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Needing to Act: Exploring Deliberate Self-Harm in Incarcerated Women

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NEEDING TO ACT: EXPLORING DELIBERATE SELF-HARM IN INCARCERATED WOMEN

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Chairperson

This dissertation meets the standards for appearance, conforms to the style and format requirements of the Graduate School of the University of North Dakota, and is hereby approved.

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Signature Jacqueline Mangrall

Date 04/26/06

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ABSTRACT

Deliberate self-harm (DSH), behavior that causes minor to moderate physical injury that is undertaken without conscious suicidal intent, is a frequent behavior in institutions such as prisons. The purpose of this study was to develop a grounded theory of DSH in incarcerated women. Seven incarcerated women who self-harm were interviewed and constant comparative analysis techniques were used to develop a model of DSH in incarcerated women. The model of Needing to Act emerged from the data of this study. Adverse childhood and adult events, such as sexual and physical abuse, were the predisposing factors for both acting out (criminal offending) and acting in (DSH). Adverse emotional experiences provided the precipitating impetus for the women in this study to act. Adverse emotional experiences included the following concepts: anxiety/tension, build up of pain/ frustration/anger, and no one to listen/no words to say it. The ways in which the participants acted out included the commission of felonies and acts that led to probation revocation. Acting in was manifested by various acts of DSH, the most frequent being cutting. Several intervening conditions were identified that impacted the nature and extent of acting out or acting in. These included the influences of children, methamphetamine, and a listening, caring support system. Three consequences common to both acting out and acting in emerged also. These included short-term, immediate relief, punishment, and embarrassment/shame. This research underscores the need to replace the

punishment model of treatment for DSH. Treatments designed to teach more adaptive ways of acting and ways of tension reduction need to be explored.

CHAPTER I

INTRODUCTION

Deliberate self-harm (DSH), the intentional destruction of body tissue, is a frequent behavior within institutions such as prisons and mental hospitals as well as in the community. This perplexing behavior has been explored in the scientific community for many years without definitive results. Recently, DSH has also gained attention in contemporary culture. Johnny Cash, in his latest release before he died recorded a song entitled: "I Hurt Myself Today." The movie "Secretary" tells of a young woman who cuts her thighs before going to work. She carries her cutting and first-aid materials with her as a subtle testimonial to her silent and secret pain. In a shocking and painful exposé, the biography of Princess Diana recounts her episodes of DSH. It appears that the incidence of DSH may be on the rise (Briere & Gil, 1998, Hawton & Fagg, 2000, Ross & Heath, 2002). Currently, the United States has seen an upsurge of culturally sanctioned self-harm behaviors in the form of tattooing, body piercing and branding. These behaviors appear to exist on a continuum from socially acceptable body modification to non-socially sanctioned self-mutilation. (Favazza, 1996).

The phenomenon of DSH has been a source of interest and concern to mental health and other healthcare practitioners for over 65 years. Despite agreement across disciplines regarding the significance of the phenomenon

there continues to be definitional ambiguity and lack of consensus regarding what DSH is and is not. Deliberate self-harm (DSH) is known by a variety of surrogate terms including self-harm (Beasley, 1999, Dear, Slattery, & Hillan, 2001), self-injurious behavior (Alper & Peterson, 2001, Bockian, 2002), repeated self-injury (Crowe & Bunclarck, 2000), self-wounding, (Huband & Tantum, 2000), and episodic and repetitive self-injury (Favazza, 1998). The literature reviewed in Chapter II relating to DSH (54 articles) calls this phenomenon by at least eight different names and defines this phenomenon in divergent ways as well. Having an agreed upon definition is clearly imperative for generalizing in terms of research, theory, and treatment but, to date, no consensus has been reached (Suyemoto, 1998). This definitional ambiguity is one of the main factors hampering the progress of true understanding of this phenomenon.

Definitional ambiguity also makes it difficult to determine the precise rate of and motivation for this behavior, but regardless of how it is defined, deliberate self-harm is a widely prevalent behavior both within society and in institutions such as prisons and psychiatric hospitals and there is some tentative evidence that its frequency has increased in recent years. Hawton & Fagg (2000) analyzed data from the Oxford Monitoring System for attempted suicide to examine trends in DSH in adolescents in Great Britain. They found an upward trend in the incidence of DSH in the period from 1985 to 1995. Increased incidence were found among all groups studied but most dramatically, among the 15 to 24 –year-old males, there was a 194 percent increase during these years. Again, the issue of definitional inconsistency makes these findings ambiguous

because Hawton and Fagg (2000) defined DSH as any injury recognized as having been deliberately inflicted and therefore, these numbers reflect both suicide attempts and DSH.

Statement of the Problem

This research is designed to address the complex, multi-layered problem of deliberate self-harm in incarcerated women, a distressing topic existing in an uncomfortable environment. The significance of this healthcare issue needs to be established from two different perspectives. First, the problem of deliberate self-harm needs to be established as a significant health issue and secondly, the population of incarcerated women needs to be established as a legitimate venue for nursing research.

Deliberate self-harm is a significant health problem in that it is a frequently occurring phenomenon. Ross and Heath (2002) found the rate of this disturbing behavior to be 13.9 percent in the high school students they surveyed. A year later, in another study, Ross and Heath (2003) found the rate of DSH to be 13 percent and 14.8 percent in the two schools that they studied. Gratz (2001) reported that as many as 38 percent of college students report having performed at least one self-harm behavior in their lifetime. Klonksy, Oltmanns, and Turkheimer (2003) determined the rate of DSH in military recruits to be four percent, a statistic that Briere and Gill (1998) also found in their survey of the general population.

While it has been historically assumed that DSH behaviors occur predominantly in women, the more recent studies clearly highlight the presence

of self-harm among men. Gratz (2001) found that 38 percent of male college students reported a history of self-harm. Zlotnick, Mattia, and Zimmermen (1999) found that 33 percent of psychiatric outpatients, both male and female, reported recent acts of self-harm. Jackson (2000) studied psychiatric inpatient men and recorded the incidence of DSH in that population to be 19 percent. The variability of these estimates is due in large measure to the inconsistent way in which DSH has been defined and operationalized. In addition, sources of incidence data may be taken from police reports or medical records leading to incidence data that only reflect cases severe enough to require emergency intervention (Suyemoto, 1999). Although the incidence of self-harm varies widely from study to study, it is clear that these distressing behaviors occur in significant numbers.

The issue of incarcerated women is also a significant problem in society today. Over 91,000 women were confined to prisons in 2000 and between 1990 and 1998 the imprisonment rate for women rose 88 percent (Bureau of Justice Statistics, 1999). It has been said that to understand society, one needs to look within it prisons. Most of the prisoners are from minorities and economically impoverished communities and thus, they represent society's most marginalized and disenfranchised. As a result, prisons comprise a microcosm of the United States population that is most vulnerable. A new layer of vulnerability is now evident in the prison system as more and more women are being incarcerated. Since 1980, due to changes in laws for drug offenses and other social policies, there has been an unprecedented increase in the number of women behind bars.

In the past two decades the number of women in prison has increased nearly sevenfold, almost twice the rate of men (Freudenberg, 2002). The societal move to 'get tough on crime' coupled with a legal system that espouses equality for women have resulted in these dramatic increases (Maeve, 1999). The women currently serving time can be largely characterized as oppressed women. They are predominantly poor and addicted. (Phillips and Harm, 1997). Additionally, compared to the general population of women, incarcerated women are far more likely to have experienced victimization prior to incarceration (Browne, Miller, and Maguin, 1999). In fact, Bradley and Divino (2002) found that for many incarcerated women, prison is the safest place they had ever been. The importance of these findings is that one of the consistent antecedents of self-harm is a history of childhood abuse.

Having established that self-harm is a problem, and having established that the thousands of women in prison are vulnerable to self-harm by virtue of the fact that they may have histories of abuse, the question remains: Is self-harm in incarcerated women a significant problem? Favazza (1996) stated that prisons are notorious hotbeds of DSH. He reviewed thirteen studies from 1939 to 1993 and concluded that DSH in these prisoners (predominantly men) was due to both the presence of psychopathology and the nature of institutional life. There is little current scientific evidence to justify or refute this assertion. Gorsuch (1998), in her study of 44 inmates on the psychiatric unit of a women's prison, found that over 54 percent of them had engaged in DSH. No other research studies were found that addressed the incidence of DSH in incarcerated women.

Epidemiologically, the incidence of deliberate self-harm establishes this phenomenon as an important area of study. Although little is known about the incidence of DSH in prison, it seems likely that these behaviors are significant health concerns in this vulnerable population which is suffering on multiple levels.

In her "Notes on Nursing" Florence Nightingale commented on "how little the real suffering of illnesses are known or understood" (Seymer, 1954, p. 191). This is sadly true when considering the phenomenon of DSH. Little is known about the causes and treatment of DSH and even less is understood of this disturbing behavior from the standpoint of those who engage in deliberate self-harm. Less still is understood of the role that DSH may play in the circumstances surrounding incarceration of these women and conversely, the role incarceration plays in DSH behaviors. It is essential that we begin to understand DSH from the perspective of those who engage in it. Only then can we develop treatment strategies that are meaningful and effective.

Purpose

The purpose of this study was to develop a grounded theory of deliberate self-harm in incarcerated women. Deliberate self-harm evokes powerful emotions and thus, those who deal with people exhibiting these behaviors tend to distance themselves and disallow discussion. (Shaw, 2002). A research model that gives a voice to those who deliberately self-harm can do much to advance the understanding and care of those experiencing this uncomfortable phenomenon.

Research Questions

Because the grounded theory methodology employed in this research is open to the emergence of theoretical questions during the process of data collection, only the overarching research questions are listed here. These include: What do incarcerated women call this behavior, how do they define it, and of what does it consist? What role does DSH play in the women's entry into the criminal justice system and into prison? How does the prison experience impact the nature and extent of DSH?

Significance of the Study

There is a paucity of research in general on incarcerated women. As Drake (1998) pointed out, correctional facilities remain a fertile field that is virtually untapped for nursing research. Singer, Bussey, Song and Lunghofer (1995) explained this dearth of data on three factors. First, women tend to commit nonviolent crimes and thus are not considered a significant societal threat. Second, women represent only a small proportion of inmates comprising an estimated six percent to eight percent of the total prison population (Acoca, 1998). Third, women, in general, have historically had unequal access to both services and research opportunities. Therefore, this research will contribute to the general body of knowledge regarding a population about which little is known. This research holds the potential for providing understanding of DSH that may, in the future, help these individuals move from self-harming to self-nurturing behaviors that will be consistent with remaining free upon their release.

This research on self-harming behaviors may contribute to the development of a detailed clinical tool to assess the presence, meaning, and psychological functions of DSH. Klonsky, Oltmanns, and Turkheimer (2003) identify this as perhaps the most important next step for research on DSH. Suyemoto (1998) agrees that a clear understanding of the psychological functions of DSH is essential in advancing effective treatment modalities as well as meaningful empirical investigation. There exists a considerable amount of descriptive information about deliberate self-harm and research is beginning to reveal possible psychophysiological mechanisms associated with DSH (Haines, Williams, Brain, & Wilson, 1995, Simeon, Stanley, Frances, Mann, Winchel & Stanely, 1992). However, there continues to be a lack of understanding regarding the complex and multiple psychological functions served by DSH.

It is hoped that this research will uncover the possible connections between DSH and criminal behavior in women. It is possible that the understanding of women's criminal offending will be facilitated by knowledge of their own self-victimization. The incarcerated women in this study will be offered a chance to explore the meaning that DSH has in their lives and behaviors that resulted in their incarceration.

Additionally, it is hoped that this research will shed some light on the potentially compounding role that the prison environment may play in self-harming behaviors. Generally speaking, the roles of culture, social structure, and environments have been absent in current discourse regarding DSH (Shaw, 2002). A grounded theory approach may serve to inform nursing as to the role

that the social structure and the culture of the women's prison plays in the reinforcement and maintenance of DSH behaviors.

Increased understanding regarding DSH would assist nurses to be 'helping nurses'. Sadly, helping behaviors appear to be lacking when nurses encounter those who engage in DSH. Nurses who care for those who self-harm often lack understanding and adopt an uncaring attitude towards these women. Self-harming patients cause discomfort in the nurse arising from fear for the patient's safety, from concern about repercussions if the patient cuts "one time too many", and from complex counter-transference mechanisms (Hubband & Tantam, 2000). This discomfort results in treatment approaches that, according to Shaw (2002), are characterized as disengaged. Current discourse reflects this disengagement and frames these women as emotional blackmailers, attention-seekers, and manipulators. As nurses' frustration and distress grows, treatment can become coercive and even abusive. Women have shared examples of being sutured without anesthesia, scrubbed with wool surgical sponges on open wounds, told they do not deserve treatment, and locked in quiet rooms for days (Shaw, 2002).

There is potential for these uncaring behaviors to be compounded in the context of a prison. While many corrections nurses are committed and competent, the reality is that jails and prisons draw some health care providers who are attracted to controlling and punishing prisoners. Maeve and Vaughn (2001) have made an uncomfortably strong and well-documented case for the existence of "penal harm nursing" in prisons and they assert that this

substandard, disengaged care has become routine. When women who deliberately self-harm are thrown into this environment, they become doubly vulnerable to the punitive and controlling approaches that may well be similar to those which precipitated both their incarceration and their deliberate self-harm. Nurses see those who self-harm as less entitled to care (Hopkins, 2002). Nurses see inmates as less entitled to care (Maeve & Vaughn, 2001). This combination of attitudes places these needy women in double jeopardy. I hope that my research contribution will help to strengthen the healing and caring mission of nursing with incarcerated women. Assisting nurses to see these women as hurting people experiencing psychic pain may assist in moving self-harming incarcerated women from a position of "other" to part of the human community.

Perhaps, most importantly, this research will give voice to women who have been silenced. Conventional social science research is accomplished by distancing the researcher from those being researched and such research approaches may serve to perpetuate the already profound silence of these women. Providing a voice to these women has been identified as a critical need (Shaw, 2002). Machoain (1998) explains that to have a "voice" is to be human. Having a voice depends on listening and being heard. A grounded theory that emerges from the voice of these women can do much to advance understanding of this enigmatic and uncomfortable phenomenon.

Boundaries

The boundaries of this study were delineated in the following ways.

1. The gathering of data took place from December 2005 to March 2006.

2. The location of the study was a women's state prison in a rural community in the Midwest.
3. Only those women who currently were engaging in DSH behaviors or who had a significant history of engaging in DSH prior to incarceration were included in the study.
4. Those women whose self-harming behaviors were self-identified as exclusively suicide attempts were excluded from the study.

Assumptions

Several assumptions guided this research. The first is assumed in grounded theory itself and asserts that people do, in fact, order and make sense of their environment. Although the world of the deliberate self-harmer may seem illogical and nonsensical to observers, it does possess a kind of situated internal logic (Harris, 2000) with common meanings and behaviors. These meanings and behaviors are amenable to exploration and discovery through a grounded theory methodology.

The second assumption is that the participants in this study will answer the interview questions openly and honestly. Despite the concern that prisons both create and sustain distrust, I entered into this undertaking expecting these women to tell me their stories with honesty and accuracy. This is not to say that I went in with an innocent naiveté but I do have the advantage of being able to establish my credentials as an outsider who is not beholden to the correctional system.

The third assumption that provides foundational truth for this study is that women who self-harm are hurting people who harm themselves to somehow alter their pain but do not ultimately act with intention of destroying themselves. Self-harm and attempted self-destruction (suicide) are not synonymous concepts.

Definition of Terms

A definition of the term deliberate self-harm was derived from the review of literature and is discussed in more detail in Chapter II. For the purposes of this dissertation, deliberate self-harm is defined as: A direct behavior that causes minor to moderate physical injury that is undertaken without conscious suicidal intent and occurs in the absence of psychoses and/or organic intellectual impairment. This definition approximates the one derived by Suyemoto (1998) in her literature review.

The term incarcerated women is defined here as adult women who have been sentenced for a crime and are serving time in a women's state penitentiary. No women in local or county jails who are awaiting trial or sentencing, or women serving time in jail are included in this definition or in the population of those being studied.

Summary

In this chapter, I outlined the importance of DSH as an area of research inquiry in incarcerated women and I established the purpose of the study and the research questions that will guide the data collection and analysis. Additionally, the study boundaries, assumptions and definitions were explicated in order to place this study in its context.

Clarke and Whittaker (1998) astutely point out that in the vast repertoire of human suffering few activities rank as puzzling as deliberate self-harm. The difficulty in understanding these behaviors is compounded when one considers these perplexing behaviors in the context of incarceration. Further exploration of the interaction of DSH behaviors and the incarceration experience needs to be accorded legitimate space in contemporary scientific literature.

CHAPTER II

SITUATING THE STUDY IN RELEVANT DISCOURSE

Introduction

This chapter details the preliminary review of literature that was undertaken as introductory study in preparation for the development of a grounded theory of DSH in incarcerated women. The purpose of this literature review was to facilitate the enhancement of theoretical sensitivity and to ascertain the general gaps in the knowledge related to women who self-harm, and, more specifically, to incarcerated women who self-harm, thus confirming the need for this study. Because grounded theory research is, by nature, an emergent type of research the literature review will be ongoing. Progressive accessing of literature was done as it becomes relevant and, as such, is regarded as part of the data collection and analysis procedures.

A literature search from 1994 to 2004 was carried out using the Health Source, Psychology Proquest, and Academic Search Premier databases. Relevant available journals were also hand searched and appropriate citations were accessed by hand, through electronic databases and e-journals, or by interlibrary loan mechanisms. Key words used in the search were: self-harm, self-injury, deliberate self-harm, self-mutilation, parasuicide, incarcerated women and women in prison.

In reviewing this literature I was mindful about the risk of tainting my view with preconceived models that may have constrained my coding and memoing. Thus, the literature review was undertaken with the goal of helping me to sharpen my understanding of literature gaps and to enhance my theoretical sensitivity rather than to impose an existing framework on the analysis process. Therefore, the review of the literature in this chapter was structured to present an evolutionary view (Rogers, 2000) of the concept of DSH.

The evolutionary view of concept analysis does not reveal precisely what the concept *is* and *is not.* Instead, Rogers (2000) points out that, "consistent with the idea of a cycle of continuing development, results serve as a *heuristic* by providing the clarity necessary to create a foundation for further inquiry and development" (p. 84). Thus, evolutionary development of the concept of deliberate self-harm serves to create a foundation for theory development grounded in the lived experience of those who engage in these behaviors.

The basic organization of this chapter is as follows: Section one identifies the surrogate terms and definitions applied to DSH and ends with a definition derived from the literature review. Section two outlines the contextual basis of the concept of DSH including its attributes, its antecedents, and its consequences. Section three provides a brief overview of symbolic interactionism, a theory that informs grounded theory itself. This theory is not one about DSH specifically, but addresses human behavior more globally. It is an approach to studying human conduct and human group life. Using a symbolic interactionist paradigm, grounded theory provides a way to study human

behavior and interaction that supports the creation of new and different perspectives. (Chenitz & Swanson, 1986).

For the sake of clarity, I have chosen to use the terms self-harm or deliberate self-harm (DSH) throughout the literature review. It should be noted, however, that much of the research discussed in this chapter used surrogate terms such as parasuicide or self-mutilation. The reasons why I have chosen the term deliberate self-harm for the concept are explicated later in this review.

Deliberate Self-Harm Defined

Wilson (1963), in his seminal book, *Thinking With Concepts*, stated that analysis of concepts "gives framework and purposiveness to thinking that might otherwise meander indefinitely and purposelessly among the vast marshes of intellect and culture" (p. ix). This statement appears to have particular relevance in considering the myriad definitions that have been attributed to the concept of DSH. Clearly, a need for a standard and universal definition is necessary in order for the scientific community to wade out of this "intellectual marsh" and advance its inquiry into this complex phenomenon. The following paragraphs delineate some of the various ways in which this concept has been defined in the research and clinical literature. Table 1, as shown on page 17, lists some examples of the variability of the terms and their definitions found in the literature.

Table 1. Examples of Various Names and Definitions for Deliberate Self-Harm.

Researcher	Population Studied	Name Given to Concept	Definition
Alper & Peterson, 2001	Borderline Personality Disordered Inpatients	Self-injurious Behavior	Any behavior in which patients cause physical damage to themselves without fatal outcome
Beasely, 2000	Psychiatric Inpatients	Deliberate Self-harm	Any behavior engaged in by an individual regardless of intent that results in deliberate harm to their body or interference with their vital functioning.
Conaghan & Davidson, 2002	Elderly	Parasuicide	Non-fatal suicide attempt.
Haines & Williams, 1997	Male Prisoners	Self-mutilation	Low lethality self-injurious behavior such as wrist cutting and skin burning.
Hubband & Tantam, 2000	Clinical Staff of Psychiatric Facilities	Self-wounding	Self-inflicted cutting, slashing, hitting, or burning.
Hurry, 2000	Children and Adolescents	Deliberate self-harm	Attempted suicide.
Isacsson & Rich, 2001	Psychiatric Inpatients	Deliberate Self-harm	Any act by an individual with the intent of harming himself or herself physically and which may result in some harm.
Klonsky, Oltmanns, & Turkheimer, 2003	Military Recruits	Deliberate Self-Harm	Intentionally injuring oneself without suicidal intent.
Ross & Heath, 2002	Adolescents	Self-mutilation	Any incident where an individual had attempted to deliberately alter or destroy body tissue without suicidal intent.
O'Connor, Sheehy, O'Connor, 2000	Patients Presenting to ER	Parasuicide	Any act of deliberate self-harm irrespective of intention.
Saxe, Chawla, & van der Kolk, 2002	Patients with Dissociative Disorder	Self-destructive Behavior	No definition
Sidley, Calam, Wells, et al., 1999	Patients Presenting to ER	Parasuicide	Self-harm which is not lethal (specifically) deliberate drug overdose.
Tulloch, Blizzard & Pinkus, 1997	Adolescents Presenting to ER	Self-harm	No definition.

Beasley (2000) called the concept "deliberate self-harm" and defined it as any self-harming behavior regardless of intent. Likewise, O'Conner, Sheehay, and O'Connor (2000) chose to ignore the "intent" component of self-harm in their definition and focused on self-harm behaviors irrespective of intention. Hjelmeland, Hawton, Nordvik, and Bille-Brahe (2002) cited the WHO/EURO Multicenter Study of Suicidal Behavior that defined "parasuicide" more comprehensively but still did not address the issue of intent. In this definition parasuicide was defined as:

> ...an act with nonfatal outcome, in which an individual deliberately initiates a nonhabitual behavior that, without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing changes which the subject desired via actual or expected physical consequences (p. 3.)

It should be noted that self-mutilation is excluded, but what they considered "self-mutilation" was not explained.

Klonsky, Oltmanns, and Turkheimer (2003) named their phenomenon of concern "deliberate self-harm" and defined it as "intentionally injuring oneself without suicidal intent" (p. 1501). Roth and Presse (2003) used a similar definition but limited it to those individuals with borderline personality disorder. Specifically, they defined "parasuicide" as ... "the nonfatal, intentional self-injurious behaviors frequently exhibited by individuals with features of borderline personality disorder" (p.21).

Intent to harm in the absence of a desire to kill oneself is also reflected in the definition of Isacsson and Rich (2001) They defined deliberate self-harm as a behavior, not an illness, and cautioned not to confuse this behavior with attempted suicide. Likewise, Dallam (1997) referred to the concept of "self-mutilation" as deliberate destruction of body tissue without conscious suicidal intent" (p. 151).

Conversely, Conaghan and Davidson (2002) defined "parasuicide" as a non-fatal suicide attempt. The intent to kill oneself is clearly a pivotal part of this definition. Reitdijki et al. (2001) also included suicide attempts and threats in their definition of parasuicide.

In summary, the literature calls this phenomenon by at least eight different names and defines this phenomenon in even more divergent ways. While some describe DSH as existing only when there is clear intent NOT to kill oneself, others define it in just the opposite way, saying it exists only when there clearly is the intent to kill oneself. Still others define it as self-harm regardless of intent. A fourth definitional approach delineated by the body of literature concerning this concept shows avoidance of defining DSH at all. For example, Stravinski and Boyer (2001) studied loneliness in relation to DSH behavior. They were careful to operationally define loneliness but avoided any definition of "parasuicide".

It is my belief that those who self-harm with the intent to kill themselves do so from far different motivations and with far different outcome expectations than those who self-harm without the intent to kill themselves. Favazza (1998) agrees and describes self-harm behavior as a morbid form of self-help that is antithetical

to suicide. In fact, one model of self-harm is named the "anti-suicide" model and focuses on DSH as an active coping mechanism used to avoid suicide. (Suyemoto, 1998). Despite this, the association between failed suicide and deliberate self-harm continues on. Clark and Whittaker (1998) describe this as "representing a persistent failure to make a distinction between two very differently motivated acts" (p. 131). Thus, it may be that the reason that a true understanding of DSH remains elusive is because researchers have been attempting to study two completely different phenomenon. For the remainder of this dissertation, the term deliberate self-harm (DSH) will be used for those whose intent is NOT to kill themselves. The assessment of 'intent' is subjective and its determination may be difficult, but exploring DSH intent is essential to gaining an understanding of the nature of this disturbing phenomenon. As stated earlier, DSH has different etiologies, antecedents, causes and expected outcomes than attempted suicide, and therefore, cannot be considered to be the same concept.

A definition of this concept is derived from the literature and for the purposes of this dissertation is: A direct behavior that causes minor to moderate physical injury that is undertaken without conscious suicidal intent and that occurs in the absence of psychoses and/or organic intellectual impairment. The disqualifiers (absence of pyschoses and organic intellectual impairment) are explained later in the literature review. This definition approximates the one derived by Suyemoto (1998) in her literature review. Suyemoto(1998), however, named this concept "self-mutilation" as does Favazza (1998). Self-mutilation,

however, seems an inaccurate term because of its more severe negative connotations and its suggestion of permanence. The Random House Dictionary defines 'mutilate' as 'to irreparably damage'. This implies a degree of self-destruction more severe than DSH. Unlike other disciplines, no nurses termed this behavior self-mutilation. I suspect that, like me, these nurse researchers were reluctant to use a term with such violent implications. Gratz (2001) echoed this discomfort and preferred the use of the term 'deliberate self-harm', stating that it has less of a negative connotation. This may be an important consideration given the idea of permanence that the word 'mutilation' evokes, the stigma attached to these behaviors, and the tendency of this phenomenon to arouse strong emotions.

Those who self-harm and have serious psychopathology or organic mental impairment are excluded from this definition because in these cases, the behavior is not motivated by the same dynamics as those who self-harm in the absence of psychoses or organic impairment (Favazza, 1996).

Limiting the definition serves the purpose of narrowing the literature review just to those studies and scholarly works that address deliberate self-harm in those who are not psychotic or organically impaired and who exhibit no suicidal intent. "Cleaning up" this concept thus allows for the development of the maturity of DSH as a concept and can generate implications for nursing inquiry. The derived definition is schematically depicted in Figure 1, as shown on page 22.

Using this definitional understanding, the following sections develop the concept of DSH following Roger's (2000) evolutionary view that calls for

delineation of the attributes, antecedents, and consequences of DSH. Rogers (2000) cautions that these categories are dynamic rather than static and context dependent rather than universal. It is worth noting also that the phenomenon of DSH, like other phenomena in nursing, is comprised of numerous interrelated elements and is interpretable only in regard to a multitude of contextual factors.

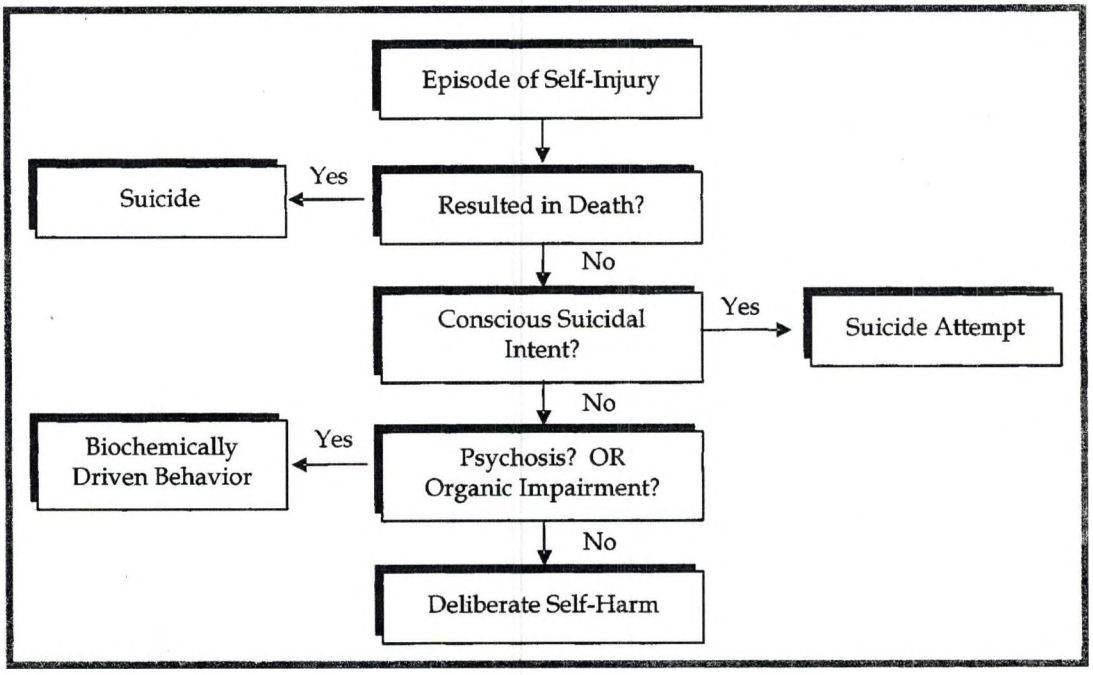


Figure 1. Differential Algorhythm of Deliberate Self-Harm.

Attributes of Deliberate Self-Harm

Self-harming behavior occurs on a continuum that ranges from altering the physical appearance of the body such as piercing one's ears to extreme forms of self-injury such as amputation of a limb. (Dallam, 1997). Examples of culturally sanctioned behaviors include ear piercing and small tattoos. These practices are considered beauty enhancing and are not considered to be DSH. At, times, however, the line between socially sanctioned self-alteration and deviant self-

mutilation is blurred. Extreme forms of body tattoos, brandings, piercings, and skin carvings cross into the realm of DSH behavior. "Bod-mod" or body modification is gaining popularity and is epitomized by Eric Sprague who has spent the last several years trying to turn himself into a lizard. He has had Teflon implants to enlarge his forehead, filed his teeth into fangs, and covered his body with tattoos of reptilian scales (Ressner, 1999). Whether or not this unique exemplar is a case of DSH can be determined by looking at which attributes Eric Sprague demonstrates. These attributes, as gleaned from the literature are outlined in the following section of this paper and include: 1.) self-harm with a nonfatal outcome, 2.) absence of suicidal intent, 3.) absence of organic or mental impairment, 4.) evidence of repetitive, addictive, or contagious behavior, and 4.) presence of Borderline Personality Disorder (BDP), Dissociative Disorder, other personality disorder features or anxiety.

Self-Harm With A Nonfatal Outcome

Obviously, the first attribute of DSH is self-harm with a non-fatal outcome for if it were fatal, it would definitionally be suicide. Several studies have found slashing to be the most common form of self-harming behavior. Skin cutting occurs in at least 70 percent of the individuals who engage in DSH (Briere & Gil, 1998; Klonsky, Oltmanns, & Turkheimer, 2003). Between 21 percent and 44 percent of self-harmers bang or hit themselves, and between 15 percent and 35 percent burn their skin (Klonsky, Oltmanns & Turkheimer, 2003).

Absence of Suicidal Intent

Deliberate self-harm behaviors differ from suicide attempts in that the intent is not death but rather improvement of a psychological state (Roth & Presse, 2003). Hjelmeland et al. (2002) argue that the understanding of intentions is essential to differentiating suicidal acts from DSH acts. They concede, however, that individuals may not often have full insight into the nature of their intentions regarding their self-harm behavior.

The idea that the intent is an important distinction to make between DSH and suicidal behaviors is a relatively new understanding. In 1920, Sigmund Freud postulated that *thanatos* (the death instinct) gave rise to self-harming behaviors. Self-harm and suicide were both seen as manifestations of an instinctive death drive and no distinction was made between the phenomena. Karl Menninger, in 1938, was the first major psychiatrist to contradict Freud's beliefs. He regarded self-harm as a way of averting total self-destruction by substituting the destruction of some part of the body (Suyemoto, 1998).

In his book, *Bodies Under Siege,* Favazza (1996) solidified the understanding that self-harm and suicide are two distinctly different phenomena. Suyemoto (1998) agreed and described DSH not as suicide attempts but rather as "antisuicide" and explained a model of DSH which focuses on DSH as a coping mechanism to avoid suicide by channeling destructive impulses into self-harm rather than self-destruction. Recent experts in this field have upheld this idea (Klonsky, Oltmanns, & Turkheimer, 2003; Ross & Heath, 2002) although many health care professionals are not aware of this distinction.

Although DSH as defined in this analysis is not inherently suicidal in nature, studies have demonstrated that patients who frequently self-mutilate are more likely to attempt suicide (Alper & Peterson, 2001). It is noteworthy that the long-term suicide rates for self-harming individuals is estimated at between 8.5 percent to 9.5 percent which is as high as long-term rates for suicides calculated for individuals who have had previous actual suicide attempts (Paris, 1990). In 1985, an episode of the Phil Donahue show focused on a social phenomenon that he termed "self-abuse." Following that show over 1,000 persons contacted the producers for information about self-abuse. A survey was sent to these people and those who harmed themselves deliberately were asked to complete the survey. Two hundred and fifty questionnaires were returned. One third of these respondents expected to be dead within five years (Favazza & Conterio, 1988). This study lacked scientific rigor, but even so, this is a finding of concern.

A two-year Swedish study of 812 patients who had deliberately harmed themselves showed that 11 percent repeated the nonfatal act and two percent committed suicide during the study period. These researchers reported that it is usually estimated that 10 percent of DSH individuals will commit suicide within 10 years (Isacsson & Rich, 2001).

In fact, however, the incidence of suicide of those who previously deliberately self-harmed cannot be accurately gleaned from the literature because, in most studies, no distinction was made between those acts of self - harm intended to end life and those that were carried out with nonfatal intent. Despite this lack of differentiation of intent, it does appear that those who engage

in DSH may be at risk for intentional suicide. In addition, suicide may be an unintended consequence of self-harm and, therefore, DSH behaviors are an ominous sign of the potential for completed suicide.

Absence of Psychoses or Organic Mental Impairment

Self-harm behaviors are not considered DSH if the act is in response to a delusion, hallucination or serious mental retardation. Repetitive self-harm in the presence of certain types of known psychopathology has generally been conceptualized as biologically driven behavior and is considered to occur outside of the realm of DSH. Complex interactions between biological, psychological, and environmental factors appear to lead to self-injury in these circumstances. (Dallam, 1997). Head banging, self-biting and self-hitting are relatively common among severely mentally retarded individuals. Compulsive biting of the lips, tongue, and fingers is seen in patients with Lesch-Nyhan Syndrome and, to a lesser extent, in Tourette's Disease (Crowe & Bunclark, 2000). Favazza (1998) classified these behaviors as stereotypic self-mutilation. This classification is characterized by repetitive acts such as head banging that have a fixed pattern of expression, and are rhythmic. Favazza also described them to be seemingly devoid of symbolism. This makes these behaviors substantially different from DSH, a set of behaviors that appears to be rife with symbolism.

Evidence of Repetitive, Addictive, and/or Contagious Behavior

DSH is viewed by many to have an addictive quality. Crowe and Bunclark (2000) addressed this attribute as one of the most striking aspects of repeated DSH and goes together with the frequent coexistence of other addictions seen in

these individuals such as alcohol and drugs. In Beasley's (2000) study, alcohol misuse was recorded in the clinical history of 71 percent of the cohort studied and illicit substance misuse in 54 percent. Beasely (2000) also reported that DSH behaviors were most prevalent in the evening hours and were found to be highly contagious. Clusters of incidents occurred non-randomly, with incident days following incident days. Clusters of incidents over a five-day period were found to involve up to 11 patients at a time.

Presence of Borderline Personality Disorder, Dissociative Disorder, Other Personality Disorders, or Anxiety

Deliberate self-harm, although termed "repeated self-harm", is included as a defining criterion for Borderline Personality Disorder in the 1998 Diagnostic and Statistical Manual – IV, Text Revision (DSM IV TR). Many studies support the classification of DSH as a symptom of Borderline Personality Disorder (Alper & Peterson, 2001, Beasely, 1999, Chamberlain & Gunn, 2000, Favazza, 1996, Maden , et al., 2000). The presence of Borderline Personality Disorder in self-harming individuals is found in diverse populations such as male prisoners, female prisoners, adolescent girls, and hospitalized psychiatric patients.

Klonsky and colleagues studied DSH in a group of military recruits and their results supported the DSM-IV-TR classification of DSH as a symptom of Borderline Personality Disorder but also found that in this non-clinical population, other personality disorders and traits may be associated as well. They found that a "self-harm" personality profile emerged. Reports by the peers of these self-harming recruits reported that these self-harmers tended to have strange and

intense emotions, and a heightened sensitivity to rejection (Klonsky, Oltmanns, & Trukheimer, 2003). These researchers also presented data on depression and anxiety and determined that while scores for both depression and anxiety were higher in self-harmers than non-self-harmers, it was anxiety, in particular, that maintained a substantial relationship to DSH over and above depression. (Klonsky, Oltmanns, & Turkheimer, 2003).

Anxiety and depressive symptomatology were also found to be present in a community sample of adolescents who self-harmed. Those who self-harmed reported significantly more depressive symptomatology as well as higher anxiety than non-self-harming students. (Ross & Heath, 2002).

Recent literature reveals another psychiatric diagnosis that may have etiological influence in DSH behaviors. Saxe and colleagues found that 86 percent of their sample of patients with dissociative disorders engage in self-harm behaviors. (Saxe, Chawla, & van der Kolk, 2002). Brodsky and colleagues studied women with a known diagnosis of Borderline Personality Disorder and his data revealed a robust relationship between DSH and dissociation in this sample (Brodsky, Cloitre, & Dulit, 1995). This makes sense since Dissociative Disorders are strongly linked to childhood abuse and the same appears to be true of DSH.

Besides Dissociative Disorder, other psychiatric diagnoses have been found to exist in those who self-harm. Zlotnick, Mattia, and Zimmerman (1999) found the diagnostic composition of the 85 self-harmers in their study to include such diagnoses as post traumatic stress disorder (11.7), eating disorders (seven

percent), substance abuse (25 percent), and intermittent explosive disorder (3.1 percent).

To summarize, current literature seems to be moving away from looking at DSH as exclusively a component of Borderline Personality Disorder as it has historically been thought to be. Recent studies have found DSH behavior to be present in tandem with other DSM-IV-TR diagnoses and other personality traits. Indeed, research support for an independent Axis I diagnoses of deliberate self-harm is beginning to accumulate (Suyemoto, 1998). As more research proceeds with a cleaner definition and with other populations who are not hospitalized perhaps new diagnostic understandings will emerge.

Antecedents of Deliberate Self-Harm

Many possible antecedent conditions to DSH are discussed in the literature. This section addresses those found frequently in the research literature. These include the build up of tension, hostility and impulsivity, feelings of depersonalization and derealization, a history of childhood abuse, psychobiological factors such as rising cortisol and serotonergic dysfunction, and a desperate hope for love.

Build Up of Tension and Anxiety

Although the reasons precipitating DSH are complex, all of the literature examined revealed that the primary antecedent or situation preceding an instance of DSH was some form of tension. Favazza and Rosenthal (1993) included this criterion in their proposed list of diagnostic criteria for repetitive self-harm syndrome. Both depression and anxiety are commonly seen in people who

engage in DSH but anxiety has been found to maintain a substantial unique relationship to DSH over and above depression (Klonsky, Oltmanns & Turkheimer, 2003). Likewise, Simeon and colleagues found that anxiety was significantly correlated with the degree of self-harm. They reported that seeking relief from tension is the most commonly cited reason for DSH. In their study of 26 self-mutilators with personality disorders, a two-tailed *t* test revealed that there was a significant difference in anxiety scores ($p<0.01$) between those subjects who self-harmed and those who did not (Simeon et al., 1992).

This antecedent is dramatically substantiated in statements made by those who self-harm. One female, age 38 stated: "I feel like a pressure cooker that's going to explode. Cutting and bleeding sufficiently is like letting out the steam. If I do this to my satisfaction, I feel immediate relief, as if injected with Valium or something. It helps stop the inner turmoil for a while" (Bockian, 2002).

Hostility and Impulsivity

Ross and Heath (2003) studied a group of 122 adolescents in two high schools who self-harmed. The results showed that while a small group of adolescents reported only feelings of anxiety, over two thirds of those who self-harmed indicated feeling both hostility and anxiety prior to acts of DSH. The results of this study lend support for the hostility model of DSH as outlined by Herpertz, Sass, & Favazza (1997). This model postulates that an individual turns to self-harm because of an inability to overtly express anger, which, in turn, leads to rising tension. One further finding of Ross and Heath (2003) was that self - harmers had greater levels of both extrapunitive hostility (cynical, resentful, easily

angered), and intropunitive hostility (self-doubt, guilt, self criticism). This tendency to become more easily angered while, at the same time, experiencing self-dislike and guilt may result in directing these hostile feelings against the self.

Simeon and colleagues (1992) also found that greater aggression and chronic anger combined with impulsivity to distinguish those personality disordered people who self-harmed from those who did not. Impulsivity did not differ between those who self-harmed and those that did not. What distinguished self-harmers was not their impulsivity alone, but their greater aggression, which when combined with poor impulse control took the form of self-harm behavior.

Feelings of Depersonalization and Derealization

The idea of feelings of unreality, or lack of a feeling state, as triggers to deliberate self-harm has not been clearly established in the recent quantitative literature although these symptoms are classic manifestations of dissociative disorder, a diagnostic category that has been frequently documented in those who self-harm (Brodsky, et al., 1995, Saxe, et al., 2003, Zlotnick, et al., 1999).

Qualitative researchers, on the other hand, have documented this as being an antecedent of DSH. In dissociation, the mind slips away from its ordinary context and the person experiences depersonalization and derealization. Harmony, one of the participants in Machoian's (1998) study described this state as being in the "Twilight Zone" and stated: "Oh, God, like, you're in a fog. It's like you're, it's like I'm looking at the world, but I don't feel like I'm here. It's like this big cloud in front of me. Do you know what I mean?" (p.76).

Cutting seems to end the dissociative episode. Although the specific mechanism causing the ending of the dissociative episode is unclear, it appears that the shock of blood flowing may be a contributing factor (Suyemoto, 1998). Briere and Gill (1998) speculated that self-harm may shift focus to the body sensations, thus interrupting the depersonalization and the derealization process.

History of Childhood Abuse

Childhood abuse is also prominently featured in the discussion of predisposing factors for DSH. Suggestions of the important link between DSH and childhood abuse have a long history and the evidence of this association is ample (Gratz, Conrad & Roemer, 2002, Klonsky, et al.,2003; Romans, Martin, & Anderson, 1995, Zlotnick, et al., 1996). Histories of sexual abuse, physical abuse, and/or psychological abuse have been shown to be significantly correlated with subsequent self-destructive behavior. Romans, Martin, & Anderson (1995) found a cumulative 'dose' effect, with more intrusive and frequent childhood sexual abuse being more strongly correlated with subsequent DSH behavior. A female, age 23, refers to this antecedent in her statement: "I injure myself to try to calm down, to try and escape the painful memories of my abuse, to try and take control of my emotions, to try to feel safe, to stop the nightmares and daymares, to try and feel" (Bockian, 2002, p.20).

Psychobiological Factors

The aggression and impulsivity characteristic of DSH has been hypothesized to be partially a function of serotonergic dysfunction. Simeon and colleagues (1992) tested this hypothesis using a platelet imipramine binding test.

Platelets are thought to be an analog of the serotonergic neuron because their uptake, storage, and release of serotonin are similar to presynaptic neurons. A smaller number of imipramine binding sites on platelets may reflect the same situation in neurons and thus provides an indirect measure reflecting brain serotonergic dysfunction in the form of reduced presynaptic release of serotonin into the neuronal synapse. Simeon and colleagues (1992) found that self-harmers had mean serotonin levels that were 44 percent lower than the non-self-harmers. The number of subjects in this component of the study was only three which compromises the strength of the study.

One other psychobiological antecedent that bears noting has been highlighted in the American Journal of Medicine. Sachsse, von der Heyde, and Huether (2002) assessed the urine cortisol level of one self-harming woman for 86 consecutive nights. She generally showed low cortisol excretion, however, whenever her cortisol level was above 20 (mu)g a night, she performed one of several acts of DSH. Subsequently, an instantaneous return to her baseline low cortisol levels was observed. These authors conclude that the results provide some initial evidence that episodes of DSH may occur as a response to hyperactivity of the central stress-sensitive neuroendocrine systems. Thus, they lend some neurobiological weight to the assumption that DSH may be regarded as an unusual but physiologically effective coping strategy for regaining control over an otherwise uncontrollable stress response. Further studies are needed to confirm this interesting finding.

In summary, there appears to be preliminary (albeit meager) evidence that DSH may have some psychobiological antecedents and thus, may not be purely a psychological or interpersonal process, but rather biology and psychology may be interactive. This reinforces the need for a holistic approach to the care of those who self-harm

Desperate Hope for Love

Machoian (1998) conducted a qualitative exploration of four adolescent girls' suicidal and self-harm behaviors through the use of psychological case studies. Her findings indicated that the onset of cutting behaviors in early adolescence signified a desperate hope for love and relationship. The girls experienced emotional neglect and perceived that no one really cared that they had experienced physical, emotional, and sexual abuse, parental alcoholism, divorce and death of significant people. Machoian (1998) asserted that, in not killing themselves, lay the inherent nature of their hope for relationship. "These girls do not want to live without someone caring and they do not want to die without someone caring" (p. 179).

While elicitation of caring is an often cited function of self-harm in the general literature, Gratz (2003) argues that this is somewhat inconsistent with the empirical data. In her review of research literature, Gratz (2003) found that the majority of studies did not find the elicitation of caring response to be a major function of DSH.

The idea of a desperate hope was indirectly confirmed quantitatively in Simeon and colleagues (1992) study of self-harm in 26 subjects with personality

disorders. One of their significant findings was that the affective profile of self-harmers demonstrated more depression than their control subjects, but they did not suffer greater hopelessness. In fact, a significant negative correlation was found between the degree of self-harm and hopelessness. The researchers speculated that this lent support to the conceptualization of self-harm as an act that provides transient restoration of hope. Thus, the idea of hope for love may play some role as an antecedent of self-harm.

Consequences of Deliberate Self-Harm

As with the antecedents of DSH, there are also many consequences listed in the literature. This section addresses three frequently cited consequences-relief of tension, communication of emotional pain, and paradoxical disengagement from caregivers.

Relief from Tension

Favazza and Rosenthal (1993) list a sense of relief when committing the act of self-harm as one of the proposed diagnostic criteria for DSH. The significance of this consequence of DSH was confirmed by Briere and Gill (1998) who found that management of stress and reduction of tension were listed by more than 70 percent of the 93 self-harmers in their study. Klonsky, Oltmanns, & Turkheimer (2003) also reported a sense of relief after episodes of DSH and there is physiological evidence that self-harmers experience a reduction in tension after an episode. Although this seems counterintuitive, the self-harm action itself seems to give immediate release and relief.

This sense of relief has been characterized as "antisuicide" in that DSH behaviors appear to provide at least a temporary respite from emotional pain and psychological tension that would otherwise be unbearable (Shaw, 2002). This sense of relief may last up to 24 hours (Crowe & Bunclarck, 2000).

Haines and Williams (1997) were able to demonstrate that deliberate self-harming male prisoners do not have significantly poorer problem solving or coping skills. The implication of these researchers was that DSH is not adopted because there is no other means of coping or problem solving. These researchers concluded that there must be some other factor that makes DSH the strategy of choice to alleviate distress. The sense of immediate relief may be that factor that makes DSH an attractive tension relief strategy.

Communication of the Degree of Pain

Another prominent theme that occurs in the literature relating to the expected outcomes and consequences of individuals who engage in DSH behavior is that of communicating the degree of pain they are experiencing. Machoian (2001) described cutting as a means of gaining a response when speaking voices fail. One of the girls interviewed in her qualitative study stated:

> It's an actualization of pain, you know...The most basic is that even if you tell people that something is wrong, a lot of times, they won't, they won't know how wrong. But all they'll do is see a cut along a vein, and they get the message right away. (p. 25)

Favazza (1996) also addressed the wish for those who self-harm to impress on others the degree of their own pain. In general, the intended consequences for

those who self-harm are: 1. to gain relief from unbearable tension and psychological pain, and 2. to communicate the degree of that pain to others.

A quote from McLane (1996) poignantly speaks to this need to impress upon others the degree of their pain.

> The reality of violation has been so ignored and destroyed that not only language, but even normal tears no longer have meaning. Only when the entire body 'cries' – when it bleeds from a cut – is this woman able to hope that anyone, herself or others, will comprehend the pain. (p.114)

Paradoxical Disengagement from Care Givers

Negative reactions of the health professional to women who self-harm is a paradoxical and unintended consequence. Machoain's (1998) qualitative inquiry of adolescent girls revealed that no sooner do girls who self-harm discover the efficacy of this language, they are denigrated for knowing it. The method that they figured out in order to be heard, paradoxically, leads to condemnation on the part of those to whom they are trying to communicate. The literature reveals general agreement that DSH is poorly understood and difficult to treat and there is a well-documented capacity for self-harmers to evoke powerful emotions in those charged with their care (Breeze & Repper, 1998, Hopkins, 2002, Hubband and Tantam, 2000). In their study of mental health staffs' attitudes to DSH, Hubband and Tantam (2000) offered the explanation that these behaviors elicit strong counter-transference reactions. As a defense against the anxiety invoked by DSH behaviors, these authors suggest that those caring for DSH patients shift responsibility away from themselves and onto the patient which may adversely

influence the outcome. Deliberate self- harm behaviors can also challenge professionals' view of their autonomy, competence and role (Breeze & Repper, 1998). Many therapists and nurses find that they need to manage their own reactions even as they attempt to manage the self-harm behaviors of their patients (Klonsky, et al., 2003).

Self-harming patients are often critical of their treatment and describe negative attitudes of their caregivers (Shaw, 2002; McAllister, Creedy, Moyle, & Farrugia, 2002). Six articles in the literature are reviewed here, some of which dispute this claim and some that support it. McAllister and associates (2002) found that nurses' attitudes towards those that self-harm are both complex and multidimensional but, generally, a negative attitude was expressed by the majority of nurses who responded. This was a large study sent to nurses of 37 hospitals but yielded a response rate of only 35 percent. Also, the relationship between attitudes and actual nursing care was not addressed.

Hubband and Tantam (2000) asked mental health staff to respond via a survey to a DSH case described in a vignette. Fifty-five percent responded to this survey and the majority of them favored an empathetic, non-rejecting approach to a woman they perceived as likely to cut again and whose behavior would be difficult to manage. Few of the respondents admitted that DSH made them annoyed or uncomfortable, but 65 percent felt that developing a nurse-patient relationship would be difficult.

Hopkins (2002) interviewed nurse key informants in her ethnographic study and found that these nurses perceived self-harmers as impeding the

functioning of the busy medical admissions unit because of their complex and time-consuming needs. She concluded that people who self-harm are seen as having reduced entitlement to care when their needs compete with those who the nurses perceive as the "really ill, poorly people".

Breeze and Repper (1998) also took an ethnographic approach to understanding mental health workers experiences with "difficult" patients. "Difficult" patients are those who were a threat to the nurses' competence and control and self-harmers were identified to be one of the four types of patients who were "difficult." These patients were demanding of time and took resources away from other patients, who, it was felt, needed them more. In an interesting addition to this study, the 'difficult' patients were then interviewed and they all expressed struggles for control and felt that their opinions were ignored and their views dismissed. In general, the data suggested that threats to nurses' competence and control were important features when defining "difficult patients" and were also identified by the patients as important factors impacting the quality of their care.

Sidley and Renton (1996) surveyed nurses and healthcare assistants aiming to discover how these health care workers perceived those who self-harm. Thirty-seven percent of the target population responded and their attitude was described by Sidley and Renton (1996) as generally a positive one. The majority felt that these patients had equal rights to treatment and should not be viewed as a lesser priority. However, 55 percent of the respondents viewed self-harmers' behaviors as attention-seeking and about half of the respondents also

felt that their colleagues disliked working with this client population. This last finding, the author acknowledges, may suggest a negative attitude in which some nurses are reluctant to acknowledge their own dislike of those who self-harm and thus, may project their own dislike onto their colleagues.

May (2001) assessed emergency department staff attitudes towards those who self-harmed. Forty-six percent responded to this survey and, in general, May found positive attitudes among all of the different health care professions working in this unit. May used the Suicide Prevention Questionaire that could arguably be said to be an inappropriate measurement tool for those who self-harm.

To summarize, the current literature finds staff attitudes towards caring for DSH to be generally positive. This is clearly a change from the literature cited prior to 1996 (Shaw, 2002). The response rates to these surveys ranged from 35 percent to 55 percent so it could be argued that those who felt more negatively towards caring for those who self-harm did not respond. In addition, a strong likelihood of a social desirability response set bias existed in these surveys. Nurses are not supposed to dislike patients or have negative attitudes towards their care and thus, they may have felt compelled to answer survey questions reflecting how they should feel rather than how they actually felt about those who self-harm.

It is interesting to note that while the quantitative surveys yielded positive attitudes, the two qualitative studies that were reviewed uncovered more negative components of nurses' attitudes towards DSH. It is possible that in-depth qualitative approaches uncovered the layers of socially desirable responses and allowed true attitudes and beliefs to emerge.

It has been established that women who self-harm are often placed in health care situations in which the nurses and other health care professionals perceive them as less worthy than others to receive care. Self-harming women, who also happen to be incarcerated, appear to be vulnerable to a double threat for disenfranchisement. Olson (1993) philosophically and empirically explored the idea that any group or population that is perceived as being culpable for causing their own illness or pain is vulnerable to uncaring attitudes and behaviors by nurses. Olson (1993), using clinical vignettes, studied nine nursing students, seven of whom were already RNs, and five of whom were in graduate programs, about factors influencing their sense of caring. Seven of those interviewed demonstrated a pattern of regard where the degree of the patients' perceived responsibility impacted their sense of caring. In these instances it was determined that context determines caring and this impacts the nursing care for those who are perceived as being culpable for their own life circumstances.

Transposing this understanding into the prison environment, it is easy to see why some nurses may have a harder time adopting caring attitudes for women who have committed crimes against society. While many corrections nurses are committed and competent, the reality is that nursing in jails and prisons draws some health care providers who are attracted to controlling and punishing prisoners. Incarcerated people may be treated with negligence or even deliberately harmed by nurses as a consequence of their moral high ground. Nurses practicing within the retribution framework which exists in correctional institutions today may become a vehicle for punishment rather than

care (Gadow, 2003). Maeve and Vaughn (2001) describe this phenomenon as penal harm nursing, a situation in which they contend that the issues of custody (intended to inflict harm) and nursing become too closely aligned. The "penal harm movement" is a current social perspective that has moved the focus of incarceration from rehabilitation to punishment. Advocates of this incarceration framework contend that prisons exist to punish by inflicting pain and suffering. Maeve and Vaughn (2001) identified that penal harm nursing exists when the nurse supports and enforces penal harm through uncaring actions. The authors asserted that, "health care is often conceptualized and delivered in ways that reflect the wider society's view of inmates as less entitled to health care than their counterparts in the free world" (p 8). Maeve and Vaughn (2001) have found, both in their research and practice, that penal harm nursing has become so routine that it passes for standard operating procedure.

Additionally, nurses practicing in prisons are placed in a situation of mandated alienation. In professional dealings with inmates, nurses are expected to be distant and formal. In a critical hermeneutical perspective, Maeve (1997) entered into dialogical engagement with prison nurses and concluded that the most significant and glaringly obvious obstacle to caring in the prison environment is that nurses are expressly forbidden to demonstrate any caring for prisoners. She found that incarcerated women are to be viewed as manipulative and that even when inmate concerns are legitimate, nurses must be continuously suspicious of being "taken in."

Thus, it is likely that incarcerated women's self-harming behaviors are seen just as further attempts at manipulation in an environment where manipulation is considered the norm. Incarcerated women may well be using their harming behaviors as manipulative devices in an environment where manipulation is the only way they perceive they can get results. But, they may also be trying to communicate their pain and these cries may be falling on the deaf ears of nurses who are indoctrinated not to care.

No research studies were found that directly measured this assertion, but one study was identified that addressed (indirectly) self-harming behaviors in incarcerated women. The main purpose of this study was to explore the characteristics of women who remain caught in the penal system in an English prison despite a clear need for more intensive psychiatric care. These women often spend long periods of time in prison, either on remand while a placement is sought, or serving a sentence if the search for a placement has failed. Gorsuch (1998) aimed to examine the history and psychological functioning of those women offenders who, despite the need for psychiatric care, proved difficult to place in appropriate care facilities. Of the "difficult to place" women, 21 (95 percent) had a history of self-harm compared with eight (36 percent) in the comparison group. A personality disorder label was often given to these women and Gorsuch (1998) surmised that this label served as short-hand for patients who are behaviorally difficult and likely to over-tax the therapeutic resources with little benefit. Underlying this assumption of untreatability was a deeper issue that was addressed by Gorsuch. She postulated that health care professionals do

not like, or want to care for, these women. The findings of her case-note study suggest why this might be. "They self-harm extensively, a behavior which, although often labeled "manipulative", frequently alienates others, arousing strong negative feelings and anxieties. Their childhood experiences of severe abuse make them, and those attempting to help them, vulnerable to extremely powerful and stressful interpersonal dynamics." (Gorsuch, 1998, p. 568) Gorsuch concluded that there is no doubt that these women are inappropriately held in prison and that alternative placement for psychiatric treatment is urgently needed.

An interesting correlational finding in Gorsuch's (1998) study was that there is a strong relationship between sexual abuse, self-harm and other-directed violence. As expected, those who self-harmed were significantly more likely to have experienced childhood sexual abuse, ($p<.001$). In addition, those who were charged with violent or dangerous offenses were significantly more likely to be self-harming than those charged with lesser offenses, ($p<.01$). No further studies were found that address the correlation between deliberate self-harm in women prisoners and the violent nature of their crimes.

To summarize this section, it is clear that women who deliberately self-harm may be perceived by nurses to be difficult patients for whom caring is uncomfortable and nurses may perceive them as less entitled to care. It has also been established that incarcerated women are perceived in the same way. Thus, incarcerated women who engage in DSH may be doubly vulnerable to disenfranchisement with its concomitant penal-harm nursing sequela.

Best-fit Attributes, Antecedents, and Consequences of Deliberate Self-Harm

There are many identified variations in the predisposing factors, manifestations and outcomes of DSH over time and across situations. This literature has attempted to identify the most common and best-fit attributes, antecedents, and consequences of DSH and this compilation is depicted in Figure 2, which follows.

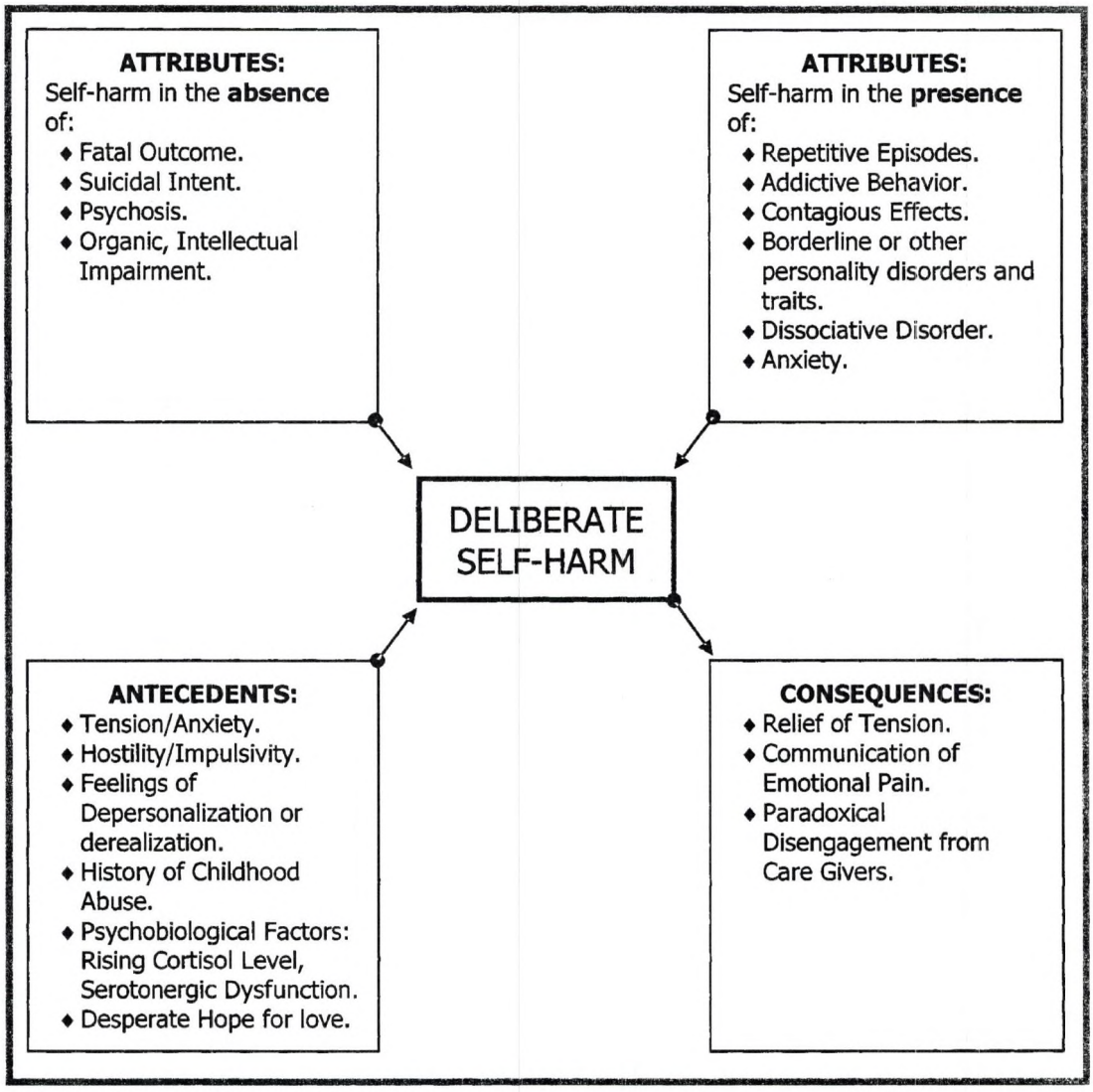


Figure 2. Best Fit Attributes, Antecedents, and Consequences of DSH.

Conceptual Framework

Grounded theory research aims to develop an emergent theory from data systematically collected through social research (Chenitz & Swanson, 1986). As such, it is preferable to enter into the research process without *a priori* theoretical schemes or frameworks. In fact, Chenitz and Swanson (1986) caution that there may be some danger in using a preexisting theory to guide grounded theory research and they caution that pre-developed theories may hamper the free discovery process that is the inherent nature of grounded theory research. Therefore, no external framework explaining the phenomenon of deliberate self-harm will be imposed on this research endeavor.

However, grounded theory research methodology itself was developed from the symbolic interactionist view of human behavior and this section briefly outlines this theory. Symbolic interactionism recognizes that the genuine mark of empirical science is to respect the nature of its empirical world, "to fit its problems, its guiding conceptions, its procedures for inquiry, its techniques of study, its concepts, and its theories to that world" (Blumer, 1969, p. 48). A methodology based on this philosophical stance is especially well suited to the study of incarcerated populations because, in dealing with the prison system, it is imperative that one respect the nature of that unique environment. Prisons are dominated by concerns for security, and the ability to engage in data collection with prisoners will be affected by these concerns. I am mindful that I am a guest in the prison where policies and rules are rigid and, as such, the symbolic interaction philosophical approach affords the flexibility to fit my procedures for

inquiry and my techniques for study into a necessarily inflexible environment. In his conclusion to Chapter I of his book on symbolic interactionism, Blumer (1969) clearly expressed permission for this flexibility when he stated this simple injunction: "Respect the nature of the empirical world and organize a methodological stance to reflect that respect" (p.60).

Symbolic interactionism foundationally rests on three premises: 1. Human beings act towards things on the basis of the meanings that the things have for them; 2. The meanings of such things arise from the social interaction that one has with one's fellows; and 3. These meanings are handled in, and modified through an interpretive process. These three premises will be briefly discussed as they apply to this grounded theory inquiry of DSH (Blumer, 1969).

The first premise is that human beings act towards things on the basis of the meanings that the things have for them. Using the symbolic interactionist perspective in my research requires that I enter into this research process with the rightful understanding that the meaning that DSH has for those engaging in it is central in its own right. Although it is expected that factors that produce and impact the practice of DSH will be uncovered in the course of the inquiry, I will focus my inquiry on discovering the meanings that DSH has for those individuals who engage in it. Shaw (2002) confirmed the primacy of understanding meaning in DSH and pointed out that the notion of DSH as meaningful has been strikingly ignored in contemporary literature and that the meanings of DSH needs to be accorded legitimate space in this discourse. My review of the literature confirms this statement.

The second premise is that the meaning of things is derived from, or arises out of, the social interaction that one has with one's fellows. Blumer (1969) references Mead who identified two forms or levels of social interaction in society, the "conversation of gestures", and the 'use of significant symbols." These two forms of social interaction appear to have particular import in the context of DSH. Cutting and other forms of self-harm are thought to be a means of communicating when speaking voices fail and thus, become the "conversation of gestures" that the self-harmer cannot vocally accomplish. DSH behaviors are thought to be significant symbols of such things as internal pain and self hate. DSH gestures signify a larger act of which they are a part. Deliberate self-harm behaviors such as cutting and burning the skin are gestures on the part of the actor (in this case, the incarcerated woman) that convey what she wants the respondent (in this case, me) to understand. Thus, the gesture has meaning for both of us. Blumer (1969) explains that when these gestures come to have the same meaning for both of us we have reached understanding. It is this interactional ideal to which I aspired in my conversations with the participants of this study.

The third premise is that meanings are handled and modified through an interpretive process. Grounded theory research is, by definition, a process of handling and interpreting meanings. Blumer (1969) stated that the actor (in this case, the researcher) "selects, checks, suspends, regroups, and transforms the meanings in light of the situation in which he is placed and the direction of his action" (p.5). Blumer has essentially described the process of grounded theory in

this statement. The constant comparative analysis clearly accomplished these actions. Understanding that the incarcerated women are also "actors" in this endeavor, it is my hope that by communicating with me, they will also be communicating with themselves. This self-interaction is a fundamental premise that distinguishes symbolic interactionism. Thus, the participants will select, check, suspend, regroup and transform the meanings of their DSH actions.

In summary, symbolic interactionism is a broad approach that provides a down-to-earth approach to the study of human conduct and human group life. Down-to-earth is not to be confused with easy. Blumer (1969) accurately reflects the rigor of this approach when he stated: "It is a tough job requiring a high order of careful and honest probing, creative yet disciplined imagination, resourcefulness and flexibility in study, pondering over what one is finding, and a constant readiness to test and recast one's views and images of the area" (p. 40).

Summary

In this chapter I have discussed the difficulties with the myriad definitions and terms that have been applied to deliberate self-harm and I have offered a definition that was derived from the literature review. The current understanding of deliberate self-harm has been explicated in this literature review and organized around the evolutionary view of concept development. Following this organizational schema, I summarized the current state of understanding regarding attributes, antecedent conditions, and consequences of deliberate self-harm. Finally, this chapter included a description of symbolic interactionism as

the guiding framework upon which grounded theory inquiry is premised and to which this study is a mutual fit.

CHAPTER III

RESEARCH PROCEDURES

Introduction

The purpose of this study was to develop a grounded theory of deliberate self-harm in incarcerated women. In order to develop this theory, the grounded theory research design as developed by Straus and Corbin (1998) was used to guide data collection and analysis and to develop an emergent theory from that data. This chapter outlines those procedures.

Grounded theory design was appropriate because, in order to interpret women's deliberate self-harm behavior, it was necessary to use the women's own accounts as a starting point. Listening to these stories enabled me to begin to situate women's self-harm in their own social context. Using a semi-structured interview guide I elicited conversation regarding the following questions: 1). What do incarcerated women call this behavior, how do they define it, and of what does it consist? 2). What role does DSH play in the women's entry into the criminal justice system and into prison? 3). How does the prison experience impact the nature and extent of DSH? As the theory evolved, other questions were asked that more specifically addressed the emerging theory and new research questions essentially replaced questions two and three. The new research questions became: What are the processes of crime and deliberate self-harm (DSH) in incarcerated women? How are they related?

Constant comparative analysis techniques were used to compare the data with itself, then against evolving original data, and finally against extant research and theoretical literature. Through application of these basic procedural steps, a grounded theory was developed that offers an explanation of the nature of the experience of being a woman who engages in deliberate self-harm in a women's prison.

Researcher's Role and Credentials

Speziale and Carpenter (2003) stated that, "The researcher is an integral part of the investigation and, consequently, must recognize the intimate role with the participants and include the implications of that role in the actual investigation and interpretation of the data" (p. 113). With this understanding, I played a role as facilitator of the communication process, as gatherer of data, as observer of behavior, and as a research instrument. I drew upon past experience gained as a psychiatric nurse dealing with women who self-harmed and with women who were in psychiatric treatment pending legal proceedings. I also drew upon the preliminary literature review to enhance my sensitivity in interacting and interpreting what was seen and heard. To offset any bias that may have been introduced into my thinking as a result of this literature review, I used a journal to enhance a my level of awareness. My personal notes enabled me to become aware of how my subjectivity may have been shaping my inquiry and analysis.

I have a master's degree in adult health nursing and worked as a psychiatric clinical nurse for 10 years in a state psychiatric facility. In addition, I have taught psychiatric nursing for 19 years and have supervised student nurses

in a prison health center. In preparation for this research I completed a course in qualitative research, a research practicum in grounded theory analysis, and a course in correctional nursing. In general, although I do not consider myself a clinical expert in corrections nursing or in DSH, neither am I a naïve outsider with romantic views or expectations.

Population and Participants

Participants were recruited from a population of women incarcerated in a women's prison in a small Midwestern rural community currently housing 116 to 120 women. Incarcerated women were chosen as the focus of this study because they comprise a particularly vulnerable population who are known to engage in DSH, although the precise incidence, nature and extent of these behaviors is not known (Favazza, 1998, Gorsuch, 1998). Incarcerated women characteristically have life histories that reveal the presence of many of the attributes and antecedents inherent in the development of DSH behaviors. Preliminary conversations with the nurses at the prison in which this research took place revealed that approximately 10 percent of the women currently engage in some form of DSH and intake histories of the women prisoners disclosed a history of DSH in 25 to 30 percent (T. Beiber, personal communication, July 7, 2005). An in-service was given to the prison nurses regarding the defining characteristics of DSH. Following this, the nurses were asked to identify and approach potential participants who met the definitional criteria to solicit their cooperation in taking part in the research. The nurses were asked to inquire of the potential participants if they would be willing to meet with

me one, two, or possibly three times for an interview that would last from ½ to 1 ½ hours. I asked the nurses to read the following statements to the potential participants:

> If you have ever hurt yourself on purpose without intending to kill yourself, I would like to meet with you and listen with an understanding ear to your account of your self-harming behavior. This conversation will be kept completely confidential and will be part of my doctoral studies in nursing. This knowledge will be used to increase the nurses' knowledge and understanding of deliberate self-harm thus, improving nursing care to meet the needs of persons such as yourself. If you are willing to participate please indicate this to the nurse. You may choose to use a different name than your own if you wish. You need not ever share your real name with me if you do not want to but please let the nurse know the name you have chosen so that I may contact you through the nurses.

Women who agreed to participate were classified as deliberate self-harmers based on their responses both on the initial screening by the prison nurses and during a semi-structured interview. Based on the derived definition articulated in Chapter II, women who reported behaviors such as reckless driving, drug abuse, or engaging in other reckless behaviors were not included in the study. Those who indicate suicidal intent to their self-harm were excluded

from the study as well as those who were under the age of 18. Seven women who met the criteria for engaging in DSH agreed to participate in the study. One volunteer was excluded after the initial interview because she did not fit the criteria for inclusion in the study. All of her self-harm episodes were suicide attempts and she was very drunk during each attempt.

Instrumentation

The instruments/tools that were used included myself, a semi-structured interview guide, a demographic data form, and, to a lesser extent, participant observation. Interviews were recorded and transcribed and I also took notes during the interviews. The interviews took place in a private conference room in the prison and lasted one to one and one half hour. Four of the women were interviewed a second time and one participant was interviewed three times. These interviews focused on further data gathering and further exploration of the codes, categories, and theory as it emerged. In addition, the last portion of three of the interviews were used for the purpose of confirming the findings.

Protection of Participants as Vulnerable Subjects

Informed Consent

Only participants who gave their permission participated in the study and a consent form was read by the participants but not signed. Their participation was considered their consent. These participants are vulnerable on several levels by virtue of the fact that they are women, they are prisoners, and they are self-harmers. Because of this, the consent form remained unsigned to safeguard confidentiality. Of particular note, this consent form contained a clause that gave

adequate assurance that parole boards will not take into account the incarcerated women's participation or nonparticipation in this research in making decisions regarding parole. This is in keeping with the Department of Health and Human Services protections pertaining to research involving prisoners (UND, 2005). The consent form was written at a fifth grade level and, following the advice of Maeve (1998), I read the consent form with each participant to facilitate a clear understanding. Following this, I asked each participant if she had any questions. The consent form used in this study is found in Appendix A.

Confidentiality

The tight confinement and limited activity in the prison setting leads to people watching people. As Maeve (1998) described it, watching people is a way of life in prison and everyone knew who was participating in this research. It was, therefore, not possible to keep the women's participation confidential but I assured them that the content of their participation would remain so. All interviews took place in a private conference room near the prison health unit. A list of the participants' names, pseudonyms and code numbers was stored in a locked file separate from the other data and only I had access to that file. Transcripts and audiotapes have no names on them and were coded with pseudonyms and code numbers. They will be destroyed three years after completion of data analysis. Again, following Maeve's (1998) advice, I made the participants aware that confidentiality would be maintained except for these three exceptions: If they told me they were planning to escape, planning to commit suicide, or planning to harm someone else. I also explained that I was bound by

law to report any child or elder abuse that was revealed during the interviews. As one further precautionary measure the transcriptionist who I hired to help me transcribe the interviews completed a Health Insurance Portability and Accountability Act (HIPAA) education module and signed a confidentiality agreement. This training module is designed to impart an understanding of, and an appreciation for, maintaining health information in the strictest confidence. As with the participants, I offered myself as a therapeutic listener to the transcriptionist should she have needed to discuss the emotional impact of the interview data that she was transcribing. On several occasions we talked briefly and she expressed the impact that these interviews had on her.

IRB Approval

The Human Subjects Review Board of the university conducted a full review and subsequent permission was granted to do the research by the state Department of Corrections and by the warden of the prison. In keeping with the guidelines for human subject protection and, in accordance with the Code of Federal Regulation (45CFR 46), I designed questions and an interview protocol that met the standards of respect, beneficence, and justice.

Benefits and Risks

Participants received no compensation for participation. Waldram (1998) pointed out that prisoners have exceptional needs by virtue of their incarceration, and the correctional system strictly controls access to resources. Because of this, any gifts of appreciation may be coercive or harmful if necessities or advantages

are provided to the participants but not to the general population of incarcerated women.

Benefits for the participants came from the opportunity to share their stories with me and know that their participation has the potential to contribute to advancing understanding of deliberate self-harm behaviors. Machoian (2001) described the therapeutic importance of simply listening to women who engage in DSH. She observed that having someone to talk to may curtail DSH behaviors. A prominent theme that occurs in the literature of DSH relates to the idea that women who self-harm feel that no one is listening to them (Harris, 2000, Machoian, 2001, Shaw, 2002). Deliberate self-harm is often a way of communicating the degree of pain that these women are experiencing. Machoian (2001) described cutting as a means of gaining a response when speaking voices fail. Failure to listen leads to a profound sense of isolation. This feeling of isolation is compounded in the self-harming woman who is incarcerated, and prison creates a profound disconnection in which communication is often suspended. Colloquially, it is said that when incarcerated, one has been put "inside", but more appropriately, the person could be described as being cast "outside" (Austin, 2001). Through this research these women were given the opportunity to be heard and it is hoped that this provided some measure of comfort and connectedness. Several of the women expressed that they had never talked about their DSH to anyone before and that it was comforting to do so.

The risks associated with this study included the potential for awakening memories of painful incidences and episodes in the participants' lives. I explained that I would listen with an empathetic ear but that I was, in no way, qualified to offer counseling. I offered the prison chaplain and a prison social worker, each of whom consented to provide therapeutic intervention for these women should it be needed. After one interview, I contacted the prison nurse to express my concern regarding the apparent depression of one of the participants. The nurse, in turn, alerted the prison staff and made an appointment with the psychiatrist for this participant. During the months of this data collection, three of the participants engaged in further acts of DSH, but I was assured by the prison nurses and the women who self-harmed that the interviews were not a conscious factor in their DSH.

Data Collection Procedures

Prior to the interview, participants were informed that the purpose of the study was to understand more about deliberate self-harm in incarcerated women and to discover ways in which deliberate self-harm may have contributed to their imprisonment and, conversely, ways in which imprisonment may have impacted their deliberate self-harm behaviors. They were told that they would be asked to describe their deliberate self-harm behaviors and factors that contributed to these behaviors. In addition, participants were told that they would be asked about other aspects of their childhood and adult life experiences. Initially, it was my intention to avoid detailed descriptions of their criminal offenses, but as the theory emerged, I began to realize that in order to fully understand the process of

their DSH, I had to have a fuller understanding of their criminal behavior and thus, in later interviews, more detailed questions were asked regarding this.

The participants were assured that their participation was completely voluntary and that all data would be kept confidential. Permission to tape-record the interviews was obtained as well as permission to take notes during the interviews.

The interviews began by obtaining demographic data. This was a fairly structured and non-threatening way of beginning the interview. Although the interviews were semi-structured (see interview guide in Appendix B), the intent was to allow participants to tell their own stories without a great deal of questioning. Therefore, although I guided the interviews, the participants were free to introduce their own concerns and thoughts related to the research questions.

Upon completion of the interview, participants were debriefed and told that I may be requesting a further meeting with them for data clarification and verification purposes. I asked them if they would be willing to provide feedback on my interpretation of the data to confirm accuracy. Returning to these participants for further theoretical sampling is a distinguishing component of grounded theory (Duchscher & Morgan, 2003). Since I could not know in advance precisely the nature of the codes and the emergent concepts, I left an opening to re-approach the participants with further questions aimed at increasing the density and clarity of the categories and the emerging theory. I was mindful of the need for saturating the data rather than the participants. My

intent was to stop the interviews when themes become repetitive without major new concepts presenting themselves.

Data Analyses

The analyses of the data were approached using the constant comparative method for grounded theory developed by Straus and Corbin (1998). Grounded theory data analysis is a circular process that requires that researchers collect, code, and analyze data at the very beginning of the study. As the data were collected the processes of coding and analysis occur simultaneously. This iterative process continued until data saturation occurred and no new or relevant data were obtained.

The interviews were read first using a technique called open (in vivo) coding. Broadly speaking, this technique is used to break down the data into discrete parts and to compare the data in terms of similarities and differences. (Straus & Corbin, 1998). Examining the transcribed interviews line-by-line enabled me to identify concepts which I then categorized, as often as possible, using the words of the participants themselves. Conceptually similar concepts were grouped into shorter code phrases and then were further grouped to develop categories. For example, during the process of open coding I identified anecdotes in which the participants stated that they had difficulty explaining their feelings and labeled this code phrase "hard to explain." I also identified a category in which the women did not verbalize difficulty in explaining feelings but demonstrated it. This code phrase I labeled "alexithymia." A third code phrase that emerged related to expression of feelings was the "lack of someone in whom

to confide." These three code phrases were collapsed into the category "no one to listen – no words to say it."

Axial coding was the second stage of data analysis. Axial coding involved relating the categories to their subcategories. According to Straus and Corbin (1998), this process is termed "axial" because coding occurs around the axis of a category. This is done as a means of beginning the process of reassembling the data that were fragmented during open coding. Procedurally, axial coding helped to contextualize the phenomenon and to relate the structure with the process.

The third stage of data analysis involved selective coding which is the process of refining and integrating the categories (Straus & Corbin, 1998). Relational statements were abstracted from the data that were used to explain, in a general sense, what was going on. The aim was to identify a core or overarching category that linked it with other categories. That core variable emerged as "a need to act" and is explained further in Chapter V. It is important to recognize that coding, in the tradition of constant comparative analysis, is a cyclical process. There were shifts from open to axial to selective coding and, at times, simultaneous coding occurred at several levels (McCann & Clark, 2003). Memo writing supported the processing of data between these shifts and provided a paper trail of thought. The iterative process of interviewing and analysis continued until theoretical saturation occurred. The participant number was not large in this study but, as Crabtree and Miller (1992) pointed out, six to eight participants will often suffice for a homogenous sample (which this was). That proved to be the case. Throughout the entire process memos were written

to reflect my internal dialogue with the data. These memos were generated to reflect such things as interpretation of the *in vivo* material, examination of relationships between codes and categories, exploration of methodological issues, and generation of theory (Eaves, 2001). They were also used as a method of enhancing my awareness of my own biases and increasing my reflexivity. A second literature review was then undertaken that linked current research and theory with the concepts and categories of the emergent theory (McCann & Clark, 2003).

This process is outlined in Figure 3, as shown on page 64. This diagram does not completely reflect the research procedure as grounded theory research is circular and iterative rather than linear. At any one time I may have engaged in any or all of the stages depicted in this diagram. Still, this diagram is helpful in demonstrating the specific steps that I took in my data analysis and how I proceeded to the next steps.

Rigor of the Study

This section addresses those actions that were taken to increase the accountability for my research actions during the course of this grounded theory inquiry. In their seminal work, Lincoln and Guba (1985) outlined four aspects of qualitative research rigor or *trustworthiness.* Although much debate is occurring regarding issues of rigor in qualitative studies, these four criteria remain the gold standard for assessing rigor. These criteria include credibility, dependability, and confirmability and transferability. Specific methodological strategies for demonstrating these criteria are briefly outlined below. These techniques, taken

together, helped to insure a faithful emergent theory of DSH in incarcerated women.

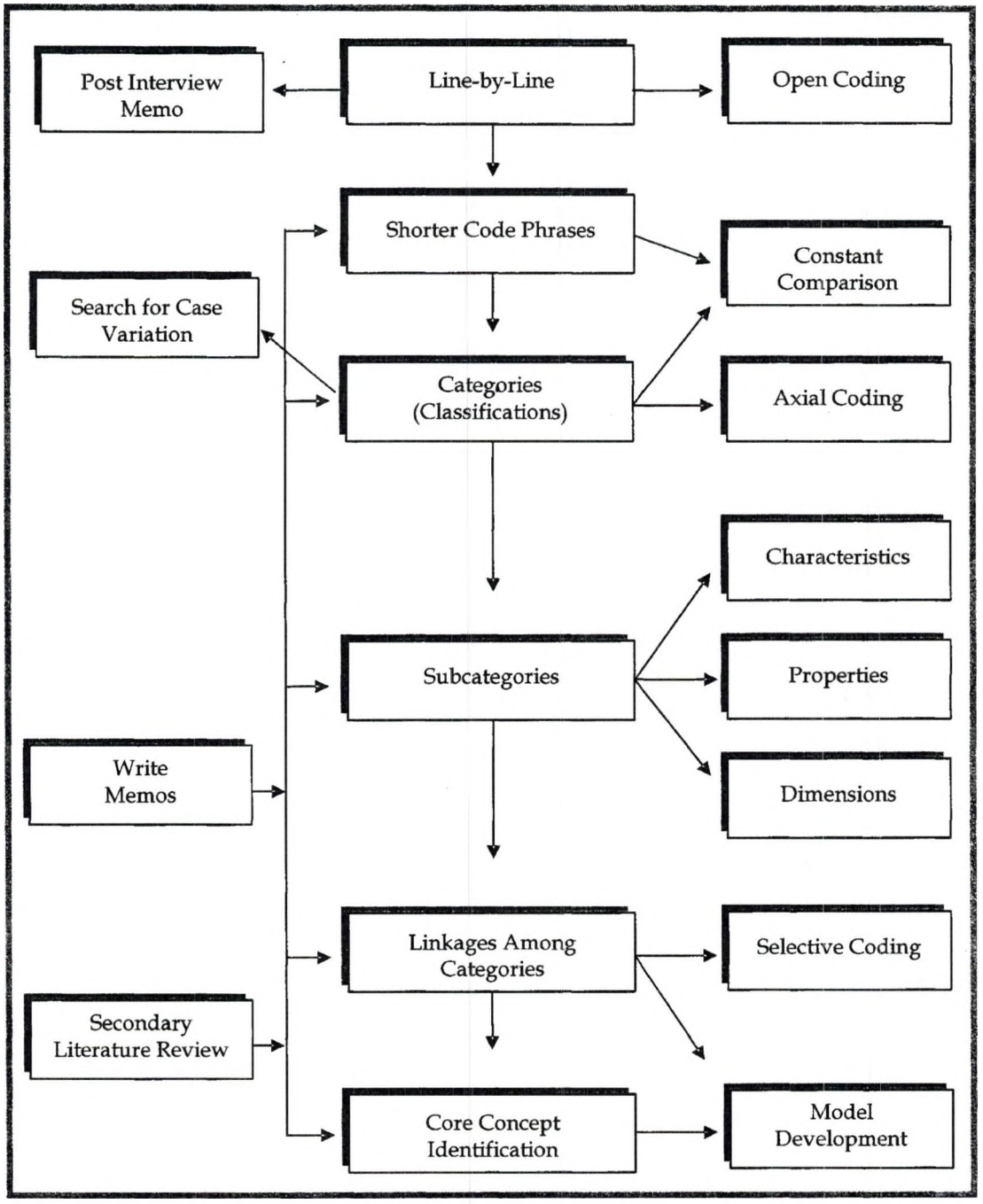


Figure 3. Diagrammatic Representation of Grounded Theory Research Method.

Credibility

Credibility refers to confidence in the veracity of the data and their interpretation. Several techniques were used throughout this study to enhance the credibility of the findings. First, through prolonged engagement with the participants, I was able to build trust and rapport with the incarcerated women and, I am confident that accurate information was obtained. Also, repeated guarantees of confidentiality enhanced the participant's comfort in being open.

A second method for establishing credibility was use of investigator triangulation. Three data sets were analyzed collaboratively with my dissertation advisor to reduce the possibility of biased interpretations.

A third technique that was used to enhance credibility was member checking. Lincoln and Guba (1985) consider this the most important technique for establishing credibility of qualitative data. Three key participants were asked to provide their reactions regarding the emerging outcomes and my analysis of them. This was carried out informally, in an ongoing way, as the interviews are conducted through summative and comparative statements and more formally after the data analysis was nearing completion and the grounded theory model had been developed.

A problem with member checks was identified by Morse, Barrett, Mayan, Olson and Spiers (2002). They pointed out that because study results have been synthesized and abstracted compositely from all the participants there is no reason to expect individuals to be able to recognize themselves or their particular experience. In fact, Morse, Barrett, Mayan, Olson, and Spiers (2002) suggested

that member checks may keep the level of analysis "inappropriately close to the data" (p. 9). Researchers, wanting to be responsive to the participants' ideas, may reduce the scientific translation to a more descriptive level. I would argue that the whole point of grounded theory inquiry is to develop a theory that is, in fact, close to, and grounded in, the participants' lived experience. Beck (1993) took a similar stance on this issue and stated that credibility is demonstrated when participants and readers who have had that human experience recognize the described experiences as their own.

As a way of accommodating these competing opinions, I chose three key informants who are judged by me to be able to appreciate the abstract nature of the findings and who were able to provide critical feedback about factual or interpretive errors and/or inadequacies.

Dependability and Confirmability

The second and third criteria used to assess the trustworthiness of qualitative research are dependability and confirmability. I assured the accuracy of verbatim interview data that was typed by the transcriptionist by listening to the audiotape at the same time that I was reading the transcribed interview. In this way, I was assured that the interviews were dependably transcribed and I could correct any errors that were observed.

Dependability, in the larger sense, refers to the stability of data over time and conditions. Confirmability refers to the objectivity of the data. Both of these criteria can be addressed through the use of an inquiry audit (Polit & Beck, 2004). Interview transcripts were kept along with the data reduction and analysis

products. Memo writing was used to keep track of insights and analytical ideas as they occurred to me during the process of data collection and analysis. I did not utilize a comprehensive inquiry audit due to time and resource constraints but I assembled the data for a partial audit so that my dissertation committee members, should they desire, can verify that substantively and methodologically sound decisions were made. Additionally, as Kock and Harrington (1998) advocate, I diligently endeavored to ensure that the analysis and discussion components of this dissertation were well signposted enabling the readers to travel the worlds of the participants and decide for themselves whether the research conclusions were confirmed.

Transferability

Transferability essentially refers to the probability that the research findings have meaning to others in similar situations (Chiovitti & Piran, 2003). Sufficient data have been provided in Chapter IV of this dissertation so that readers can evaluate the applicability of the data to other contexts. It is pointless to address the criterion of transferability if credibility does not exist. As Guba (1978) pointed out, there is no point in asking whether meaningless information has any general application. Thus, to an extent, establishing credibility is one method of enhancing transferability.

There are two additional methods described by Chiovitti and Piran (2003) to assist others to assess the transferability of research findings. The first is to delineate the parameters of the research in terms of sample and setting. In this

study, the demographic characteristics of the sample are reported in detail in Chapter IV. Also, the types of DSH and criminal behaviors are described.

The second method by which the reader might judge the transferability of this research is the highlighting of similarities between my findings and theoretical constructs found in the secondary literature review (Chiovitti & Piran, 2003). This secondary literature review linked extant research and theories with the components of the emergent grounded theory. Literature is interwoven into the discussion and serves to illuminate, support, or refute the emergent theory. Through its correspondence with other literature, the reader is able to assess the transferability of the findings to other settings and contexts.

Limitations of the Design

The major strength of this qualitative approach to the study of deliberate self-harm lies in its ability to give voice to people who have not historically been heard in the health care arena. Paradoxically, it is this same voice that precipitated a threat to the validity of this study. As Shaw (2002) stated: "The hallmark of self-injury is that it touches us profoundly" (p.209). The researcher is expected to be objective in collecting data and, at the same time, needs to demonstrate an empathetic attitude. This "detached closeness" was hard to maintain in the face of participant accounts of bodily harm and overwhelming emotional pain. The use of personal memos and talking with the prison nurses were helpful to me in reestablishing perspective and objectivity.

Another methodological constraint arose from the sensitive nature of the topic and the concomitant risk for the participants of exposing personal

information to a stranger. I sensed an openness in the participants and a willingness to share their accounts of DSH with me, even though there was risk involved for them. Acts of DSH result in harsh disciplinary action in this prison. Therefore, I cannot be certain that the full nature and extent of their DSH was disclosed to me.

In addition, there was a lack of racial diversity among the participants that is characteristic of the region and state in which this prison is located. Five of the seven participants were white and two were Native American. However, the diversity present is representative of the major racial groups of the state.

Conclusion

The use of grounded theory enabled me to enter the incarcerated women's experience with deliberate self-harm from their unique perspective providing the opportunity to explore their perceptions and the process of DSH. This chapter outlined the procedural steps used in gaining access to the participants and assuring their protection. The basic procedural steps used in gathering and analyzing the data were outlined as well as the steps taken to strengthen the trustworthiness of this study. This method was adapted to increase the likelihood that the emergent theory would reflect the daily realities of incarcerated women who self-harm. I conclude this chapter with a quote by Koch and Harrington (1998) that is reflective of what I hoped I would attain in the final product that was born of these methodological procedures. "The final research project resembles a thoughtfully constructed tapestry. Its appreciation will rely upon each needle point and the craft of its makers. If, in addition, it is written

with eloquence and incorporates reflective accounts, the reader may well consider the research as believable and plausible" (p. 10).

CHAPTER IV

REPORTING COLLECTED FINDINGS

Introduction

This chapter addresses the analysis of the interview data that were gathered for the purpose of developing a grounded theory of deliberate self-harm in incarcerated women. A total of 12 interviews were conducted with seven women, each lasting ½ to 1½ hours. As themes began to emerge, four of the women initially interviewed were once again approached with additional questions and one participant was interviewed three times. This chapter begins with a discussion of demographic information concerning the participants of this study, and is compared to state and national statistics where available. Crime and sentencing information and mental illness profiles of the study participants are also described. The next section of this chapter answers the first research question which asked: What do incarcerated women call this behavior, how do they define it, and of what does it consist? Their definitions and descriptions are then compared to the evolutionary components (attributes, antecedent, and consequences) of the concept of DSH as outlined in the literature review in Chapter II.

The other two research questions initially addressed what role DHS played in the women's entry into the criminal justice system and into prison, and how the prison experience impacted the nature and extent of DSH. As is often

the case in grounded theory research, the study focus changed as the processes of criminal offending and DSH became more conceptually developed through the generated data. Speziale and Carpenter (2003) pointed out that truly accurate research questions are impossible to ask before beginning any grounded theory study. I found that my original research questions lost relevance as others arose that had more meaning in the lives of these participants. Therefore, the research questions I am more directly answering in this chapter are not the ones that I originally asked. More accurately, the research questions addressed in this chapter are: What are the processes of crime and DSH in incarcerated women? How are they related?

Descriptive Profile of the Participants

This section details some demographic information about the participants that will assist in making comparisons regarding how characteristic these women are of the general population of incarcerated women. I have listed the demographic data using a participant number in each of the following tables. In each of the tables I have randomly switched the order of the participant numbers so that participant #1 in the first table is not the same person as participant #1 in the second table, and so on. This was done as one further assurance that the participant profiles will not accidentally lead to individually identifiable information.

Age, Marital Status, and Number of Children

The age, marital status, number of children, and custody status of the participant's children are listed in Table 2, as shown on page 73. The average age of the incarcerated women who participated in this study was 31 which is

consistent with the national median age for women incarcerated in state prisons (Owen, 2001). None of the participants were currently married and all are mothers who, with one exception, have lost custody of their children, either temporarily or permanently.

Table 2. Age, Marital Status, Number of Children, and Custody Status of Children.

Participant	Age	Marital Status	# of Children	Custody Status
#1	30	Single	5	Lost custody
#2	21	Single	1	Joint custody
#3	32	Divorced	6	Lost custody
#4	35	Single	1	Lost custody
#5	24	Divorced	3	Lost Custody
#6	27	Divorced	3	Lost Custody
#7	33	Single	5	Mother has temporary custody

Nationally, about 65 percent of women in state prisons have young children ("Incarcerated Women," 2006) and so this small group of participants clearly exceeds that national average. The participants of this study have an average of 3.4 children which is consistent with the national norm of three children (Pollock, 2004).

Also typical is their desperate desire to maintain a relationship with their children. Women prisoners tend to differ from male prisoners in the degree of attachment they maintain (or try to maintain) to families outside of prison. Unlike male prisoners who tend to be somewhat peripheral to family caretaking, female inmates are embedded in complex child care arrangements and their absence

causes much more family disruption (Enos, 1997). While men tend to "do their own time", women try to remain active in the lives of their children (Owen, 2001). The impact of children in influencing both crime and deliberate self-harm in these women will be explored later in this chapter.

Ethnicity and Education

Table 3, as shown below, outlines the ethnic and educational background of the participants of this study.

Table 3. Ethnicity and Education Profile of Participants.

Participant	**#1**	**#2**	**#3**	**#4**	**#5**	**#6**	**#7**
Ethnicity	White	Native American	Native American	White	White	White	White
Education	1 Year College	GED	GED & 1½ Years College	GED	GED	GED	GED

The ethnic profile of the participants is similar to national numbers in that non-whites are disproportionately represented in the prison population as compared to the general population. Nationally, the population of women's prison is 50 percent African American, nine percent Hispanic, and three percent Native American (Bureau of Justice Statistics, 2000). Two (29 percent) of the participants of this study were Native American. In this rural prison in general, the population is comprised of 50 percent Native Americans. Considering that, state-wide, Native Americans comprise 4.9 percent of the total population, it is clear that in this state, Native American women are incarcerated at a significantly higher rate than non-Native Americans.

The state in which this study was conducted is very predominantly white. It is therefore not surprising that this study had no African American participants. The state women's prison in which this study took place contains four African American women who comprise three percent of the prison population. This is clearly an over-representation of African American women since this state's population of African Americans is only 0.6 percent.

Educationally speaking, these women are slightly more educated than the average woman who is incarcerated. National statistics show that forty two percent of female state prisoners have not completed high school or earned a GED (Bureau of Justice Statistics, 2003). The participants of this study have all completed at least a GED.

Crimes and Sentences of the Participants

The participants ranged in prison experience from first-time inmates to experienced recidivists. Five of the seven are serving time because of probation revocation. With the arguable exception of one of the participants, the women are not in prison because of violent crimes. They are in prison because of crimes basically against themselves such as illegal drug possession or use, or for property crimes against others such as conspiracy to commit fraud, writing bad checks, or theft. All of the women admitted back into custody for probation revocation were readmitted because of incidents involving the use of methamphetamine or other drugs. Table 4, as shown on page 76, outlines the sentence profile of the participants of this study.

Table 4. Sentence Profile of the Participants.

Participant	# of Incarcerations	Primary Reason for Current Incarceration	Sentence Length	Time Served	Next Parole Hearing
#1	4	♦ Conspiracy to commit theft	2 years	8 months	1 week
#2	3	♦ Accomplice to theft ♦ Conspiracy to commit forgery	3 years	6 months	3 months
#3	1	♦ DUI (3) * ♦ DUS (4) ** ♦ Assault on Police Officer	12 months	8 months	1 week
#4	1	♦ Possession of drug paraphernalia ♦ DUI ♦ DUS ♦ Delivery of illegal drugs	3 years	6 months	9 months
#5	3	♦ Possession of meth ♦ Failure to register as a sex offender	2 years	16 months	1 week
#6	2	♦ Possession of meth with intent to deliver	18 months	11 months	?
#7	4	♦ Forgery ♦ Possession of meth with intent to deliver	5 years – 2 years suspended	9 months	10 months

* = (DUI) Driving under the influence

** = (DUS) Driving while license was suspended

Owen (2001) opined that the war on drugs has become a war on women, and it has contributed to the explosion in the women's prison population. The very significant impact of drug use, in particular methamphetamine, is a major factor in the offending patterns of these participants. The national statistics also show this to be a national trend. Recent sentencing laws for drug offenses are the single biggest contributor to the remarkable increase in the women's prison population. According to the Bureau of Justice Statistics (2000), one in three women are incarcerated on a drug offense.

Because of mandatory sentencing laws, judges are required to give minimum mandatory sentences and are prohibited from taking into account individual circumstances such as minor children, steady employment, first-time offense status, or other factors that might provide a case for effective alternatives to prison (Watterson, 1996).

Mental Illness Profile of the Participants

All except one of the women in this study reported being diagnosed with at least one mental illness. National rates of mental illness among incarcerated women have not been definitively determined but estimates range from 25 percent to 66 percent of the population (Acoca, 1998). Jordon and colleagues, in their study of the prevalence of psychiatric illnesses in prison found that two thirds of the women incarcerated in North Carolina met the diagnostic criteria for one or more mental illnesses (Jordon, Schlenger, Fairbanks, & Caddell (1996).

The 2000 Sourcebook of Criminal Justice Statistics reports that 9.7 percent of all prisoners, male and female, receive a psychotropic medication.

The rural state in which this study took place reported in 2000 that 39.3 percent of their incarcerated population was taking psychotropic medications (Bureau of Justice Statistics, 2000). It is evident that disparity exists in the reporting of mental illness of incarcerated women but despite these disparities, it is clear that a large percentage of the women who go to prison are suffering from some form of mental illness. Table 5, as shown on page 79, lists the mental illness that the participants have been diagnosed with at some point in their lives, and the psychiatric symptoms that they report recently experiencing. In addition to those listed, all participants have a past and recent history of some form of deliberate self-harm, and six of the seven reported a history of methamphetamine use or abuse even though only two of them currently have this diagnosis listed in their medical record.

To summarize this demographic and other descriptive data, these women can be characterized as young, economically impoverished, single mothers who have few marketable skills. All have some degree of mental illness and all have problems, to some degree, with chemical abuse or dependence, especially methamphetamine. They differ from the national profile only in that they tend to have slightly more education than other women in prison and they are predominantly white. The next section of this chapter answers the first research question addressing the names given to DSH, the definitions the participants gave, and the attributes, antecedents, and consequences that constitute DSH found in this study as compared to the evolutionary view of the concept of DSH that was outlined in Chapter II.

Table 5. Mental Illness Profile of Participants.

Partic-ipant	Adverse Childhood Experiences	Axis I Diagnosis	Axis II Diagnosis	Other Self-Reported Psychiatric Symptomatology
#1	◆ Physical abuse ◆ Sexual abuse ◆ Drug addicted mother	◆ Paranoid Delusional Disorder ◆ Depressive Disorder ◆ PTSD ◆ Anxiety Disorder ◆ Methamphetamine Abuse	◆ Borderline Personality Disorder ◆ Antisocial Personality Disorder	◆ Depressed ◆ Anxious ◆ Periods of "unreality" ◆ 2 suicide attempts
#2	◆ Physical abuse ◆ Sexual abuse ◆ Loss of mother	◆ None	◆ None	◆ Depressed ◆ High anxiety ◆ Panic attacks ◆ 3 suicide attempts
#3	◆ Physical abuse ◆ Rape at age 15	◆ Fetal Alcohol Syndrome ◆ Major Depression ◆ Bipolar Disorder ◆ PTSD with Dissociation ◆ Alcohol Dependence	◆ Borderline Personality Disorder	◆ Highly anxious and nervous ◆ Dissociative feelings of derealization ◆ Suicide attempt
#4	◆ Physical abuse ◆ Sexual abuse ◆ Murder of father ◆ Incarceration of mother	◆ Panic Disorder ◆ Bipolar Disorder ◆ Possible Dissociative Identity Disorder	◆ None	◆ Suicide Attempt ◆ Depression ◆ Anxiety
#5	◆ Physical abuse ◆ Sexual abuse	◆ Major Depression ◆ Amphetamine Dependence	◆ None	◆ Very anxious ◆ Frequent dissociation
#6	◆ Physical abuse ◆ Drug addicted parents	◆ Bipolar Disorder	◆ None	◆ Anxious
#7	◆ Physical abuse ◆ Sexual abuse	◆ Panic Disorder ◆ Bipolar Disorder ◆ PTSD	◆ Borderline Personality Disorder	◆ Anxious ◆ Suicide attempt

What Do Incarcerated Women Call this Behavior?

Below are some of the responses given to the questions related to the names given to DSH. A few women did not offer an answer and didn't really seem to care what it was called. Some did not have a name for it, per se, but used a descriptive phrase instead, such as: "*Just cutting*," "*Just release*," "*Just relief*," "*Letting go of the badness*," "*Letting out the bad stuff*," "*Externalizing anger*," "*Deliberate self-help*."

Because the name for DSH did not seem to be of great importance to the women of this study, I will not dwell on their particular names and descriptions but two thoughts struck me as I read through their definitions and descriptions. First, I found it interesting to note that several of the participants began their names for DSH with the word "just." The implication here is that, for these women DSH appears not to be a problem in and of it self. The word *just* in the Webster's Dictionary has several definitions, one of which is *merely. Just* cutting, *just* relief, and *just* release seem to be statements that imply that these behaviors are *merely* behavioral reactions to something much more significant. DSH is not the problem. It is merely a symptom of something bigger and "badder."

The second theme that struck me as I pondered these names for DSH was the idea that DSH is related to "badness." Two of the participants referred to this behavior as "letting go of the badness" or "letting out the bad stuff." Harris (2000), in her research on DSH, also expressed a fascination with her participants' reference to "the bad". She focused her study on this phenomenon and found that "the bad" was an externalized phenomenon that is a metaphor for

the wrongs of others committed against these women. She postulated that removing "the bad" helps women feel absolved.

Angel was one of the participants who used the word "badness" in her name for DSH. Her story is certainly one of "badness." Angel described being victimized by physical and sexual abuse that has become a life-long pattern for her. Sexual abuse, for her, began at age five. "And that was from cousins, and I, at the time, I thought it was normal, you know, it happened so often, you know, at least once a day, if not more, you know, so it was an ongoing thing with me and, to me, it was normal, you know, I never knew any different." Alcohol use, DSH, and methamphetamine use subsequently began for Angel in her early teens and may have been a way of letting out the "badness" or anesthetizing the pain involved with it. Angel is not unique among the participants. All of them experienced "badness" – severe, distressing abuse prior to commencing their DSH.

How Do They Define It?

Not all women were able to offer a definition of DSH when directly asked, but as the interviews unfolded some of their definitions emerged. Below are some the ways in which the participants described/defined their DSH.

- "Self-harm is when I feel trapped by my own self, my own anger and frustration. I just, I don't see any way of getting out of it. There's no one to talk to and I wouldn't know how to talk about it if there was someone to talk to. So, I just relieve it."
- "Just, the top, the very top, the cutting is just the top of something that is so deep that it's, you know, real bad."

- "Some sort of traumatic experience that happened and is still happening."
- "Shooting up [meth], that wouldn't be my definition of self-harm. My definition of self-harm would be when you want to hurt yourself, you know, you want to cut, you want to burn, you want to swallow glass."
- "Just something that you do to yourself cause you're hurting inside."
- "[Something to] take the pain that I was feeling here in my heart and it gave me pain here (points to arms) and it caused my mind not to always think about the pain here (points to heart). So it was a distraction for me and it, like I said, it made the pain switch, so it was not an emotional pain anymore, it was a physical pain. And I could deal with that easier than dealing with this. I don't know how to deal with this [emotional pain]."
- "An escape route whenever I was so frustrated or I was in so much pain or I was just (sigh) overwhelmed and not sure what to do. Um, taking it out on myself felt good. It did, it just felt wonderful to do that."
- "Hurting yourself to release all the bad stuff inside so you can feel normal again. I mean, well, not normal, but so that you can feel."
- "A person who needs help and, um, let's see, a person who needs help and is unable to gain it from others. Something you do when anybody or everybody is unavailable to you except yourself."

A combined definition, derived from the above statements would look something like this: Deliberate self-harm is a need to act to externalize and

escape overwhelming emotional pain through the substitution of physical pain by inflicting some manner of non-lethally-intended physical wounding.

Of What Does It Consist?

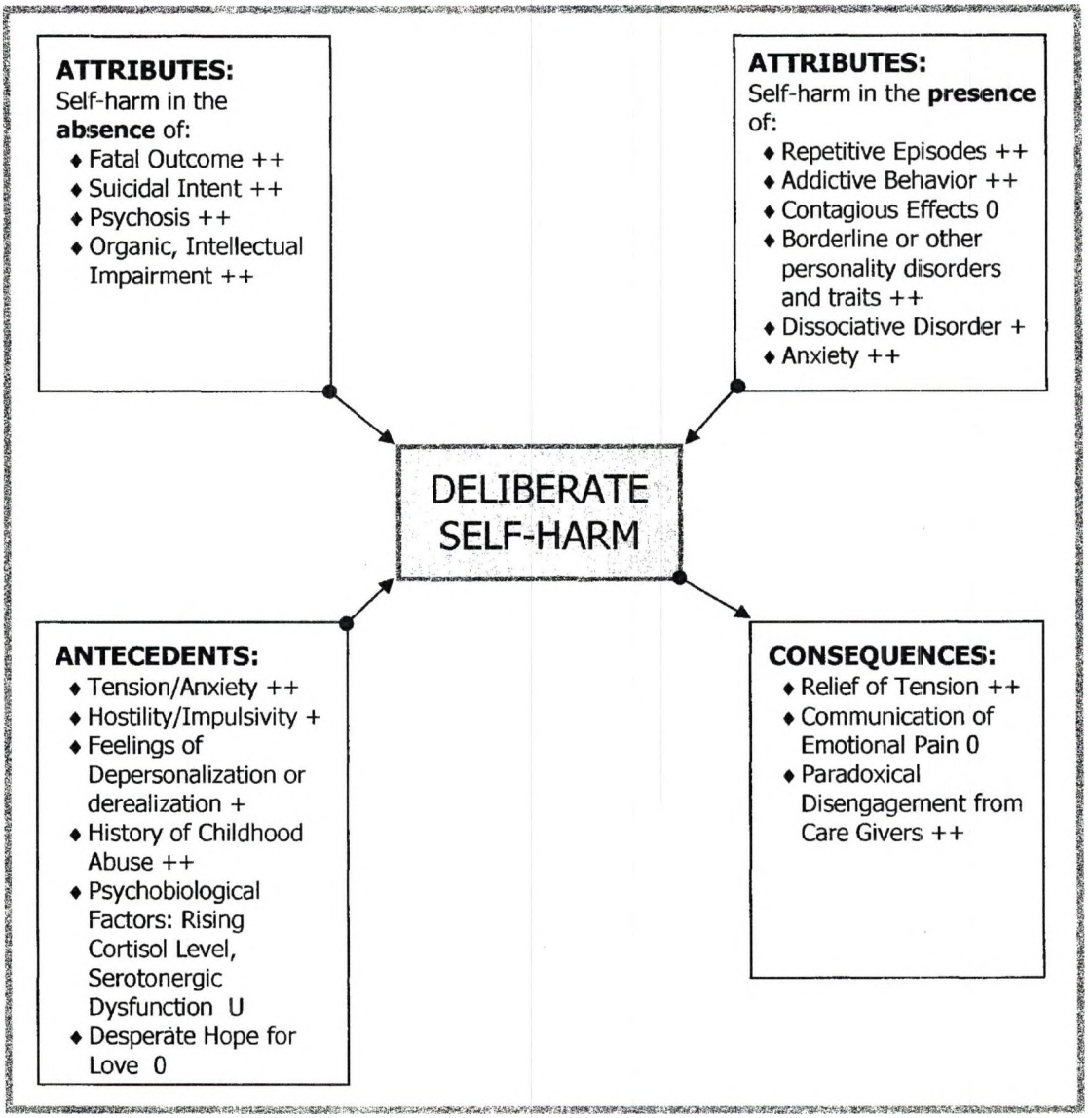
In talking with the participants it was apparent that, whatever they called this phenomenon, and however they defined it, the attributes, antecedents, and consequences of their DSH closely paralleled those that emerged in the preliminary review of the literature. Figure 4, as shown on page 84, is a reiteration of the "Best-Fit" attributes, antecedents, and consequences of DSH as they emerged in the preliminary review of the literature. In this framework, I have placed a plus sign by those items that emerged from the data as being present in one or two of the participants' interviews. Two plus signs indicate that three or more of the participants described or evidenced that attribute, antecedent, or consequence.

Attributes

Absence of Fatal Outcome, Suicidal Intent, Psychosis, Organic Intellectual Impairment

It goes without saying that there was not a fatal outcome to any of the self-harming acts and the participants were able to identify their DSH as being clearly NOT attempts to kill themselves. Elaine expressed it in this way: "There's a difference between saying, 'OK, I want to do this [DSH]' and saying, 'I want to die.' There's a big difference, a big difference, and I can distinguish the difference. If I couldn't cut, I would have to kill myself." Marie, however, expressed some uncertainty about one episode of a particularly deep cut on her

wrist stating that her motivation to end her life was "about fifty percent –wise when I did my wrists."



0 = Not evidenced by the Participants
\+ = Evidenced by one or two of the participants.
++ = Evidenced by three or more participants.
U = Unable to determine from the data

Figure 4. Comparison of the Attributes, Antecedents, and Consequences of Participants' DSH to Those Identified in the Literature Review

Although, there was a clear distinction between DSH and attempted suicide most of the time for most of the participants, it bears noting that DSH is clearly a harbinger of actual suicide attempts. While DSH is often an active mechanism to avoid suicide, Marie and other participants expressed that those who self-harm clearly have periods in their lives when harming isn't enough and life extinction is attempted. As Paris (1990) pointed out, the long-term suicide rates for those who self-harm is equivalent to the suicide rates for those who have previously attempted actual suicide. As the mental health profile previously showed, four of the seven women of this study have attempted suicide on one or more occasions.

None of the participants of this study demonstrated any active psychosis or any organic intellectual impairment that would explain their DSH. Although they share many psychiatric diagnoses, none showed any propensity for the stereotypic self-mutilation that is characterized by those who self-harm as a psychotically or biologically driven behavior.

Presence of Repetitive Episodes, Addictive, or Contagious Behaviors

All participants described the repetitive nature of DSH and all had harmed multiple times. None described their DSH as addictive in itself, but most of these women clearly are dealing with issues of chemical abuse and/or addiction. None of the participants described a contagious effect, however, the punishment for DSH is so severe in prison that the women are driven to carry out their self-harming in secret and thus, there is little awareness of when and how other women are self-harming.

Presence of Borderline Personality Disorder, Other Personality Disorders and Traits, or Dissociative Disorder

Three of the seven participants have been diagnosed with a personality disorder. While none have been formally diagnosed with a dissociative disorder, two of them identified dissociative symptoms of depersonalization and derealization, and one has a possible dissociative identity disorder.

Antecedents

Tension/Anxiety

It was clearly apparent that the participants experienced their lives through a lens of anxiety and tension. They described themselves as carrying around a good measure of trait anxiety but also explained the mounting tension that builds to an unendurable crescendo just prior to an episode of DSH. High stress, tension and anxiety would not be unexpected given the chaotic and traumatic nature of their lives which were fraught with constant life changes over which they had little power. Tension and anxiety constitute such an integral part of their lives and is such a clear antecedent to DSH that these concepts will be further developed in the grounded theory. Thus, I will not discuss this in any great detail in this section. The following quotation from Rose will suffice here to indicate the nature of the tension experienced by these women. "Yeah, kinda like a balloon, like if you only keep blowing a little at a time and then when you cut, then it's like the balloon popping and you start all over again."

Hostility/Impusivity

Only one participant described her DSH as displaced hostility towards others. Marie described being trapped by anger before cutting and explained that cutting was an outlet for her anger. After an episode of DSH she explained that she "didn't have all that anger penned up anymore with no way to get rid of it. ...If I couldn't hurt them...like physically, you know, I would hit walls, you know, or carve on my skin, you know, or break everything in the room, you know, stuff like that."

Feelings of Depersonalization and Derealization

While none of the participants were formally diagnosed with a dissociative disorder, two of them did report dissociative feelings of depersonalization or derealization prior to an episode of DSH. This antecedent was not consistently found to be a precursor of these women's DSH but appears, intermittently, to be a factor. Elaine described a frightening episode of being in a motel with her children as they were waiting to move into a house. She cut her arm and could hear her daughter screaming and she could see herself and her terrified daughter from afar but she couldn't get back to either of them until a sufficient amount of blood was shed to end the depersonalization episode. Elaine described her dissociation in this way: "Um, in the unreal part, like, I feel numb sometimes, and those times, I cut." Rose also explained that she has episodes of being dissociated and cutting "just brings me back."

History of Childhood Abuse

All participants had histories of neglect, abuse, chaos, and disruption in their childhood that continued into their adult lives. This antecedent will be explored further in the grounded theory that emerged from the data and thus, will not be explained in great detail here, but one quotation by Elaine serves to sum up the stories of these women. "I've been physically abused in relationships since I've started in relationships. Every relationship I've ever been in I've gotten beat up pretty bad."

Psychobiological Factors

This research endeavor was not designed to explore any psychobiological parameters such as platelet imipramine binding, alterations of which are hypothesized to occur during DSH (Sachsse, Van der Hyde, & Heuther, 2002). These theories are in their infancy and provide preliminary empirical evidence that episodes of DSH occur in response to the physiological neuroendocrine response that is activated in emotional arousal. The participants clearly expressed the release of tension and immediate relief from stress after an episode of DSH which would lend indirect support to the idea that DSH may serve as a mechanism for self-regulation of hyperarousal and for regaining control over an otherwise incontrollable physiologic stress response.

Desperate Hope for Love

None of the participants directly expressed their DSH as a hope for love, but several of the participants expressed an acute sense of being alone, lonely, and unloved when they self-harmed. In several of these instances, the

aloneness was precipitated by loss. Cavelle's mother died when she was small. Angel described being neglected and abandoned stating, "My boyfriend would just run off...I was alone." Angel would carve her boyfriend's name on her skin. "Ya, see, I'll carve like, like my [boyfriend's] name, for instance, on me because he makes me feel better but then, I mean, just to look at his name or, you know." Cavelle swallowed glass because she was feeling like "everybody had just given up on me and nobody really cared, and there were lots of things going on in my life at the time and my family didn't want anything to do with me."

Cavelle described an episode of cutting while she was living with a foster care family as a teenager. After the crisis was past and the wounds were sutured, Cavelle recalled that her foster mother expressed gladness that she didn't die and told Cavelle that she really wanted to be a good mom to her. Cavelle became tearful as she related this memory and explained: "That was the only ever sense of somebody wanting me, or somebody wanted me to be there, you know. I grew up my whole life with people not wanting me around."

Rose started cutting at age thirteen when her grandmother died, her parents divorced, and her dad disappeared. Her friends were also lost to her at this point because she and her mother (with whom she did not get along) moved out of town and "when we moved around, I just cut myself." Cavelle cut herself last on Christmas Eve when she tried to call her daughter and the father of her daughter, who has custody, hung up on her. She stated that she cut because, "at that point I was like, she obviously don't need me, you know."

These examples give credence to the desperate hope for love as an antecedent to DSH. While none of the women directly expressed a hope for love and connectedness as a precipitator to DSH, they were all clearly expressing a painful lack of these.

Consequences

Relief of Tension

All participants expressed a reduction of tension and a release of pressure as a direct and immediate consequence of DSH. This process is explored further in the grounded theory.

Communication of Emotional Pain

Interestingly, none of the women in this study identified that the end-result of their DSH was the communication of emotional pain. While on some underlying level, this may have been a motivation for self-harm, all of the participants went to considerable effort to hide their DSH, both in and out of prison, and did not use it as either a direct or indirect way of communicating their pain. They also expressed embarrassment about their scars and a need to hide them. As Lisa pointed out: "It wasn't something I talked about or whatever, 'cuz then I felt that I was seeking attention or something and that's what most people think- its seeking attention...I just wanted to feel better." Similar to the participants of this study, Adler and Adler (2005) found a need in their participants to self-harm, but not a need to communicate it. In their study with 25 participants who self-harmed, they concluded that self-harming people are loners

in their deviance and kept to themselves because they viewed their harming behaviors as private and not to be shared with others.

Lisa is correct in assuming that her DSH is likely to result in others thinking that she is seeking attention. These behaviors are assumed to be manipulative attempts on the part of women prisoners and what little literature there is concerning DSH in prison bears this out (Clarke and Whittaker, 1998). For example, Franklin (1988) reviewed records of 64 prisoners referred for self-injury; 32 reported that they had injured themselves in order to accomplish some goal other than suicide. Franklin divided these 64 subjects into two groups: those who were suicidal and those who were "manipulative." In his concluding comments Franklin remarked that: "Intuitively, it makes sense that deliberate self-harmers, viewed as manipulative and attention seeking, would be provided treatment different in some ways from that provided to suicidal patients who are viewed as crying for help." Franklin was one of the very first to study the phenomenon of self-harm in prisoners and, lacking the understanding we have today of this complex phenomenon, it may never have occurred to him to look any further than the manipulation theory of deliberate self-harm. But the idea that DSH is exclusively manipulative behavior exists in prisons today and is the reason why the women in this prison are severely punished for engaging in any self-harm behavior. These women clearly do not have the luxury of communicating their emotional pain by self-harm.

Not only do they feel a need to hide their DSH, they also expressed a need to hide their scars. Several of the participants expressed embarrassment

about their scars and, in particular, wanted to hide them from their children. Marie, for example, expressed chagrin when considering the scars on her arms and stated, "...Like, I see these scars now and I'm just, you know, I make up stories on why they're there, you know." As Adler and Adler (2005) point out, prior to 1996, questions about scars were not a great problem because they could be explained away with almost any ridiculous answer. There is now much more awareness of DSH and others are more suspicious of what they are seeing. Adler and Adler (2005) noted that this has led long-term cutters to move their cutting to less visible body locations such as their inner thighs and stomachs.

Paradoxical Disengagement from Caregivers

Three of the participants described that when they have been treated for their self-harm, emergency room staff are basically aloof. One participant said they were "weird" and another described them as "weirded out." Lisa probably described it best: "Weird, I mean respectful, for the most part, but they were really 'stand-offish." The care givers in the emergency departments where these women had gone periodically to receive care for their self-harm were basically disengaged. The prison staff demonstrate a more dramatic disengagement. They act swiftly to isolate the prisoners who self-harm, much the same way as they do when the prisoners act out.

One of the consequences of both criminal behavior and DSH is alienation from those with whom these participants most want to maintain connectedness.

This type of punishment will be explored further in the structural model and the grounded theoretical model.

The structural model of Needing to Act is described in the remainder of this chapter. Anecdotes and quotes from the participants are given that illustrate the process of *needing to act* by *acting in* and *acting out.* Research and theoretical literature is included that substantiates or enriches the findings that emerged form the data. The data analysis was undertaken to answer the two remaining research questions: What role does DSH play in the women's entry into the criminal justice system and into prison? How does the prison experience impact the nature and extent of DSH?

The Structural Model of Needing to Act

The constant comparison of the interview data revealed that there was a process for the development of deliberate self-harm. A second process emerged from the data that closely paralleled the DSH trajectory and that was the process of criminal offending. These two processes (the DSH trajectory and the criminal offending trajectory) emerged as remarkably similar phenomena in terms of predisposing factors, precipitating factors, intervening conditions, and consequences. Only the strategies for acting changed. The process of criminal offending, I termed *acting out.* The other process, that of DSH, I termed *acting in.* The core variable that emerged was the *need to act* – somehow, someway. This combined process is illustrated in Figure 5, as shown on page 94.

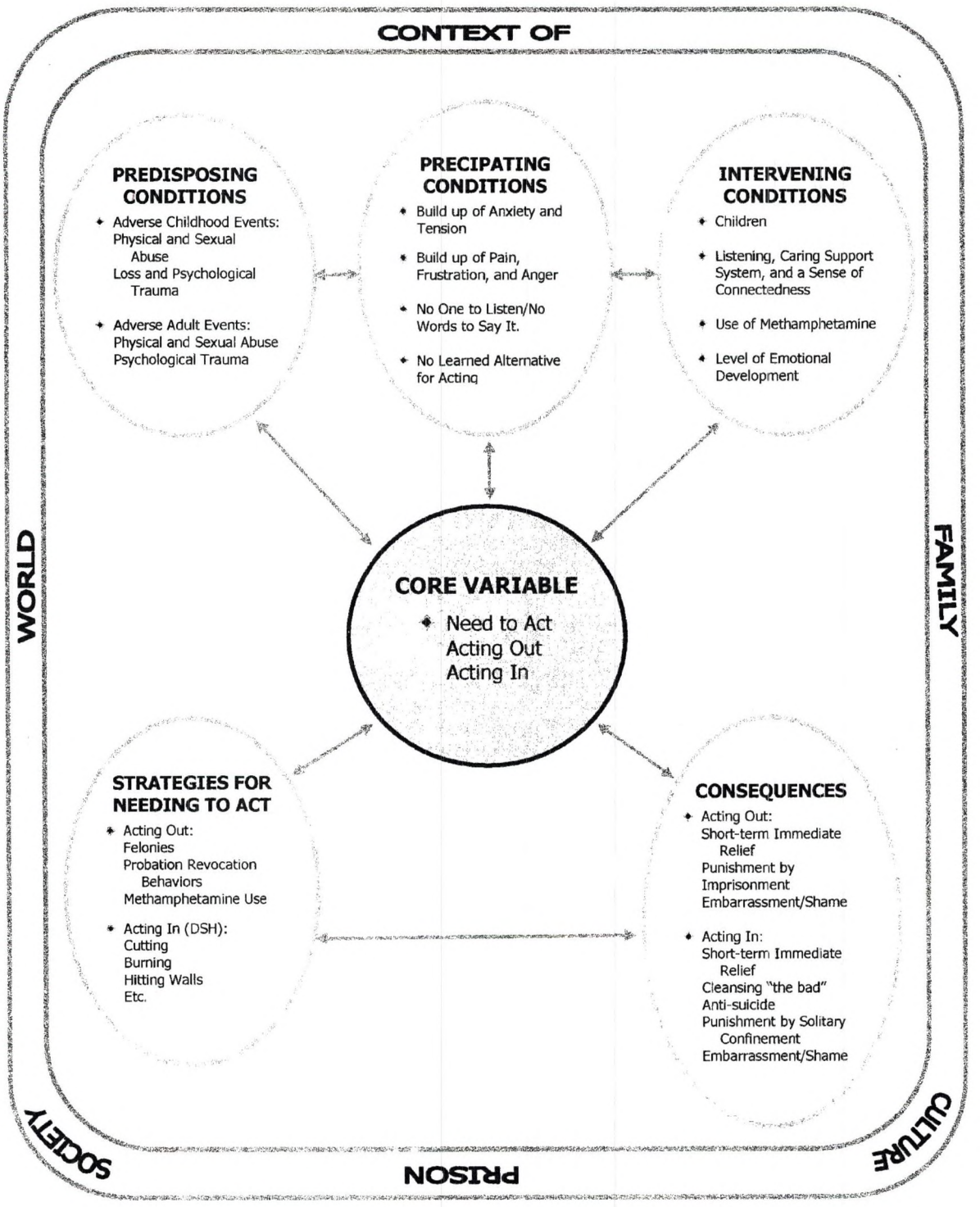


Figure 5. Structural Model of Needing to Act.

The remainder of this chapter will describe the components of this model and will offer participant stories and comments that add richness and relevance and that demonstrate how this model is grounded in the experience of these women. For the remainder of this chapter the words *acting in* and deliberate self-harm (DSH) will be used interchangeably. Likewise, the terms *acting out,* crime, and criminal offending will all signify the same concept.

Core Variable - Need to Act

Repeatedly, the participants of this study found themselves in an unbearable situation and, lacking the power or resources to act directly on the situation, they acted instead against society or against themselves. As children, the women of this study found themselves needing somehow to act to diffuse the stress at home. As adults, they found themselves in a situation similar to those in their childhood and, again, needed to act. The problem here is that, never having been given the tools to develop appropriate ways of acting *on* a situation, they instead *acted in* or *acted out.* Throughout this chapter, their ways of acting will be elucidated. Why did these women choose a*cting in* or a*cting out?* The answer is not given in this study because the women don't know.

For one possible explanation, I drew upon the work of Lane and Schwartz (1987) who developed a cognitive-developmental theory of emotional awareness. Their primary thesis is that emotional awareness develops sequentially through five levels. The five levels are 1) awareness of bodily sensations, 2) awareness of the body in action, 3) awareness of individual feelings, 4) awareness of blends of feelings, and 5) awareness of blends of blends of feelings.

It is the first two levels that seem to be the operational levels for emotional expression in the women of this study. It is thought that in homes with disordered or disinterested caregivers, the emotional developmental processes are derailed and the children are unable to progress through the levels of emotional awareness. If the caregiver is not able to assist the child to know his/her affective states, the child can only rely on sensorimotor expression as the outlet to organize emotional experience (Petterson, 2004).

The first level of emotional development is awareness of bodily sensations. There is no cognitive awareness of feelings at this level and emotions consist of bodily sensations only. This may, in part, explain why women who self-harm feel such a visceral-level response to stress. Their emotional discomfort, unnamed, becomes a physical discomfort that must be relieved. DSH serves to discharge the emotions that are felt as bodily sensations only.

The second level of emotional development, according to Lane and Schwartz (1987), is the awareness of the body in action. At this level, emotion is experienced as both a bodily sensation and an action tendency, but the ability to experience emotion as a conscious feeling state has not yet developed. If emotional development has not proceeded beyond this level, some form of acting, either acting out or acting in, may be the logical consequence during times of emotional arousal.

Failure to successfully navigate through the first two levels of emotional awareness renders the individual unable to progress through the developmental process of emotional maturity. The progressive attainment of the awareness of

feelings is thwarted, as is the expansion in range and sophistication (blends) of feelings.

I have pondered the question: Why do the women of this study act in and act out and I don't? I have experienced negative emotions in my life in which I could clearly identify that my autonomic system was kicking into overdrive. But, the difference between my emotional state and that of the participants of this study may be that, through the nurturance of my childhood caregivers (my parents) I learned now to name and express my emotions. My emotional awareness evolved to a psychological as well as a somatic experience. Somewhere in my development, I learned about blends of feelings and I learned how to differentiate and integrate complex feelings. I learned the capacity to fully experience my feelings on a cognitive level and to give them a name and a voice. In short, my emotional development was allowed to progress along with my cognitive development because I was given the emotional nurturance to allow that to happen. I don't need to act out or act in because I can verbalize it and understand it.

But what if my parents had been alcoholics and had spent their lives in a haze of alcoholic stupor? Would they have been attentive to me and helped me learn and know my feelings? What if my father had sexually abused me and told me time and time again that it was bad to talk? What if my parents had been physically abusive and I learned that emotion was nothing more than physical action? These were the childhood experiences of the women of this study. It was apparent, in talking with some of the participants, that they did indeed have

difficulty naming and expressing their feelings. In light of this expressive deficit, the women of this study appear to have the propensity to *act in* or *act out* their feelings. This expressive deficit is explored in greater detail as my grounded theory unfolds.

Predisposing Conditions – Adverse Events

The factors that set the stage for the need to act were adverse childhood events (ACEs) and adverse adult events (AAEs), These predisposing conditions (Figure 5, page 94) are similar in nature and it is apparent that the women of this study moved into adult traumatic experiences that mirrored their childhood.

Adverse Childhood Events (ACEs)

All seven of the women in this study described experiences of some type of physical abuse in their childhood and all the participants, except Angel, described incidents of sexual abuse as children. I have singled out physical and sexual abuse in this discussion because the research literature clearly supports the occurrence of these types of abuse as predisposing factors in the development of DSH, criminal offending in women, and drug abuse. The following paragraphs briefly review some examples of research that support this assertion.

One of the most universally shared findings of women in prison is that they are more likely than men in prison to have experienced both childhood and adult abuse-- both sexual and physical (Bradley & Davino; 2002, Brown, Miller, & Maguin, 1999; Pollock, 2004, to name a few). One of the most comprehensive studies to date was conducted by Browne, Miller, & Maguin (1999). They

examined the prevalence of pre-prison interpersonal violence among incarcerated women. They reported a 70 percent rate of child physical abuse by a caretaker, a 59 percent rate of childhood sexual abuse, a 49 percent rate of rape as an adult, and a 75 percent rate of severe physical abuse by an intimate partner as an adult.

In their study of incarcerated women, Bradley & Davino (2002) found that 86.2 percent of the incarcerated women experienced childhood sexual abuse and 56.9 percent reported a history of childhood physical abuse. Fifty-five percent of their participants reported both. Most significantly, only five percent of the 65 incarcerated women that they studied did NOT report any experiences of abuse in either childhood or adulthood.

In a parallel vein, one of the most consistent findings of women who engage in DSH is that they experienced both physical and sexual abuse as children. The literature on DSH has revealed that the relationship between childhood abuse and DSH has received the most systematic attention from researchers of all the possible predisposing factors to DSH and that the preponderance of evidence suggests a strong relationship (Brodsky, et al., 1995; Gratz, et al., 2002; Gratz, 2003; & Zlotnick, et al., 1996). The preliminary review of evidence discussed in Chapter II gives further evidence of the amplitude of the association between childhood abuse and the development of DSH.

A third parallel is drawn here between childhood abuse and the development of adult substance abuse. (Brems, Johnson, Neal, & Freeman, 2004). I have singled out the acting out behavior of substance abuse because it

was a common denominator in almost all of the criminal offenses of the women in this study. Brems, Johnson, Neal, & Freeman, 2004) studied 830 admissions to a substance abuse treatment center (556 men and 274 women). Of the predominantly white and Native American subjects, they found that 28 percent of the women reported physical abuse and 31 percent of the women reported sexual abuse. Both forms of abuse were reported by 15.7 percent of the women. Additionally, 49 percent of the women in their study reported physical neglect in their childhood. Brems and colleagues (2004) also found that those with a history of childhood abuse reported an earlier onset of substance abuse, more severe psychopathology, and a higher likelihood of having encountered legal problems related to substance abuse.

Liebschutz, et al. (2002) found a much higher rate of physical and sexual abuse than did Brems and colleagues. In their study of 470 patients in a detoxification unit, they found that 81 percent of the women reported a history of physical and sexual abuse and that abuse was significantly correlated with more substance abuse consequences ($p < 0.001$).

Because the women of this study used methamphetamine predominantly, I scanned literature for research evidence of the relationship between childhood abuse and methamphetamine specifically. Two studies were found that clearly established a relationship between childhood abuse and methamphetamine use. Brecht, O'Brien, von Mayrhauser and Anglin (2004) found in their descriptive inquiry that 44 percent of the women they studied who were being treated for methamphetamine use had been sexually abused as children and the 32 percent

had been physically abused. Poly-drug use and early initiation into drugs were common in this sample.

Cohen and colleagues (2003) studied a sample of 1016 methamphetamine users. Participants' reporting of abuse and violence was extensive. In this study, the researchers measured both adult and childhood physical abuse together so the ability to draw conclusions regarding childhood abuse is limited. However, a history of sexual abuse and violence was reported by 57.6 percent of women in the study.

It is clear that the participants of this study confirmed what the literature revealed but to an even larger degree. While the literature revealed incidence the of sexual and physical abuse to range from 15.7 percent (Brems, et al., 2004) to 86.2 percent (Bradely & Davino, 2002), in the participants of this study, 100 percent experienced some type of abuse as a child. Not only was abuse a component of their childhood but other traumatic events disrupted their young lives as well. The following interview excerpts reveal childhood histories of multiple losses and stresses in their vulnerable years. Again, the reader is reminded that the names used here are pseudonyms.

> **Marie**: "I never bonded with anybody when I was a baby, nobody was ever around. My mom was a drug addict, my dad was an alcoholic, my brother was an ass-hole, so I never learned how to, um, you know, express my feelings....My mom and dad were divorced when I was five, and then we moved. Um, the sexual abuse started when I was six, my mom was a heavy drinker, so was my dad. He's really bad, he's really sick right now,

um, and my mom was a drug addict too so then, I don't know how to explain it, um, I was just always ignored and then the sexual abuse started when I was six until the time I was about fourteen, fifteen. But when I was twelve, but see, then I started acting out 'cause I was really mad at my mom... I don't know if she really cared but she signed me over to the state when I was twelve 'cause she couldn't care for me anymore so then I was locked up from twelve to sixteen, except for here and there on home breaks when I could go visit my dad or something...Like, I grew up in the State Industrial School. I was there three times, I was in a group home twice, many foster homes. Like, right now, at 30 years old, I've spent over eleven years of my life incarcerated."

Cavelle: "Um, well my life is pretty complicated. When I was three my mom died so I lived in foster care before my mom even died. And then my great aunt took care of me until I was twelve, or my grandma, so during that whole time I lived with her. And then, when I was twelve I grabbed a knife and I tried to kill my aunt, ...not literally trying to like really do it but I tried to stab her and, um, my grandma or my aunt said that she couldn't take it any more so she said I was too much to handle so I was ...thrown into a juvenile correction place right away when I was twelve. Tried different foster homes but ended up running away from them. Lived in foster homes, group homes to placements, you name it, I've been there, you know. ..I guess they ran out of options for me in placements cause they were paying a lot of money for me ...they just couldn't do it anymore

so I was emancipated at seventeen and I've been on my own ever since...My family disowned me because I informed the police or somebody in authority about my sexual abuse and what was going on in my life...nobody believed what happened to me or, if they believed it, they didn't want to admit it...And it was like my great aunt, you know, and she said I don't want anything to do with you. She totally denied it ever happening. You know, maybe she's come to terms with it now but then it was just like no, that didn't happen, you're lying."

Rose: "My parents divorced and then we separated and um, I'd just lost my grandma, my great-grandma, I mean, and me and her were really close. Me and my mom were never close. She was always mean, and my dad I kinda looked up to but he just disappeared and I don't know where he went."

Elaine: "My parents were really strict with me and so I was still 16 years old and not allowed to leave the yard. So I turned 17 years old and I'm running away from home and from there it's just, 18 years old and pregnant. I took freedom and I run with it, you know...When I was raped my mom called me a tramp...We [brothers and sisters] got tired of it and I went to Social Services, and I asked for help and they wouldn't listen. My parents put it out there like we were the bad kids and they believed that, they believed that! Here I am, years and years, and now I look like the bad kid. I made myself out to be what everybody thought I was way back then."

These examples tell a story of young girls who were not only physically and sexually abused, but were also betrayed by abandonment, neglect, and by being disbelieved. They witnessed violence, they lived with chemically dependent parents, they experienced death of loved ones, and were moved from home to home or institution to institution. The cumulative adverse events in the lives of these women during their childhood are devastating.

Childhood abuse and other traumatic childhood events have historically been studied individually and the cumulative presence and effect of these events has not been well established in the literature. Dong and colleagues (2004) examined the co-occurrence of various childhood adverse events (ACEs): childhood abuse (emotional, physical, and sexual), witnessing domestic violence, parental marital discord, living with substance abusing, mentally ill, or criminal household member. Dong and colleagues (2004) found that the presence of one ACE significantly increased prevalence of having additional ACEs. They provided strong evidence that ACEs are interrelated and that more than just childhood abuse needs to be assessed when determining childhood trauma.

The combined impact of ACEs on the risk of drug use was studied by Dube and colleagues (2003). In this large study (N=18,175), the researchers found that each ACE increased the likelihood for initiation of drug use in early adolescence. Compared with people with no ACEs, people with five or more ACEs were seven to ten times more likely to report drug abuse and addiction. They concluded that ACEs seem to account for one half to two thirds of serious problems with drug use. ACEs were identified by Dube and colleagues (2003)

as: emotional and physical abuse, sexual abuse, emotional and physical neglect, and household dysfunction variables (parental divorce/separation, household substance abuse). This study reports findings relevant to the impact of combined ACEs on the later development of substance abuse. No studies were found that address the combined impact of ACEs on later development of criminal offending.

One study did address the impact of ACEs on DSH. Gratz, Conrad, and Roemer (2002) looked at several ACEs in the their study of risk factors for DSH including sexual abuse, physical abuse, maternal insecure attachment, maternal emotional neglect, paternal emotional neglect, and childhood separation. The most significant ACEs contributing to risk for the development of DSH was childhood sexual abuse, maternal emotional neglect, and paternal emotional neglect. The researchers concluded that these risk factors warrant further consideration in light of the fact that, aside from sexual abuse, few of the risk factors have been examined in the research literature.

This review of the literature underscores the idea that, in addition to sexual and physical abuse in childhood, other adverse childhood events also contribute to the risk for later development of substance abuse and DSH. For this reason, I have chosen to include the general category of ACEs in the model rather than childhood abuse only.

The exact mechanism of why ACEs cause acting out and acting in is unknown and the knowing of that is beyond the scope of this research, but a brief

discussion of one theory provides some insight into behaviors of adults who were subjected to physical abuse as children.

Bloom (1997) outlined Trauma Theory and part of the focus of this theory involves an explanation of the physiologic response to prolonged danger. Prolonged danger (as might be found in situations where multiple ACEs are present) results in a chronic hyperarousal state. Bloom theorized that prolonged danger causes prolonged hypersensitivity to stress by upsetting the regulation of the hypothalamic-pituitary-adrenal (HPA) axis and the sympathetic nervous system. Under stress, the flight-or-fight response, which is biologically regulated by the HPA axis and the sympathetic nervous system, kicks in. Under prolonged stress, the systems fails to shut off and the person is never able to relax, psychologically or physiologically. What was once an adaptive fight-or-flight response becomes highly maladaptive, especially if the chronic hyperarousal developed during childhood. Sustained fear evolves during everyday life and children grow up to live with the expectation that anything can signal danger. In essence, Bloom (1997) explains that this is a loss of "volume control" over outside stimulation. This state of chronic hyperarousal is very uncomfortable and there is a need to act in order to alleviate this uncomfortable feeling. Drugs and alcohol are used as a means of acting on and anesthetizing these feelings. Bloom (1997) noted that DSH also is used to act on hyperarousal feelings explaining that: "upping the body's ante with real, tangible danger causes a new bolus of endorphins that, at least temporarily, provides a feeling of calmness. Often, however, agitation rebounds with even greater ferocity" (p. 20).

The Trauma Theory seems to be a fitting explanation of why the participants of this study engaged drug usage, DSH, and other dangerous behaviors. This component of the Trauma Theory, however, does not entirely explain theft, forgery, and other criminal acts committed by these women. But, Bloom (1997) continues to explain that decision making is also compromised by chronic hyperarousal. During periods of hyperarousal, human bodies are hormonally conditioned to act quickly rather than thoughtfully. Bloom refers to these actions as trauma-organized behaviors and explains that these behaviors result in the lack of development of adult responsibility and the lack of a mature, integrated sense of self. The women of this study who committed theft, who conspired to commit theft, or who drove while their licenses were suspended, clearly evidenced the impaired judgment that comes with acting quickly rather than thoughtfully.

Adverse Adult Events (AAEs)

Adverse experiences did not end in childhood for these women. The participants all described ongoing experiences of abuse and household dysfunction woven into the fabric of their adult lives. I have labeled these events adverse adult events (AAEs). That these women should continue to be traumatized by adverse experiences in their adulthood is consistent with the literature. Browne, Miller and Maguin (1999), for example, found that, as compared to the general population of women, incarcerated women were disproportionately likely to have experienced interpersonal victimization prior to incarceration. They reported a 49 percent rate of rape as adults, and a 75

percent rate of severe physical abuse by an intimate partner as an adult. Further, they found that the interpersonal violence reported by these incarcerated women was more frequent, severe, and ongoing, as compared to rates reported in other populations.

In following the logic of Trauma Theory, due to their childhood ACEs, these women were hard-wired to exist in a state of constant hyperarousal. In the presence of adult adverts events (AAEs), not the least of these being incarceration, it is easy to see how these women could enter into a state of "circuit overload" which precedes the need to act. The following anecdotes of the participants serve as exemplars of the myriad AAEs experienced by the participants.

Marie described needing to leave her intimate partner when she was pregnant with their child because of his extreme abusiveness to her. She ran to five different places but was pursued by her partner and found in each place.

Elaine was admitted to the emergency department after she cut herself so deeply that it required stitches. She described the emergency department staff as "weirded out" by the incident. They couldn't understand why she had cut herself as she had just had a baby. Besides her self-inflicted DSH she was so badly beaten by the father of her baby that her right check bone was broken. She described being beaten many times by the men in her life and several of those episodes were sufficiently severe that they resulted in broken bones. Another incident she shared was being locked in a basement by her partner for three days without food or water.

Cavelle described being raped at gun-point by a drug dealer when she was six months pregnant. He is currently serving a sentence of fifty years for that offense.

These anecdotes, by no means, comprise the totality of the AAEs that the participants shared with me, nor were the anecdotes shared with me the totality of the AAEs that these women experienced. Lisa, for example, when asked to share the types of bad things that had happened to her as an adult just sighed and shrugged and said: "You could write a book about that." And she truly wishes that someone would write her story.

In summary, this section outlined the adverse childhood events (ACEs) and the adverse adult events (AAEs) that, according to Trauma Theory, provide the predisposing events that result in a chronic state of hyperarousal and its concomitant need to act. I conclude this section with a quote from McLane who expressed this psychophysiological process in a more poetic way. "The primary pain of abuse is experienced as the structure of the world itself, something that has been taken in like the nerves absorb lead or hemoglobin inhales carbon monoxide" (p. 110).

Precipitating Conditions - Emotional Build Up

While adverse childhood and adult events seem to provide the predisposing conditions for the *need to act,* it is the situational emotional build up that provides the precipitating impetus for the incarcerated women of this study to act in or act out. The situational emotional experiences that emerged in the data include: a build up of anxiety and tension; a build up of psychic pain/frustration/anger; and

no one to listen/no words to say it. These are depicted in the model as shown on Figure 5, page 94.

Anxiety and Tension

Consistent with the literature on DSH (Klonsky, et al., 2003, Ross & Heath, 2002) and with the hyperarousal state described in Trauma Theory (Bloom, 1997), the incarcerated women in this study consistently described high levels of anxiety. Some participants described periods of dissociation and, for some, there were times of depression, but all of them described anxiety as a constant in their life. For three of these women, anxiety crescendos to the point of panic at times. Marie described living in a state of anxiety and attributed it to: "...not being sure what's gonna happen from moment to moment, week to week. There always seems like [something] happens unexpectedly all the time."

Cavelle described her panic attacks in these words: "I couldn't breathe and I'd be, like, gasping for air and I couldn't breathe. I couldn't breathe. I couldn't breathe and I'd get down on my knees and I was just like, I can't breathe, I can't breathe. It would last for, like, half an hour."

Angel panics when the noise level is too high in the prison or when she is forced to be in too close proximity to other women prisoners. "Everywhere you go", she says, "there's something going on and it's so loud it echoes, and I, I panic. I can't take this noise and then there's, like, one hundred people crammed in this little cafeteria so there's no elbow room. I can't handle that."

Anxiety is clearly a significant part of their lives and DSH is clearly used as relief of this anxiety. Rose, for example, explained that she feels like she is going to explode if she doesn't cut.

Elaine described a build up of tension in the home that ended in one of two ways: a beating by her partner or an episode of DSH. "It had to be something. It's like, I can deal with things for a long time, but it takes something. I think the beatings were the self-harm thing, you know. I think that's what did it for me. I kept thinking that because if I didn't get beat up for awhile, then I ended up hurting myself. Then I would feel OK, you know, I'd kind of feel like the pain would be gone."

There is an interesting dynamic at play here. It seems that "other" inflicted harm can have the same tension reduction function as self-harm. But whatever the cause of the harm, these women clearly live with high levels of inherent anxiety and also experience high levels of situational anxiety. This is not surprising given the chaotic and traumatic nature of their lives where anything and everything can signal danger.

Build Up of Pain, Frustration, and Anger

Right before she cuts herself, Marie described her feelings in this way: "Kind of, um, maybe helpless and maybe frustrated and angry because whatever the situation is, I'm helpless to do anything about it. Whatever, I feel helpless over it- no control over it."

Maries identified frustration and anger before cutting and described it this way: "I feel trapped by my own self, my own anger, and frustration. I just, I don't

see any way of getting out of it." Likewise, Lisa used DSH "as an escape route when I was in so much pain or I was so, just, (sigh) overwhelmed and not sure what to do. Um, taking it out on myself felt good."

The women of this study did not directly express a build up of pain, frustration, or anger as a cause of their criminal offending. They did, however, act out their frustration and anger when they were arrested for crimes. Their aggression was directed towards the police officers. It is a highly stressful event when one is arrested. The body goes into a state of fight-or-flight, or more appropriately for these women, a state of fight-or-cut. When one is handcuffed, one cannot cut. The only option available is to fight and they acted out their frustrations in the only way available to them at the time - one participant spit, one bit, and one kicked.

Acting in or acting out their pain, anger, and frustration was the only option available to these women because they have not learned alternative ways of expressing their emotions. Revisiting Bloom's (1997) theory of trauma sheds some light on the dynamics of this behavior. When severely stressed by anger, frustration, or psychic pain, there is a diminished capacity for thoughtful decisions. What was learned during overwhelming adverse childhood conditions is forever embedded. As Maeve (2000) stated, "Life, after all, cannot be unexperienced" (p. 478). Both experiences, acting out and acting in, are triggered by phenomena that resemble past traumatic events. Clearly adverse childhood conditions prevent the learning of alternative responses that would be more adaptive.

No One to Listen – No Words to Say It

The first of these two contextual components emerged easily in the data. It seems that when there is no one to talk to about their pain, anger, or frustration, these women let their blood do the talking because people listen to blood. Two of the women in this study told me that they had never talked about their DSH before.

Rose felt a desperate need to cut a few months ago and urgently requested to talk to a counselor. It was in the evening and she was told by the prison staff that the best she was going to get was the supervisor on duty. She asked the guard: "Can't you call and find out who's on call for that, and they never checked. So then, after I did it [cut wrists], I went straight to the staff and told them what I had done." Angel also described the sense of *no one to listen* in prison.

> You know, so there's not much help, especially here in prison. There's only two counselors -one- there's only one that you can actually talk to and there's how many women here? You know, there's not enough time in a day to come down and say, hey, OK, let's spend an hour together. How are you doing this week?... They just don't have enough time. There's too many women, you know, and for her to take the time to be able to come and talk to me, just was almost too much to ask."

Upon further reflection regarding this matter, Angel decided that asking for a listening ear was probably futile anyway. "You can ask your counselors for help, you could ask. I could ask you for help, but you can't offer me the help that

I really need, so the only way for me to get it is self-help, and that's cutting on myself."

Elaine was adamant that in order to prevent her self-harming she needs someone to listen. Of the prison experience she stated:

> ...And you don't have that release here. You don't have that somebody [to whom] you could just say 'You know, I just want to cut myself, you know.' You don't have that here and ...it sucks, it sucks that you can't trust, to just be able to say that. Because, if you tell that to somebody you're gonna go into that room right there." (She points to a lock-down seclusion room).

Generally, although the women stated that they had friends in the prison, there was a pervasive lack of trust and a reluctance to get too close to other prisoners or to confide too much. Angel expressed it this way: "So you talk to anybody on the floor downstairs, they take and run with it and make up stories, and all this and all that, and I wasn't about to go through that." Kelly also commented that if you talk to another prisoner, it becomes everybody's business. Angel does have friends in prison but she is doubtful that her friends really are capable of helpful listening. When I asked her how she thought her friends would react if she told them that she wanted to cut herself she replied: "One of them would sit on me and torture the shit out of me until I said, Hey, OK,OK,OK!"

Elaine probably explained the whole issue of confiding in prison friends the most succinctly. She explained that to tell someone that you want to hurt

yourself is revealing a weakness. I asked: "What happens if you reveal a weakness? Her response:

> They're thinkin' that she's suicidal and that makes her weak. You know, they don't understand the whole concept of it, you know. She could be the strongest person in the world to me, but she just needed a tension breaker you know. But, they're thinking that she's weak and they're gonna make her go crazy."

At first, I attributed the distancing behaviors of these women as a part of the inmate code that seems to be inherent in this women's prison and in others like it. Owen (2004) describes this code as "doing your own time", and "minding your own business." Owen (2004), in describing the culture of imprisoned women, explained that the successful prisoner stays out of "the mix" and creates a daily existence that meets her material needs without drawing undo attention to herself. Similarly, Yurkovich and Smyer (2000) found a lack trust between prison inmates in their grounded theory study. In this study, it was found that male inmates maintained superficial relationships and a restricted degree of self-disclosure in order to prevent the perception that they were weak.

During later visits to the prison, I learned that while lack of trust may exist, lack of caring does not. Several of the women expressed a deep sense of caring for Rose who had recently been placed in lock-down confinement for 135 days. This is a severe solitary sentence and they were gravely concerned about Rose's welfare. I interviewed four women on that day and they all expressed sincere concern for Rose. It was a topic that they all brought up early and often in the

interviews that day and it was clear that Rose's situation was weighing heavily on them. Because Rose was one of the women in the study, I was allowed to visit with her briefly through the window of the seclusion cell. When the other participants learned this, they all wanted me to express to Rose that they were concerned for her and thinking about her. The behavior for which she was being punished -- she cut herself.

The women said that, for the most part, talking about their need to self-harm was not an option because there were too few professional staff to listen, too little trust of the other women prisoners who lack the ability to listen helpfully, and too much fear of grave reprisal in the form of solitary confinement.

One other major drawback to the use of verbal language as a replacement for the act of DSH is that these women demonstrated some difficulty in identifying their feelings and in finding the words to express them. As I repeatedly asked the questions: "How did you feel when...? What were you feeling before...? What were you feeling after...?" I repeatedly got the response: "I don't know." Marie's response was: "Um, it's like, God I don't know how to, it's just, ... maybe I'm a bad person for this because I just, I just don't know how to identify feelings very well, but it's just really, um, it's a real intense feeling of no control." When I asked Cavelle to describe how it feels to be high on methamphetamine. she responded: "

> So when you're, when you shoot up meth, it gives you this instant rush, and this instant high that, you know, people get all "whoa" and you just, like, you'd have to cough because the vapors in your throat are so, like,

great, you know what I mean. I don't know, not great, but like overwhelming, and then you're just like "whoa", and then you see a little, like, I don't know, when your eyes get that, I don't know if you ever had your eyes dilated before but it feels weird, I don't know, like, you know how, like, your, like, just like "whoa".

It was apparent that she just had no words to describe a methamphetamine high, but it is evidently, a very profound experience. "Whoa" was an expression used as well by Angel as she struggled to explain what she was feeling after an episode of cutting her arm. She said: "Yah, it was, I don't know what it was, but then when I cut on my arm, it was like, whoa, wait, what are you doing? Hello, you know, and so I came back to reality."

Cavelle also explained that in her childhood she had some people who were willing to listen but she would not or could not communicate her true feelings.

I think some people tried [to listen] but sometimes I would tell them differently from what I actually thought or how I actually felt, or what I actually wanted. I would tell them, like, "I don't want to be here', but really, I mean, I was completely OK with being there, you know...Most of the time I have so many feelings all at once that I don't even know what I am feeling.

Cavelle, was tearful when she explained this to me. She was referring to the only foster family that she ever cared about and she was not able to tell them that she cared for them and wanted to stay there. Between the first and second

interview with Cavelle, she had received a letter from this foster mother and it was a source of great joy to her.

Pearl explained her inability to understand her feelings regarding her cutting behavior in these terms:

> What am I doing to myself? Why am I doing this to myself? I didn't quite understand, you know, that everything was going through my mind at the time. I didn't understand why I was doing this to myself. And I couldn't, I mean, I could look back now and say, 'Ah, you know, I was going through some stuff.' I see why I did it but at the time I couldn't see, you know, I couldn't say I'm going through this in my life so this is why I did it, you know.

Marie explained the following relationship between her disordered childhood and her difficulty in expressing feelings.

> I'm getting better at it. Um, learning how to describe feelings and put feelings to certain moods or situations, or whatever. I've always had a hard time with that because I was never taught how to feel growing up so I didn't know what feelings were, I didn't know, but I'm getting better at it.

There is a word for this in ability to know, name, and express feelings. It is alexithymia and it is closely associated with the cognitive developmental theory of emotional awareness (Lane & Schwartz, 1987) described earlier in this chapter. Alexithymia is a personality construct that has been associated with psychosomatic and psychiatric disorders. It is defined by the following salient features: 1) difficulty identifying and describing subjective feelings; 2) difficulty

distinguishing between feelings and the bodily sensations of emotional arousal; 3) constricted imaginal capacities, as evidenced by a paucity of fantasies; and 4) an externally oriented cognitive style (Graeme, 2000). It is not possible to make any assumptions from the data of this study regarding the imaginal capacities or cognitive styles (points #3 and #4) of the participants of this study but they do appear to have some real difficulty identifying and describing their feelings (point #1). They also may have some difficulty in distinguishing between feelings and the body sensations of emotional arousal (point #2) which is clearly consistent with the idea that DSH is a physical response to adverse emotional experiences that, unnamed, can only be expressed as a bodily build up of tension.

The deficits underlying alexithymia are attributed to arrested emotional development during childhood. Unable to accurately identify their subjective feelings, individuals with alexithymia are not able to reflect on and modulate their emotions. They also communicate their emotional pain to others very poorly, and thus, fail to gain support or comfort from others. Empirical data on the association between alexithymia and childhood physical or sexual abuse are inconclusive, but the data suggest that inadequate parenting and childhood physical and sexual abuse are associated with alexithymia in adulthood (Kooiman, Vellinga, Spinhoven, Draijer, Trijsburg, & Rooijamsns, 2004). A search of the literature revealed no research that directly studied alexithymia in women who self-harm, but this construct has gained recognition from those who study substance abuse, eating disorders, panic attacks, and various psychosomatic diseases (Graeme, 2000).

It seems that alexithymic people cannot put words to feelings and thus, cannot elevate their emotions to a conscious level. Thus, their emotions remain sensory, visceral and kinesthetic (Graeme, 2000). Those with alexithymia are, in essence, "lost for words" and thus, remain disconnected from their own subjective emotions. This construct has applicability to DSH. Their apparent inability to identify and voice their emotions prevents these emotions from being released verbally and thus, they can only be manifested as physical tension. I draw on the poetic words of McLane (2004) to summarize this idea better than I can.

> When hidden pain starts to speak, it will speak silently. Its voice may appear as a cut on the leg, a burn on the arm, skin ripped and scratched repeatedly. There will be no sound, not any, only unfelt, and silent pain which makes its appearance in another pain, self-inflicted, and when that second, collateral pain emerges, it will articulate in blood or blisters the open definition you desire, although it may not be in a language you care to see. This, it says, is pain, and this is real in any language you care to speak. (p. 111)

Intervening Conditions

Thus far, my structural model has hypothesized that adverse childhood experiences (ACEs) and adverse adult experience (AAEs) as predisposing conditions, in the presence of emotional build up as precipitating conditions, lead to a need to act, and that action takes the form of acting out or acting in.

There are several intervening conditions, the presence or absence of which, serve to modify the nature and extent of acting out and acting in. These conditions include the influence of children, and the influence of a caring support system, and the influence of methamphetamine use.

Children

Intuitively, it would seem to make sense that children would provide an incentive to refrain from DSH and criminal behavior. This influence is, in fact, a component of several theories explaining the gender differences in crime rates. It is thought that women with family responsibilities are less available to commit crimes because of the over-arching responsibilities of childrearing and family maintenance (Enos, 1997). As Pequero and Sealock (2004) pointed out, women, who are generally more strongly invested in their relational networks than men, may have more incentive to avoid criminal behavior that would threaten these ties. For the women of this study, their crimes, their addictions, and their self-harm were responsible for the loss of custody of their children. For those who still have some connection to their children or for those who hope to regain connection, their children are powerful motivators to refrain from further crime, drug use, and DSH. But, paradoxically, children also provided cause for self-harm with these women.

Between the seven women of this study, there are 24 children. Six of the seven have lost custody of their children and have not seen their children while they have been in prison. Some are content with this and some are very disturbed by this. For, those who have maintained, at least partial custody of their

children, trying to maintain a relationship with their children is a pivotal and often frustrating part of their lives.

Lisa carries a picture of her son with her at all times. When she feels the need to engage in some type of DSH, she looks at the picture and realizes what she stands to lose by engaging in some form of self-harm behavior. Elaine stated her major DSH episodes were basically related to abandonment issues, one of the most significant being when her children were taken away from her. She cut most recently, when she received word that her 13-year-old daughter was becoming sexually involved with a 29 year-old man. After Elaine became aware of this situation she felt very distressed and stated: "

> I was supposed to keep her safe and I wasn't there, you know. After I found this out, I searched around and around for somebody to help her, somebody to understand and nobody, there's nobody there, you know. I can't talk to mom because when it happened to me, when I got raped, my mom called me a tramp so how can I tell my mom because my mom will make my daughter feel like shit...So I was sitting in the bathroom with a razor torn apart cutting my fingers.

Elaine showed me a few superficial cuts on her fingers and explained that she was able to stop herself before they became too severe. But, she added that the cuts were too superficial. She needed more depth and more blood. "I wish I could a have done it better because I've been depressed ever since, I've been crying".

Fear of child abandonment also was a theme in Pearl's DSH. Her last episode occurred in prison about one month prior to this interview.

> I can remember the last time I cut myself. It was Christmas Eve. It was my daughter's birthday, and I had just called her and her dad hung up on me. At that point, I was like, she obviously don't need me, you know. And it was at that point in time, I think is when I needed someone to listen the most, when nobody was there.

It is clear from these anecdotes, that children were both seen as reasons to self-harm and reasons not to self-harm.

Children were also perceived by the women of this study to be reasons for both curtailing and escalating their acting out behaviors related to drug use. Cavelle stayed off methamphetamine while she was breastfeeding her baby. When the baby was six weeks old, she started using again. The baby's father would take the baby on the weekends and Cavelle would spend the weekend high on methamphetamine. When Cavelle got her baby back on Monday she would be sober again. Finally, at the father's pleading, Cavelle admitted herself into treatment, however, she ran from the treatment facility. She got high for a month, stating that in that month:

> I never done so many drugs in my life. Because I wanted to be with my baby, and I couldn't be with her because I was so high....She was constantly on my mind, but like, I didn't know how to come down and be a mom to her like I should have been, you know.

She went to prison and after her incarceration, her life again centered around conflicting imperatives, one, to get high, and the other, to stay clean for her daughter. Cavelle described it like this:

> I would stop using [meth] on Wednesday and stay clean until after the baby. [The baby would visit on Fridays.] But, then, after the baby, I'd be high until the next Wednesday again, 'cause that would give me enough time to get myself together until, like, I see her.

Cavelle described one acting out behavior that stopped completely as a consequence of having her child and that was her drug dealing. "Ever since I had my daughter I quit dealing drugs so the whole idea of dealing drugs was no longer a thought in my mind."

Marie also was able to refrain from methamphetamine use during her pregnancy and for some time after and was able to stay straight for 13 months. Then, her housing arrangements were delayed and she had no place to live. Her daughter was consequently taken away from her. Six days later, her housing arrangements came to fruition and she describes herself as doing pretty good at that time. Her lawyer and her social worker were proud of her and they were ready to restore her daughter to her. From this point on, she told a poignant story of a downward spiral. She knew she couldn't maintain the sobriety. She knew she couldn't care for her daughter.

> I just self-destructed myself, I just, I quit my job, I started using meth again. I admitted to it, you know, 'cause I didn't want her back with me if I wasn't gonna be right, you know. I went ahead and admitted to my

probation officer that I had been using and I got sent back to jail. I was doing so good, you know, and then I just, I think I was afraid of succeeding or something. I just threw it all down the drain.

Thus, children emerged as an intervening condition for the need to act. In some cases, the hope for reuniting with children provided the motivation for refraining from acting out or acting in. For other participants, frustration and fears related to their children caused a tension build up and a concomitant need to act.

Listening, Caring Support System

Having no one to listen when they needed to vent was clearly identified by the participants of this study as a precipitating factor for the need to act. It logically follows that having someone to care and listen would serve to mitigate the need to act out or act in. Two examples follow that demonstrate how the presence of a caring listener might have served to alleviate the need to act in and two examples are given to illustrate this same principle for acting out. Elaine cut herself during an extremely painful period of her life when the cutting was a substitute for what she really needed.

Like, with my kids, when my kids were taken from me or when I'm overwhelmed and I feel that I have nobody, I just, I just can't deal with this and I think other people are like that, too. You're searching for somebody, somebody to listen, somebody to talk to, and something, somewhere.

Angel also identified that if someone was just there to listen, she would not have to speak through the voice of her skin.

> If I had someone to sit and talk about it, I think it would help me. You know, that's all anybody should be able to need is someone to talk to, you know not even to have anybody respond back to you, just to vent it and say, hey I'm mad because of this, I hate the fact that this happened, I don't like this, I don't want that, I don't, I, I, I, I.

Elaine expressed that, had someone really cared about her and listened to her when she was young, her trajectory of acting out and criminal offending may well have taken a less dramatic course.

> When I was a kid, I had borderline personality disorder. There was a counselor who told it to my parents, and if somebody would have listened to him, um, things could have been solved way back then but nobody would listen. Instead, they just sat back and watched, you know, to see what happens next. And here I am, years down the road.... I just hope that when those kids go into social services and stuff that people listen because they go in for a reason. They are going there for something, you know.

Use of Methamphetamine

Several of the participants identified the use of methamphetamine as a deterrent or a substitute for DSH, in essence, using an acting out behavior to substitute for acting in. Pearl described her use of methamphetamine as an alternative way of numbing her feelings explaining that methamphetamine causes one to focus on only what is going on at the moment. She explained it thus: "I just can't feel anything. All day, all I'm thinking about is how high I am."

Marie also explained that the use of methamphetamine actually helped her to avoid DSH.

> It would help me not [self-harm] because using methamphetamine would numb me. I would still know that I was sad over things and feel guilty and remorse over a lot of things. But meth would make me not want to cut my throat open.

Likewise, Elaine explained the emotionally anesthetizing function of methamphetamine in this way:

> Um, it felt good, made me mellow, made me take everything. It didn't hurt no more, you know. The pain that I was feeling at the time was the hardest thing that I've ever had to deal with in my whole life.

Lest one is tempted to contemplate that the use of methamphetamine might be used as treatment for DSH, it should be noted that Marie also described herself as being a "crying mess" when she came down from the drug. As Zweben and colleagues (2002) point out, the use of methamphetamine can result in depressive symptoms, not only after the use episode, but for many months thereafter. These symptoms can be lasting and, for some, possibly permanent. Although the feelings of intense misery may abate, a period of anhedonia often extends for many months following the last use of methamphetamine. Thus, it may be that the use of methamphetamine, while providing temporary respite from the need to self-harm, may in the long term, actually promote a more pronounced need for DSH.

While methamphetamine may, at least temporarily serve as a deterrent to DSH, the use of methamphetamine obviously was not a deterrent to crime because using methamphetamine is, by definition, a crime. All except one of these women had either a primary criminal charge related to methamphetamine, or were remanded back into custody following a methamphetamine-related probation violation.

Strategies for Acting Out and Acting In

Onset of Acting Out and Acting In

Although I did not directly explore a complete crime history, it is apparent that for these women, delinquent acting out and acting in behaviors began at approximately the same time in early adolescence at around ages 12 to 14. Earlier episodes of acting out included such things as drinking, running away from home and reckless driving. Several of the participants directly referred to their adolescent behaviors as "acting out." Marie was one such participant and she described her adolescence in this way:

> I started acting out, so then I was a juvenile delinquent, and I was in a lot of trouble with the juvenile [authorities]. Like, I grew up in the state industrial school. I was there three times. Like right now, at age 30 years old, I have spent over eleven years of my life incarcerated.

Her mother recalls that at age six or seven, Marie would stab herself with pins into her thighs. Marie's first memories of acting in (DSH) were of carving designs and boyfriends names all the way up her arms. This began in junior high.

Cavelle, at age 12, attempted to stab her aunt with a knife but explained that she was not really trying to kill her. She was placed in a juvenile correction facility. That began, for her, a series of placements in foster homes, group homes, and various placements too numerous for her to remember. It also was the beginning of a series of stealing items from cars during her school lunch breaks, and then, stealing the cars, themselves. It culminated in her incarceration as an adult for auto theft. At about the same time in her adolescence her first episodes of cutting also began. She described that her acting in (DSH) however, went way beyond cutting. At age 15, she broke some glass and tried swallowing it in what she described as her first real suicide attempt.

In summary, it is apparent that for the women of this study, acting out behaviors commenced at the same developmental stage that acting in behaviors began. Adolescence has been established as the usual time at which girls begin the process of DSH. One study found that 25 percent of those who self-harm started these behaviors in sixth grade or younger, 60 percent said they started in seventh or eight grade, and 12 percent in the ninth grade (Kennedy, 2002).

Strategies for Acting Out

The adult acting out behaviors of the participants can basically be classified into two categories: those felonies for which they are currently incarcerated and probation revocation behaviors that caused them to be remanded back into custody after release on parole. Methamphetamine use and methamphetamine related behaviors were the single biggest contributors to both

felony charges and probation revocation. A detailed sentence profile is outlined in Table 6, as shown on page 131.

Except for the physical actions directed at the officers during arrest, only one woman was incarcerated for a crime that could be considered violent. As is typical of the national crime profile, these women were predominantly property offenders and drug offenders.

Several themes emerged from talking with the women regarding their crimes. First, in several instances, there seems to be a blurred boundary between their victimization and their offending. For example, Lisa was arrested for driving with a suspended license but she stated that her driving was a desperate attempt to flee from an extremely abusive spouse.

Angel, who is in prison because of charges as a sex offender described committing this crime because of her fear of her intimate partner. Regarding this incident, she said:

> He was interested in this girl (a minor) and we had an abusive relationship. I was very scared of him and he told me to go ask this girl if she wanted to have a three-some with us and if I did not do that he was going to hurt me if not kill me.

Angel had good reason to be afraid of this man. He had beaten her repeatedly and badly. On three different occasions she required emergency treatment as a consequence of these beatings, once with a broken wrist and once with broken ribs.

Table 6. Current Conviction Profile of Participants.

Participant	Current Conviction	Sentence Length
#1	♦ Conspiracy to commit theft of property ♦ Aiding an offender in the first degree	1 year
#2	♦ Accomplice to theft of property ♦ Conspiracy to commit forgery ♦ Conspiracy to commit theft	3 years, 1 year suspended
#3	♦ DUI (3) ♦ DUS (4) ♦ Eluding police & preventing arrest ♦ Simple assault on a police officer ♦ Actual physical control	1 year
#4	♦ Possession of drug paraphernalia ♦ DUS ♦ Possession of marijuana ♦ Leaving scene of an accident ♦ Delivery of cocaine ♦ Delivery of methamphetamine ♦ Contact by bodily fluids (spitting on an officer)	3 years
#5	♦ Possession of a controlled substance ♦ Failure to register as a sex offender	18 months
#6	♦ Possession of methamphetamine with intent to deliver ♦ Possession of drug paraphernalia	18 months
#7	♦ Forgery ♦ Possession of drug paraphernalia ♦ Possession of methamphetamine with intent to deliver	5 years,2 years suspended

DUI = Driving Under the Influence
DUS = Driving While License was Suspended

These anecdotes give credence to the idea that in order to understand women's offending one must understand their victimization. (Maeve, 2000). I am not so naïve as to assume that these women were not, to a degree, responsible for their criminal conduct. I am, however, suggesting that their criminal acts were clearly connected to their victimization and the environment in which these women were living severely limited their choices and their judgment.

A second theme that emerged in considering the criminal profiles of these women was that their crimes were often entwined with their need for connectedness. Two of the participants were directly charged as accomplices to crime or in conspiracy to commit crime. Four of the women described either their drug use or their other crimes as a consequence of affiliating with friends and intimate partners who enlisted them in their criminal acts. Pearl, for example, rode along when her friend would steal cars. Later, with another friend she described: "I'd be along, like, I'd have a friend that would, like, go rob bars and I'd be, like, the get-away driver, you know. I never dug my feet in and done it with them, you know." Elaine's drug use was "part of the boyfriend thing." "I was chasing my boyfriend and other buyers and I wanted to be like them."

Pearl stated that she actually took "the rap" for her boyfriend. The charge was robbery and since the sentence was to run concurrently with her other charges, she figured that he had more to lose than she.

Steffensmeir and Allan (1996) in their gendered theory of female offending, assert that when women commit crimes like theft, they are less likely to be solitary and more likely to serve as an accomplice. For women, crimes often stem from relational involvements, and women are often introduced into crime by husbands or intimate partners. Women, it seems, are more easily persuaded to "do it all for love."

The participants of this study had difficulty being compliant with the terms of their conditional release from prison and five of the participants are back in prison for breaking parole. Of those five, three of them broke parole by using

methamphetamine primarily and other drugs secondarily. One was remanded into custody for failing to register as a sex offender and one for assaulting a police officer while she was intoxicated. It seems that they felt a need to act out even when they knew that these behaviors would result in sure and swift reincarceration.

Strategies for Acting In

The acting in (DSH) behaviors of these women are varied in type as well as frequency. All have decreased the frequency of their acting in behaviors while in prison (or have gone underground with it) because of fear of punishment if they engage in these behaviors. Table 7, as shown on page 134, lists the types of behaviors that were described by each participant.

As is evidenced by Table 7, the most common method of DSH for these participants is cutting. The literature reveals that this is the most common method in general for those who self-harm (Beasley, 2000, Favazza, 1998).

The women were all willing to show me their scars and they range from small and barely visible to very substantial scarring. Most of the women, at some point, have required stitches to close wounds that were deeper than they intended. Rose has needed stitches almost every time she has cut and her cuts have been severe enough to require up to 22 stitches. She described one of her wounds as insubstantial – only eight stitches.

Table 7. Methods of Deliberate Self-Harm.

Participant	Types of Acting In (DSH)
#1	♦ Stabbing thighs with pins. ♦ Carving arms. ♦ Cutting on legs. ♦ Abraiding skin with pencil erasers. ♦ Burning with an iron.
#2	♦ Cutting arms. ♦ Swallowing glass shards. ♦ Snipping at veins with fingernail clippers.
#3	♦ Cutting arms. ♦ Burning arms and legs with cigarettes. ♦ Poking skin with mirror shards. ♦ Scratching skin with nails.
#4	♦ Cutting wrists. ♦ Stabbing arms with pencils.
#5	♦ Carving names on arms. ♦ Self tattooing. ♦ Meth related picking "bugs" out of skin.
#6	♦ Injecting meth into subcutaneous tissue. ♦ Punching walls until hands are damaged. ♦ Cutting wrists. ♦ Smashing hands through windows.
#7	♦ Cutting wrists and arms. ♦ Carving names on arms.

When implements are not available for carrying out DSH, alternative methods have been found. Fingernails have been used to scratch the skin until it is raw. Teeth were used to tear away at the stitches from a previous self-harming episode. One of the participants has begun to punch the walls with her hands and when the skin breaks she feels the relief that comes after a self-harm episode. The prison staff and nurses are not aware of this behavior. The fingers of her right hand are misaligned and it is clear that she has broken her knuckles

or hand on at least one occasion but she has not sought treatment for these wounds.

One of the most unusual methods of DSH was the use of methamphetamine as a means of deliberate self-harm. One of the participants would intentionally miss her vein and inject the methamphetamine into her subcutaneous tissue. She called this behavior "missing." Methamphetamine is highly caustic and causes inflammation and ulceration when injected directly into the subcutaneous tissue. The participant showed me ten or twelve circular, pea-sized to dime-sized scars on the underside of her forearms that resulted from her "misses."

The preceding paragraphs have addressed the strategies for acting in (DSH). Reading the list and the descriptions of ways to self-harm can make one squeamish when one contemplates the physical pain involved in these behaviors. Surprisingly, physical pain does not seem to be a major component of these behaviors. All of the participants indicated that they feel no pain during the act of DSH, or, if they do, it is a non-aversive pain. The pain begins about an hour later, but the act itself is not accompanied by a physical sensation of pain. Angel described that "it just feels good", and Lisa said, "It just feels wonderful."

The phenomenon of painlessness found in the participants is typical of DSH even though the injuries can be severe (Haines, Williams, Brain, & Wilson, 1995). Painful sensations commonly return hours, or even days, after the episode. Haines and colleagues (1995) theorized that the absence of pain is

most likely caused by the release of endogenous opiates caused by the extreme hyperarousal state during the stress reaction prior to cutting.

Consequences of Acting Out and Acting In

For both acting out and acting in behaviors, several shared consequences emerged from the data. These include short-term relief, punishment, and embarrassment/shame.

Short-Term, Immediate Relief

The short-term consequences of the participants' acting out, in some instances, clearly led to short-term relief, or at least the hope for relief from mounting psychosocial tensions. I am sure that when Rose assaulted her probation officer it provided some measure of perverse relief from the frustrations inherent in being taken back into custody. It probably felt very gratifying for Lisa to spit in the eye of the officer who was arresting her. The thefts and forgeries committed by the participants were motivated, at least in part, to provide relief from financial burden. Possession of, use of, and selling of methamphetamine are all behaviors directly related to the need for relief from methamphetamine craving and for relief from extreme distress and dysphoria. As Marie put it: "For me, meth was never about partying. From the moment I first tried meth, I knew this was what I always wanted to be on because this doesn't make me feel like I'm going to hang myself." For the first time in years Marie found some relief from the chronic sadness that she was experiencing.

Acting in (DSH) also provides an immediate, short-term relief. The women in this study repeatedly used two words, relief and release, to describe the

consequence of their DSH behaviors, and the relief was instant and profound. Rose described her sense of relief by simply using the expression, "aaahhh" (sigh of relief). Marie, after one deep cutting episode, fell to her knees and cried with relief. Rose expressed a sort of cleansing relief when she explained that cutting released all the bad stuff inside. For Lisa, DSH took away "the pain in her heart."

Several of the women used metaphors to explain their relief. Rose explained it as, "Kinda like a balloon, like, if you only keep blowing a little at a time and then when you cut, then it's, like, the balloon is popping." Elaine's metaphor was "things bottling up and bursting." Angel's metaphor: "It's kinda like when you're boiling something on the stove and it's steaming and you open the lid and all the steam comes out. That's what it feels like."

Pearl's statement most succinctly expressed the profound need for this relief when she said: "If I couldn't cut, I would have to kill myself." DSH is clearly relief, release, and ultimately, anti-suicide. The irony here, of course, is that if one cuts too deeply, that which was intended to prevent suicide ultimately becomes the cause of it.

Researchers investigating the psychophysiology of DSH were able to measure relief on a physiological level. Using guided imagery Haines, Williams, Brain, and Wilson (1995) demonstrated that after the 38 participants who self-harmed were shown pictures of an act of DSH they reacted with a physiologic tension reduction response. Psychophysiological measures that were measured included such things as finger blood volume, heart rate, respirations, and skin

resistance levels. They were able to demonstrate an immediate reduction in psychophysiological arousal and a physical relaxation response was evident. They concluded that DSH is an efficient means of reducing tension and providing relief.

Punishment

Acting out leads to punishment and so does acting in (DSH). Prison is punishment. There is argument today, however, regarding the appropriateness of this type of punishment for people who have chemical dependency problems. As Watterson (1996) points out, by making the use or possession of certain drugs or their paraphernalia illegal, we have created an enormous category of crime. She stated: "I believe that our drug laws and mandatory prison sentences for drug offenses...will someday be understood to have been a tragic misplacement of priorities." I am sure that Elaine would agree. She stated: "I've only done drugs for five months and I will have done, after I get out of prison, I will have done seven years for drugs."

Punishment is also harsh for prisoners who engage in any kind of DSH. Offenders are thrown in "the hole," also known as "solitary confinement," "isolation," "disciplinary detention," and, ironically, in this institution, "crisis intervention." On my fourth visit to the prison, three of the participants of this study were unavailable to me for interviews because they were in "crisis intervention." They had cut themselves and, as a consequence, were in "the hole," one for 35 days, one for 135 days, and one for an unspecified period of time. The "hole" is a room about eight feet by eight feet. It contains a very small

sink, a toilet, a small shower, and a bed. There are no windows and the room is painted an institutional gray.

In the US, according to Maeve (2000), women are sent to solitary confinement at three times the rate of men and for less serious offenses and with more serious consequences. Maeve (2000) stated: "For too many women, going to one's room may trigger the recall of abuse suffered during those childhood isolations" (p. 480).

I think that Elaine would readily identify with this statement. She was locked in a basement for three days without food or water by her intimate partner. When she ended up in "crisis intervention" after cutting herself she described the experience in her understated way as "a bad situation." She experienced many panic attacks during that confinement. She fears two things, being enclosed and being alone. Elaine identified that the major reason that she cuts is feeling abandoned. For her, the pain of abandonment is the cause of her DSH and by being placed in "the hole", abandonment effectively becomes the consequence of her DSH as well.

Abandoning women who self-harm by locking them in "the hole" is not helpful, at least for the one who is being locked up. Angel expressed that this "intervention" is really to help the staff, not the person who self-harmed. She stated:

> It might help the staff not to have to deal with you but it doesn't help you personally to get over something...They put you in a little bitty room, you know, not much bigger than a bathroom, and you sit there and all you see

are these four walls and you don't even have your regular clothes on, you know. So it kinda gets to a person, you know.

When these women are most in need of someone to listen and care, they are isolated. When they most need some caring human contact they are disconnected from any but the most minimal human interaction.

Embarrassment and Shame

The participants of this study did not want anyone, especially their children, to see their DSH nor did they want anyone to notice the scars. Marie said: "I see these scars now and I'm just, you know, I make up stories on why they're there you know. I can't hide the ones here now um, so, I'm embarrassed by them...." After an episode of cutting, Cavelle stated that she just felt stupid, just embarrassed. Lisa is concerned that her son will see her scars. Several of the women used the expression: "what am I doing?" They recognize the need to self-harm, but also recognize that it is a deviant behavior and it invokes a sense of shame.

Most of the participants expressed embarrassment regarding their crimes and a sense of shame regarding their offenses and also regarding their status as a prisoner. Angel probably best exemplifies the shame and embarrassment of her crime. She was in a therapeutic group session in the prison and the women began talking critically about women in the sex trade. Angel explained: I used to...sleep with guys for money, oh my God, I did that... What do they think of me? I'm such a bad person...Oh my God, that's what they think of people like me? How degrading. She is particularly guilt ridden about her sex offense crime

and becomes visibly agitated whenever we broached this topic in our interviews. She stated:

> I am really tore up about it... I have a lot of guilt on the issue (referring to her sex offense crime.) I didn't stop this individual from this harm. I could have walked out, I could have went to the cops, you know. I could have took the chance of getting myself hurt rather than that individual.

Lisa's Story

Up to this point in this chapter, I have segmented the grounded theory of acting out and acting in and explained how I arrived at each individual component of the theory. I will now reconstruct the theory as it applies to Lisa. In telling Lisa's story I intend to accomplish two things. My first objective is to demonstrate the process of acting in an acting out as it unfolded in the life of one participant. My second and most important objective is to give a voice to Lisa. She is rightfully amazed that she has survived, given the circumstances of her life thus far, and was eager to have a listening ear to tell her story. Even though she is in prison she feels that she is in a better position than she has been in years and is poised to move on with her life in a more conventional and constructive way. When asked if I could focus a part of this research on her specifically she stated: "...There is so much more that I have in my life that I could tell you, so much more, where I've been. And, it's just amazing how I've reached this far and what I've been through....I would love to tell you. It's just amazing where life takes us."

Lisa is a young woman with beautiful hair and large, expressive eyes. Her fresh, good looks belie the hard life she has led in her young years. In terms of *adverse childhood events (ACEs),* Lisa has experienced them in full measure. She didn't elucidate specific events of her earlier childhood other than to say that, as a child, she was emotionally and physically abused. She began her story at the tender age of ten when she witnessed the murder of her father. Her mother was not the murderer but had some part in the crime and is now serving twenty five years in a federal penitentiary. In one violent moment, she lost all the security she had ever known. She stated: "I never really had a mom. Now my mom's going to die in prison so I'm never gonna have a mom."

The adverse childhood events (ACEs) of her childhood culminated in her *need to act.* At about age ten she began to deliberately self-harm. She remembers beginning these behaviors after her father was shot. She started cutting herself and stabbing herself with pencils, "little things, you know." By the age of twelve she described herself as a "street child" and resorted to prostitution because she perceived this as her only survival option. She offered the following explanation for turning to prostitution: "Before I had learned other ways to fend for myself that [prostitution] was the easiest and the quickest and the most supposedly safest." She quickly learned, however, that this life style was not safe.

> But, I was beat if I did not do this. I literally had to get up and go on command when they were ready, when it was time for me to do what they

wanted me to do. And if I didn't, I was hurt. I was thrown into a trunk of a car. I mean just amazing things happened.

But, Lisa had a dream of a secure life that she envisioned as a nice house with a white picket fence and a family. Somehow, she managed to leave the urban environment where she spent her years on the street and move to a rural, Midwest area. She met a man, fell in love, and had a baby boy. But, it turned out that this man was abusive, so much so, in fact that she ran from him. She had no work skills and had been a stay-at-home mom for the past five years. In addition, to this she had a mental illness that was taking its toll on her.

> I was really lost. I was out there. I couldn't get my meds. I tried to get on disability but I couldn't. I was homeless, even ate out of garbage and stuff, you know, because I didn't know what to do. Nobody in [this town] would help me... And, by that time my mental health frame of mind was so bad that, I mean, it was almost like a deranged animal, you know, a wounded animal.

And thus it was, that the *adverse adult events* piled up in her life and she again felt a desperate *need to act.* This time, her acting out behavior took the form of running methamphetamine. In return, she was given a place to stay. But, ultimately, she was arrested and her place to stay ended up being a bed in the women's correctional facility for several years. Once again, she said: "I lost my whole life."

The complete story isn't as clean as this. There were incidences of driving while intoxicated, driving with a suspended license, and running into a brick

building with a car and fleeing the scene. Still, the boundary between her victimization and her criminal offending is blurred. Many of her acting out behaviors were driven by the need to survive.

Lisa, describes herself as a very *anxious* person. During my interviews with her she was fidgeting and constantly rubbing the scars on her wrist. She is anxious over many things-- how she is going to live when she gets out of prison, how she is going to get her son back, how she is going to support him. So, she carries around a good measure of worry and anxiety. She also described that a *build up of frustration, anger* and *emotional pain* were the factors that precipitated her DSH which manifests itself in cutting. She has thought about cutting herself again lately. The recent incidence of several other women's cutting episodes in prison has caused her distress and brought her own history of cutting to mind. But, she is determined not to cut. She commented that she touches her scars a lot, possibly as a comfort measure. This behavior was very apparent during our interview.

Unlike some of the other participants of this study, Lisa does not show evidence of the precipitating condition labeled *no words to say it.* Lisa seems to have no deficit of words to describe her feelings. She is fast, fluid, and highly descriptive in telling her story and her emotions are very apparent, but her narrative is often disjointed and confusing. However, a common theme in her narrative was that there was *no one to listen.* She has gone to the States' attorney, written to a senator, gone to the police, written to a judge in her home state, and by her account, they have all dismissed her concerns regarding

custody issues and disability pay issues. I wonder if part of this lack of concern on the part of the authorities might stem from the fact that they also found her story disjointed and confusing. Perhaps the lack of narrative coherence obscured the desperate needs that she was trying to convey. She did, however, express very clearly that she lacks a caring and supportive person and has *no one to listen.* When I asked her if she could talk with the nurse when she feels her frustration and anxiety escalating, she stated that talking with the nurses is "like talking to the cops". Lisa is very aware of the "prison code" and fears the consequences of having other inmates suspect that she is saying things to the prison nurses and other staff. There are no fellow prisoners with whom she can confide, Lisa explained: "I don't care for women too much. I don't really have no friends. I didn't come here to make friends and they all have stories that I don't have." Mentally and physically she sets herself apart from women who are really not that different from her.

So, with the build up of pain and frustration, and with no one to talk to, she sometimes feels a strong need to either *act out* or *act in.* She knows that *acting out* or *acting in* is not an option available to her at this time and recognizes that "I just have to buckle under, I have to keep my mouth shut, you know, I have to take all the crap I am doled." This approach reflects a lack of coping strategies and sets her up for an explosive *need to act* moment.

Lisa is determined to be a model prisoner. Her motivation for this is to get out on parole sooner because she wants her son back. Lisa's little boy is four-years old. Lisa has not seen her child for two years and is desperate to see her

son. Just prior to my last visit with her, Lisa had learned that the father of her child, who currently has custody of the boy, told her son that his mommy was dead. Lisa was tearful, anxious, and distressed during the entire interview and despaired of every seeing her son again. She expressed with tearfulness and bitterness:

> I always have to pay. Am I gonna pay forever? I'm sorry, you know. I learned my lesson. I'll do anything in this world to be a better part of a community and society with my son. That's all I want to do is be a mom...The only thing that keeps me going is my boy and I'm getting to where maybe that's not enough because right now he doesn't even know who I am and you'd think that this place would at least help me see my son. They enforce every other court order and why can't they enforce this one so that I can see my son? All's I want to do is see my son. Have you ever known anybody to want to be a mom so bad?

It is this desperate need to see her son that, on the one-hand prevents her from self-harming, but paradoxically, causes her increased need to self-harm. She has been able to resist the urge to self-harm by carrying around a picture of her son at all times. The picture is old and very worn and creased. This picture is her comfort and her motivation to refrain from acting in or acting out.

> I wanted to cut so bad I remember breaking a razor and having it in my hand....but I was just holding it and I wanted to so bad and all I could picture was this little boy's voice. One of these times God is not going to save me and, and I don't want to die, I want to be there for my son.

Lisa carries these burdens all alone. She has no family or resources that might serve to intervene on her behalf.

> I just, I don't have a lot of help. I don't have a lot of resources, I don't have any family back here. I really don't have any friends. I have mental disorders that most people back here, I don't think, know how to deal with.

Lacking in any other resources to provide intervening conditions for her acting in and acting out behavior, she must rely entirely on the hope of being reunited with her son to provide the impetus for refraining from the need to act.

Lisa has demonstrated *acting out* behavior in many ways from early on in her life. She described herself as "hell on wheels" when she was living in another state. "I can't tell you how many felonies I have in [the other state] and they thought I would definitely be a three-strikes candidate or dead." Yet, surprisingly, she does not have an extensive history of drug use. Ironically, even though her current incarceration is related to delivery of methamphetamine, she has never used methamphetamine and does not drink alcohol. She does admit to a history of using marijuana but states that she has been drug free for several years and she is critical of those women in prison who she perceives as having chosen drugs over children. She states that the authorities in the urban area in which she previously lived would be very proud of her if they could see her behavior now. I have referred to some of her more current acting out behaviors earlier in the narrative and in the interest of avoiding information that might identify her, I will not give any more specifics of her criminal history but will say

that as far as I can tell, her criminal offenses have largely been motivated by her victimization and her need to survive.

Lisa's *acting in* behaviors have all been episodes of cutting on her arms. Her last episode of this occurred six months ago. She minimized the severity of this incident by saying: "I took a razor blade and just cut, and I only had probably eight stitches." (Lisa was one of two participants that described "only eight stitches" as a minor incident of DSH.)

Lisa clearly identifies that her crimes were committed to provide *short term immediate relief* from the dire circumstances in her life. Hunger and homelessness are powerful motivators and one does what one has to do to survive. Lisa would sleep in cars or loiter in hotel lobbies just to get arrested so she had a bed and a meal. But, in her case, as in the others, *short term relief* gave way to long term *punishment*. She has currently served six months of a three-year sentence and her next parole hearing will occur in seven to nine months.

Lisa has been punished for her acting in behaviors as well. She sees "the hole" as the worst of all possible solutions for someone who has self-harmed. She has been there and it was an extremely distressing experience for her. "That is one of my biggest fears – that I'm gonna be punished for hurting myself and they take their good time." She described being placed in "the hole" in a different facility after she cut herself.

> I don't think it should be used as punishment and I've actually been punished for it, stripped down, thrown in a cell where there's nothing but a

hole, a little hole in the ground to pee in and a camera to watch you, and you have no clothes on or nothing and I think that is the most degrading and humiliating thing.

I am happy to report that in the women's prison where Lisa currently resides, "the hole" is far less stark than that. Still, it is barren of comfort, color, stimulation, and, I suspect, barren of hope as well.

Lisa fears confinement in "the hole" to the extent that she expressed to me that if she really just had to cut herself she would cut, not just to harm, but to die. Her statement regarding this sent chills up my spine.

You know, I have thought about it in the last couple of weeks. What happens if I do [cut]? Do you think I'm gonna do this so they can lock me up in a cage? I'm gonna cut my jugular or something to make sure... I mean, if I'm gonna kill myself, I'm really gonna kill myself.

The last consequence of acting out and acting in for Lisa is *embarrassment and shame*. She is ashamed of the crimes she committed, she is ashamed of being a prisoner, and she is embarrassed by her scars. In the past few weeks she has been going into the medical center in a nearby town for physical therapy to treat a long-term back problem. She is taken into the medical center in chains. The last time she went for therapy there was a little boy in the waiting room that was about her son's age who was staring at her. She interacted briefly with the young boy and his fear subsided but his look pierced her heart and she said: "I would never want my son or anybody to see me like that. I was so embarrassed and just very humiliated."

This concludes Lisa's story. It is a story of abuse, a desperate *need to act*, and of a desperate need for connectedness in an uncaring environment. The writing of it touched me profoundly. Those reading this story who have had any experience with women in prison will, no doubt, be sniggering at my profound naiveté and may be tempted to "try to sell me a bridge." I know that this story is somewhat skewed. I know that she slanted the details in her favor and omitted others that might prejudice me against her. But, understanding that, I still like her and respect her courage in telling me things that were hard to tell. If even half of this story is true (and I believe it is) then society does not deserve retribution from Lisa – Lisa deserves it from us.

Summary and Conclusions

This concludes the analysis of the data as it relates to the first research question addressing the name, the definition, and the evolutionary essence of what DSH is and is not from the participant's perspective. In this chapter, I also explicated the structural model of Needing to Act, a model that was grounded in the experiences of seven women in prison who self-harm. I explained how adverse events in childhood and adulthood laid the predisposing groundwork for the need to act in or act out. I described the emotional build up that precipitated the need to act and identified intervening variables that served to either ameliorate or exacerbate the need to act. The specific strategies for acting out and acting in were explained as were the consequences of acting out and acting in.

I took this model back to three of the participants in this study and asked them if I got it right. There was minimal verbal comment, but my explanations were met with many "yahs," "uh-huhs," and "oh, for sures." Each woman pointed out a piece or two of the model that did not quite fit for her, but generally, this model demonstrated face validity with the women. After I finished explaining the model to Angel, she paused for a few seconds and then responded: "I just hope you can help somebody with this thing." So do I, Angel. I hope that in the explaining of the process of *need to act* I can find a way to help somebody not to *need to act.*

It would be tempting to end the inquiry here. It would be clean and purely descriptive but grounded theory research does not allow cleanliness, precision, or mere description. It demands that the researcher look deeper into the data to uncover processes that integrate the multiple parts of the study into a logical whole. As Straus and Corbin (1994) point out, it is not enough to simply describe a phenomenon. A grounded theory researcher assumes responsibility for interpreting what is observed, heard, and read.

Mere description would also not do justice to the lives of these women or to the complex processes that lead to their criminal offending and to their deliberate self-harm. Therefore, Chapter V presents a theoretical model that addresses the interconnectedness of the crimes and the deliberate self-harm of the women in this study.

CHAPTER V

CREATING THE THEORETICAL MODEL

Introduction

Chapter IV addressed the three research questions of this study. Question one addressed the terms the participants used to refer to their DSH, the definitions and descriptions that they applied to DSH, and the attributes, antecedents, intervening variables, and consequences of their DSH. These theoretical codings are very similar to Glaser's six C's of Causes, Contexts, Contingencies, Consequences, Covariances, and Conditions (Glaser, 1978). These categories were compared to the evolutionary view of the concept of DSH that was outlined in Chapter II.

Research questions two and three were revised after the emergent data from the participants' interviews resulted in the need to refine the questions. Thus, the revised questions became: What are the processes of crime and DSH in incarcerated women? and How are they related? A structural model of the emergent core variable, *needing to act*, was developed in answer to these questions as an organizing framework and is depicted in Figure 5, as shown on page 94.

In this chapter, I will go one step beyond the structural model of Needing to Act and a grounded theoretical model will be explicated that combines

elements of the participants' data with the related theoretical and research literature discussed in Chapter IV. A schematic representation of the theoretical model is depicted in Figure 6 as shown on page 154. What follows in the remainder of this chapter is an explication of the schematic representation of Needing to Act.

There are, however, two caveats. First, this is an *introduction* to the theoretical model of Needing to Act. All of the propositions hypothesized here exist in this one moment in time among this particular population (women who self harm) which may not represent maximum variation of the population in other prison systems. Some may later be shown to be valid, others may not, and new concepts and propositions will possibly be added; qualitative research is a dynamic process. Second, a specific woman may not seem to fit neatly into one specific trajectory. The boundaries between the trajectories are probably quite blurred in reality. The last comment I will make before beginning my discussion of the model is that, as in Chapter IV, I have used the term acting out interchangeably with the term crime. The terms acting in and DSH have also been used interchangeably.

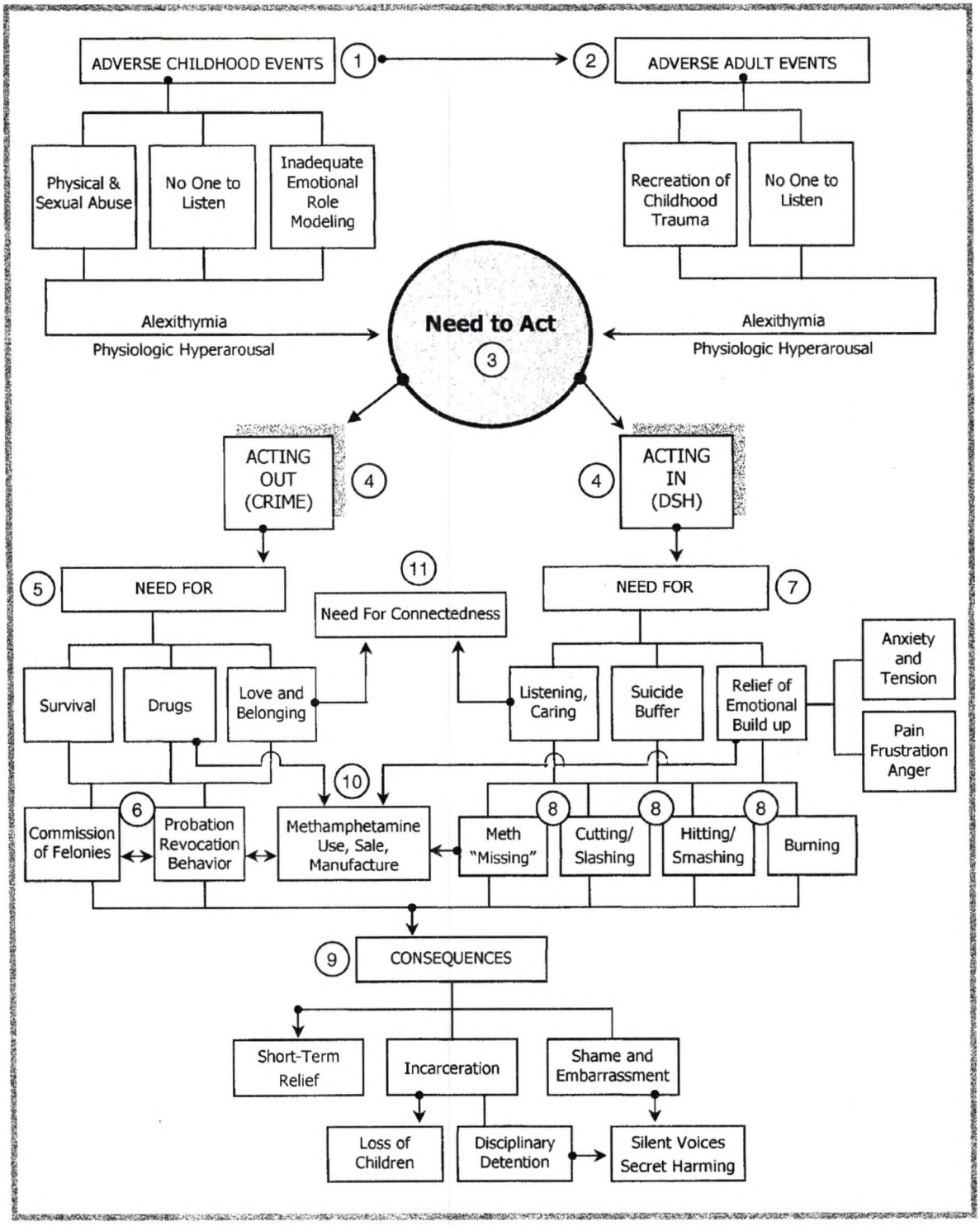


Figure 6. Theoretical Model of Needing to Act.

Explication of the Theoretical Model

Development of the Need to Act

The following statements are numbered to match the theoretical model and explicate the meaning of the model (Figure 6, page 154).

1. Children who are traumatized in childhood by physical and sexual abuse and by other adverse childhood events fail to develop emotional maturity. In the absence of adequate role modeling to assist in the identification and naming of emotions, traumatized children can only experience their emotions as a visceral sensation. This is a highly uncomfortable state of tension and physiologic hyperarousal. This is also supported by the work of Bloom (1997).
2. Children who grew up in an adverse environment tend to enter into relationships in their adulthood which recreate their childhood trauma. The volatile relationships into which they enter are characterized by the absence of anyone to listen which perpetuates the continuance of alexithymia and physiologic hyperarousal.
3. Placed in situations where adverse events build, and with limited emotional skills to mitigate the physiologic hyperarousal state, emotion is experienced both as a bodily sensation and an action tendency (Lane and Schwartz, 1987). A need to act develops.
4. In incarcerated women that enact DSH, the need to act manifests in two different trajectories. One is the acting out trajectory that relates to the

criminal behaviors. The other is the acting in trajectory in which deliberate self-harm behaviors are manifested.

The Acting Out Trajectory

5. The specific type of acting out behavior is motivated, at least in part, by a combination of any of these three things: the need to survive, the need for drugs (methamphetamine, in particular) and the need for love and belonging.
6. Regardless of the motivation, there are two general categories of acting out and methamphetamine use, manufacture, and sale play a pivotal role in each. The two general categories of acting out are, 1) the commission of felonies, and 2) probation revocation behaviors.

The Acting In Trajectory

7. Acting in behavior, manifested by DSH is motivated by a need for relief of *emotional build up* of tension, pain, frustration, and anger. When these emotions cannot be discharged by verbal expression in a caring, supportive environment, then relief is effectively accomplished by DSH. DSH, in some circumstances, provides the only mechanism for avoiding ultimate self-destruction and thus, DSH can be considered a suicide buffer. The need for a listening, caring person with whom to connect is also expressed by acting in behavior. Abject aloneness often results in using the body as a desperate cry for connectedness.
8. DSH behaviors include, but are not limited to, cutting and slashing the skin, hitting or smashing hands against walls, burning with cigarettes or

irons, and injecting the subcutaneous tissue with methamphetamine (meth missing).

The Interface of the Acting Out and the Acting In Trajectory

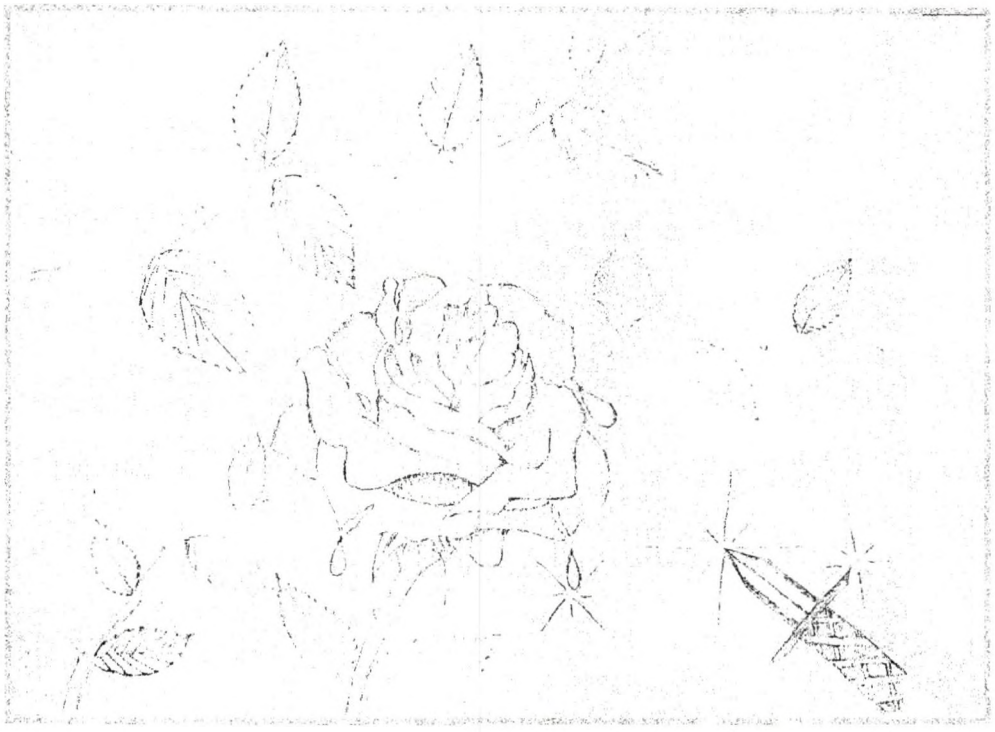
9. The acting out and acting in trajectory diverge at the point of *needing to act* and reconnect again in the form of shared consequences. The consequences for both acting out and acting in include short-term relief, loss of freedom, and a sense of shame and embarrassment. For acting out behaviors the consequence is short term relief followed by loss of freedom in the form of incarceration which results in the loss of their children. For acting in behaviors in the prison, the consequence is short term relief followed by disciplinary detention. Both acting out and acting in behaviors result in a sense of shame and embarrassment. For those who act in, the combined effects of fear of disciplinary detention, shame and embarrassment result in the silencing of the women who fear reprisal if they voice their need to act in. This same fear of reprisal, shame, and embarrassment result in secret self-harm that is not disclosed to others, especially the prison staff.
10. The unique relationship of methamphetamine to both crime and DSH provides another interconnection between these two trajectories. Because methamphetamine is the most easily accessible illicit drug and one of the less expensive, it stands out here as the current drug of choice. Methamphetamine addiction is one of the needs motivating crime such as theft. Methamphetamine manufacturing and selling and use are, in

themselves, a crime. Methamphetamine use is one of the methods of relief from tension, anxiety, pain, frustration and anger and is used as an alternative to DSH. The subcutaneous injection of methamphetamine can be used as a method of DSH.

11. The need for connectedness provides yet another interface between acting in and acting out. Women assist men in committing crimes in an effort to maintain their relationships with the men. Women "take the rap" for men who have committed crimes as an act of love. Through the use of their skin, women deliberately self-harm as voice their need for connectedness.

Conclusion

It is important to reiterate that the theoretical model of Needing to Act remains untested through empirical methods but this theoretical model provides some understanding of the complex and interrelated processes of incarcerated women who self harm. This concludes the discussion of the theoretical model of Needing to Act. The task of developing this model was arduous and true to the information shared by the participants. I am pleased with this outcome. However, I was humbled by a letter I received from Rose, one of my participants. She is currently in disciplinary detention for an act of DSH and, needing some diversion, she drew me a picture that represents her grounded theory of deliberate self harm. Her depiction of the rose as her symbol and her explanation of its symbolism is elegant and powerful. With her permission, I conclude this chapter with her drawing and her letter.



This is me in the middle. A beautiful rose in the middle of thorns. If you try and touch me, you'll just get hurt. (Too many thorns). You can only look at me, here all by myself. (There might be others.) The knife is how I show my feelings. Happy, sad, depressed, angry, and just a feeling of knowing the real. Five drops. Five feelings. Why knife helps me express feelings. It's a beautiful knife. If you look at the center, I'm still a rose with heart only. I'm wilted in spots but still beautiful to look at. Just don't touch. If you try, please be careful of thorns. They hurt. The knife meant to protect me.

Sincerely,

Me

CHAPTER VI

DISCUSSION OF FINDINGS AND IMPLICATIONS FOR ACTION

Overview of Chapters

This chapter summarizes the major findings, discusses the surprises in the study and the limitations, and addresses implications for action and for future research. The first chapter established that, although the exact incidence of DSH in incarcerated women is unknown, these behaviors are a significant health concern in a vulnerable population that is suffering on multiple levels. Up to 54 percent of incarcerated women may engage in DSH. It is a behavior that is shrouded in mystery and evokes powerful emotions in those who care for these women.

Chapter II contains a preliminary review of the current literature that was undertaken to facilitate the enhancement of theoretical sensitivity. The chapter was organized into two basic sections. The first section established that DSH is known by at least seven different names and is defined in divergent ways as well. Based on the review of literature, this unified definition was offered: A direct behavior that causes minor to moderate physical injury that is undertaken without conscious suicidal intent and that occurs in the absence of psychoses and/or organic intellectual impairment. The remainder of the literature review was

organized using the evolutionary view of concept development in which the most common attributes, antecedents, and consequences of DSH were identified.

Chapter III outlined the research methods designed to answer the research questions and to develop a grounded theory of DSH in incarcerated women. Issues of consent and confidentiality were discussed as they related to the particular vulnerabilities of incarcerated women. Methods for enhancing the rigor of the study were outlined.

Chapter IV contained demographic data of the incarcerated women who were the participants of the study and the best-fit description of the seven participants of this study is summarized here. She is a single, 31 year-old woman who is a mother of three children. She has earned a GED and has limited job skills. She spent her childhood years in adverse conditions and these same adversities followed her into her adult life. She began delinquent behaviors and self-harming behaviors at age 13 or 14 and carried these behaviors into adulthood as well. She is currently serving a sentence for a methamphetamine related crime and is back in prison after parole violations relating to methamphetamine.

Chapter IV also answered the first research questions which was: What do incarcerated women call this behavior, how do they define it, and of what does it consist? Details addressing each of the three components of this question are summarized here.

For the most part, the women of this study had no particular name for this behavior and felt it should be called just "cutting" or just "relief." One participant

named it "deliberate self-help." A composite definition of DSH derived from their responses was: DSH is a *need to act* to externalize and escape overwhelming emotional pain through the substitution of physical pain by inflicting some manner of non-lethally-intended physical wounding.

The evolutionary components (attributes, antecedents, and consequences) of DSH were described in order to answer that part of the first research question which asked, "of what does it consist?" The majority of the attributes, antecedents, and consequences of DSH found in the women of this study were consistent with those found in the literature review. Many of the attributes, antecedents, and consequences of DSH were also found to be the same for criminal offending in these women. These items provided the "stones", neatly categorized by color, that were then reassembled in Chapter V into the mosaic that became the grounded theoretical model of Needing to Act.

The remainder of Chapter IV explained the structural model of Needing to Act that emerged from the data of the seven participants of the study. Adverse childhood and adult experiences provided the precipitating factors and adverse emotional experiences provided the precipitating impetus for the women of this study to either act out (commit crimes) or act in (deliberately self-harm). This need to act became the core variable of the study. Several intervening conditions were identified that impacted the nature and the extent of acting out or acting in these included the influence of children, of methamphetamine, and of a listening, caring support system. Three common consequences of acting in and acting out emerged from the data. These included short-term immediate relief,

punishment, and embarrassment/shame. The consequences of acting in also included a cleansing of "the bad stuff" and a prevention of suicide.

In Chapter V, the grounded theoretical model of Needing to Act was revealed. The theoretical model combined elements of the participant's data with related theoretical and research literature that was discussed in Chapter IV. The theoretical model explained the development of the *need to act*, the acting out trajectory, the acting in trajectory, and the interface of the two.

Surprises of the Study

I was surprised by several understandings that emerged during the course of the study. The first was that the women's prison was a place with a mission and activities geared towards correction and rehabilitation, not just punishment. The women of this study and those that I observed during my time at the prison were involved in therapy groups, vocational training, anger management classes and many other teaching and corrective activities. In addition, the small, rural community in which this prison is located is a strong supportive presence in this prison. Volunteers from this community offer Bible studies, Alcoholics Anonymous groups, parenting classes and several other supportive groups and activities. The prison in which this research took place has been a political "hot potato" and the legislature has struggled with concerns regarding costs and cost-overruns for this facility. I am well aware of the budgetary constraints under which the prison labors. Despite this, I was impressed by the efforts of the prison and the community to provide tools and skills to increase these incarcerated women's chances of survival after they are released.

Another surprise was the willingness of the women to talk with me and the generally apparent veracity of what they told me. They were open with me about their criminal offending and accurately portrayed their crimes, sentences, and mental illness history. I asked the prison social worker and the nurses to verify these items for me and there was consistency between what the participants said and what the social worker and nurses reported.

I was surprised by the degree that methamphetamine presented as a problem in these women and in the prison in general. I was also surprised by its unique relationship to both acting out and acting in. It was the primary reason for the incarceration of four of these women and was a factor in the probation revocation of all of them. Methamphetamine was also used as a form of acting in. One of the participants wounded herself by injecting methamphetamine into the subcutaneous tissue. Methamphetamine also served a deterrent to acting in by providing an emotionally numbing effect that substituted for the need to self-harm.

I was surprised to learn that the women of the prison are allowed to have razors and that they were sold in the commissary. When I inquired of the warden why this was so, he stated that it is routine for prisons to offer these items but he was looking into the possibility of replacing razors with electric shavers.

The last surprise that I uncovered is a little known provision in the 1996 federal Work Responsibility and Personal Responsibilty Act (welfare reform) that prohibits those who have been convicted of drug-related felonies from receiving public benefits (Acoca, 1998, Pollack, 2004). Ironically, this law bars assistance

to women with a drug violation, but an offender with the violent crime conviction is still eligible. Obviously, this law has profound effects for many women leaving prison with a drug conviction and severely compromises their efforts to make a new life for themselves and their children. Lisa has great hope of reuniting with her son after her release but does not know how this will be possible once she is released. She is worried about the loss of benefits and stated: "I'll live in a dumpster, I don't care, as long as my boy is alright. But, how am I gonna get my boy? If I'm living in a dumpster, OK, 'Hop into the other side of the dumpster there, buddy.' I can't do that."

Part of me can relate to the logic of this law. I am sick of crime, sick of drugs, and I particularly loathe what is happening in society today with methamphetamine. But, loss of assistance and welfare benefits will have a profound effect on these women. A measure that was intended to curtail crime may well have the opposite effect. As Lisa said: "I'll do whatever it takes, and if that includes selling drugs, I'll do it...but, boy, I never, ever want to be in that position." With no help out there and no one to listen, the adverse adult events and the adverse emotional events will mount. We are setting these women up for a desperate need to act, and this research clearly points to the directions that this need to act will take.

Limitations

Limitations of the study design were addressed in Chapter III but I would like to briefly address two other limitation of this study, one being the limited number of participants and the other, the homogeneity of the sample. The

nurses were able to identify only seven participants who clearly met the criteria for inclusion in the study. I asked the participants how many women engaged in DSH in this prison. Their answers ranged from 60 percent (three out of five) to 90 percent. It appears that DSH is a frequent underground behavior in this prison and one of which the correctional and health care staff are unaware. I was reluctant to pursue the identification and potential inclusion of these women in the study because I was aware of the risk for punishment that might ensue if it became known that these women were self-harming.

Another limitation concerned the fact that there was little variation in the participants and they constituted a remarkably homogenous sample. If I were to continue this study, I would revisit the women who I was unable to see the second time and elicit responses geared towards looking more closely for differences.

Although only seven women took part, I did get a sense that data saturation had occurred though the repetition of themes. There was remarkable consistency in the data and I am comfortable that the grounded theoretical model emerged from the data. In several areas, my inability to re-interview three of the women resulted in a compromise of the richness of the data. There were areas where participants noted the presence or absence of a certain component of the model but did not elaborate. Had I been able to re-interview the three women who were in "the hole," I may have been able to elicit more anecdotes and details to support the model. I was able to visit with two of the participants who were in "the hole," but I was not alone with them and there was a door separating us with

only a small, glass window through which to interact. It seemed inappropriate to try to get my data collection needs met at that time, and our brief interaction time was spent talking about things of importance to them.

Implications for Action

Several implications for nursing care of the incarcerated women who self-harm came to light as a direct result of this research. I will begin this discussion with two approaches to the treatment of those who self-harm that will NOT work in the prison, those being punishment and allowance of delicate cutting. DSH serves a purpose for the women of this prison and simply forbidding it or harshly punishing it may lead to more drastic acting out or acting in behavior. DSH, according to the participants' own definition, is a coping mechanism and taking that away without providing alternative ways of coping can only increase the desperate need to act.

Crowe and Bunclark (2002) recognize the important self-preservation function that DSH can have and advocate a treatment approach that is based on harm minimization or allowance of delicate cutting rather than abstinence. They try to tolerate self-harm within limits. Given that the women in this study appear to have an innate, hardwired inability to control their hyperarousal and their need to act, this may not be the safest route to take in a women's prison. DSH can be viewed as an extreme response to extreme circumstances and, given the extremity of their circumstances, it might be too risky to casually allow for what might become an extreme act. Recall that two of the women of this study considered a cut requiring eight stitches to be a relatively minor injury. Therefore,

although allowing for delicate cutting may be an intriguing treatment idea, it may be too risky in a women's prison.

What is needed, first, and foremost, in the women's prison environment is to "decriminalize" DSH. The very worst thing to do for a woman who self-harms is to throw her in isolation. Careful assessment by the nurses is a necessary first step to distinguish between DSH and suicide attempts, neither of which should be considered a disciplinary issue. The burden of accurate assessment is a heavy one but, fortunately, there are several clinical aids that assist in making this distinction. Standard suicide assessment tools are available to assist in determining the degree of suicide intent and safety risk. Kress (2003) stressed the importance of a thorough suicide assessment in those who self-harm. Lacking in assessment tools to directly assess for DSH, if one can rule out suicide ideas and intent, then it is likely that the self-harming behaviors that the person is demonstrating are DSH. In this way, suicide assessment scales have some utility in determining DSH by default.

Gratz (2001) developed a scale to measure DSH – The Deliberate Self-Harm Inventory (DSHI). There is some preliminary psychometric data suggesting the reliability and validity of this scale. The DSHI provides for assessment of the presence and frequency of self-harm and asks in several different ways, if the intent was or was not to kill oneself. While principally designed to provide a standardized, empirically validated measure of DSH for research purposes, this scale could be adapted to facilitate assessment of DSH in the prison and other institutions.

If an incident of self-harm is determined to be a suicide attempt, suicide precautions and standard procedures for therapeutic crisis intervention should be instituted. If the self-harm episode was clearly not a suicide attempt- what then? Unfortunately, the literature provides little help for this question. Hawton, Arensman, Townsend, and Bremner (1998) conducted a systematic review to determine psychosocial and pharmacological treatments for patients who had recently self-harmed and found insufficient evidence on which to make recommendations. They found one study with promising results using problem-solving therapy. While it makes intuitive sense that this type of therapy might be effective for some who self-harm, given the extreme nature and extent of the problems of these women and their inherent powerlessness to do anything about them, I wonder if it might be asking too much of problem solving therapy.

Dialectical behavior therapy (DBT) has been used for borderline women who self-harm with some promising results but the studies cited by Hawton and colleagues (1998) included too few subjects to have the statistical power to detect clinically meaningful differences between the treatment and control groups. Roth and Presse (2003) described their program for female offenders who self-harm that successfully utilizes DBT (much like cognitive behavior therapy). Their Intensive Healing Program utilizes various activities for teaching and role modeling the transforming of thoughts and behaviors. This program is delivered by an interdisciplinary team. Each individualized program for change is headed by a primary therapist who works with the inmates to design their own change process.

Alper and Peterson (2001), using a program similar to the one outlined above, showed that DBT can be effective. The institution of their program resulted in a reduction of DSH by 50 percent over a four-month period. Conversely, Tyrer and colleagues (2004) found no greater efficacy in their DBT trial than in the control groups. Therefore, in the face of conflicting findings, and in consideration of the labor-intensiveness, and consequently, the costliness of DBT, it may not be a feasible option for the self-harming women of this prison at this time.

Rothe and Presse (2003) outline a protocol that, along with DBT is part of their unified program for preventing DSH. This protocol provides some guidelines for nurses working in prisons, and I will point out some of these items here because they seem to fit with the grounded theoretical model of this study. Item numbers 1 thru 5 were identified by Rothe and Presse. I added item number 6 which seems to make sense for this population.

1. Inmates are expected to inform staff immediately if their DSH urges are becoming difficult to manage. Staff then will have the opportunity to provide a listening ear in a non-punitive way and can intervene to maintain the inmate's safety. Alternative ways to defuse emotional build up can be discussed.
2. If a DSH incident occurs, inmates are required to hand in any item used for DSH, as well as any items stored away for future use.
3. Following an act of DSH, first aid or more detailed care should be given in an efficient, detached manor. Psychiatrists should not

prescribe additional medications at this time. These interventions and their accompanying attitudes are designed to prevent DSH from having any secondary gains.

4. After a self-harming incident, the inmate is required to provide a verbal or written commitment that she will not continue to self-harm. If she is unable to make this commitment, she should be placed in a close observation room for her own protection-either willingly or against her will. Using this protocol, the DSH act is not punished except when resistance is occurring. An act of DSH may result in no punishment and resumption of normal activities unless the inmate cannot commit to no further DSH. In this case, detention ensues, but it is clearly safety motivated rather than punitive.
5. Within 24 hours of the DSH incident, the inmate must complete a behavior change analysis. It is this point that has particular relevance to the model of acting in and acting out. The inmate must consider the entire incident in detail, including precipitating factors and triggers (adverse emotional experiences) that resulted in a need to act. Alternative strategies that could have been used are also identified. This analysis could then be discussed with the nurses providing opportunity for a listening ear and for the inmate to practice skills in identifying feelings that contributed to the need to act. In terms of the theoretical model of Needing to Act, this part of the plan provides for someone to listen and for the assistance in finding words to say it.

6. [My addition]. Allow no razors or razor blades in the prison. Electric razors should be provided.

Education of the nurses in the prison would be the first step to instituting this plan. The nurses, who are highly respected in the prison, could act as change agents. An important initial task of theirs would be to educate the prison staff regarding the true nature of DSH. Moving away from the perception that DSH is manipulative behavior would assist the staff to accept a more gentle and humane approach to its treatment.

It is likely that more women will report the urge to self-harm and that a higher recorded incidence of DSH may occur after the institution of this protocol. Care must be taken to reassure the staff that the actual incidence of DSH has probably not increased, only the women's honesty in reporting it has. The women of the study repeatedly commented that the best thing that the prison nurses could do to help them was to "just listen." This simple protocol gives the nurses permission to "just listen" and the women permission to "just talk" without fear of reprisal. The therapeutic value of this is underscored by Rose's letter and artwork. After being given the opportunity to talk about her deliberate self-harm, she was able to express it and conceptualize it in the form of art and writing. To conclude this section, the plan outlined above may be an effective and manageable protocol for caring for those women who feel the impending need to self-harm or who have recently self-harmed.

Implications for Future Research

The following recommendations for further research were gleaned from the review of literature and from the model itself. First, in light of the definitional ambiguity that still shrouds the concept of DSH, the continued development of a reliable and valid instrument to measure DSH would do much to standardize the construct and to provide continuity in what is actually being measured. The construct of DSH needs to be standardized before research in this area can advance.

Second, the relationship between DSH and methamphetamine needs to be further explored. Methamphetamine played an intricate and interwoven role in the acting out behaviors of the women in the study but also seemed to influence the nature and extent of DSH.

Third, alexithymia appears to be evident in these women but was not clinically assessed. Alexithymis has been shown to be an etiological factor in eating disorders, substance abuse, and in various somatic illnesses (Graeme, 2000, Petterson, 2004). The development of alexithymia has also been correlated with childhood adversities (Kooiman, et al., 2004). A more formal assessment of alexithymia in women who self-harm may shed some light on the role that this construct may play in both acting out and acting in.

Finally, the efficacy of dialectic behavior therapy as a treatment for DSH needs to be further explored and the possibility of expanding its use in acting out as well as in acting in should be considered.

Conclusion

This study has addressed a distressing topic in an uncomfortable environment. The choice of this topic for my dissertation research was a source of puzzlement for some of my friends and colleagues. As Watterson (1996) pointed out, "crime makes most of us so angry that we don't want to think about the people committing crimes as human beings with problems" (p. 19). If they cut, we are tempted to say, go ahead, just cut a little deeper. In fact, a prison nurse once told me he would be glad to show a self-harming prisoner how to do it the right way.

For the women in this study, there exists a blurred boundary between their victimization and their offending. These women committed crimes for which they must pay, but as Lisa lamented, do they have to pay forever? It is my hope that this dissertation can, in some small way, advance the understanding that acting out and acting in behavior is a response based on the need for these women to survive under adverse conditions not completely of their own making. Marginalized outside of conventional society, these women reacted outside of legitimate enterprises. The process of *acting out* and *acting in* is simply a response to being denied the physical or psychological resources to *act on* situations by appropriate means.

Straus and Corbin (1998) likened "process" to a piece of music. "It represents the rhythm, changing and repetitive forms, pauses, interruptions, and varying movements that make up sequences of action/interaction" (p. 164). If the process of *needing to act* is music, then it is a sad song that is filled with

turbulent crescendos and discordant arpeggios in a complicated minor key. But, underneath the discordant notes is some beauty and some hope for harmony. To continue with the musical metaphor, in a way, the development of this grounded theoretical model is my opus, but I take little credit. The women of this study sang the song, I just wrote it down.

APPENDICES

APPENDIX A
INFORMED CONSENT

Informed Consent

I have asked you to be a part of a research project with me. I am Jackie Mangnall. I am studying self-harming behaviors for my doctoral degree. I am a nurse and I also teach nursing. Through this study I hope to learn what this behavior means. I also hope to learn how you deal with it. This subject was selected because I want to know how I can be more helpful to women who self-harm. I also want to help other nurses to understand what self-harm is.

If you agree to talk with me it will take about 1 to 11/2 hours. I may also need to meet with you again as I learn more about self-harm and have other questions. Finally, I may meet with you a third time to show you what I have learned. This research will take place from December 2005 to May, 2006. In those eight months, I may need to meet with you one, two, or three times.

These interviews will be taped. Then they will be typed out word-for-word by me or by my typist. What you have told me will be kept confidential. Code names will be used and your real name will never be used. No one will be able to identify you in anything that I may write about this research.

I am aware that telling your story might be difficult. I will treat what you tell me with great respect. I will listen with understanding. I am not a therapist. I am in no way qualified to provide counseling. If you or I determine that the interview is causing you to be very uncomfortable, I will stop the interview. I will refer you to the prison counselors. You do not have to answer any questions that you do not want to. You can end the interview at anytime. Nothing will happen if you decide not to continue to talk to me.

Being a part of this study may or may not provide any direct benefit for you. It may, in the future, help someone else with problems like yours. It may be helpful to you to have someone listen and learn from you. I cannot pay you for this. I can only say thank you. There will be no cost to you.

Any data that I obtain in this study will be kept confidential. It will be shared only if you say so. There are several exceptions to this. I will tell the prison staff if you tell me that you are planning to escape. I will tell the prison staff if you tell me that you intend to kill yourself. I will tell the prison staff if you tell me that you intend to harm someone else.

I am required by law to report child abuse or abuse of mentally ill or developmentally disabled persons. If I have a reasonable cause to believe that previously unreported abuse of any of the above persons is occurring I must comply with state law and report this to the appropriate human service agency.

The data will be kept in locked file cabinets in my office. The data will be kept for at least three years. Then the data will be shredded. Only my advisor, my typist, the people who oversee my research, and I will see the data. Only I will know your real name if you choose to give it to me.

Being a part of this study is voluntary. You are free to stop at any time. Your decision to be or not to be involved in this research will have no effect on your parole.

I will answer any questions you have about this research. I want you to ask any questions about this research that you may have in the future. Questions may be asked by e-mailing me at mangnall@jc.edu. You may call me at 701-252-3467, extension 2497. You may also contact my advisor, Dr. Eleanor Yurkovich at 701-777-4554. If you have any further concerns please call the UND Office of Research and Program Development at 701-777-4279.

I have read all of this consent form. I have had all of my questions answered by Jackie Mangnall. I agree to be a part of this study.

You will receive a copy of this consent form and a report of the research findings if you want it.

INTERVIEW GUIDE

Background Information

Date and Place of Birth:

_____

Ethnicity:

_____

Relationship Status: ☐ Single ☐ Married ☐ Divorced

Number of Children _____

Level of Education:

_____

Employment History:

_____

_____

Criminal History

"Would you mind telling me a bit about your most recent conviction, the one that brought you here?"

What have you been incarcerated for?

_____

_____

Is this your first incarceration? ☐ Yes ☐ No

How much time have you served on your sentence? _____

How much time do you have left to serve on your sentence? _____

Psychiatric and Substance Abuse History

"Many incarcerated women have had experiences of abuse at some point in their lives. If you are willing, I would like you to share some of this information with me."

Have you ever experienced Physical Abuse? ☐ Yes ☐ No
Emotional Abuse? ☐ Yes ☐ No
Sexual Abuse? ☐ Yes ☐ No

What was the abuser's relationship to you?

At what age did this abuse begin to occur?

How often did this abuse occur?

For how long did this abuse happen?

"Many incarcerated women have had problems with chemical abuse of some kind. These questions will address this issue."
Prior to incarceration did you use or abuse any chemical substances? ☐ Yes ☐ No

Do you think your chemical use contributed in any way to your crime?

Please explain

Do you think your chemical use contributed in any way to your self-harming behaviors?

Please explain

"Many women who self-harm have been given a psychiatric diagnosis."
Have you ever been diagnosed with a psychiatric illness? ☐ Yes ☐ No

If so, what was your diagnosis?

What treatment did you receive for this diagnosis?

Would you ever describe yourself as depressed? ☐ Yes ☐ No

Would you ever describe yourself as nervous or anxious? ☐ Yes ☐ No

Would you ever describe yourself as disconnected, floating, or unreal? ☐ Yes ☐ No

Would you ever describe yourself as having no feelings at all? ☐ Yes ☐ No

Research Question # 1: What do incarcerated women call this behavior, how do they define it and of what does it consist?
Describe your current self-harming behaviors.

What do you call your self-harming behavior? What do you think it should be called? (DSH? Self-mutilation? Parasuicide?)

How often does this occur?

Is it ever your intent to kill yourself when you engage in this behavior?

How often did it occur before you were incarcerated?

Describe how you feel prior to engaging in a self-harm behavior.

Describe how you feel while you are engaging in self-harm behavior.

Describe how you feel after the self-harm behavior.

What functions does your self-harm serve for you?

Based on what we have talked about here, how would you define your self-harm behaviors?

Research Question #2 – What role does DSH play in the women's entry into the criminal justice system and into prison?
Can you describe for me any ways in which your DSH behavior influenced or affected your criminal conduct and/or becoming incarcerated?
(Examples: related to drug use? Related to relationship difficulties? Related to violence against others?)

Research Question #3 – How does the prison experience impact the nature and extent of DSH?
More DSH? Less DSH? Different DSH?

Reaction from the prison staff.

Reaction from the health care staff.

Reaction from other women prisoners?

Eliciting the Participants' Suggestions
"You are the expert on this experience and so if you had one piece of advice for how corrections could help women who deliberately self-harm, what would it be?

What would you want health care providers and the rest of society to know?

Conclusion
Is there anything else you would like to talk about? Anything more about this subject that you think I should know?

Do you have any questions about the interview or anything else?

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