectionism, approval and reassurance – which, if unattained, could lead to self-harm in an attempt to reduce the anxiety produced by the preoccupation (Turner, 2002). Individuals who self-harm typically become ritualistic and obsessive with regard to instances in which they harm themselves – often leading to a diagnosis of Obsessive Compulsive Disorder. Furthermore, Turner (2002) notes that individuals with Panic Attacks may be tempted to resort to deliberate self-harm in order to relieve the intense physiological sensations; as self-harm often results in a de-escalation of anxiety and apprehension.

Fifth, self-harm is considered to be characterised by impulsivity (Turner, 2002). As such, the act of self-harm may be seen as an impulsive reaction to situations of extreme stress, anxiety, guilt, agitation, frustration, loneliness, or anger. As such, Turner (2002) notes that self-harm may have several other Impulse Control Disorders as co-morbid conditions. Such co-morbid psychological diagnoses may include Kleptomania (stealing), Pyromania (fire setting), and Trichotillomania (hair-pulling). Although several authors argue that Trichotillomania is a form of compulsive deliberate self-harm, similar to compulsive skin picking, the disorder is currently still recognised as an Impulse Control Disorder according to the DSM (Simeon & Favazza, 2001; Turner, 2002). Trichotillomania and deliberate self-harm are similar in that the tissue damage is often severe enough to cause permanent scarring, the increased tension before the incident and consequent de-escalation following the instance of hair-pulling or self-harm, and excoriation present in both Trichotillomania and self-harm. Various individuals who self-harm also experience difficulties with these conditions – and as Trichotillomania is not yet considered a specific form of deliberate self-harm – these disorders are often noted to be co-morbid in individuals who self-harm. It should be noted that several authors argue for the inclusion of deliberate self-harm in the spectrum of Impulse Control Disorders in the DSM, such as Simeon and Favazza (2001) and Turner (2002). The debate of inclusion of deliberate self-harm in the DSM is discussed in length later in this section.

Sixth, a key symptom of Dissociative Disorders such as Dissociative Identity Disorder (DID) is commonly found among individuals who self-harm: dissociation. According to Turner (2002), dissociation falls on a continuum ranging from depersonalisation – the perception of being detached from one’s body or mental state – to severe dissociation – in which the individual has no recollection of his/her actions or thought processes for a period of time. Dissociation in self-harm is typically characterised by extreme distress and anxiety – and is referred to by many as “spacing out” (Turner, 2002). Although Dissociative Identity Disorder (DID) is considered to be a controversial diagnosis, many individuals who have experienced severe physical and/or sexual abuse or self-harm have been diagnosed with this condition (Turner, 2002). However, the diagnosis of individuals who self-harm with DID may be incorrect – in that the dissociative condition in self-harm is not pervasive, and is often merely associated with the intense emotional arousal that leads to deliberate self-harm.

Seventh, Turner (2002) notes that Mood Disorders – such as Major Depressive Disorder and Bipolar Disorder – may go unnoticed in individuals who self-harm for prolonged periods, even though the disorder remains. As such, some authors argue that individuals who self-harm are not more depressed than non-self-harming individuals; although it has been noted by others that the sadness, worthlessness, hopelessness, lack of pleasure and interest and changes in appetite and sleeping patterns characteristic of Mood Disorders are also found in many individuals who self-harm (Turner, 2002).

Lastly, Walsh and Rosen (1988) note that deliberate self-harm often occurs among individuals with Psychosis. However, the authors warn that “as psychosis is at the extreme end of the continuum of psychopathology, the [self-harm] of these individuals is at the extreme end of the spectrum of self-destructiveness” (Walsh & Rosen, 1988, p. 113). Deliberate self-harm is, according to Walsh and Rosen (1988), commonly found among chronically psychotic patients – such as those diagnosed with Schizophrenia and Psychotic Depression. There are several characteristics of the self-harm among psychotic patients that are noteworthy: Firstly, the authors argue that an inverse relationship exists between the severity of self-harm and the number of incidents that occur – as such, the self-harm among those psychotic patients who only harm

themselves once throughout their lives, appears to be the cases in which the most severe self-harm occurs (Walsh & Rosen, 1988). Secondly, the delusional thinking that characterises psychosis generally influences the episodes of self-harm extensively. As such, the delusions experienced by the patient may be the motivating factor for the occurrence of the self-harm – in that the patient perceives the self-harm to be a natural reaction to the conclusion he/she has drawn from the content of the delusions (Walsh & Rosen, 1988). Thirdly, patients with psychotic diagnoses often use self-harm as a means of manipulating others. Although this is also common among individuals with Borderline Personality Disorder, the self-harm – and manipulation of others, such as nursing staff or care takers – originates in the psychotic transference found in the patient (Walsh & Rosen, 1988). Lastly, Walsh and Rosen (1988) note that psychotic patients commonly target areas of the body – such as the eyes, nipples and genitals – for self-harm, that are infrequent targets for self-harm among the general population.

Many authors argue for the inclusion of deliberate self-harm in the Diagnostic and Statistical Manual (DSM) – as Impulse Control Disorders Not Otherwise Specified (Favazza, 2009; Turner, 2002). Deliberate self-harm is currently merely noted as a symptom in various psychological disorders such Borderline Personality Disorder, Major Depression, and Stereotypic Movement Disorder (Favazza, 2009). Favazza (2009) argues that the inclusion of deliberate self-harm in the DSM will allow for the establishing of clear terms, definitions, and characteristics of self-harm – which will further allow for greater accuracy in the literature and research concerning the phenomenon. Further, Favazza (2009) suggests that although many clinicians consider self-harm to be a symptom of underlying psychopathology, similar arguments could be made concerning conditions included in the DSM as a separate diagnosis – such as Trichotillomania, Encopresis and Substance Abuse Disorders. Walsh and Rosen (1988) note that Impulse Disorders may be especially prevalent among adolescents who self-harm – as these adolescents often become violent, truant, and self-harm. As such, Walsh and Rosen (1988, p. 70) consider self-harm to be an “impulsive act” – which may justify the inclusion of self-harm in the DSM under the specified category. Furthermore, Turner (2002) developed the possible criteria for deliberate self-harm as a syndrome or dependency – in which the addictive nature of the self-harm, as well as the severity of

the behaviour, is considered. As such, Turner (2002) illustrates her opinion that deliberate self-harm is similar to other addictions – such as alcoholism and chemical dependence – as the author argues self-harm to be characterised by physical dependency, cravings, and total personal involvement in severe cases of deliberate self-harm. This view, however, necessitates more research in order to validate and confirm the argument made by Turner (2002).

2.5 THE LINK BETWEEN DELIBERATE SELF-HARM AND SUICIDE

As noted in the definition of deliberate self-harm (Chapter 1), self-harm is not conducted with suicidal intent. However, several previous research endeavours have indicated that deliberate self-harm and suicidal ideation, suicidal attempts and non-fatal suicidal behaviour may be connected (for example, Hawton & Harriss, 2007; Hawton, Rodham, Evans, & Weatherall, 2002; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006; Nock, Prinstein, & Sterba, 2009). Specifically, the twenty-year longitudinal study by Hawton and Harriss (2007) aimed at investigating the possible connection between deliberate self-harm and eventual suicide indicated that 43 of the 141 deaths of participants in the study were due to suicide. It is imperative, however, to note the differences between deliberate self-harm and suicidal attempts and non-fatal suicidal behaviour – so as to assist the designed treatment for each of these two distinct behaviours. Deliberate self-harm and non-fatal suicidal behaviour can, according to Walsh (2006) be differentiated based on nine factors: intent; level of physical damage; frequency of the behaviour; use of multiple methods; level of psychological pain; constriction of cognition; helplessness versus hopelessness; psychological aftermath of the incident; and the core problem associated with the behaviour. These factors are discussed in this section – so as to illuminate the factors specific to self-harm that should be considered when addressing the behaviour.

2.5.1 Intent of the Behaviour

Walsh (2006) notes that through persistence and compassion, it is possible for a clinician to determine the intent of either suicidal or self-harming behaviour – even if

the motivations for the behaviour appear ambiguous to the individual. The intent of suicidal behaviour revolves around the permanent termination of negative emotional and psychological states (Walsh, 2006). Individuals who self-harm, on the other hand, intend to alter consciousness – in order to relieve or improve current emotional or psychological state. According to Walsh (2006), the intent of self-harm can be classified in two categories: Firstly, the majority of individuals who self-harm note the intent to relieve an excess of emotions – typically anger, shame, anxiety, panic, depression, frustration or contempt – that overwhelms the individual. Secondly, Walsh (2006) and Walsh and Rosen (1988) note that the intent of deliberate self-harm could also center around the release from the absence of emotional states. As such, a small portion of individuals who self-harm report a distinct period of the absence of emotions – often characterised by dissociation – that could be relieved by self-inflicted injuries (Walsh, 2006).

2.5.2 Level of Physical Pain Caused by the Behaviour

Walsh (2006) notes that the physical damage – as well as the methods used in the behaviour – could be indicative of the intent of the behaviour. As such, the ambiguous nature of the intent of the behaviour exhibited by an individual could be classified as having either suicidal- or self-harming intent based on the methods an individual employs in the incident; as the commonly used methods in these two behaviours typically differ extensively (Walsh, 2006). Firstly, the most commonly employed methods for suicide attempts – for all ages, including the age group in which self-harm most commonly occurs (15 to 24 years of age) – include the use of a firearm; suffocation or hanging; poisoning (including an overdose); a lethal fall from a height; cutting or piercing; and drowning (Walsh, 2006). As such, the number of individuals who commit suicide by the most common method of self-harm – being cutting – is much lower than publicised in the media. Noting any of the abovementioned behaviours in an individual – especially the intent to utilise a firearm; suffocation; poisoning or jumping from a height – should alert a clinician to the increased possibility of suicidal intent (Walsh, 2006). Secondly, although research results differ on the most commonly reported methods of self-harm; the methods of deliberate self-harm commonly noted in

research and literature include cutting; scratching; carving; excoriation of existing wounds; self-hitting; self-burning; head banging; and self-inflicted tattoos (Walsh, 2006). According to Walsh (2006), these methods have a lesser possibility of being lethal – as such, noting these behaviours in individuals could result in a tentative conclusion that the intent of the behaviour is not suicidal.

2.5.3 Frequency of the Behaviour

The frequency with which the two forms of behaviour occur differ extensively between non-fatal suicidal behaviour and deliberate self-harm (Walsh, 2006). As such, individuals who attempt to commit suicide generally do so only once or twice – thereafter, treatment is sought, and the attempts subside. Individuals who do attempt suicide more frequently or recurrently typically have a psychological diagnosis such as Major Depression or Borderline Personality Disorder; and employ methods that are less likely to result in death, or result in discovery by individuals in the immediate environment (Walsh, 2006). Deliberate self-harm, on the other hand, occurs at a much more frequent rate than suicide (Walsh, 2006). Although the amount of self-harm for individuals vary – in a single episode, as well as the amount of episodes that occur for an individual throughout a period of time – Walsh (2006) notes that the amount of self-harm for a single individual may be in the hundreds.

2.5.4 Use of Multiple Methods

Walsh (2006) notes that suicidal behaviour and self-harm can be distinguished by the use of single or multiple methods of causing injury. As such, individuals who do attempt to commit suicide recurrently typically employ a single method – being poisoning (overdose of prescribed or other medications); whereas the majority of individuals who self-harm generally employ multiple methods (Walsh, 2006). The reason for employing multiple methods in deliberate self-harm is two-fold: Firstly, individuals who self-harm may prefer different methods of self-harm in different situations. As such, an individual may prefer cutting when anxious or depressed, and self-burning when frustrated or enraged (Walsh, 2006). Secondly, circumstances could determine which methods of

self-harm are more executable. For example, individuals in a residential setting or inpatient treatment facility may not have access to methods that they would generally prefer (Walsh, 2006). As such, individuals who typically self-harm by cutting may only be able to self-harm by self-biting or self-hitting in the residential setting.

2.5.5 Level of Psychological Pain

The level of psychological pain in non-fatal suicidal behaviour and deliberate self-harm differs somewhat (Walsh, 2006), generally indicating the need for a clinician to evaluate and interview the individual in order to determine this level of psychological pain. In individuals who are suicidal, the extreme psychological pain results in the conclusion by the individual that the only solution would be permanent escape (Walsh, 2006). As such, the psychological pain is “intolerable, unlivable...resulting in profound psychic fatigue” (Walsh, 2006, p. 13). The level of psychological pain in deliberate self-harm, however, appears to be “interruptible and intermittent” – as the act of self-harm serves to temporarily reduce the negative emotional states and psychological pain (Walsh, 2006, p. 13).

2.5.6 Constriction of Cognition in Self-Harm versus Suicide

According to Walsh (2006) and Walsh and Rosen (1988), suicidal behaviour is often characterised by a complete constriction of cognition. As such, individuals who are suicidal generally perceive the world in an “all-or-nothing” perspective, for example claiming “If I fail Maths, I will kill myself”. The thought patterns of individuals who self-harm, on the other hand, tend to be disorganised or fragmented – however, a degree of rationality and realistic thought processes are present (Walsh, 2006; Walsh & Rosen, 1988). As such, an individual who self-harms recognises that there are a variety of options available to him for reacting to a specific situation – the individual consistently chooses to self-harm in reaction to the events (Walsh, 2006).

2.5.7 Helplessness and Hopelessness

According to Walsh (2006) there are two further essential aspects of suicidal behaviour that are lacking in individuals who self-harm: Firstly, Walsh (2006) notes that helplessness is a core feature in suicidal individual, in that individuals who are suicidal typically report a loss of control in all situations. As such, these individuals perceive themselves to have no influence on the outcomes of their current or future situations. This contrasts with individuals who self-harm – in that individuals who self-harm generally do so in order to regain control over their psychological pain (Walsh, 2006). These individuals may even find comfort in the knowledge that self-harm – as a coping mechanism for psychological pain or discomfort – is readily available and possible in most situations. Secondly, hopelessness refers to the perception that psychological pain is endless, permanent and without a possible positive outcome – that any future will be characterised by enduring psychological pain (Pillay & Wassenaar, 2007; Walsh, 2006). Individuals who are suicidal generally perceive their suffering to be permanent – as such, the only solution that remains to escape the constant psychological pain, is suicide. According to Pillay and Wassenaar (1995), hopelessness is the most important feature of individuals who are suicidal. Individuals who self-harm typically acknowledge that their psychological pain is temporary, though recurring – in that the self-harm serves to alleviate the overwhelming psychological pain experienced by the individual before the harming episode (Walsh, 2006). Thus, self-harm as a coping mechanism for psychological pain is the contradiction of helplessness and hopelessness. Walsh and Rosen (1988) note that self-harm is generally precipitated by a sense of alienation from the self, rather than a sense of helplessness and hopelessness.

2.5.8 Psychological Aftermath of the Incident

The psychological aftermath of an incident differs extensively between non-fatal suicidal behaviour and self-harm – it is therefore often a key indicator of the intent of the behaviour. Walsh (2006) notes that the psychological aftermath of an individual who attempted suicide typically involves an increase in psychological pain – as well as self-

criticism. This is due to the disappointment with the self for the failed attempt – as well as the fact that the failed suicide attempt did not provide a solution for the psychological pain experienced (Walsh, 2006). The main attraction of self-harm for those who engage the behaviour, on the other hand, lies in the fact that the act of self-harm reduces psychological pain and results in relief (Walsh, 2006). As such, the psychological aftermath of a self-harm episode is generally characterised by a reduction in the emotions that led the individual to self-harm – be it frustration, anger, contempt, anxiety, shame or guilt.

2.5.9 The Core Problem Associated with the Behaviour

The core problems associated with the suicidal or self-harming behaviour generally differ extensively. As such, individuals who attempt or commit suicide tend to be characterised by a combination of depression, sadness and hatred (Walsh, 2006). It is therefore important for the clinician to determine the source of the hatred – which could be either the self or another – and to reduce the hatred toward this source. In self-harm, the core problem revolves around a poor body-image – or, alternatively, intense stress, peer influences, and a lack of adequate and appropriate self-soothing skills (Walsh, 2006).

2.6 EXISTING LITERATURE ON DELIBERATE SELF-HARM AMONG ADOLESCENTS IN CHILDREN'S HOMES

There are only two documented studies that focus on the deliberate self-harm of adolescents in children's homes: Firstly, Walsh (1987) conducted a study in the United States of America to find empirical support for the two risk factors he identifies for self-harm among adolescents. These risk factors include childhood conditions and experiences – under which Walsh and Rosen (1988) include the loss of a parent, childhood illnesses, physical and/or sexual abuse, marital conflict, and familial self-defeating behaviours – and adolescent conditions – which include recent loss, social isolation, bodily alienation and the presence of an impulse control disorder (Walsh & Rosen, 1988). The study attempted to determine the influence of the above-mentioned

factors on the deliberate self-harm of adolescents – through interviews with 52 adolescents who self-harm, and 52 adolescents who do not self-harm. The findings indicate that adolescents who are either in foster care or in children's homes – and therefore experienced the loss of a parent – are more likely to self-harm than adolescents from stable home environments (Walsh, 1987; Walsh & Rosen, 1988). The high prevalence of deliberate self-harm in both foster care and children's homes is, according to Walsh and Rosen (1988, p. 61), due to the “separation from a parent without permanent termination of the relationship”. Secondly, the research by Stanley (2007) in children's homes in the United Kingdom comprised of two components: Firstly, the research attempted to provide information regarding the general perceptions of adolescents in children's homes (Stanley, 2007). Secondly, the research aimed to determine the concerns of personnel involved in the care of adolescents in their care. Concerning the perceptions of adolescents, the findings indicate that “the context in which [the adolescents] are living and developing is heavily implicated in their mental health problems... the [children's home] system can entail separation from family, moves and disruptions, variable standards of care and exposure to the distress and disturbance of other children” (Stanley, 2007, p. 259). Stanley's (2007) findings indicate that personnel in children's homes are concerned about high-risk behaviours – for example eating disorders, substance abuse and deliberate self-harm – in which adolescents engage. As such, 49% of personnel reported knowledge of occasional or rare deliberate self-harm, 27% reported knowledge of regular deliberate self-harm, and 10% reported knowledge of frequent deliberate self-harm among adolescents in their care (Stanley, 2007).

To date, no research has attempted to understand the self-harm among adolescents within South African children's homes. The current study attempts to explore the prevalence, methods, and severity of deliberate self-harm among South African adolescents in children's homes employing a small sample – so as to address the lack of in-depth understanding concerning this phenomenon.

2.7 EXISTING LITERATURE ON THE CONTAGION OF DELIBERATE SELF-HARM

Walsh and Rosen (1988) consider the contagion of deliberate self-harm a characteristic that distinguishes these behaviours from other psychological disturbances. Furthermore, Nock (2009) notes that more research is required to understand the influence of the information provided by individuals in a person's environment can contribute to deliberate self-harm. In this section, both the literature and empirical evidence for the phenomenon of contagion of self-harm is discussed.

The contagion of self-harm – defined in Chapter 1 – can occur in two ways: Firstly, an individual can acquire deliberate self-harm through the observation of the methods and rewards for the behaviour in others; and secondly, an individual's self-harm can trigger the self-harm of others in the same environment – a phenomenon often referred to as “epidemics” of deliberate self-harm (Walsh & Rosen, 1988). The current study refers to both the acquisition of deliberate self-harm through observation, as well as the epidemics of deliberate self-harm as contagion of self-harm. According to Yates (2004), the contagion of self-harm occurs mainly due to social learning processes, supported by the Social Learning Theory. Originally proposed by Bandura (1977), the Social Learning Theory is understood as “an approach to the study of social behaviour and personality... based upon the role of observation and the mimicking or imitation of behaviours observed in others, usually referred to as models” (Reber & Reber, 2001, p. 689). As such, individuals observe self-harm in others – for example, peers, relatives or through the media – and thereafter adopt the behaviour. Reber and Reber (2001, p. 615) define reinforcement – an important concept in the Social Learning Theory – as the “operation of strengthening, supporting or solidifying something, or the event that so strengthens and supports it... most commonly found in conditioning and learning”. Reinforcement is typically used to understand the maintenance of self-harm (Yates, 2004). According to Nock and Cha (2009, p. 72) “it is likely that modeling the behaviour of others plays a significant role in the occurrence of [deliberate self-harm]”. As such, these authors consider both peers and the media to have a considerable influence on the development of an adolescent's self-harm – indicating the contagion of

self-harm. However, Nock and Cha (2009) recognise that not all adolescents exposed to peers or media that illustrate self-harm do adopt the behaviour – which emphasises the need for research on factors that may cause the adolescents to adopt the self-harming behaviour.

According to Plante (2007), adolescence is characterised by vulnerability to peer influence – which could be applicable to many forms of self-destructive behaviours; such as eating disorders, substance abuse, violence, suicide, and deliberate self-harm. Adolescents in residential settings are, furthermore, more likely to adopt self-harming behaviour through contagion for several reasons: Firstly, removal from parental care and placement in inpatient or residential settings could indicate underlying psychopathology common to individuals who self-harm – such as personality disorders or impulse control disorders (Plante, 2007). Secondly, Plante (2007) notes that the context could exacerbate existing psychopathology in adolescents – as the setting reduces an individual's sense of control over environmental events. This perceived lack of control and anxiety within the specific environment could translate into attempts to regain control; often in the form of self-destructive behaviours such as deliberate self-harm. Lastly, adolescents may gain a sense of belonging and acceptance by engaging in behaviours common to fellow adolescents (Plante, 2007; Ross & McKay, 1979). In such instances, the adolescent may initiate self-harming behaviour due to the lack of close relationships within the environment – which is characterised by an estranged or lack of relationships with the family.

Walsh (2006) and Walsh and Rosen (1988) provide a comprehensive discussion of the possible motivations for a specific episode of contagion of self-harm. In this summary, the authors consider four motivations: communication patterns, the attempts to alter the behaviour or actions of others, peer group influences, and the contagion of self-harm as a response to the residential staff or treatment. Firstly, the contagion of self-harm as a pattern of communication refers to two opposing situations: the desire for acknowledgement, in which the observers of the act of self-harm or the scars acknowledge the internal pain, anger, loneliness and depression that underlie the act of deliberate self-harm; or the desire to punish others, in that an adolescent could

communicate the resentment of a peer following a perceived offence through self-harm (Walsh, 2006; Walsh & Rosen, 1988). Secondly, Walsh and Rosen (1988) note that the contagion of self-harm within a peer group could be employed as a method of shocking others – and thus changing the behaviour of others. In such instances, the motive for the episode of self-harm could be to offend or disgust either nonmembers of the self-harming peer group; or challenge and shock the existing group members with more extreme forms of self-harm – which could result in a continuous cycle of attempts within the group to shock or offend others (Walsh, 2006; Walsh & Rosen, 1988). Alternatively, the contagion of self-harm could be utilised in order to change the behaviour of others through manipulation. As such, individuals who self-harm commonly employ the threat of self-harm as a method of manipulating others – gaining attention or compliance with demand in interpersonal relationships (Walsh & Rosen, 1988). However, adolescents in a peer group of self-harming individuals generally use the actual act of self-harm in order to manipulate the group members – as the mere threat of self-harm is ineffective with other self-harming individuals who use similar tactics – which could result in an episode of contagion in order to manipulate others. Third, peer group influences in the contagion of self-harm could refer to three distinct situations. In the first instance, the peer relationships formed between a group of individuals who self-harm are often experienced by the group to be more intense than friendships in normative situations (Walsh, 2006; Walsh & Rosen, 1988). As such, the possibility of serious injury of one of the group members, the lack of alternative close relationships and the shared underlying psychological struggles of the group members create a situation in which all group members experience a strengthened connection with fellow members – thus resulting in a maintenance and co-occurrence of self-harm among members (Walsh & Rosen, 1988). In the second instance, individuals in a group setting may have reduced inhibitions regarding deliberate self-harm through the modeling of the behaviour – resulting in multiple incidents of self-harm across individuals (Walsh, 2006; Walsh & Rosen, 1988). Through observing the self-harm of others in a group setting – and the lack of pain advocated by those who engage in the behaviour – the general perception that self-harm is socially undesirable, stigmatising, disfiguring and indicative of psychopathology may become obscured and replaced by an attempt to experience the release of emotional turmoil. The study by Nock and Prinstein

(2004) – in which the contextual features and functions of deliberate self-harm among adolescent participants was explored – provides support for this tendency; in that 82.1% of the participants reported instances of deliberate self-harm among at least one of their peers or friends. Furthermore, the researchers concluded that these instances were feasibly directly influenced by the modeling of self-harm behaviour (Nock & Prinstein, 2004). Lastly, episodes of self-harm contagion could occur in groups of peers due to the hierarchies formed within the group (Walsh, 2006; Walsh & Rosen, 1988). Typically, the factors that determine a member's prominence within a group of self-harming individuals include the severity of the self-harm, the amount of self-harm that occurs, the severity of the individual's underlying psychological difficulties, and the ability of the member to provide support to others during episodes of crisis. These factors could result in the contagion of self-harm within a group setting – as the adolescents contend for status and prominence within the group (Walsh & Rosen, 1988). Lastly, the responses to staff and treatment could influence the contagion of self-harm in two ways: In the first instance, the poor staff-to-adolescent ratio in a residential setting could result in a competition for resources for the adolescents in the facility (Walsh, 2006; Walsh & Rosen, 1988). As such, the adolescents may resort to exhibiting self-harming behaviour in an attempt to gain the care and attention of staff members – resulting in contagion of self-harm among the adolescents in the facility. In the second instance, the anticipation of consequences within the residential setting may influence the contagion of self-harm – in that adolescents discern that certain behaviours hold more aversive consequences than do others (Walsh, 2006; Walsh & Rosen, 1988). As such, engaging in violence or serious suicide attempts could result in more severe consequences for an adolescent in a residential facility; whereas engaging in self-harm is likely to result in less aversive consequences – especially if staff resources do not allow for immediate detection or treatment of the self-harm. In these situations, an adolescent may prefer engaging in self-harm during times of extreme emotional states; allowing for the possibility of the contagion of self-harm (Walsh, 2006; Walsh & Rosen, 1988).

Although there is an abundance of literature concerning the theoretical underpinnings of the contagion of self-harm, few studies have been conducted to address this phenomenon. The most prominent empirical investigation of the contagion of self-harm

is found in the research conducted by Walsh and Rosen in 1985, who studied the contagion of self-harm among adolescents. These researchers collected data on a daily basis for a period of one year on the deliberate self-harm of 25 adolescents at the Community Treatment Complex in Massachusetts, United States of America. Their findings indicate that deliberate self-harm clusters in time, “suggesting that the adolescents were triggering the behaviour in each other” (Walsh & Rosen, 1985, p. 120). Multiple incidents of deliberate self-harm across participants occurred in nine days throughout the year, implicating severe contagion of the self-harming behaviour. Walsh and Rosen (1985) note that the contagion of deliberate self-harm can be attributed to the strong influence of peer relationships on adolescents; and may necessitate the development of group-orientated treatment within psychiatric institutions. It should be noted, however, that the findings in the research may have been influenced by variables other than those investigated. Taiminen et al. (1998) replicated the study by Walsh and Rosen (1985). As such, these researchers interviewed ten adolescent participants at the Turku University Central Hospital in Finland, who had been identified as being involved in episodes of contagion within the psychiatric institution. Participants were asked about their personal experiences of self-harm, their motivations for self-harm as well as their perceptions concerning the possible contagion of self-harm among adolescents within the psychiatric institution (Taiminen et al., 1998). The findings indicate that 37 episodes of contagion occurred during the 12 months of the study – with two participants first acquiring the self-harming behaviour during this period. The researchers concluded by noting: “Our results suggest that a majority of [deliberate self-harm] incidents on an adolescent psychiatric ward may have been influenced by contagion” (Taiminen et al., 1998, p. 215). In their conclusion, Walsh and Rosen (1985, p. 120) note that “the replication of [their results] would provide additional concrete evidence to document that self-harming contagion is a psychological phenomenon”. Considering the lack of research concerning the contagion of deliberate self-harm – which is evident in the research gap following the research by Taiminen et al. (1998) and Walsh and Rosen (1985) – and the plight of researchers for the continued interest in this phenomenon, a study on the contagion of the deliberate self-harm of adolescents in children's homes in Pretoria will prove beneficial.

In this chapter, several aspects of deliberate self-harm – as theorised, explored and further investigated in previous accounts – have been discussed. The applicability of the literature to the findings in the current study is addressed in Chapter 4, as the current study may confirm and possibly expand on previous literature concerning deliberate self-harm.

CHAPTER 3: RESEARCH METHODOLOGY

In this chapter, several aspects of the methodology employed in the current study – being the research context(s); participants in the study; research design; data collection procedures; ethical concerns; as well as the relevance of the current research are discussed. By doing so, the researcher explains and clarifies the research methodology of the current study – including clear motivations for the methodology selected in the current study – so as to allow for possible replication of the findings in later research.

3.1 RESEARCH DESIGN

The current study employed both quantitative measures, for the measurement of the methods, frequency, severity and motivations of deliberate self-harm; and qualitative measures, which allowed the researcher to explore the perceptions of the adolescent sample concerning the experience of deliberate self-harm and the two forms of contagion of self-harm. Here, these two designs are discussed in relation to the current study.

There are several characteristics of quantitative research in the social sciences. Firstly, descriptive strategies, which form an integral part of quantitative research, obtain data from participants in order to describe psychological phenomena for a group of individuals as a whole. Secondly, quantitative research often attempts to examine various variables for each participant that varies in quantity – such as magnitude or duration (Gravetter & Forzano, 2009). Third, the findings obtained from individual participants in quantitative research are compared to establish commonalities (Gravetter & Forzano, 2009). Lastly, quantitative measures are statistically analysed to identify significant correlations (Gravetter & Forzano, 2009). The current study assesses the differences in individual participants' self-harm – by assessing the severity, duration, frequency and motivations of self-harm through two self-report measures, being the DSHI (Gratz, 2001) and the FASM (Lloyd, 1997). The researcher aims to compare the responses on these questionnaires in order to determine possible commonalities in self-harm among the adolescent sample (similar to the research conducted by Gratz, 2001).

Similar to quantitative research, there are several key characteristics of qualitative research. Firstly, qualitative research often “explores a particular, possibly unique, phenomenon or experience in great detail” (Gravetter & Forzano, 2009, p. 17). Secondly, qualitative research is conducted in 'real-life settings' to eliminate the artificiality often introduced into quantitative research. Third, researchers employing qualitative measures typically reflect on their own involvement and roles in the research (Willig, 2008). Fourth, qualitative research aims to gain greater insight into the participants' perspectives – by collecting complete accounts of psychological phenomena. Lastly, participants in qualitative research are often provided the opportunity to review the findings – and therefore provide feedback on the accuracy of the interpretation of the findings (Willig, 2008). The current study employed the use of qualitative measures to explore the possible contagion of deliberate self-harm among adolescents in children's homes. As such, the current study attempted to gain a complete account of the contagion of self-harm through the use of semi-structured interviews – in order to explore the perceptions of the adolescent sample. The current study furthermore provided all participants the opportunity to comment on the accuracy of the interpretations of the transcribed interviews. The study lastly utilised a descriptive qualitative design, in which participants were enquired with regard to the functions and motivations for their self-harm, as well as the possible contagion of self-harm (similar to the design employed by Rissanen et al., 2008).

Employing a quantitative design therefore allows for standardised, detailed information regarding the nature of deliberate self-harm – by using questionnaires with predetermined items – whereas including a qualitative design allows for richer information to be explored – particularly for the possible contagion of deliberate self-harm, for which no predetermined data collection measures exist.

3.2 RESEARCH CONTEXT(S)

Four children's homes in the Pretoria area, Gauteng, agreed for participation in the current study. The adolescent participants were housed at these four children's homes – in accordance with Section 15(1C) of the Child Care Act, Act 74 of 1983, as amended –

and were therefore under the guardianship of the head of each children's home (Terminology Committee for Social Work, 1995). The researcher conducted both sections of the data collection procedure – the completion of two questionnaires by the adolescent participants, as well as the three semi-structured interviews with the participants – at the children's home where each participant was housed. The data collection procedure occurred in a quiet office in each of the children's homes, where interruptions and excess distractions were minimal.

There are four main advantages of employing the selected context in which the data was collected in the current study. Firstly, Dyer (2006) notes that conducting a study in a context with which participants are familiar often results in greater willingness to provide information essential to the study. This might be especially important in the current study – as the study aimed to explore in-depth the experiences and perceptions of adolescents concerning their deliberate self-harm; and willingness to report information of a sensitive nature was essential. Although the context may be experienced by participants in some instances or aspects to be non-nurturing, the context remains a familiar and predictable environment – in which participants may have been more inclined to provide information essential to the study. Secondly, the increased willingness of participants to provide information essential for the study may be especially true in studies that employ the use of adolescent samples (Eder & Fingerson, 2002). According to Eder and Fingerson (2002), the possibility of a power-relationship between the researcher and participants becomes of particular concern in studies employing adolescent samples – which emphasises the need for conducting the study in a context with which the adolescents are familiar and comfortable. A reduction in the power-relationship between the researcher and participants – caused by greater confidence in the familiar environment – allows for an increase in the willingness to report information of a sensitive nature, such as deliberate self-harm. Lastly, conducting the study at an office at each children's home prevented the need for the adolescent sample to explain their absence from the children's home to other children housed at the facility. By eliminating the participants' fear of having to divulge or explain their whereabouts while participating in the study; the adolescents may have been more relaxed and provided the essential in-depth information the study aimed to explore.

3.3 PARTICIPANTS

The current study employed a nonprobability sampling method; in which “the population is not completely known, individual probabilities cannot be known, and the selection is based on factors such as common sense or ease, with an effort to maintain representativeness and avoid bias” (Gravetter & Forzano, 2009, p. 134). As the actual prevalence of deliberate self-harm was difficult to determine in a setting such as a children’s home, this method of sampling was considered most appropriate for the current study. The sample for the study consisted of 12 adolescents from the four children’s homes in the Pretoria area, Gauteng – ranging between the ages of 12 and 17. For a break-down of the demographic features of the sample, see Figure 1.

Pseudonym	Current Age	Age of removal from parental care	Reason(s) for removal from parental care (according to participant)	Parents/ Guardians	Siblings
Bianca	17	7	Negligence and inconsistent parenting	Father unknown, mother missing	N/A
David	13	3	Inconsistent parenting	Mother deceased, father remarried	N/A
Chris	15	9	Physical abuse	Divorced	N/A
Natalie	14	12	Criminal charges against parents	Unmarried	1 sister, 1 brother
Michelle	13	10	Inconsistent parenting	Divorced	1 brother, in children's home
Faith	12	9	Inconsistent parenting	Divorced	1 sister in children's home, 1 half-sister
Liza	16	8	Death of biological mother, lack of care	Mother deceased, father remarried	N/A
Megan	12	11	Inconsistent parenting	Mother deceased, father remarried	1 sister, in children's home
Felicity	13	3	Criminal charges against parents	Married	1 brother, in children's home
Emily	16	9	Sexual abuse, lack of care	Unmarried	1 sister, adopted
Willow	17	15	Inconsistent parenting	Mother deceased, father remarried	1 half-brother
Kate	16	9	Physical abuse, lack of care	Married	1 sister

Figure 1: Demographic Features of Participants

While the size of the sample in the current study does not allow for generalising to the greater population; it allowed the researcher the opportunity to explore in-depth the experiences and perceptions of the adolescent sample concerning their deliberate self-

harm, as well as the possibility of contagion of self-harm occurring in the children's homes.

It is essential in a study utilising an adolescent sample that the parents or legal guardians of each participant provide consent for participation by the minor – who until the age of 18 is considered incapable of providing informed consent for participation in a research study (Gravetter & Forzano, 2009). In the case of utilising an adolescent sample from a children's home, the head of the children's home is responsible for providing consent for the adolescents to participate in the study – as the head of the children's home serves as the legal guardian for the adolescents in his/her care, in accordance with Section 15(1C) of the Child Care Act, Act 74 of 1983, as amended (Terminology Committee for Social Work, 1995). As such, the researcher contacted the four children's homes in the Pretoria area, Gauteng; and thereafter invited the personnel of each children's home to a meeting – during which the personnel at the children's homes were informed of the purposes of the current study, as well as how the data will be collected, interpreted and utilised. After the researcher clarified any uncertainties with regard to the study, the head of the children's homes agreed for the participation of the adolescents residing at each children's home.

After consent for participation was obtained from the head of the children's homes; the social workers involved in the care of each adolescent explained the purposes of the study to possible adolescent participants; and gained permission from those adolescents interested for contact with the researcher. The potential adolescent participants were thereafter contacted and invited to an introductory interview with the researcher. Assent for participation was obtained from each individual participant after the researcher again explained the purposes of the research study, the methods employed, and emphasised the voluntary nature of participation – as well as clarified any ambiguities with regard to participation in the study.

3.4 DATA COLLECTION PROCEDURES

The data collection procedures for the current study consisted of two sections – allowing for the triangulation of methods: The first section of the data collection procedure in the study consisted of the completion of two questionnaires concerning deliberate self-harm; while the second section of the study consisted of the completion of a logbook by each participant concerning their self-harming behaviour, as well as three semi-structured interviews with each individual participant, in order to gain greater insight into the perceptions, emotional states and experiences of adolescents who self-harm – with specific focus on instances in which contagion of deliberate self-harm occur (as suggested by Dyer, 2006). Here, these two sections of the current study are discussed, in order to clarify the procedures followed.

During the first section of the data collection procedures in the current study, the adolescent participants from the four children’s homes in the Pretoria area, Gauteng, completed two questionnaires – the DSHI, and the FASM – designed to quantitatively determine the nature of deliberate self-harm in those who complete the questionnaires. The DSHI developed by Gratz (2001), measures the frequency, duration and severity of several methods of deliberate self-harm – as reported by participants. The methods included on the questionnaire are those most often reported by individuals who engage in self-harm – based on findings from testimonials, clinical observations of individuals who self-harm, and previous research – and include cutting, scratching, burning, carving, biting, inserting objects under the skin, and the use of chemicals such as bleach (Gratz, 2001). The questionnaire requires participants to respond with simple “yes” or “no” answers to the 17 methods of deliberate self-harm provided on the questionnaire – which are allocated either a score of 1 or 0, respectively, during data analysis. Following these responses, participants are enquired about the frequency, duration and need for medical attention due to each method of self-harm practiced by the participant (Gratz, 2001). The DSHI – in the current study – was employed in order to yield descriptive data concerning the deliberate self-harm of the adolescent participants. The DSHI has been indicated to have a high internal consistency – with the calculated Cronbach’s alpha at ($\alpha = .82$) and a mean item total correlation of $r=.43$. The DSHI also indicates

adequate test-retest reliability over a period of two to four weeks – with a mean of 3.3 weeks ($\Phi=.68$, $p<.001$) – emphasising the DSHI’s reliable categorisation of individuals as either self-harming or non-self-harming (Gratz, 2001; Nock & Prinstein, 2004). The DSHI further proves to be adequate with regard to construct validity; and indicates convergent and discriminant validity when compared to single-item measures commonly used to measure deliberate self-harm (Gratz, 2001). Although no data exists concerning the reliability and validity of the DSHI in South Africa, international data indicates that all issues with regard to reliability and validity have been addressed. The DSHI has been employed in various research endeavours – including the research by Castille et al. (2007); Gratz and Roemer (2004); Heath, Toste, Nedecheva and Charlebois (2008). The FASM developed by Lloyd (1997) measures the frequency, methods, and motivations of deliberate self-harm. Nock and Prinstein (2004) note that the FASM may be considered especially appropriate for the measurement of deliberate self-harm among adolescents – as the FASM was developed following an extensive review of literature, and focus groups held with adolescents who self-harm, in order to identify items and methods included in the FASM. Only the last 23 items on the questionnaire – concerning the motivations for the self-harm of the adolescent participants – were utilised in the current study, as the first sections of the questionnaire closely resemble those items completed by participants in the DSHI. Participants were required to respond on a scale from “never” to “often” on these 23 items (Lloyd, 1997). A response of “often” could indicate a greater severity of self-harm, as the respondent note a greater number of motivations for self-harm. Guertin, Lloyd-Richardson, Spirito, Donaldson and Boergers (2001) report adequate internal consistency of the FASM ($r=.65-.66$) in their study. Nock and Prinstein (2004) further assessed the structural validity of the FASM – particularly as it assesses functions of deliberate self-harm, an interest of these authors – and found that their results supported the structural validity of this measure. The FASM has been successfully employed in previous research endeavours, such as research on a community sample of adolescents by Lloyd-Richardson, Perrine, Dierker and Kelley (2007); research by Najmi, Wegner and Nock (2007); and research by Nock et al., (2006) on the self-harm among adolescents. It is important to note, however, that the questionnaires were not the main focus of the current study. Instead, the DSHI and FASM allowed for the greater exploration of the

nature of deliberate self-harm of the adolescent participants during the three semi-structured interviews. As such, the researcher addressed key features of the adolescent participants' self-harm during the semi-structured interviews – by eliciting greater detail concerning the responses provided in the questionnaires.

The second section of the data collection procedure in the current study consisted of the completion of a logbook by each participant – a specific form of structured diaries, which prevents the reliance on retrospective memory only during the semi-structured interviews – as well as multiple semi-structured interviews with each adolescent participant. The logbook – on which participants noted the date, time of day, incident (being any event that leads to a negative emotional reaction), emotional reactions and coping strategies (which could include, amongst others, deliberate self-harm) – resembled many of the properties of a structured diary. Although this method of data collection is not used as extensively as many other methods in qualitative research (Willig, 2008); this method was considered especially appropriate for the current study, for several reasons. Firstly, adolescents may feel more comfortable recording information regarding their deliberate self-harm in a logbook that appears similar to a diary – as many of the adolescent participants may have a personal diary. Secondly, the adolescent participants may be more comfortable responding to questions during the semi-structured interviews for which they have been prepared – as the interviews mainly focus on gaining greater insight into some of the information noted in the logbook (Willig, 2008). After noting the information concerning their deliberate self-harm in the logbook, the adolescent participants may anticipate further questions concerning the specific incidents. Third, the completion of the logbooks throughout the duration of the study prevents the reliance on retrospective verbal reporting alone (Willig, 2008). As there were intervals of one week between each of the three interviews held with each adolescent participant – it is likely that some details concerning episodes of self-harm could have been forgotten, if not for a written cue of the event. Fourth, the logbooks could provide greater insight into the motivations for the participants' deliberate self-harm – for both the researcher and the adolescent participants. By discussing the information noted in the logbooks during the semi-structured interviews, the researcher and participants may become aware of unknown triggers for the self-

harm, as well as common causes of the self-harming thoughts and behaviours – which could essentially be beneficial for the adolescent participants as well. This method of gaining insight into the triggers for an individual’s self-harm – referred to as a ‘self-injury log’ – is commonly employed in the therapeutic process for self-harm (Walsh, 2006). Lastly, the information noted in the logbooks of all the adolescent participants may provide a cue for the researcher concerning possible episodes of contagion of deliberate self-harm. The researcher would then also be able to follow up on these instances – and clarify any possibility of such contagion occurring. The logbooks were provided to each adolescent participant after completion of the two questionnaires. At the time, the researcher again explained the purposes thereof, how the information provided in the logbooks would be kept confidential throughout the duration of the study, and how the participants would go about completing the logbooks. The researcher furthermore clarified any practical concerns with regard to the logbooks – such as clarifying any terms that might have been unclear to certain participants. The adolescent participants were requested to complete the logbooks daily – or as incidents of self-harm occur – throughout the three weeks during which the data collection occurred. The primary purpose of the logbooks was to indicate any instances in which self-harm co-occurred in the children’s homes – which could suggest episodes of contagion of deliberate self-harm. As such, the content of the logbooks were discussed at length with each adolescent participant during the three semi-structured interviews – to elicit greater detail on the antecedents of the incidents in which self-harm occurred. The logbooks were stored at the offices of the social workers assigned to the care of the adolescent participants throughout the duration of the study. As such, the logbooks were kept in a cabinet used by the social workers – to which access is restricted. The participants had free access to the offices – whilst still protected for the privacy and confidentiality of the contents of the logbooks. The social workers assigned to the care of the participants agreed to the protection of the logbooks in their offices – and further committed to uphold the confidentiality of the participants in the study.

Multiple semi-structured interviews held with each adolescent participant followed the completion of the two questionnaires, and coincided with the completion of the logbooks. Dyer (2006, p. 32) notes that, in semi-structured interviews “the general

direction of the interview may be mapped out in advance as a series of topics but as the interview proceeds, the questioning process is guided by the content in the [participant's] answers". Semi-structured interviews allow for the gaining of greater insight into psychological phenomena, as it encourages participants to elaborate on their personal experiences; whilst the researcher maintains some control over the progression and direction of the interview (Dyer, 2006; Willig, 2008). The semi-structured interviews were initiated through an introduction between the researcher and each adolescent participant. This introduction allowed the researcher and participants to establish rapport, and discuss the issues of confidentiality, the right to withdraw from the study at any stage, the tape-recording of the semi-structured interviews and the subsequent transcription thereof, and the various methods that were employed in the study (as suggested by Seidman, 2006). Participants in the current study were enthusiastic and willing to explore their perceptions of their deliberate self-harm openly during the process of the three semi-structured interviews. Although the majority was initially withdrawn and anxious with regard to the process – at which stage the researcher again affirmed the confidential nature of the study, and withdrawal from the study at any stage – the adolescent participants indicated enthusiasm concerning the study. Several participants reported interest in the study and the findings thereof, as well as relief to be in a position to discuss their self-harm openly without fear of judgment or reprimand. Participants responded well to the majority of the questions posed by the researcher, however, discussions of the participants' histories and reasons for removal from parental care elicited indifference or anxiety in some cases. These were addressed and responded to by the researcher. Furthermore, several participants appeared relaxed and comfortable in the setting – though apprehension was clear concerning the tape-recording of the interviews.

3.5 DATA ANALYSIS

The current study employed both quantitative measures – being the completion of two questionnaires concerning deliberate self-harm – and qualitative measures – being the semi-structured interviews conducted with each adolescent participant. These different measures required different approaches to data analysis or interpretation. It is therefore

essential that the processes of data analysis or interpretation for both sections of the current study are discussed. Here, these processes are briefly reviewed; whereafter examples are provided relating to the current study.

The data gained from the two questionnaires – being the DSHI developed by Gratz (2001) and the FASM developed by Lloyd (1997) – were analysed as quantitative data. The data gained from the two questionnaires in the current study were descriptive in nature – indicating that the data are “intended to summarise single variables for a specific group of individuals” (Gravetter & Forzano, 2009, p. 167). The data from the two questionnaires in the study were, therefore, analysed in order to yield mean averages and percentages (Gravetter & Forzano, 2009). For example, the mean or average age of onset of deliberate self-harm (being 11.55 years of age for cutting in the current study), the mean duration (being 3.73 years for cutting in the current study), as well as the mean frequency of the adolescents' self-harm (being 45.91 for cutting in the current study) was determined. The percentage of adolescents who endorse specific methods of deliberate self-harm – such as cutting (91.67% in the study), burning (58.33%), carving (91.67%), scratching (33.33%) or biting (8.33%) – was determined, typical of descriptive analysis (Gravetter & Forzano, 2009).

The information gained from the semi-structured interviews in the current study were formally transcribed – as close to verbatim as possible – using the methods suggested by Gail Jefferson (Willig, 2008). As such, the current study used detailed transcription of the information provided by the adolescent participants, and therefore provided a rich description of the interviews by including nonlinguistic features (Willig, 2008). These transcripts were notated from the tape recordings made during the multiple semi-structured interviews with the participants in the study. To ensure the accuracy of the transcription of the information provided by the adolescent participants in the current study, the participants were allowed ample time to review the transcripts (Willig, 2008). Following the transcription of the semi-structured interviews, the qualitative data in the study was analysed to yield a thematic interpretation. The analysis of qualitative data consists of four stages (Willig, 2008): First, the researcher produces a range of notes and thoughts concerning the interview material. Second, the researcher identifies themes in

each section of the interview material that can be labeled (Willig, 2008). During the third stage, the researcher reaches clusters of themes that are related – such as a cluster consisting of motivations for self-harm. The final stage of analysis includes the production of a table that summarises the themes identified as well as quotations that represent each theme (Willig, 2008).

3.6 ETHICAL CONCERNS

There were three ethical concerns with regard to the current study: Informed consent, confidentiality and anonymity, and psychological harm. These possible ethical concerns – as well as the countermeasures taken to reduce the possibility of these ethical concerns influencing the study – are addressed in this section.

Gravetter and Forzano (2009, p. 587) define informed consent as “the ethical principle requiring the investigator to provide all available information about the study so that the participant can make a rational, informed decision regarding whether to participate in the study”. Due to the special circumstances with regard to employing an adolescent sample from four children’s homes in the Pretoria area, Gauteng, gaining informed consent for participation was somewhat complicated. As such, informed consent was first gained from the head of each children’s home participating in the current study – as the head of the children’s home serves as the legal guardian of all minors removed from parental care and placed in the children’s home. After the heads of the children’s homes were informed of the objectives, focus, data collection processes as well as how the information gained will be utilised, the heads of the children’s homes were provided with an informed consent letter stating all the information as such. The heads of the children’s homes were then allowed the opportunity to provide consent for the participation of the adolescents in the study. After gaining informed consent from the heads of the children’s homes, the adolescents were contacted by the researcher. During an initial meeting between the researcher and each individual potential participant, the researcher explained the purposes, voluntary nature, and data collection procedures of the current study – as suggested by Gravetter and Forzano (2009). The potential participants were, furthermore, informed of the potential risks of participation in the

study – such as the potential psychological harm caused by participation – as well as the measures taken to reduce the possibility of such instances occurring in the study. The potential participants were then provided with a letter with written confirmation of these points – on which the potential participants were able to indicate their assent for the study.

During the initial meeting between the researcher and each individual participant, the researcher explained how the anonymity of each participant would be ensured in the current study. As such, the names of the participants, as well as the four children's homes participating in the study, were not used in any of the research material. Pseudonyms were employed for all participants in the study. Any further identifying particulars – of either the adolescent participants or the children's homes – were altered in order to protect the privacy of the individual participants as well as the institutions that aim to protect their interests and encourage their adaptation into society. The current study furthermore ensured that all information provided by the adolescent participants would be kept confidential – emphasising the confidential nature of the study, a feature considered essential in psychological research (Gravetter & Forzano, 2009). The confidential nature of the current study was explained and clarified during the initial meeting between the researcher and the adolescent participants. As such, the information gained throughout the data-collection procedure in the study were kept private – in that none of the information was shared with any individuals not directly involved in the process of obtaining or interpreting the information. According to Gravetter and Forzano (2009), ensuring confidentiality in psychological research could result in greater openness and honest reporting on the part of study participants. In the current study, the greater openness with regard to the participants' deliberate self-harm could have resulted in a greater understanding of the phenomenon. Confidentiality of the logbooks was considered especially important for the current study. The logbooks were kept at the offices of the social workers, at the children's homes, throughout the data collection procedure of the current study – if participants preferred this option. This allowed the adolescent participants access to the logbooks at any convenient time; whilst still protecting their privacy and the confidential nature of the information written in the logbooks. It should be noted, however, that the adolescent participants in the

current study were informed of the circumstances under which the researcher would be obliged to breach confidentiality – such as indications of severe physical injury due to deliberate self-harm or suicidal ideation, as well as reports of past or current abuse not known by the children's homes. Although confidentiality of information was ensured in the study, the researcher was ethically obliged to convey any information regarding those aspects to those professionals responsible for the safety of the adolescent participants. No instances or experiences of abuse were reported by participants in the study that was unknown to the social workers assigned to the care of the participants in the study.

The most prominent ethical concern for the current study was the possible psychological harm that participation could cause. The possibility of psychological harm in the study centered on the use of an adolescent sample, in that such a sample may feasibly be more susceptible to apprehension with regard to participation; the extensive data collection procedures; and the sensitive subject matter of the study. As such, the study focused on the behaviours and perspectives of adolescents who self-harm – a phenomenon that may be an especially private and sensitive subject matter – which could have precipitated even greater levels of anxiety and apprehension than typically encountered in psychological research. Several measures were taken in the current study to reduce the possibility of psychological harm being caused. Firstly, both the heads of the children's homes and adolescent participants were made aware of the potential risks associated with participation in the study, as well as how these will be countered. As such, all parties involved in the current study were vigilant for this potential harm – and are encouraged to inform the researcher if such instances do arise. Secondly, the adolescent participants were informed before the commencement of the first interview that they can terminate any session with the researcher at any time throughout their participation. If indeed necessary, a new interview could be arranged with the participant. This allowed for the possibility that the adolescents could be particularly emotional on certain days – and thus more susceptible to psychological harm if an interview ensues. The adolescents were also informed that they could refuse to divulge any information concerning their personal experiences or experiences of deliberate self-harm throughout the study. Participants were furthermore informed

before the initiation of the first interview that withdrawal from the current study would be possible at any stage – and that if indeed they were uncomfortable, to inform either the researcher or social workers involved in their care. Third, the social workers involved in the care of each adolescent participant continued their contact with the participants throughout the data collection procedure of the study. As such, the social workers were able to notice any subtle negative changes in the adolescents during participation in the study – and could have informed the researcher if such instances were to arise. Fourth, a voluntary counselor was made available to the participants in the current study. The contact details of the counselor were left at the social workers assigned to the care of each adolescent participating in the study – allowing the participants access to the counselor through their respective social workers. Facilities were made available for the counselor to use at each children’s home – if participants would have indicated the desire to attend counseling following participation in the study. Lastly, as proposed by Gravetter and Forzano (2009) and similar to previous research concerning deliberate self-harm (for example, Rissanen et al., 2008), the three semi-structured interviews held with each participant in the current study were concluded with a debriefing – during which the researcher enquired about the possible negative emotions participation evoked, as well as whether participants felt that attending counseling would be beneficial for their psychological well-being.

This chapter specifically focused on the clear discussion of the research methodology of the current study. By highlighting the relevance of utilising the various measures of data collection with regard to the aims and objectives of the current study – an exploration of the perceptions of adolescent participants concerning their deliberate self-harm; as well as the methods, frequency, duration and severity of adolescent self-harm in children's homes – the researcher allows for the possible replication of the current study in future research. Furthermore, emphasising and discussing possible ethical concerns with regard to the current study allows for the reduction in these concerns in the current study, as well as future studies employing a similar sample of participants.

CHAPTER 4: FINDINGS OF THE CURRENT STUDY

The findings of the current study are discussed in this chapter – following careful descriptive analysis of the two quantitative measures employed in the study, being the DSHI developed by Gratz (2001) and the FASM developed by Lloyd (1997); as well as intensive thematic analysis of the qualitative data collected through the three semi-structured interviews conducted with the adolescent participants. The chapter is structured according to the three research questions posed by the researcher, so as to illustrate instances in which these questions have been fully addressed. As such, the chapter includes a review of the research questions as discussed earlier; the findings pertaining to the perceptions concerning the possible contagion of deliberate self-harm; the findings with regard to the methods, frequency, duration, severity and emotional context of deliberate self-harm among the adolescent participants; and the motivations of self-harm provided by the adolescent participants. Furthermore, the researcher includes a discussion on information gained during the current study not specified in the research questions – including availability of psychological intervention for the participants; personal histories of the adolescent participants; psychological diagnoses of the participants; and instances of suicidal ideation or attempts among the adolescent participants in the current study.

4.1. RESEARCH QUESTIONS POSED BY THE CURRENT STUDY

The current study attempted to answer three questions regarding deliberate self-harm. Similar to the research conducted by Taiminen et al. (1998) and Walsh and Rosen (1985), the current study firstly attempted to answer the question “What are the perceptions of adolescents who self-harm in South African children's homes regarding the contagion of self-harm?” This question was addressed through the use of multiple semi-structured interviews with adolescent participants in children's homes within the Pretoria area, Gauteng, who self-harm. Secondary to this, the current study attempted to answer the question “What is the frequency, methods, duration, severity, and emotional context of self-harm among adolescents in South African children's homes?” This question was addressed by employing the DSHI – developed by Gratz (2001) – which

was completed by the adolescent sample; as well as the semi-structured interviews conducted with the adolescent sample. As such, the DSHI was employed in order to address the frequency, methods, duration and severity of the self-harm of the participants in the current study; whereas the emotional context of the self-harm of the adolescents in the study was explored during the second interview conducted. A further exploration of the results within the DSHI was made during the semi-structured interviews conducted with the adolescent participants in the current study. Lastly, the current study attempted to answer the question “What are the motivations of adolescent self-harm in South African children's homes?”; which was addressed by the completion of the FASM, developed by Lloyd (1997) for completion by adolescents who self-harm. The motivations obtained through the completion of the FASM were explored in depth during the semi-structured interviews with the participants – so as to clarify and gain a greater understanding of these motivations.

4.2. FINDINGS WITH REGARD TO THE PERCEPTIONS CONCERNING THE CONTAGION OF DELIBERATE SELF-HARM AMONG ADOLESCENTS IN SOUTH AFRICAN CHILDREN'S HOMES

The main aim of the current study was to explore perceptions of adolescents in South African children's homes concerning the possible contagion of deliberate self-harm. The contagion of deliberate self-harm has been defined as the “sequence of events in which an individual inflicts deliberate self-harm and is imitated by others in the immediate environment” (Walsh & Rosen, 1985, p. 119). As such, the contagion of deliberate self-harm can refer to two separate, but inter-related situations: Firstly, the contagion of self-harm can refer to the initial acquisition of the behaviour; in which one individual observes the self-harm of another individual, and thereafter adopt the behaviour. Secondly, the contagion of deliberate self-harm can refer to instances in which the self-harm of one individual triggers another individual to self-harm – resulting in episodes of co-occurring deliberate self-harm among various individuals. The latter form of contagion of self-harm has been studied in previous research endeavours – such as the study by Taiminen et al. (1998) and Walsh and Rosen (1985) – however, these studies employed psychiatric samples, whereas the current study employed a sample of 12

adolescents in children's homes in the South African context. The findings with regard to the contagion of deliberate self-harm among the adolescents in the current study were noteworthy; in that support for both forms of contagion – the initial acquisition of the behaviour through the observation of the self-harm of other individuals, as well as episodes in which the self-harm of one individual triggers self-harm in another and consequently result in episodes of co-occurring deliberate self-harm – were found. Instances of both forms of contagion of deliberate self-harm were further found to be more prevalent among adolescent participants housed in children's homes in which accommodation is structured similar to a hostel – possibly due to the increased interaction and lack of privacy in these settings; which the researcher recommends be addressed in further research. Furthermore, both forms of contagion of self-harm were found to occur not only within the setting of the children's homes where the adolescent sample is housed; but also outside the children's homes – thus, before placement in the children's homes, or in settings such as schools. As such, the findings concerning the contagion of deliberate self-harm are discussed under each of these circumstances.

4.2.1 Acquisition of Deliberate Self-Harm Through Contagion of Deliberate Self-Harm

Ten of the 12 adolescent participants in the current study reported the initial acquisition of their self-harming behaviour to have occurred due to the observation of self-harm of other individuals. As such, these participants were exposed to a situation in which the observation of the self-harm – as well as the rewards thereof – of another individual occurred; and thereafter adopted the behaviour themselves, specifically due to the exposure. During the exploration of this acquisition of the self-harm of the adolescent participants in the second semi-structured interviews conducted, several participants indicated the contagion of self-harm occurring outside the children's home; whereas others reported the adoption of the self-harm within the children's home setting.

4.2.1.1 Acquisition of Deliberate Self-Harm Outside the Children's Home

The adolescent participants in the current study reported various situations outside the children's homes – thus, before placement in the children's homes, or in settings such as

schools – in which the acquisition of self-harm occurred through contagion. As such, there are five noteworthy features prevalent with regard to the acquisition of self-harm outside the children's home through contagion, based on the findings of the current study: Firstly, the situations in which the participants were first exposed to self-harm outside the children's home included the observation of the self-harm of friends, acquaintances, and children at a place of safety. The majority of the adolescents who reported the acquisition of their self-harming behaviour to occur through contagion outside the children's homes, indicated that their exposure to the self-harm – or expressions concerning the effectiveness of self-harm to relieve negative emotional states – of friends or other children known to them resulted in the adoption of the behaviour. Furthermore, the participants in the current study expressed indifference with regard to the exposure to the self-harm of their friends, or the later acquisition of the behaviour.

As noted by Faith:

“The first time I cut, my mom and dad were fighting... And then I remembered that one of my friends said that her way of solving her problems is to cut herself... Then I tried it with a knife”.

Secondly, and somewhat related to the previous point, the findings from the current study indicate that the acquisition of deliberate self-harm through contagion occurred through the visual media – supporting the proponents of the Social Learning Theory advocated by Bandura (1977) noted in Chapter 2. Bandura (1977) proposed that behaviour can be acquired through the observation of such behaviour – through direct observation of individuals in the environment, or through the media – as well as the rewards thereof. In the current study, one adolescent participant indicated the adoption of self-harm at age six – following exposure to visual media in which deliberate self-harm was portrayed as an effective coping mechanism.

As noted by Bianca:

“I was watching a movie. I think I was six years old. I was watching a movie... The main character also went through difficult times, so she started cutting herself. And it solved all her problems... So I was sitting at home, and every time she made a cut, I made a cut. So I was like: 'This actually feels cool'... So that's when I started cutting”.

As a third feature, the adolescent participants in the current study referred to specific events that occurred before the adoption of the self-harming behaviour through contagion. The participants in the current study rarely adopted self-harm immediately following exposure to the self-harm of another individual – thus, participants noted specific negative events in their environment that resulted in thoughts concerning self-harm, based on their earlier exposure to the self-harm of individuals outside the children's home. As such, several events perceived by the adolescent participants to be negative were reported to precipitate the self-harm; including familial disturbance and violence, difficulties at school and with educators, and negative thoughts of familial relationships. As previously noted, one of the adolescent participants in the current study, Faith, observed the physical abuse of her mother by her father that consequently led to her deliberate self-harm.

Fourth, all of the participants in the current study who acquired self-harming behaviour outside the children's homes through contagion noted that following the specific events – discussed above – thoughts of self-harm were immediately present. As such, the thoughts concerning self-harm – as effective coping mechanism, based on exposure to the deliberate self-harm of other individuals outside the children's homes – were immediately present following the events participants perceived to be negative. Thus, the exposure to the self-harm of various individuals outside the children's homes may have been especially prominent for the adolescent participants in the current study –

explaining the salience of the thoughts concerning self-harm, as opposed to normative coping mechanisms, following an event perceived to be negative.

Lastly, and related to the previous point, the majority of the adolescent participants in the current study expressed indifference with regard to the observation of the self-harm of individuals outside the children's homes. As such, the participants referred to multiple instances in which they had observed the self-harm of other individuals – or the rewards of the behaviour, being the reduction or elimination of the negative states precipitating the deliberate self-harm – before acquiring the self-harming behaviour themselves. Therefore, it is possible that the participants in the current study had become desensitised with regard to deliberate self-harm; in that the recurrent observation of the deliberate self-harm of other individuals in their environment may have resulted in the normalisation – thus, the perception that performing acts of deliberate self-harm is not as negative as initially perceived – of the behaviour. This normalisation of deliberate self-harm outside the context of the children's homes may have contributed in a reduction of apprehension or fear of performing such acts. This feature confirms the motivations provided by Walsh (2006) and Walsh and Rosen (1988) for the contagion of self-harm – in that individuals may develop reduced inhibitions regarding deliberate self-harm through modeling of the behaviour.

As noted by Megan:

“The first time I cut myself... I wondered whether it was true what other people say: 'Cutting releases pain' ... And then I tried it, and it worked. Many people say that”.

4.2.1.2 Acquisition of Deliberate Self-Harm in the Children's Home Setting

The majority of the adolescent participants in the current study who reported acquiring self-harming behaviour through contagion noted that such contagion occurred within the setting of the children's homes. There are four features with regard to the acquisition of deliberate self-harm within the children's homes through contagion that are

noteworthy: Firstly, the specific negative events preceding the acquisition of self-harm of the adolescent participants in the current study are specific to the environment in which the participants are housed. As such, the events that preceded the first experience with self-harm for the participants were either arguments with the caregivers at the children's homes, or punishment enforced by the children's home.

As noted by Michelle:

“The first time I cut myself, it was with one of the girls also at the children's home. We both decided to cut ourselves after a fight with one of the caregivers. She had grounded us for no reason”.

Secondly, similar to the acquisition of deliberate self-harm outside the children's home through contagion, the majority of the participants in the current study who acquired self-harming behaviour through contagion within the setting of the children's home indicated that the thoughts concerning self-harm were present immediately following the events discussed in the previous point. As such, the immediate connection made by participants in the current study between events that elicit negative emotional states and deliberate self-harm as an effective coping mechanism may indicate the prevalence – as well as salience – of deliberate self-harm within the children's home setting. Therefore, the immediacy of the option to self-harm following exposure to the self-harm of other children housed at the children's homes may indicate the profound exposure to the self-harm of other children in the children's homes; possibly resulting in desensitisation with regard to deliberate self-harm. One participant in the current study, however, indicated that no negative event was present immediately preceding her first experience with self-harm – and, as such, no specific event led to thoughts of self-harm. According to the participant, Kate, her first experience with deliberate self-harm was completely “random” and unrelated to specific thoughts or occurrences in her environment.

As noted by Kate:

“The first time I cut myself, I was sitting in my room. Writing a poem. I had a sharpener. And I knew everyone cut themselves. And then I just wanted to know what it feels like. So then I tried it, and it felt good. I became over-joyed after I had cut myself”.

Third, one of the participants in the current study noted that she acquired her deliberate self-harm through contagion within the setting of the children's home the day following her placement in the children's home. As such, Emily noted that her initial adaptation to the children's home setting was poor – as she was uncertain within the environment, and became depressed following punishment for behaviour she had not known was prohibited by the children's home. The uncertainty within the new environment led the participant to notice the self-harm of an adolescent at the children's home – after which the participant acquired the self-harming behaviour. It may therefore be necessary for South African children's homes to address the emotional state of children immediately following placement in the children's home; and to assess for susceptibility to depression and poor adjustment to the setting.

Lastly, the majority of the participants who acquired self-harm through contagion within the children's homes noted frequent observations or conversations regarding deliberate self-harm in the children's homes – possibly resulting in desensitisation concerning self-harm, as in the motivations for the contagion of self-harm provided by Walsh (2006) and Walsh and Rosen (1988). The frequent observation of self-harm within the children's homes further resulted in perceptions that it is “cool” to self-harm – as popular children in the children's homes often participate in self-harming behaviour. The salience of deliberate self-harm within the children's homes could, furthermore, result in curiosity concerning self-harm, as is evident in two participants in the current study, including Emily.

Noted by Emily:

“One day, I saw that my roommate has scars. When I asked her about it, she said that she had cut herself. Then I asked her how she did it, and she told me she used the blades from pencil sharpeners. So then I took one of those plastic sharpeners and broke it... And I took the blade to cut myself”.

The room-mate referred to by Emily in the above quote furthermore advised her on concealing and caring for the wounds and scars following self-harm. Later in this section, I refer to episodes in which Emily and her room-mate would self-harm simultaneously.

4.2.2 Episodes of Co-occurring Deliberate Self-Harm as Contagion of Deliberate Self-Harm

The second form of contagion of deliberate self-harm concerns instances in which the self-harm of one individual triggers another individual to self-harm – resulting in episodes of co-occurring self-harm among various individuals. Previous research focused somewhat exclusively on this form of contagion of self-harm – and was, furthermore, conducted in psychiatric settings (Walsh & Rosen, 1985; Taiminen et al., 1998). As such, the current study aimed to provide further empirical support for the phenomenon of contagion of self-harm – and to do so employing a sample of adolescents in South African children's homes. Ten of the 12 adolescent participants in the current study referred to instances in which this form of contagion occurred. As with the previous section on the acquisition of deliberate self-harm through contagion, this section discusses the episodes of co-occurring self-harm in two separate settings, being episodes of co-occurring self-harm outside the children's homes, and episodes of co-occurring self-harm within the setting of the children's homes.

4.2.2.1 Episodes of Co-occurring Deliberate Self-Harm Outside the Children's Home

Several of the adolescent participants in the current study referred to specific instances in which observation of the deliberate self-harm of another individual outside the children's homes resulted in the participant's own self-harm. As such, the participants in the current study became triggered by the self-harm of another individual to such an extent that the participant felt the desire to self-harm immediately following the encounter. There are four aspects that are noteworthy with regard to the episodes of co-occurring self-harm outside the children's homes, as evident in the current study: Firstly, one participant in the current study, David, referred to an incident in which he had observed self-harm in visual media – a film broadcast on television while the participant was visiting his biological mother during a school holiday – and thereafter became triggered, resulting in later deliberate self-harm in the participant. As such, David specified that he had had previous instances in which he had cut himself due to negative emotional states brought on by his past and current experiences; however, this specific incident of self-harm had been triggered by observing the self-harm of characters in visual media.

As noted by David:

“I saw a movie on television once... The people hurt themselves in the movie. I first didn't think it was bad. But in the end, everyone hurt themselves... It made me want to hurt myself as well...”

Secondly, the majority of the adolescent participants in the current study who noted instances in which observing the self-harm of another individual triggered their own consequent self-harm outside the children's homes, referred to instances in which they had observed the self-harm of friends or acquaintances. As such, these participants generally referred to individuals with whom they had a close personal relationship – and a context in which they had been aware of the self-harm of the other individual. Furthermore, the participants in the current study noted that it is in this close personal relationship that the contagion of self-harm was possible – and indicated that awareness

of the personal histories of those other individuals, as well as the motivations for the self-harm had influenced the co-occurrence of the deliberate self-harm. This confirms the motivations provided by Walsh (2006) and Walsh and Rosen (1988) for the episode of contagion – as peer groups who self-harm may be characterised by intensified connections due to the self-harm.

With regard to this, Chris noted:

“My friends started hurting themselves more at the beginning of this year... I always see the wounds... It just feels as though I want to do it too. Because they've gone through that pain, so I want to go through it as well... Once, in class, my friends showed me that they had cut themselves earlier. And then my one friend cut himself again. So then I took the scissors and hurt myself, too...”

Third, several participants in the current study noted growing popularity of deliberate self-harm among adolescents in the community. As such, the perception of self-harm as “cool” results in the increased exposure to the self-harm of other individuals not known to them – which, for the adolescent participants in the current study, often result in thoughts and consequent episodes of co-occurring deliberate self-harm outside the children's homes. The participants who indicated awareness of the growing trend among adolescents to self-harm due to the popularity thereof; further noted that adolescents they believe to self-harm for this reason fail to conceal their wounds, typically revealing their wounds and scars in public – whereas the self-harm of friends or acquaintances are generally concealed and occur in private. The visibility of the self-harm of other children not known to the participants consequently result in thoughts of their own self-harm becoming salient or triggered, generally resulting in an episode of self-harm – whereas the triggers due to the observation of the self-harm of a friend or acquaintance were influenced by the close personal relationships, and knowledge of motivations and personal history.

As noted by Natalie:

“The children see or hear about someone who hurts themselves, and then they hurt themselves too... Because they think it's funny. And that it's cool to do what other children do”.

Lastly, and related to the previous point, several participants in the current study referred to instances in which they observe the self-harm of peers at school – resulting in their own deliberate self-harm. As such, these participants indicated that they had previous instances of self-harm due to negative emotional states brought on by experiences outside and within the children's homes; however, the participants referred to instances in which adolescents self-harm during class at school – without attempts to conceal the wounds. Such observation of self-harm in the school context typically results in episodes of self-harm for the participants in the current study. The participants in the study further indicated indifference by the educators to address such instances – possibly due to the failure to notice such instances, a lack of knowledge concerning deliberate self-harm, or the lack of appropriate intervention at the schools to address such instances.

As noted by Faith:

“I started using pencil sharpener blades because I saw a child at school using it to cut himself... He showed me how to get to the blade. So I did it as well... It makes me feel bad to see children at school cutting themselves. Because then I want to do it too. And I want to stop”.

4.2.2.2 Episodes of Co-occurring Deliberate Self-Harm in the Children's Home Setting

Several of the adolescent participants in the current study referred to instances in which they had an episode of deliberate self-harm following the observation of the self-harm

of another adolescent at the same children's home. As such, there are three aspects of contagion of deliberate self-harm, through the co-occurrence of self-harm among various individuals, that are noteworthy: Firstly, the adolescent participants in the current study noted that deliberate self-harm had become especially prominent within the children's home setting – as exposure to, or knowledge of, the self-harm of other adolescents housed at the same children's home is inevitable. The visibility of the self-harm of other adolescents housed at the children's homes may be somewhat influenced by the frequent contact and interactions between the adolescents – as the participants in the study generally have one or multiple room-mates. The privacy in such situations may be limited, resulting in the visibility of deliberate self-harm to other adolescents at the children's homes. Again, this feature confirms the motivations provided by Walsh (2006) and Walsh and Rosen (1988) concerning the reduced inhibition of individuals who self-harm to the exposure to the self-harm of others known to them.

As noted by Emily:

“It's happened many, many times that I cut myself when I know of children in the children's home who had cut themselves”.

Secondly, the majority of the adolescent participants in the current study noted that episodes of co-occurrence of self-harm in the setting of the children's homes are influenced by the relationship between the individuals, confirming the motivations concerning the contagion of self-harm due to the intensified relationships between individuals who self-harm (Walsh, 2006; Walsh & Rosen, 1988). As such, the participants indicated that a close personal relationship – often close friendships – with another adolescent at the children's home increases the possibility of the co-occurrence of self-harm. This, according to the participants in the current study, is due to three factors: The shared experiences in the children's homes; knowledge of the personal histories of other children who self-harm; and empathy with regard to the self-harm of the other adolescent. Firstly, the adolescents in the current study noted that knowledge of the experiences of close friends within the setting of the children's homes influence

instances of co-occurring episodes of deliberate self-harm. As such, the adolescent participants referred to experiences of other children who self-harm within the children's home setting that they consider similar to their own experiences – such as isolation from peers at school due to their personal histories and placement in the children's homes, and failure to adapt to placement in the children's home – as well as experiences shared by several children housed at the same children's home – for example, punishments within the children's home, and treatment by personnel at the children's home. According to the participants, such knowledge of similar or shared experiences influence the development of closer relationships – in which empathy with such experiences are intensified – often resulting in episodes of co-occurring self-harm in the event of salience of such experiences. Second, several participants referred to clear knowledge of the personal histories of their close friends within the setting of the children's homes – noting that conversations concerning the personal histories of children housed at the children's homes are a common occurrence. Awareness of the experiences of close friends before placement in the children's home were noted to influence awareness of the motivations for the deliberate self-harm of close friends – resulting in episodes of co-occurring self-harm. Lastly, both previous factors were noted by the adolescent participants in the current study to influence the development of close friendships in which empathy is central. The intense empathy between several children within the setting of the children's home therefore influence episodes of co-occurring deliberate self-harm within the setting of the children's homes – as the empathy remains salient for those participants who indicated that instances of co-occurring self-harm are prevalent within the children's homes.

As noted by Emily:

“I think you should have a bond with a person if you cut yourself because they do... It's like you feel the pain of the person... I want to cut myself after seeing that my friends had cut themselves... Especially if I slide my finger over their cuts. Then, I don't know, I

go to my room and cut myself. And then I feel better”.

Lastly, two of the participants who noted instances in which the self-harm of another adolescent at the children's home resulted in their own self-harm referred specifically to situations in which simultaneous self-harm occurred – in which the participant and another adolescent housed at the children's home had engaged in self-harm at the same time. Upon further exploration, it became evident that both participants had acquired the self-harming behaviour following the observation of the self-harm of the adolescent with whom they engage in the simultaneous self-harm episode – thus indicating both forms of contagion of deliberate self-harm for these two participants. Both participants who engage in simultaneous self-harm with another adolescent indicated that a close personal relationship had developed between themselves and the other adolescent following their initial encounter with deliberate self-harm – with a central focus on discussions of self-harm. For one of the participants, Emily, the simultaneous self-harm was furthermore influenced by what she perceived to be guilt on the part of her friend and roommate. According to Emily, her friend had acquired self-harming behaviour before Emily had been placed in the children's home herself; and had advised Emily on the methods, tools, as well as care and concealing of the wounds following deliberate self-harm. This participant specifically referred to a conversation with the friend that had advised her on self-harm – thus directly influencing the acquisition of Emily's self-harm – in which the friend had admitted that she feels compelled to self-harm whenever the participant engages in an episode of deliberate self-harm; as she feels responsible for advising the participant on the methods of self-harm, and feels responsible for the participant as a roommate. The consequence of the friend's guilt was, according to the participant, the simultaneous episode of deliberate self-harm.

As noted by Emily:

“Every second or third day, I would go to my roommate, and it would be like: 'I'm in the mood to cut myself'. And she'd be like: 'OK'. And then we

would sit in our room, and then I cut myself. Then she'd cut herself. And then I'd cut myself. And that's how we made the cuts together. If I make a cut, she makes a cut”.

4.3. FINDINGS WITH REGARD TO THE FREQUENCY, METHODS, DURATION, SEVERITY AND EMOTIONAL CONTEXT OF DELIBERATE SELF-HARM AMONG ADOLESCENTS IN SOUTH AFRICAN CHILDREN'S HOMES

The current study aimed to gain an understanding of the frequency, methods, duration, severity and emotional context of deliberate self-harm among adolescent participants in four children's homes in the Pretoria area, Gauteng – due to the lack of South African research concerning deliberate self-harm among adolescents, as well as a lack of research concerning the self-harm among adolescents in children's homes. In order to explore these aspects of deliberate self-harm, the participants in the current study firstly completed the DSHI – developed by Gratz (2001). This questionnaire is designed to gain information regarding the nature of deliberate self-harm among participants. As such, the questionnaire provides 16 items concerning specific methods of self-harm; and requests participants to note various aspects with regard to each specific method. The DSHI was employed in the current study as a means of gathering descriptive data with regard to the self-harm of the adolescents participating in the study. As such, the sample consisting of 12 adolescents from four children's homes in the Pretoria area, Gauteng, completed the questionnaire – whereafter the information gained was explored in full during the semi-structured interviews. The second interview conducted with the adolescent participants in the current study focused exclusively on gaining a greater understanding of all relevant experiences concerning the self-harm of the adolescent participants – while incorporating the information gained from DSHI completed by the participants. As such, several significant aspects of the deliberate self-harm of the adolescents in the children's homes were explored while utilising the information from the DSHI. In this section, the findings with regard to both the DSHI and the semi-structured interviews are discussed; including the methods most often and least often

employed, the tools employed in self-harm, bodily areas commonly targeted for self-harm, the amount of wounds inflicted during an episode of self-harm, the frequency of the self-harm, whether tools are typically kept or discarded, care of wounds following self-harm, methods to prevent exposure of the deliberate self-harm, as well as the emotional context of deliberate self-harm among adolescents at the children's homes.

Method of DSH	Number of Participants (percentage)	Average Age of Onset	Average Number of Instances	Average Last Occurrence	Average Number of Years
1 Cutting	11 (91.666%)	11.545	45.909	2010	3.727
2 Burning with a Cigarette	3 (25%)	12.667	35.667	2010	4.333
3 Burning with a Lighter or Match	7 (58.333%)	13.571	16.714	2010	1.429
4 Carving Words into Skin	11 (91.666%)	11.818	21.455	2010	2.182
5 Carving Pictures or Patterns into Skin	7 (58.333%)	11.571	38.571	2010	3
6 Scratching	4 (33.333%)	13.25	14	2010	1
7 Biting	1 (8.333%)	13	1	2007	1
8 Rubbing Sandpaper	2 (1.667)	14	1	2008	1
9 Dripping Acid onto Skin	1 (8.333%)	11	1	2010	1
10 Bleach or Ovencleaner onto Skin	1 (8.333%)	13	1	2010	1
11 Sharp Objects through Skin	8 (66.666%)	12.75	6.625	2010	1.625
12 Rubbing Glass into Skin	4 (33.333%)	14.25	5.25	2009	1.75
13 Broken Own Bones	9 (75%)	11.5	3.5	2010	3.5
14 Banging of Head	4 (33.333%)	13.75	17.75	2009	1.25
15 Punching Self	8 (66.666%)	12	39.5	2010	4.125
16 Preventing Wounds from Healing	4 (33.333%)	12.25	45.25	2010	4.25

Figure 2: Summarised results from the Deliberate Self-Harm Inventory (DSHI)

4.3.1 Methods Employed in Deliberate Self-Harm

From the results obtained from the DSHI in Figure 2, above, as well as the second interview conducted with the participants, it is clear that two methods of self-harm were reported by the greatest number of participants in the current study – being the cutting of various areas of the body without suicidal intent, and carving words into the skin. As such, these were the two methods of self-harm that were most commonly reported by the sample in the current study. Moreover, the number of instances in which the participants in the current study had used cutting as a method of self-harm is the highest for any method employed – being 45.91 times on average for the 11 participants employing this method. The average number of years employing cutting as a method of deliberate self-harm was further high in comparison to several of the other methods of self-harm reported in the DSHI – at an average of 3.73 years engaging in this method. This is similar to previous studies employing the DSHI, in which participants note a preference for cutting as a method of deliberate self-harm (Dyl, 2008; Stanley, 2007; Suyemoto, 1998).

The participants in the current study furthermore often noted a clear motivation for the preference of cutting as a method to self-harm – in that the majority of the adolescent participants noted that cutting as a method of deliberate self-harm is more controlled and planned; whereas a method such as self-punching may occur in a situation of extreme provoked anger, and indicates spontaneous or impulsive self-harm.

Furthermore, three methods were reported by participants in the current study to be the least commonly used method of deliberate self-harm – being biting, dripping acid onto the skin, and the use of bleach or oven cleaner on the skin. Furthermore, those participants who indicated that these methods had been employed reported only one incident of such self-harm – whereas the majority of more commonly reported methods of self-harm had been used by the sample on multiple occasions.

Lastly, nine of the adolescent participants in the current study reported breaking their own bones as a method of deliberate self-harm – either prior to placement in the

children's homes, or following their placement in the specific children's home. The majority of the participants who did note this method of self-harm referred to instances in which they had jumped from a height specifically with the intent to harm themselves and break bones; engaged in dangerous and reckless driving and causing accidents in order to break bones; as well as having hit their fists against hard surfaces repeatedly in order to break smaller bones in their hands and wrists. Moreover, the leg, arm, and small bones in the hands were most often reported as the bones broken in such instances. The participants in the current study who indicated preference for breaking their own bones as a method of deliberate self-harm, specifically referred to the spontaneous nature of such instances – generally, with the lack of availability of tools commonly employed in other methods of self-harm. Information with regard to this method of deliberate self-harm was confirmed with the social workers assigned to the care of each participant who noted the method – after consent was obtained from the participants to confirm such information. This method was confirmed with the social workers of several participants, with the social workers indicating that medical treatment had been sought for those instances in which participants employed this method.

4.3.2 Tools Employed in Deliberate Self-Harm

The tools employed by the participants in their deliberate self-harm were explored during the second semi-structured interview conducted with the participants; both confirming and adding to the tools reported in previous research endeavours. As such, the adolescent participants in the current study noted that several tools may be employed for their deliberate self-harm through cutting; including razor blades (including the general razor blades used for shaving; as well as minora blades, which are more flexible, sharper, cheaper and easier to hide than general razor blades), glass, knives, scissors, blades from pencil sharpeners, broken plastic, wire, broken mirrors, and the tops of aluminum cans. The adolescent participants in the current study expressed a preference for three tools mentioned above – these being minora blades, general razor blades, and blades from pencil sharpeners – for various reasons. Firstly, minora blades were preferred by the participants in the current study due to the sharpness of the blades – therefore, the ability of this tool to cause greater physical

injury. Participants who preferred this specific tool were generally those who had been self-harmed for a longer period of time; and had a greater severity of deliberate self-harm (based on frequency of self-harm, number of wounds inflicted during an episode of self-harm, as well as need for medical attention due to the self-harm).

Secondly, general razor blades and blades from pencil sharpeners were the preferred tool for self-harm due to the accessibility of these tools, as well as the ability to hide these tools and prevent exposure of deliberate self-harm. Furthermore, the majority of the participants in the current study noted that general razor blades or blades from pencil sharpeners were the tools employed during the first experience of deliberate self-harm – whereas the more specific minora blades became a preferred tool following a longer period of engagement in deliberate self-harm.

4.3.3 Bodily Areas Commonly Targeted for Deliberate Self-Harm

Several bodily areas commonly targeted for self-harm were addressed during the interviews with the adolescent participants in the current study. As found in previous studies concerning deliberate self-harm (Nock & Prinstein, 2004), the majority of the participants in the current study noted that the forearms and wrists as the most commonly targeted areas for self-harm through cutting. Upon further exploration, one participant expressed a preference for these areas due to the possible discovery of the wounds following the episode of deliberate self-harm by other individuals; whereas the remaining participants were ambivalent regarding this aspect. Other bodily areas targeted for self-harm in the current study were the upper-arms, legs, feet, elbows, and the abdomen.

4.3.4 The Number of Wounds Inflicted During an Episode of Deliberate Self-Harm

The participants in the current study varied greatly with regard to the amount of wounds inflicted during a single episode of deliberate self-harm. While the majority of the participants in the current study were unaware of the number of cuts made during an

episode of self-harm through cutting, and expressed indifference with regard to this matter during the semi-structured interviews; two participants expressed a specific amount of wounds inflicted during each episode of self-harm – being 112 wounds and 90 to 150 wounds, respectively. Upon further exploration, both participants expressed a desire to control the number of wounds inflicted during an episode of self-harm through cutting – which may possibly be indicative of a compulsivity of the deliberate self-harm among these participants.

4.3.5 The Frequency of Deliberate Self-Harm

For 12 of the 16 methods of deliberate self-harm provided in the questionnaire, participants in the current study reported employing the method within the last year. Upon further exploration during the interviews conducted with the adolescent participants, several participants noted occasional self-harm; while other participants indicated that an incident of self-harm could occur multiple times a week, or on a daily basis.

Willow noted:

“I cut basically every day... And if things were calm, it could be like three times a week... If things were bad, it could be four times a day.”

4.3.6 Discarding of Tools, as Opposed to Keeping Tools

The majority of the adolescent participants in the current study noted the tendency to either keep or discard specific tools following an episode of deliberate self-harm. While several participants expressed a preference to discard of the tools following an episode of self-harm – due to the fear of exposure if tools were discovered among their personal possessions, or fear of infection if a specific tool is employed over a period of time – the majority of the participants in the current study expressed the desire to have the tools preferred for their self-harm available for instances in which they desire to self-harm.

The participants who prefer to keep specific tools for their deliberate self-harm expressed an awareness of the possibility of the tools resulting in the exposure of their self-harm to the head and the caregivers employed at the children's homes.

4.3.7 Care of Wounds Following Deliberate Self-Harm

The second semi-structured interviews conducted with the participants in the current study explored the care of wounds following an incident of deliberate self-harm. The majority of the adolescents in the study noted that they go to great lengths to prevent infection – due to knowledge of others who self-harm that have experienced infections following self-harm, with consequent exposure of the self-harm. One participant expressed a preference to self-harm in the shower; as the blood from the injuries would immediately be washed away, and the wounds washed clean. The diligence of the participants to prevent infections and treat their wounds following an episode of self-harm corresponds with the relatively few instances in which medical help had been sought for deliberate self-harm – as reported in the DSHI (Gratz, 2001).

Several participants expressed reluctance or negligence to clean the wounds and prevent infection, however, though aware of the possible consequent infection. For example, one participant specifically noted that the immediate emotional relief following an act of deliberate self-harm causes her to fall asleep before the wounds could be cared for.

The consequences of deliberate self-harm proposed by Walsh (2006) as part of the Biopsychosocial Model of Deliberate Self-Harm made reference to precautions made by individuals who self-harm to prevent infections. Diligence to prevent infections, according to Walsh (2006), is indicative of a lesser degree of severity of the self-harm.

4.3.8 Methods Employed to Prevent Discovery of Deliberate Self-Harm

The majority of the participants in the current study were extremely concerned with the prevention of discovery of their deliberate self-harm. As such, the participants noted that they employ simple methods to prevent such discovery – for example, wearing long

sleeves or jewellery to cover the wounds; lying about the causes of the injuries; or targeting areas of the body where discovery would be unlikely. Few of the participants in the current study, however, noted either indifference toward discovery, or a desire to flaunt their wounds publicly. These participants therefore did not employ any means of preventing other individuals from seeing the wounds produced through their self-harm. One participant expressed indifference toward the possibility of an authority figure – and specifically, educators at school – discovering her wounds; as the participant noted an increase of self-harm in schools, resulting in the failure of the authority figures to report such instances.

4.3.9 Emotional Context of Deliberate Self-Harm

Walsh (2006) proposed a summary of several affective antecedents of deliberate self-harm in his Biopsychosocial Model of Deliberate Self-Harm. These affective antecedents are those emotions that can be either present for some period of time before the episode of self-harm, or are of sudden onset; and contribute to the self-harming behaviour at the specific time. There are furthermore several consequences of deliberate self-harm – including immediate psychological relief of those emotions that precipitated the episode of self-harm. In this section, the affective antecedents, emotions prevalent during the episode, as well as the psychological relief experienced following an episode of deliberate self-harm – as expressed by the adolescent participants in the current study – are discussed.

Firstly, the majority of the adolescent participants in the current study noted several emotions present immediately before an episode of deliberate self-harm; including anger, depression, sadness, frustration, anxiety and disappointment. The participants in the study generally indicated that either anger or depression was the two emotions most commonly present before their self-harm – and that the reasons therefore typically revolve around occurrences at the school or children's homes.

As noted by Felicity:

“Most of the time I'm angry before I cut myself...
Most of the time I want to die. Other times, I'm very
sad...”

The affective antecedents expressed by the participants in the current study therefore confirm – and supplements – those reported by previous research concerning deliberate self-harm (for example, Dyl, 2008; Suyemoto, 1998).

The current study secondly explored the emotions present during an episode of deliberate self-harm for the adolescent participants. As such, one participant noted that his psychological relief occurs immediately while he cuts himself with a razor blade.

Chris noted:

“Cutting makes me feel better. I can feel the pain as I
cut myself with the blade. And I see the wounds... I
see the pain as I cut”.

Another participant noted that her emotional numbness transcends into physical numbness during an episode of self-harm. As such, the participant expressed a lack of sensation during the act of cutting herself – specifically referring to the sensation as 'normal'. Finally, a participant noted that her emotions disappear during an episode of self-harm, and that her thoughts solely center on the act of self-harm.

Faith noted:

“I always wonder: Will I hurt myself? Will I cut an
artery? You concentrate on those things, not on what
you were thinking or feeling”.

Finally, in the consequences of deliberate self-harm, Walsh (2006) specifically refers to psychological relief experienced by individuals who self-harm. As such, the emotions an individual experiences immediately before an incident of self-harm are typically reduced by the act of self-harm – therefore, the act of self-harm serves to eliminate the negative or intolerable emotions individuals who self-harm experience. The results of the current study support the psychological relief proposed by Walsh (2006); in that the majority of participants reported a reduction of the emotions experienced before an episode of self-harm following the incident.

Natalie noted:

“I feel good after cutting myself. I feel better...”

It is important to note, however, that several of the participants in the current study expressed interplay of both psychological relief and an increase of alternative negative emotions following an incident of deliberate self-harm. As such, the participants experience the psychological relief proposed by Walsh (2006) – in that emotions such as anger are reduced – while fears of exposure of their self-harm, or ambivalence concerning the self-harm in itself become present for the participants.

As noted by Megan:

“I feel better after cutting in a way, but also worse. Because, well, I don't have to concentrate on my pain any more. But if somebody sees it, they will have a different way of seeing me – they won't see who I really am. They will think that I only want attention, because that's what most people think of people who self-harm”

4.4. FINDINGS WITH REGARD TO THE MOTIVATIONS OF DELIBERATE SELF-HARM AMONG ADOLESCENTS IN SOUTH AFRICAN CHILDREN'S HOMES

The FASM – developed by Lloyd (1997) – is designed to quantitatively measure the extent to which participants employ self-harm for various motivations. Participants are requested to mark 'never', 'rarely', 'some' or 'often' to 22 motivations provided within the questionnaire – while allowing for the possibility of alternative motivations for deliberate self-harm. As with the DSHI (Gratz, 2001), the FASM was employed in the current study as a descriptive measure. As such, the responses provided by the adolescent participants to the items on the questionnaire were explored in-depth during the semi-structured interviews – so as to gain a greater understanding of the perceptions of the adolescent participants in the current study concerning the motivations for their self-harm. In this section, the results obtained from the FASM are discussed. Thereafter, the results are discussed with regard to the Functional Approach proposed by Lloyd (1997). It should be noted, however, that one of the participants in the current study was incapable of completing the questionnaire – with assistance – due to intellectual limitations. As such, 11 of the 12 participants in the current study completed the questionnaire.

The findings with regard to the FASM developed by Lloyd (1997) are summarised in Figure 3. There are several important findings pertaining to the results of the FASM in the current study. Firstly, the item 'to stop bad feelings' was marked by the adolescent participants in the current study as the motivation most often employed in their deliberate self-harm. As such, the greatest number of participants reported that this item is 'often' employed – eight of the 11 participants who completed this questionnaire in the study marked this motivation. The emotions the participants attempt to reduce or eliminate through their self-harm include anger, sadness, disappointment, irritation and depression – as was explored during the second semi-structured interview with the adolescents. This finding is in line with what has been reported in previous studies concerning the motivations underlying deliberate self-harm (Nock & Prinstein, 2004; Rissanen et al., 2008) – in that self-harm serves as an automatic-negative reinforcement



Motivation for Deliberate Self-Harm	Number of Participants Marking 'Never'	Number of Participants Marking 'Rarely'	Number of Participants Marking 'Some'	Number of Participants Marking 'Often'
1 to avoid school/work/other activities	6	0	3	2
2 to relieve feeling 'numb'/empty	1	4	1	5
3 to get attention	8	0	0	3
4 to feel something, even if it was pain	2	1	1	7
5 to avoid having to do something unpleasant you don't want to do	6	1	3	1
6 to get control of a situation	2	2	2	5
7 to try to get a reaction from someone, even if it is a negative reaction	8	1	0	2
8 to receive more attention from your guardians/ caregivers/friends	8	1	0	2
9 to avoid being with people	6	0	4	1
10 to punish yourself	4	1	1	5
11 to get other people to act differently or change	8	2	1	0
12 to be like someone you respect	8	2	0	1
13 to avoid punishment or paying the consequences	8	1	1	1
14 to stop bad feelings	0	2	1	8
15 to let others know how desperate you were	7	3	1	0
16 to feel part of a group	8	2	0	1
17 to get your guardians/caregivers to understand or notice you	6	2	1	2
18 to give yourself something to do when alone	5	2	1	3
19 to give something to do when with others	10	0	1	0
20 to get help	8	2	0	1
21 to make others angry	10	0	0	1
22 to feel relaxed	2	2	0	7
23 other	It is cool I like the blood			

Figure 3: Summarised results from the Functional Assessment of Self-Mutilation (FASM)

function. As such, individuals who self-harm generally attempt to reduce negative emotions.

Secondly, four of the motivations for self-harm provided in the FASM were marked by several of the participants – being 'to feel something, even if it was pain', 'to get control of a situation', 'to punish yourself', and 'to feel relaxed'. These motivations are included in the Functional Approach proposed by Lloyd (1997) – as discussed in Chapter 2 – as automatic-positive reinforcement motives, as these motivations allow for the individual who self-harms to experience positive emotional states as opposed to the negative emotional states experienced prior to self-harm, as well as allowing the individual to justify emotional pain (Suyemoto, 1998); as well as social-negative reinforcement, in which the individual who self-harms attempts to regain control over the environment or specific situations. The majority of the participants who reported these motivations, referred to instances within the children's homes that result in their deliberate self-harm for these motivations. As such, participants indicated during the semi-structured interviews that treatment and discipline within the children's homes – by caregivers, social workers, and the head of the children's homes – result in the perception that they do not have control over their environment, or the ability to voice an opinion. In such instances, these participants often self-harm in order to calm down following what they perceive to be harsh or unjust discipline or punishment – as an alternative to responding with aggression, which may result in further punishment.

Third, two items on the questionnaire were marked by the adolescent participants in the current study as a motivation never prevalent for their deliberate self-harm. Ten of the 11 participants in the current study rated these two items – being 'to give yourself something to do when with others' and 'to make others angry' – as 'never' on the FASM.

Lastly, two alternative motivations for deliberate self-harm were provided by the adolescent participants in the current study. The first alternative motivation provided – being 'because it is cool' – was reported by two of the participants. Both participants conveyed a nonchalant disposition towards their deliberate self-harm during the semi-structured interviews, as well as indifference with regard to the possible implications

and consequences of the self-harm. Moreover, several of the participants in the current study indicated knowledge of other individuals who self-harm due to the increasing popularity of deliberate self-harm among adolescents. As such, the participants referred to self-harm as a mechanism of gaining popularity within peer groups, as opposed to the typical conceptions in which self-harm is considered to be a coping mechanism for negative emotional states. The increasing popularity of deliberate self-harm was discussed in greater detail earlier in this chapter.

Faith noted:

“It's fun... It just is... I don't really know why I think it's cool...”

The second alternative motivation provided by the adolescent participants on the FASM was 'I like the blood'. This motivation was reported by three of the participants in the current study – for various reasons explored during the semi-structured interviews. One participant, Emily, noted that the smell of blood could trigger her into an episode of self-harm.

As noted by Emily:

“I like the smell of blood. When I smell it, especially Kate's (a participant in the current study at the same children's home) blood... I want to cut too. I like the smell of it. Is that weird?”

The remaining two participants reported during the semi-structured interviews that the sight of blood contribute to the continuation of their deliberate self-harm. While for Kate, the sight of blood results in a state of over-excitement and further deliberate self-harm; the sight of blood calms Chris down to the extent of a prevention of further immediate self-harm. Although the sight of blood eliminates the immediate need to self-

harm for Chris, the participant's self-harm continues due to the further need for the sight of blood – as well as various other reasons.

Chris noted:

“I scratch off the scabs afterwards. It bleeds again. I like the blood... I don't know why... I just like seeing it. It makes me calm down. I like seeing the blood”.

4.5. FINDINGS NOT SPECIFIED IN THE RESEARCH QUESTIONS

There are several aspects related to deliberate self-harm that were explored during the semi-structured interviews with the adolescent participants – although not stipulated in the research questions. As such, four important aspects of the self-harm of the adolescent participants in the current study were explored to gain greater understanding of the self-harm of the participants; including the availability of psychological intervention for the self-harm, the personal histories of the participants that may have influenced the acquisition of deliberate self-harm, diagnosed psychological disorders that may have influenced the development of deliberate self-harm in the participants, as well as instances of suicidal ideation or attempts. In this section, these aspects are discussed – with relevant quotations by the adolescent participants.

4.5.1 Psychological Intervention for the Deliberate Self-Harm of Participants

The current study explored the psychological intervention provided to the adolescent participants specifically regarding their deliberate self-harm. As such, psychological intervention concerning the self-harm of the participants could originate from three sources: Psychological intervention provided by individuals outside the children's home, such as parents, friends or educators; psychological intervention arranged by the children's homes; as well as psychological intervention provided by staff at the children's homes.

Firstly, several of the participants in the current study noted attempts made by individuals outside the children's homes to intervene in the deliberate self-harm by the participants. As such, individuals including parents, friends and educators have expressed concern about the self-harm of the adolescents in the current study. These attempts at intervention were, however, reported to have been unsuccessful due to either the lack of persistence on the part of those individuals who attempt to provide the intervention; or the indifference or reluctance of the participants who self-harm regarding the possible intervention. The majority of the participants who expressed rejection of the possible intervention by individuals outside the children's home noted that the reluctance to accept the intervention is due to the ignorance and judgmental approach employed by the individuals in the process of advocating psychological intervention.

As noted by Faith:

“My dad saw the cuts I made the first time. He wanted to punish me. But then I told him that I hadn't known what I had done. He's never spoken to me about it again... And my mom. She wants to kill me because I cut myself. Because my sister did it too...”

Secondly, one of the participants in the current study noted that the staff at the children's home arranged psychological intervention for his deliberate self-harm. As such, the social worker assigned to the participant's case arranged for the participant to attend psychotherapy both at a psychological institute, as well as at the children's home. However, the participant expressed indifference to the intervention provided – specifically noting a dislike of the therapists and their methods.

Lastly, the majority of the adolescent participants in the current study who's self-harm had been discovered by the staff at the children's homes noted that several unsuccessful attempts at psychological intervention have occurred. The participants expressed

negative experiences with regard to the psychological intervention provided by both the caregivers and social workers assigned to their cases – in that, again, the approach followed by these individuals were counterproductive in addressing their self-harm.

As noted by Felicity:

“They just say that I shouldn't cut myself, because I'm damaging God's temple. I'm a beautiful girl. I should not do it... I feel bad. I don't want people to say that to me”.

One participant, however, noted a successful attempt at psychological intervention provided by the social worker assigned to her case. Following the intervention provided by the social worker, the participant quit her deliberate self-harm.

As noted by Megan:

“The social worker told me she's glad I went to her. Because it shows that I want to get help. And then she said that she'll help me get through it...”

4.5.2 Findings Pertaining to the Personal Histories of Participants that Could Influence the Acquisition of Deliberate Self-Harm

The first semi-structured interview conducted with the adolescent sample in the current study focused on exploring in-depth the experiences of the adolescent participants before removal from parental care and consequent placement in the children's homes. As the adolescents are removed from parental care for specific dysfunctions in their parental homes that are deemed harmful to the physical and psychological well-being of the adolescent; the personal histories of the participants in the current study reflect those familial dysfunctions. It is therefore possible – and reasonably expected – that the factors discussed in this section may not be evident – or evident to such a degree – in a

study employing a community sample of adolescents. The aspects explored during the first semi-structured interview with the adolescent participants include the experience of physical abuse; observation of parental or guardian alcoholism; the experience of neglect; the experience of sexual abuse; the experience of human trafficking; as well as the experience of emotional abuse. In this section, these aspects of the personal histories of the adolescent participants are discussed. Thereafter, these experiences of the adolescent sample in the current study are compared to those found in previous studies concerning the personal histories of individuals who self-harm in later life – as stipulated in the Biopsychosocial Model of Deliberate Self-Harm proposed by Walsh (2006), discussed in Chapter 2 of this paper.

4.5.2.1 The Observation or Experience of Physical Abuse Before Removal From Parental Care

Several adolescent participants in the current study note either the observation or experience of physical abuse – before removal from parental care. As such, both the observation and experience of physical abuse are discussed in this section, with specific reference to relevant quotations by participants in the current study.

Firstly, two of the 12 adolescents from the four children's homes in the Pretoria-area, Gauteng, who participated in the current study noted the observation of physical abuse in their parental homes. As such, these participants observed the physical abuse of another individual in their home – without being the target or experiencing the physical abuse themselves.

As noted by Natalie:

“My mom and dad had a fight... He hit her in the face with a fist. And he hit her over her body, that she had bruises...”

Secondly, nine adolescent participants in the current study noted specific instances of experiencing physical abuse. The perpetrators of the physical violence against the

participants in the current study include biological fathers, step-parents, as well as the lovers of biological parents.

As noted by Kate:

“From since I can remember, until I was about five years old, it was normal. It was just hitting and punishment. And then it got worse... He'd started drinking more... He'd scare me on purpose so I would wet my bed at night... Then he'd hit me because of it”.

The majority of the participants in the current study noted one of two responses to the physical abuse: Firstly, several of the participants expressed a fear to disclose the information to another individual outside the parental home at the time the abuse occurred – as threats of increased physical abuse were often present. Secondly, participants noted a lack of reaction or intervention from those individuals to whom the physical abuse was disclosed. As such, these individuals failed to notify the relevant authorities of the abuse – resulting in the continuation thereof.

The current study therefore confirms the connection noted by Walsh (2006) in his Biopsychosocial Model for Deliberate Self-Harm – discussed in Chapter 2. In this model, Walsh (2006) notes a connection between physical abuse or violence in the parental home, and the later adoption of self-destructive behaviours or cognitive schemas in the observer that result in deliberate self-harm – in the discussion of the environmental and cognitive factors of the Biopsychosocial Model.

4.5.2.2 The Observation of Parental or Guardian Alcoholism Before Removal From Parental Care

Six of the participants in the current study made specific reference to the observation of parental alcoholism during the semi-structured interviews. As such, these adolescents disclosed information with regard to the exposure to excessive alcohol consumption

within the parental home – either by biological or step-parents. In some instances, participants noted an increase of physical abuse or violence within the home during times in which the alcoholism had increased in severity.

As noted by Kate:

“My dad really drank a lot. So eventually the landlord told him to leave. He wasn't allowed to come close to us, we got a court order... The abuse had gotten worse because he started drinking more”.

Several participants, such as Felicity, indicated the continued alcoholism of parents following the removal of the adolescent from parental care.

As noted by Felicity:

“My mom still drinks sometimes. So, if she drank a lot, she becomes very mean... She wants to fight with everybody”.

Furthermore, two of the participants in the current study who noted alcoholism or substance abuse by relatives before placement in the children's home later reported similar personal abuse of substances. One of the participants further noted the realisation that she had adopted behaviour similar to that of her alcoholic biological father.

Kate reported:

“I hate bars. I used to drink a lot. I changed into my dad a lot more than I would've wanted to last year... I drank a lot last December. Every morning, afternoon, night... Until I reached a moment where I realised

that I was busy turning into my dad, and then...
Yeah.”

The alcoholism of relatives within the parental home has been linked with an increased likelihood of deliberate self-harm among the observers of the alcohol abuse (as evident in Walsh, 2006). As such, Walsh (2006) noted in his Biopsychosocial Model of Deliberate Self-Harm the adoption of self-destructive behaviours – such as later adoption of the behaviour observed; and specifically, self-harming behaviour – among individuals who observe the alcohol or substance abuse of relatives. Alcohol abuse could result in the adoption of self-harm in the observer in later life, in that the relative models a belief that life is painful and that other individuals cannot assist in the suffering (Walsh, 2006).

4.5.2.3 The Experience of Parental Unavailability Before Removal From Parental Care

Although not as evident as other forms of aversive experiences in the personal histories of the adolescent participants, the experience of parental unavailability remains noteworthy in its influence on the later development of self-harm. As such, one participant in the current study noted experiences of parental unavailability in the upbringing.

Bianca noted:

“My mom wasn't there when I needed her... I made my own food. She worked until late at night... I don't have a mother-daughter relationship with her... And I didn't have someone to talk to when I had problems”.

As discussed in Chapter 2, the Biopsychosocial Model of Deliberate Self-Harm – proposed by Walsh (2006) – notes a specific connection between experiences of parental neglect or unavailability and self-harm in later life. According to Turner (2002), parental neglect or unavailability could result in later self-harming behaviour among

individuals, in that these experiences contribute to psychological distress and symptoms that resemble those of physical and sexual abuse. These experiences could further result in social isolation for an individual – which has been linked to self-harm (Turner, 2002).

4.5.2.4 The Experience of Sexual Abuse Before Removal From Parental Care

Of the 12 adolescent participants in the current study, five reported instances of sexual abuse before being removed from parental care; and one participant reported sexual abuse following removal from parental care, but before placement in the children's home. The perpetrators in the instances reported by the participants in the study include biological fathers, stepfathers, lovers of biological mothers, cousins, male friends, male children at a place of safety, and the couple to whom a female participant was sold (discussed in full in Section 4.5.2.5).

Noted by Willow:

“I can remember everything myself. He molested me when I was about three years old. He took me to the bedroom, and put me on the bed. He took off my clothes, and started touching me... So I went to tell my mom afterwards”.

Several participants in the current study made specific reference of the lack of reaction from individuals to whom they disclosed the sexual abuse.

Emily noted:

“I told my mom. She told me she doesn't believe me. And eventually she told me she doesn't care what I say. She loved him too much... She didn't even apologise or explain, she just chose him over us”.

Furthermore, the adolescent participants in the current study referred to specific methods employed by the abuser to prevent disclosure of the sexual abuse by the

victims – allowing for the continuation of the sexual abuse. As such, various participants noted receiving monetary rewards, or being threatened by the perpetrator. Natalie, one of the female participants, noted possible grooming for sexual abuse in her personal history. In this instance, the participant was sold to an unfamiliar couple by her biological father – and was subject to requests for sexual activities and molestation by this couple. This instance is discussed in full in the following section on human trafficking, in Section 4.5.2.5. Lastly, one female participant noted the expressed desire of her biological father that she had rather been born male – specifically, in order for the biological father to teach the son how to sexually abuse young females, such as the participant's older sister.

The current study confirmed the elements of the Biopsychosocial Model of Deliberate Self-Harm by Walsh (2006) – as discussed in Chapter 2. In this model, Walsh (2006) specifically refers to the link between past sexual abuse and later deliberate self-harm. According to the model, environmental factors such as sexual abuse experienced in the parental home generally result in emotional and psychological distress, symptoms of Posttraumatic Stress Disorder, depression, powerlessness, low self-esteem and self-destructive behaviour – all of which has been researched as contributing factors to self-harm among clinical and community samples (Briere & Gil, 1998; Plante, 2007; Walsh & Rosen, 1988). Individuals who self-harm furthermore typically develop self-defeating cognitive patterns following the experience of sexual abuse – such as forming negative interpretations of environmental events (Walsh, 2006). Due to the fact that the participants in the current study are in an environment – being the children's home – in which negative environmental events may be more likely, these negative interpretations of the events may be exacerbated.

4.5.2.5 The Experience of Human Trafficking Before Removal From Parental Care

An especially noteworthy aspect reported during the interviews conducted with the adolescent participants in the current study, is the incident of human trafficking disclosed by the one participant. In this incident, the participant conveyed a lack of belonging in her parental home following a period during which she was housed at an unfamiliar couple to whom her biological father had sold her at age 13. Of the four

siblings in her household – three of whom were female – the participant had been sold to the couple, and possibly groomed for sexual abuse before returning to her parental home.

Natalie noted:

“My dad sold me to other people... They smoked marijuana. And drank. And then they fought with me, and told me that I'm a whore. I was 13 years old. My dad only sold me, not my sisters. Because I was naughty. But I wasn't that naughty... They asked me to have sex with them, and they touched me. They gave me a lot of clothes. Clothes I left there when I ran away back home”.

As instances of human trafficking – and the psychological consequences thereof – may be difficult to research, the possible connection between human trafficking and later deliberate self-harm remains to be explored. The separation from the parents during the time spent at the unfamiliar couple, however, could possibly be linked to the later self-harm of the participant, however, as separation from parents or caregivers has been noted as a contribution to the later development of self-harming behaviours – as discussed in the Biopsychosocial Model of Deliberate Self-Harm (Walsh, 2006).

4.5.2.6 The Experience of Emotional Abuse Before Removal From Parental Care

Several participants in the current study noted experiences of emotional abuse. All instances of emotional abuse explored in the current study occurred in the parental homes – and were perpetrated by the biological fathers.

Megan noted:

“My dad mostly tried to commit suicide when my step-mother and sister didn't get along... And then

they'd get along, because of the attempt. But when they started fighting again, he would threaten to kill himself again... He tries to use the suicide”

Although not noted in the Biopsychosocial Model of Deliberate Self-Harm proposed by Walsh (2006), emotional abuse could result in insecurities and psychological distress similar as those caused by parental neglect, and physical or sexual abuse. It is therefore further possible that emotional abuse could result in social isolation – which has been linked to deliberate self-harm in previous research (Turner, 2002).

4.5.3 Diagnosed Psychological Disorders that may have Influenced the Acquisition of Deliberate Self-Harm

Following extensive research, certain psychological diagnoses – including Borderline Personality Disorder (BPD), Eating Disorders, Mood Disorders, Psychosis, Impulse Control Disorders, and Anxiety Disorders such as Posttraumatic Stress Disorder – have become associated with deliberate self-harm (Ross & McKay, 1979; Turner, 2002). As such, several of the characteristics of these specific psychological disorders and self-harm closely correlate; and co-morbidity between these disorders and deliberate self-harm may occur. Several of the participants in the current study have been diagnosed – either formally, at psychological institutions; or informally, by the personnel at the children's homes – with psychological disorders. These diagnoses were obtained from the social workers assigned to the care of each participant, with permission from the adolescent participants. In this section, the psychological diagnoses – both formal and informal – of the adolescent participants in the current study are discussed; with references to the connections made by previous research concerning these psychological diagnoses and deliberate self-harm.

Firstly, several of the adolescent participants in the current study have existing Mood Disorders, such as Major Depressive Disorder and Bipolar Disorder. Several of the participants who reported a diagnosis of Mood Disorders during the data collection of the current study noted that psychological and/or pharmacological intervention for these

diagnoses have been present in the past – specifically, participants with a diagnosis of Bipolar Disorder have been institutionalised to address severe behavioural disturbances associated with the diagnosis. The participants furthermore indicated the reluctance to discuss the possible influence of the diagnosis of Mood Disorders on their deliberate self-harm; as the majority of these participants deny the diagnosis to be correct. The diagnoses of Mood Disorders found among the adolescent participants in the current study confirm the connection advocated by Turner (2002). According to Turner (2002), several characteristics of Mood Disorders are commonly found in individuals who self-harm – such as worthlessness, hopelessness, lack of pleasure and interest, and changes in appetite and sleeping patterns. As such, the author claims that Mood Disorders may well be a co-morbid condition for deliberate self-harm.

Secondly, Walsh and Rosen (1988, p. 95) claim that “in the minds of clinicians, the diagnostic category most closely associated with the occurrence of [deliberate self-harm] is borderline personality disorder”. The close association between borderline personality disorder and deliberate self-harm is considered to be due to the common features between the two conditions; including disturbances in identity (Ross & McKay, 1979; Walsh & Rosen, 1988), the inadequate coping skills prevalent in both conditions (Ross & McKay, 1979), the non-suicidal intent of self-harming behaviour evident in both conditions (Walsh & Rosen, 1988), the greater level of impulsivity characteristic of both conditions (Walsh & Rosen, 1988), and the inability of individuals with either borderline personality disorder or deliberate self-harm to manage negative emotions (Ross & McKay, 1979). Two of the adolescent participants in the current study have diagnoses of borderline personality disorder. As such, both participants receive pharmacological treatment for the disorder – however, the effectiveness of the treatment was poor, as noted by the participants. The diagnosis of borderline personality disorder preceded the self-harm of one participant; whereas the diagnosis had followed the acquisition of self-harm for the other participant. Thus, the current study provides further support for the co-morbidity of borderline personality disorder and deliberate self-harm.

Third, two of the adolescent participants in the current study have been diagnosed with Attention-Deficit Hyperactivity Disorder (ADHD). Although no current association between ADHD and deliberate self-harm has been made; it is possible that the continued impulsive behaviour on the part of these participants – characteristic of individuals diagnosed with ADHD – may contribute to the impulsive deliberate self-harm of these participants. In support of this, both participants diagnosed with ADHD referred to specific instances in which their self-harm is an impulsive action following aversive events.

Lastly, it should be noted that one of the adolescent participants in the current study has been diagnosed with poor intellectual functioning. Though outside the scope of the current study, previous research concluded that deliberate self-harm may be especially prevalent among individuals with lower intellectual functioning (Rojahn, Matson, Lott, Esbensen & Smalls, 2001).

4.5.4 Instances of Suicidal Ideation or Attempts

From the definition of deliberate self-harm employed in the current study – being “the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent, but resulting in injury severe enough for tissue damage to occur” (Gratz, 2001, p. 253) – it appears to be clear that self-harm is conducted without suicidal intent. As such, deliberate self-harm can be differentiated from suicide based on nine factors; including the intent of the behaviour, the level of physical damage, the frequency of the behaviour, the use of multiple methods, the level of psychological pain, constriction of cognition, helplessness versus hopelessness, the psychological aftermath of the incident, and the core problem associated with the behaviour (Walsh, 2006) – as discussed in Chapter 2.

Three of the adolescent participants in the current study, however, noted a history of multiple suicide attempts. These participants referred to specific instances in which deliberate self-harm had failed as a coping mechanism; resulting in increased desperation to relieve negative emotional states. As such, the participants attempted

suicide through various methods – such as hanging, drowning, strangulation, overdoses on either illegal substances or prescribed medications, as well as cutting of the wrists. These participants further indicated that self-harm had remained an ineffective coping mechanism for some duration following the suicide attempt – as feelings of helplessness and hopelessness, typical of individuals who attempt suicide, persisted for some time following the failed attempts. Moreover, the suicide attempts by these adolescent participants in the current study occurred not only before the acquisition of deliberate self-harm, but also after the acquisition of self-harm.

In this chapter, the findings of the current study – following a data collection procedure in which both quantitative measures, being the DSHI and the FASM; and qualitative measures, being the semi-structured interviews conducted – were discussed, in a structure based on the research questions posed by the study. As such, several important features of the findings are noteworthy: Firstly, the findings of the current study provide clear support for the existence of the contagion of self-harm, in that 10 of the 12 adolescent participants in the current study reported instances of both forms of contagion. Secondly, the findings of the current study provide support for previous research concerning the methods, frequency, duration, severity and emotional context of self-harm. Third, the findings of the current study confirm the motivations underlying self-harm found in previous research (Nock & Prinstein, 2004). Lastly, the current study found information not specified in the research questions through the three semi-structured interviews conducted with the participants. As such, the findings indicate that several psychological diagnoses may correlate with deliberate self-harm; as well as the possible connection between deliberate self-harm and suicide.

CHAPTER 5: CONCLUSION

In this chapter, several aspects are discussed that may be relevant for future research on a similar topic as that of the current study. As such, this chapter provides an overview of the findings of the study; an evaluation of the study, which includes both the contributions and limitations of the current study; the implications of the findings of the study; as well as recommendations for future research concerning deliberate self-harm.

5.1 CRITICAL DISCUSSION OF THE FINDINGS

In this section, the findings of the current study – following a data collection procedure in which both quantitative measures, being the completion of the DSHI and the FASM; and qualitative measures, being the semi-structured interviews conducted are employed – are discussed, including a critical discussion of these findings. As such, several important findings are noteworthy: the findings with regard to the contagion of self-harm; the findings concerning the methods, frequency, duration, severity and emotional context of self-harm; the findings concerning the motivations underlying self-harm; as well as information not specified in the research questions.

Firstly, the findings of the current study provide clear support for the existence of the contagion of self-harm, in that 10 of the 12 adolescent participants in the study reported instances of initial acquisition of deliberate self-harm through contagion. The adolescent participants who indicated that they had adopted self-harming behaviour following exposure to another individual who engaged in self-harm reported two settings in which this contagion could occur: Outside the children's homes – thus, before placement in the children's homes – through friends, acquaintances and other children at places of safety; and within the setting of the children's homes, in which the participants indicated frequent observations of the self-harm of other children – possibly resulting in desensitisation with regard to deliberate self-harm. It is possible that the adolescent participants in the current study had become desensitised with regard to deliberate self-harm through repeated exposure to, or knowledge of, the self-harm of other children in their environment – which may have resulted in the normalisation of the behaviour. This

normalisation of self-harm may have contributed to a reduction of the initial apprehension or fear of performing such acts – both outside and within the setting of the children’s homes. This finding necessitate further research into possible psychological interventions that may be successful in treating deliberate self-harm among adolescents in general in the South African context. 10 of the 12 adolescent participants in the current study further reported episodes in which the self-harm of another child resulted in their self-harming behaviour immediately following the exposure to the other child’s self-harm – thus providing support for the second form of contagion of self-harm. As with the acquisition of self-harm through contagion, the episodes of co-occurring self-harm were reported to occur in two different settings: Outside the children’s homes, participants indicated that they had frequent observations of the self-harm of friends, peers at school or acquaintances which specifically allowed for the episode of co-occurring self-harm – and indicated awareness of the personal histories of those other individuals and the motivations for their self-harm. Within the setting of the children’s homes, participants reported exposure to, or knowledge of, the self-harm of other adolescents housed at the same children’s home is inevitable – which essentially allows for the possibility of contagion of self-harm. Furthermore, close relationships and empathy within the setting of the children’s homes contributed to the co-occurrence of self-harm within the children’s homes - which is due to the shared experiences in the children’s homes and knowledge of the personal histories of other children who self-harm within the children’s homes. The extreme perceptions of the adolescent participants in the current study with regard to the visibility and exposure to self-harm within the children’s homes may necessitate the development of intervention programs to assist in the reduction of deliberate self-harm within such settings, as well as proactively assess and treat the underlying causes of the behaviour. It should be noted that the information gained in the current study concerning the contagion of deliberate self-harm relied largely on self-report measures. As such, the perceptions of the participants concerning the contagion of deliberate self-harm may be due to the over-reporting of the participants. This is unlikely, however, given that several measures were employed to reduce the possibility of such over-reporting. Specifically, the information gained concerning the contagion of self-harm was confirmed through the triangulation of methods in the study; and the use of non-directive interviewing.

Secondly, the findings of the current study provide support for previous research concerning the methods, frequency, duration, severity and emotional context of self-harm. As in previous research (Dyl, 2008; Stanley, 2007; Suyemoto, 1998), cutting and carving of words into the skin were found to be the methods most commonly employed. The number of instances in which the participants in the current study had used cutting as a method of self-harm is the highest for any method employed – being 45.91 times on average for the 11 participants employing this method. Though the arbitrary number of instances in which participants have employed cutting as a method of self-harm may have been exaggerated, it indicates the perceptions of the participants of the concerning the extent of their deliberate self-harm. Three methods were reported by participants in the current study to be the least commonly used method of deliberate self-harm – being biting, dripping acid onto the skin, and the use of bleach or oven cleaner on the skin. Moreover, nine of the adolescent participants in the current study reported breaking their own bones as a method of deliberate self-harm – a method not commonly found among a large number of participants who engage in self-harm. The majority of the participants who did note this method of self-harm referred to instances in which they had jumped from a height specifically with the intent to harm themselves and break bones; engaged in dangerous and reckless driving and causing accidents in order to break bones; as well as hitting their fists against hard surfaces repeatedly in order to break smaller bones in their hands and wrists. The information gained concerning the breaking of bones as a method of self-harm was confirmed through discussions with the social workers assigned to the care of the participants – after consent was obtained from the participants – so as to allow for a reduction in the over-reporting of such instances. The tools employed by the participants in their deliberate self-harm both confirm and add to the tools reported in previous research endeavours. As such, the adolescent participants in the current study noted that several tools may be employed for their deliberate self-harm through cutting; including razor blades (including the more specific minora blades), glass, knives, scissors, blades from pencil sharpeners, broken plastic, wire, broken mirrors, and the tops of aluminum cans. The adolescent participants in the study expressed a preference for three tools mentioned above – these being minora blades, general razor blades, and blades from pencil sharpeners. Several bodily areas

commonly targeted for self-harm were addressed during the interviews with the adolescent participants in the current study. As found in previous studies concerning deliberate self-harm (Nock & Prinstein, 2004), the majority of the participants in the current study noted that the forearms and wrists are the most commonly targeted areas for self-harm through cutting. While the majority of the participants in the current study were unaware of the number of cuts made during an episode of self-harm through cutting, and expressed indifference with regard to this matter during the semi-structured interviews; two participants expressed a specific amount of wounds inflicted during each episode of self-harm – being 112 wounds and 90 to 150 wounds, respectively. Upon further exploration, both participants expressed a desire to control the number of wounds inflicted during an episode of self-harm through cutting. For 12 of the 16 methods of deliberate self-harm provided in the questionnaire, participants in the current study reported employing the method within the last year. Upon further exploration during the interviews conducted with the adolescent participants, several participants noted occasional self-harm; while other participants indicated that an incident of self-harm could occur multiple times a week, or on a daily basis – depending on the emotional state of the participants at the given time. While several participants expressed a preference to discard of the tools following an episode of self-harm – due to the fear of discovery of their self-harm if tools were discovered among their personal possessions, or fear of infection if a specific tool is employed over a period of time – the majority of the participants in the current study expressed the desire to have the tools preferred for their self-harm available for instances in which they desire to self-harm. With regard to care of the wounds following an episode of self-harm, the majority of the adolescents in the current study noted that they go to great lengths to prevent infection – due to knowledge of others who self-harm that have experienced infections following self-harm, with consequent discovery of the self-harm. One participant expressed a preference to self-harm in the shower; as the blood from the injuries would immediately be washed away, and the wounds washed clean. Furthermore, several participants noted that they had sought medical treatment for their wounds – if necessary. Generally, medical supplies provided by the caregivers at the children’s homes sufficed for the treatment of minor infections. Several participants expressed a reluctance or negligence to clean the wounds and prevent infection, however, though aware of the possible

consequent infection. The majority of the participants in the current study were extremely concerned with the prevention of discovery of their deliberate self-harm. As such, the participants employ simple methods to prevent such discovery – for example, wearing long sleeves or jewelry to cover the wounds; lying about the causes of the injuries; or targeting areas of the body where discovery would be unlikely. Few of the participants in the current study, however, noted either indifference toward discovery, or a desire to flaunt their wounds publicly. With regard to the emotional context of the self-harm – as discussed in the antecedents and consequences of self-harm by Walsh (2006) - the majority of the adolescent participants in the current study noted several emotions present immediately before an episode of deliberate self-harm; including anger, depression, sadness, frustration, anxiety and disappointment. The results of the current study furthermore supports the psychological relief proposed by Walsh (2006); in that the majority of participants reported a reduction of the emotions experienced before an episode of self-harm following the incident.

Third, the findings of the current study confirm the motivations underlying self-harm found in previous research (Nock & Prinstein, 2004); indicating that the most common motivation for deliberate self-harm among adolescents in the study was to 'stop bad feelings'. This motivation is considered to form part of the automatic-negative reinforcement category of the functions of deliberate self-harm – which has been suggested to be the main function of self-harm (Nock & Prinstein, 2004). Four of the motivations for self-harm provided in the FASM were marked by several of the participants – being 'to feel something, even if it was pain', 'to get control of a situation', 'to punish yourself', and 'to feel relaxed'. The majority of the participants who reported these motivations referred to instances within the children's homes that result in their deliberate self-harm for these motivations – such as treatment and discipline within the children's homes that result in the perception that they do not have control over their environment, or the ability to voice an opinion. Two items on the questionnaire were marked by the adolescent participants in the current study as a motivation never prevalent for their deliberate self-harm. Ten of the 11 participants in the current study rated these two items – being 'to give yourself something to do when with others' and 'to make others angry' – as 'never' on the FASM. Furthermore, two alternative motivations

for deliberate self-harm were provided by the adolescent participants in the current study – being 'because it is cool', and 'I like the blood'. Lastly, the current study found information not specified in the research questions through the three semi-structured interviews conducted with the participants. As such, the findings indicate that several psychological diagnoses may correlate with deliberate self-harm – in that the adolescent participants had diagnoses of Borderline Personality Disorder (BPD), mood disorders including Bipolar Disorder, ADHD, and poor intellectual functioning. Although no current association between ADHD and deliberate self-harm has been made; it is possible that the continued impulsive behaviour on the part of these participants – characteristic of individuals diagnosed with ADHD – may contribute to the impulsive deliberate self-harm of these participants. With regard to the possible connection between deliberate self-harm and suicide, three of the adolescent participants in the current study noted a history of multiple suicide attempts. These participants referred to specific instances in which deliberate self-harm had failed as a coping mechanism; resulting in increased desperation to relieve negative emotional states. As such, the participants attempted suicide through various methods – such as hanging, drowning, strangulation, overdoses on either illegal substances or prescribed medications, as well as cutting of the wrists. Previous suicide attempts made by participants were confirmed by the researcher with the social workers assigned to the care of the participants – with consent from the participants. Such attempts made by participants while at the children's homes resulted in the institutionalisation of the participants at psychiatric facilities – where diagnoses of psychological conditions were made if prevalent, and medication for the conditions prescribed or adjusted. During the semi-structured interviews conducted with the participants in the current study, several features of the personal histories of the participants may have influenced their later adoption of deliberate self-harm – as proposed by Walsh (2006) in the Biopsychosocial Model of Deliberate Self-Harm. Participants referred to experiences of physical, emotional and sexual abuse; the observation of parental alcoholism; experiences of parental unavailability before removal of parental care; as well as experiences of human trafficking before removal from parental care. The majority of the adolescent participants in the current study however indicated reluctance to consider the influence of these aversive experiences on their later adoption of deliberate self-harm. Based on

the findings concerning the failed attempts at psychological intervention provided to the adolescent participants in the current study, the researcher recommends that those individuals who provide psychological intervention with regard to deliberate self-harm be adequately trained and informed on the therapeutic skills and information necessary to address the self-harm of adolescents. It is possible, however, that the retrospective reporting of the attempts at psychological intervention may be extremely negative due to the current circumstances and unchanged emotions experienced by the participants of the study.

5.2 EVALUATION OF THE CURRENT STUDY

In this section, the current study – including the data collection procedures, as well as the findings – is evaluated according to both the contributions of the study and the limitations thereof. The limitations of the current study are reformulated in the following section so as to provide recommendations for future research with a similar focus and data collection procedures.

5.2.1 Contributions of the Current Study

There are several contributions of the current study – based on the gaps in existing literature concerning several aspects of deliberate self-harm, as well as the methodological strengths of the current study. In this section, the contributions of the findings of the current study are discussed – in a format provided by the gaps in literature.

Although abundantly addressed in literature as a hypothetical psychological phenomenon, few studies have attempted to provide empirical support for the possible contagion of deliberate self-harm – the main focus of the current study, and the first research question posed by the study. As such, only two previous studies have explored the contagion of self-harm: The study by Walsh and Rosen (1985) investigated the contagion of self-harm in a quantitative study conducted among adolescent psychiatric patients in the United States of America. The research methodology for the study

consisted of staff at the psychiatric institution completing logbooks on which the number of wounds observed for each participant was reported. As such, the adolescent participants were never interviewed throughout the one-year period through which data collection occurred – thus, the perceptions of those individuals engaging in the behaviour were not explored. In a replica study of the research conducted by Walsh and Rosen (1985), Taiminen et al. (1998) investigated the possible contagion of deliberate self-harm in Finland. As with the study by Walsh and Rosen (1985), Taiminen et al. (1998) employed a sample consisting of adolescent psychiatric patients; and failed to explore the perceptions of the participants concerning the phenomenon of contagion of self-harm. The current study focused on gaining an in-depth understanding of the phenomenon of contagion of deliberate self-harm. As such, the data collection procedures for exploring the possible contagion of self-harm focused on three semi-structured interviews conducted with the adolescent participants in the current study – thus allowing for the exploration of the perceptions of the participants concerning the possible contagion of self-harm. The current study was furthermore conducted within the South African context – as the findings within the South African context may differ from the international context.

The current study secondly aimed to gain information with regard to the methods, frequency, severity, and emotional context of deliberate self-harm among adolescent participants. The findings with regard to these aspects in the current study provide support for – as well as expand – on the findings of previous research. Moreover, the current study was conducted from a South African perspective, thus providing findings with regard to these aspects of deliberate self-harm relevant to the South African context.

The current study focused on exploring the motivations of deliberate self-harm from the adolescent participants – by employing the FASM developed by Lloyd (1997), and elaborating on the motivations provided during the semi-structured interviews conducted. As such, the current study provides findings concerning the motivations for self-harm from a South African perspective – and explored the perceptions of participants with regard to the motivations provided.

The current study provides relevant information regarding several aspects of deliberate self-harm not specified in the research questions. As such, the current study provided information regarding the perceptions of psychological interventions provided to adolescents in children's homes who engage in self-harm; the personal histories of participants that could have influenced their later adoption of self-harming behaviour; psychological disorders with which the participants who self-harm have been diagnosed; as well as the link between deliberate self-harm and suicidal ideation or attempts. As with the previous points, the current study provided these findings within the South African context – which may differ from international contexts.

Lastly, there are two methodological strengths of the current study, being the successful use of qualitative measures, and the triangulation of methods employed in the current study. As such, the successful use of the three semi-structured interviews conducted with each adolescent participant – being a qualitative measure – lies in the exploration of information not stated in the research questions. Thus, the use of the interviews in the current study allowed for the exploration of additional information provided by the participants during the interviews – which is one of the greatest advantages of employing qualitative measures in psychological research. Furthermore, the triangulation of methods in the current study – which included the completion of two questionnaires, the logbook completed by the participants throughout the duration of the data collection procedure, and the series of three semi-structured interviews conducted with each participant – allowed for the confirmation and further exploration of information provided by the adolescent participants in the measures. As such, the researcher was able to explore in-depth the information provided by the participants in the two questionnaires completed – for example, the researcher was able to gain information regarding the method of 'breaking own bones', a method reported by nine participants in the current study during the semi-structured interviews. Thus, by using a triangulation of methods in the current study, the validity of the findings was increased.

It is important to note that the current study is the first study in which the perceptions of adolescents housed in children's homes are explored. Although previous research

concerning self-harm in children's homes has been conducted (for example Stanley, 2007), the current study is the first research endeavour focused on exclusively gaining the perceptions of these adolescents.

5.2.2 Limitations of the Current Study

Although the current study has made several contributions to the knowledge and understanding of deliberate self-harm, there are limitations of the current study. In this section, these limitations are addressed – which will allow for recommendations for future research.

During the data analysis of the current study, the researcher became aware of a critical limitation of the current study, being the failure to discuss programs employed by South African children's homes with regard to the care of the adolescents housed at the children's homes. Although the current study specifically aimed to explore the perceptions of the adolescents participating the study, gaining an understanding of the procedures employed by the personnel at the children's homes to address both the care of adolescents as well as deliberate self-harm may have been worthwhile. With regard to the procedures to address the self-harm among adolescents in the children's homes, several contradictory perceptions were provided by the participants in the current study – some indicating that harsh punishment and reprimand were provided by the personnel upon discovery of the self-harm, while others indicated an understanding and supportive approach followed by the personnel. Gaining an understanding of the procedures followed by the personnel at the children's homes – through discussions with the personnel concerning the guidelines and procedures prescribed for such instances – may have contributed significantly to the in-depth understanding of possible faulty perceptions of adolescents who engage in self-harming behaviour. Though not the focus of the current study, the researcher is of the opinion that an in-depth exploration of the instances of suicidal ideation and attempts among participants engaging in deliberate self-harm may contribute significantly to the understanding of the link between self-harm and suicide. Although previous research has investigated the link between these two behaviours (for example, Hawton & Harriss, 2007; Hawton et al., 2002; Nock et al.,

2006; Nock et al., 2009), the researcher recommends that future research explore this connection between self-harm and suicidal ideation and attempts in full – possibly in a qualitative study employing interviews as data collection procedure.

The data collection procedures of the current study included the completion of logbooks provided to each adolescent participant – allowing the researcher insight into the possible episodes of contagion occurring throughout the data collection process. Although participants were willing to complete these logbooks – and duly noted instances in which thoughts of self-harm occurred – the logbooks were somewhat unsuccessful in the current study due to several reasons: Firstly, few participants engaged in episodes of self-harm throughout the duration of the study – as the majority of the participants noted that they were in the process of attempting to stop their deliberate self-harm. Episodes of self-harm during the data collection process were noted in the logbooks, however. Secondly, while the logbooks aimed to reduce the reliance on retrospective reporting alone, the adolescent participants who noted episodes of self-harm in the logbooks were capable of vividly reporting the episode without referring back to the logbooks. Thus, the information noted in the logbooks – being the event, emotions prevalent before the coping mechanism, coping mechanism (self-harm), and emotions prevalent after the coping mechanism – were readily available in the memory of the participants and explored during the semi-structured interviews, possibly indicating that instances in which the participants self-harm are particularly memorable for the adolescents. Lastly, several of the adolescent participants in the current study requested to keep the logbook – excluding pages on which episodes of self-harm were indicated. Upon further exploration, the participants indicated a sense that the logbooks may serve a therapeutic purpose for them in the future – allowing them to comprehend the underlying features of their self-harm, such as the common triggers for their self-harm. Although not the case in the current study, it is possible that the use of logbooks in psychological research concerning deliberate self-harm may influence the findings of the research – as the therapeutic use of the logbooks provided for research purposes may result in a reduction of episodes of self-harm, and consequently confound the results.

5.3 IMPLICATIONS OF THE CURRENT STUDY

The findings of psychological research provide implications for future research concerning similar topics – as the findings influence the understanding of the phenomenon investigated. There are several implications of the findings of the current study, being: It confirms the existence of a phenomenon generally considered to be hypothetical; the findings expand on previous research concerning the methods employed in deliberate self-harm; the findings provide information concerning a connection between self-harm and suicidal ideation or attempts, as well as a connection between several psychological disorders and self-harm; the findings provide insight into the perceptions of individuals who self-harm in a setting not previously explored; and the findings of the current study could contribute to the contextual understanding of self-harm in the South African context. In this section, these implications are addressed.

As previously discussed, the main aim of the current study was to explore the possible contagion of deliberate self-harm, a phenomenon generally perceived to be hypothetical. As such, little research has been conducted in order to explore this hypothetical phenomenon (see for example Taiminen et al., 1998; Walsh & Rosen, 1985) – in which either the individual initially acquires deliberate self-harm following the observation or knowledge of the self-harm of another individual; or an individual who has a history of engaging in self-harm becomes triggered and consequently self-harms due to the observation or knowledge of the self-harm of another individual at a specific time, thus resulting in episodes of co-occurring deliberate self-harm – although an abundance of literature focuses on explaining this possibility. The findings of the current study provide clear support for the existence of both forms of contagion of deliberate self-harm – as 10 of the 12 adolescent participants indicated personal experiences of each form. The instances in which the contagion occurred for the adolescent participants – as well as the antecedents and consequences, and emotional context of such instances – were furthermore explored during the semi-structured interviews, expanding on the purely quantitative data that has been found to support this phenomenon prior to the current study. As such, the contagion of deliberate self-harm is no longer merely a hypothetical phenomenon – which allows for the exploration of

possible psychological interventions for a phenomenon for which clear support has been provided.

The findings of the current study expand on several aspects of self-harm generally researched from a quantitative approach – such as the use of the DSHI developed by Gratz (2001) which aims to gain empirical data on the methods, frequency and severity of deliberate self-harm – through the further exploration of these aspects during the interviews conducted with the adolescent participants. The findings indicated that although cutting and carving words into the skin is the two most commonly employed methods of self-harm among the adolescents participating in this South African study; methods generally ignored in international literature are commonly employed by the adolescent sample. As such, nine of the 12 adolescent participants in the current study reported intentionally breaking their own bones as a method of self-harm – a method not typically supported by the majority of participants in research concerning deliberate self-harm. The findings of the current study therefore indicate that methods not commonly reported among participants in international research may be more prevalent among individuals in the South African context that engage in self-harm – although this may be limited to the setting in which the current study was conducted, being South African children’s homes. The current study furthermore explored the emotional context – thus, the emotions prevalent immediately preceding, during, as well as immediately following an episode of self-harm – of each method of deliberate self-harm reported by each adolescent participant. As such, the findings indicate that specific emotions – for example, anger – trigger the intention of the participants to use specific methods of self-harm – for example, punching oneself – which the participants have come to associate with the specific emotion. The association between certain emotions and specific methods of self-harm may have diagnostic and therapeutic implications for the treatment of deliberate self-harm – in that the use of specific methods of self-harm may indicate underlying emotions for the clinician, of which the individual engaging in the behaviour may not be aware. Extensive research would be necessitated to link the emotions and specific methods of self-harm, however, before such applications could be made in practice.

Although Walsh (2006) proposed several key differences between deliberate self-harm and suicide – including intent, psychological aftermath, and emotions prevalent – previous research indicate a close connection between self-harm and suicidal ideation or attempts (Hawton & Harriss, 2007; Hawton et al., 2002; Nock et al., 2006; Nock et al., 2009). The findings of the current study provide further support for the connection found between self-harm and suicidal ideation and attempts – in that several participants referred to instances in which self-harm had failed them as a coping mechanism, and suicide was perceived to be the remaining alternative. The participants in the current study indicated, however, that there are clear differences between instances of self-harm and suicidal ideation or attempts – based on the degree to which the participants perceived the instances to be persistent and unavoidable. The implications of the association between self-harm and suicidal ideation and attempts in the current study are similar to those of previous research: Psychological intervention is necessary for those individuals that indicate both engaging in deliberate self-harm and possible suicidal ideation, as the possibility of episodes in which self-harm failed as coping mechanism may result in suicide.

The findings of the current study provide data support for the connection found in previous research between deliberate self-harm and certain psychological diagnoses – such as Bipolar Disorder, Borderline Personality Disorder, and Major Depression. These associations between psychological disorders and deliberate self-harm – both internationally, and within the South African context due to the current study – necessitate the awareness of clinicians concerning the possible signs of self-harm in clients diagnosed with these disorders, so as to address such connections adequately in practice. Furthermore, one participant in the current study has a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) – which has not been associated with self-harm. The participant however perceived his impulsiveness and hyperactivity caused by the ADHD to influence his deliberate self-harm – as he perceived his self-harm to generally be an impulsive action following aversive events. Implications of the prevalence of a diagnosis such as ADHD in a participant engaging in deliberate self-harm are twofold: Firstly, if a clear connection between the diagnosis of ADHD and self-harm could be established, the treatment for both would be influenced by common

characteristics; and secondly, a clear connection between ADHD and self-harm may provide further support for the inclusion of deliberate self-harm in the Diagnostic and Statistical Manual (DSM), as ADHD is classified as an Impulse Control Disorder and commonalities between these conditions may necessitate an investigation into the possible inclusion of self-harm.

The current study was conducted with adolescent participants housed in four children's homes in South Africa, and specifically aimed to explore the perceptions of these adolescents concerning their deliberate self-harm. Few previous studies concerning deliberate self-harm have employed a sample consisting of children or adolescents housed within such a setting (for example, Stanley, 2007); thus, limited literature exists pertaining to the contextual features of self-harm within settings where separation from parents is prevalent. According to Walsh and Rosen (1988), divorce of parents; placement in group care; and placement in foster care may contribute to the later adoption of deliberate self-harm – as such experiences are characterised by temporary and ambiguous separation from parents or guardians that could result in a sense of loneliness in the individual. There are two implications of exploring the perceptions of adolescents within a setting such as a children's home – as well as the findings related to the self-harm of these adolescents. Firstly, the findings from psychological research conducted within settings such as children's homes – in which social services are dominant, and psychological services may be limited – provide necessary information to personnel at such settings with regard to the topic of the research. As such, the findings of the current study allow knowledge and insight for the personnel at children's homes concerning the self-harm of adolescents housed at the children's homes. Secondly, the importance of the findings in a setting such as children's homes lies in the use of the findings to address the deliberate self-harm of the children and adolescents housed at the children's homes. Application of these findings to develop and implement interventions would only be possible, however, following further quantitative research aimed at investigating self-harm within these settings.

Lastly, the current study focused on gaining quantitative data – through the completion of two questionnaires, the DSHI (Gratz, 2001) and the FASM (Lloyd, 1997) – on the

methods, frequency, severity, emotional context, and motivations of deliberate self-harm among a community sample of adolescents in the South African context. By employing such a sample in a study concerning these aspects of self-harm, the current study provides initial literature on these aspects of self-harm within the South African context.

5.4 RECOMMENDATIONS

There are several recommendations for future research on topics similar as that of the current study – based on both the contributions and limitations of the current study. In this section, these recommendations – being alterations made to the FASM and the DSHI; the use of logbooks in psychological research; research on the connection between self-harm and suicide; research on the connection between self-harm and psychological diagnoses; and further research on the contagion of self-harm among community samples – are discussed.

Firstly, several participants provided alternative motivations for their deliberate self-harm on the FASM developed by Lloyd (1997). The first alternative motivation provided – being 'because it is cool' – was reported by two participants in the current study. Both participants conveyed a nonchalant disposition towards their self-harm during the interviews – specifically indicating the use of self-harm as a mechanism through which to gain popularity within certain groups – as well as indifference with regard to the possible implications and consequences of the self-harm. The second alternative motivation provided by the adolescent participants on the FASM is 'I like the blood'. This motivation was reported by three of the participants in the current study – who referred to the smell of blood as a trigger; and the sight of blood as having either a calming or disinhibitory effect. From these two alternative motivations provided – with clear explanations by the participants in the current study for these motivations – the researcher would recommend the possible inclusion of these items on the FASM for future research.

Two recommendations for the future use of the DSHI developed by Gratz (2001) can be made following the findings of the current study. The researcher would recommend that

the questionnaire be amended to include an item for the indication of the number of wounds made on each occasion that the specific method of deliberate self-harm is employed – as including such an item on the questionnaire would allow for greater assessment of the severity of the self-harm of the individual. As such, the researcher suggests that, for example, an item be included in which a participant could specifically report the number of cuts made during a single episode of self-harm through cutting. Several of the participants in the current study were able to indicate this during the semi-structured interviews conducted to explore further the particulars of their deliberate self-harm. Furthermore, the researcher would recommend the possible inclusion of trichotillomania in the questionnaire as a method of self-harm. A female participant in the current study reported employing this method on occasion – without underlying psychopathology or diagnosis of an Impulse Control Disorder.

As discussed in the limitations of the current study, the researcher would recommend careful use of logbooks as a data collection procedure in future psychological research concerning deliberate self-harm – due to the possible use of the logbooks by participants as a therapeutic tool as opposed to a research tool, that could confound findings if not employed appropriately by the researcher. Although the logbooks did not influence the findings of the current study – in that participants were made aware of the research purposes of the logbooks and the use thereof – future research should give due consideration to this possibility.

The findings of the current study indicated that several of the participants had experienced instances of either suicidal ideation or attempts – though not specified in the research questions. Previous research has furthermore provided support for the connection between deliberate self-harm and suicidal ideation and attempts, thus emphasising the need for continued research on this connection. The researcher would recommend further research, both quantitative and qualitative in nature, to investigate and gain understanding on the characteristics of self-harming behaviour that may be closely associated with suicidal behaviour.

As noted in the contributions of the current study, the findings of the research provide further support for the possible connection between deliberate self-harm and several psychological disorders – including Bipolar Disorder, Mood Disorders, and Borderline Personality Disorder. The findings of the current study further indicate a possible connection between self-harm and Attention-Deficit Hyperactivity Disorder (ADHD) that has not been addressed in the literature. The participant diagnosed with ADHD moreover provided insight into the reasons for the influence of his diagnosis on his self-harming behaviour – indicating the commonalities to center on the impulsiveness brought on by his ADHD. The researcher would recommend further research into these connections between self-harm and various psychological diagnoses, as clear evidence for these would allow for the early intervention and diagnostic abilities of both conditions.

Lastly, the researcher would recommend further qualitative research into the phenomenon of contagion of deliberate self-harm. Due to the extensive contagion found in the current study – in that 10 of the 12 adolescent participants indicated experiences of both forms of contagion of self-harm – further research is indicated in community settings to gain greater understanding of this phenomenon. By gaining an understanding of the factors that contribute to the likelihood of contagion occurring in certain settings – as the researcher concluded that the close proximity and continuous contact between adolescents in children's homes contribute to the contagion within this setting – professionals in the social sciences may be able to limit contagion in the future by reducing these factors.

In this chapter, the aspects of the current study that are relevant for future psychological research concerning the aspects of deliberate self-harm explored in the current study were addressed. As such, the contributions of the current study – being the support provided for the contagion of deliberate self-harm, a phenomenon previously considered hypothetical; as well as providing support for and expanding on existing knowledge concerning aspects of self-harm such as the methods, frequency, severity, emotional context and motivations – were discussed; while the limitations of the current study – and recommendations on how to reduce these limitations – were provided. Moreover,

the implications of the findings of the current study – and recommendations on methods to give due diligence to these implications – were addressed.

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