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Charting A Path From Data To Action: A Culturally Sensitive Intervention For Adolescent Self-Harm In Sri Lanka

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CHAPTER 11

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Sri Lanka, formerly Ceylon, is a small island nation off the south-east coast of India. With a population estimated at 20.5 million, it is home to people of four of the world's major religions (Buddhism, Hinduism, Islam and Christianity) and whose ancestry ranges across much of the globe. The country's religious, linguistic, and cultural diversity reflects the wide range of those who have travelled to Sri Lanka over the centuries as religious emissaries or seekers, traders, conquerors, or colonizers. Colonization by European powers began in 1505 and lasted until 1948.

The end of the colonial era brought about dramatic changes in Sri Lanka. I focus on one such change, the beginning of a precipitous increase in deaths by suicide in the half-century following its independence from Britain. In particular, the period from the late 1970s to the mid-1990s witnessed a dramatic rise in self-inflicted deaths. At the peak in 1995, Sri Lanka recorded what was claimed to be the highest rate of suicide in the world – nearly 48 deaths per 100,000 (Levi et al., 2003). This represented an increase of more than 700 per cent since 1950.

Many ideas have been advanced concerning the factors that might have pushed up the rates of self-inflicted death, most of them pinpointing economic, social and material factors that have destabilized social life. For example, post-independence Sri Lanka has been rocked by repeated episodes of violent civil strife, armed militancy and state repression, which have eroded village and family solidarity and stability (Argenti-Pillen, 2002). Also, a sweeping and abrupt 'liberalization' of the economy following the change of government in 1977 triggered a sharp decline in the economic prospects of the agricultural sector (a sector that comprised much of the population in rural areas). Moreover, large-scale internal migration into newly

irrigated lands in the 1980s produced high rates of suicide in the new settlement areas (Kearney & Miller, 1987). More proximal factors include increasing exposure to modernization and westernization, possibly leading to intergenerational struggles and other familial conflicts. Lastly, at the most concrete level, the late 1970s ushered in widespread use of imported chemical pesticides in farming. From then onwards, most farm households had an agent of self-harm that was both lethal and within easy reach. All of these factors may have contributed in some way to rising rates of suicide and self-harm; however, how these factors give rise to specific local situations or personal motives behind self-harm and suicide needs examining.

Today, the incidence of death by suicide has diminished from the peak level of the mid-1990s, although it still remains far higher than the 1950 level and roughly twice as high as in the United Kingdom or the United States. Moreover, nonfatal self-harm has been noted as a significant problem by medical personnel, public health officials, and psychosocial researchers. I use the term nonfatal self-harm in preference to the terms attempted suicide or suicide attempts because there is ample evidence that, in the Sri Lankan context, many (perhaps most) of such episodes are not intended to lead to death (Marecek, 2006; Widger, 2010). There are no national data regarding the incidence of nonfatal self-harm. Indeed, even local data, which are culled from hospital records, are imprecise because individuals whose episodes do not demand medical treatment (for example, attempts at drowning, hanging, or self-immolation that are interrupted by onlookers) are not brought to professionals' attention. Based on a set of admissions data for hospitals in one district in Sri Lanka, the South Asian Clinical Toxicology Research Collaboration (SACTRC) estimated that the rate of self-harm (fatal and nonfatal) was 1268 per 100,000, with a nine-to-one ratio of nonfatal to fatal cases (P.V.P. Chatura Palangasinghe, personal communication, May 2009).

Needless to say, suicide and self-harm engender considerable personal and familial distress and turmoil. In addition, they often lead to financial hardship, shame and loss of honour for the individual and the family. Communities often shun households in which a suicide has taken place, and victims and their family members may suffer taunting and humiliation (Marecek & Senadheera, in press). Moreover, the large caseloads of self-harm patients burden the already overburdened health care system. One study, for example, reported that 41 per cent of patients in the intensive care unit of a large rural hospital had been admitted for pesticide poisoning; in all but a few cases, the poisoning was intentional and self-inflicted (Eddleston, Rezvi Sheriff, & Hawton, 1998). More recently, a researcher who analysed the treatment regimens necessary to manage deliberate paracetamol overdoses declared that the expense incurred was 'colossal' (Ariyananda, 2010).

A closer look at the data shows considerable difference in the incidence of suicide and self-harm among groups differing by age, sex, religion and region. Although the official statistics do not permit direct urban-rural comparisons, it appears that the rate of suicide is higher in the countryside and rural towns than in the country's two large cities. The data regarding sex differences in suicide cases reveal a complex pattern, with sex differences varying dramatically over the age span. Based on the 2007 countrywide data, most of those who died by suicide were men, with a male-to-female ratio of 3.47:1 (Sri Lanka Police Service, 2007).

However, among young people (aged 20 and under), the male-to-female ratio was only 0.76:1, a dramatic reversal of the overall sex difference. Put another way, suicides committed by young women (those 20 years old or younger) accounted for roughly 25 per cent of the total of women's suicides; in contrast, suicides committed by young men (those 20 years old or younger) accounted for only 6 per cent of men's suicides. We do not have evidence about national patterns of nonfatal self-harm. However, it appears that young people (adolescents and young adults) and women comprise a disproportionate number of cases of nonfatal self-harm.

My colleagues and I have been interested specifically in young people's self-harm. We studied patterns of admissions for self-harm over a seven-year period (from 2001 to 2007) in a large hospital in the south of Sri Lanka. The hospital records showed that among adolescents, girls outnumbered boys by three to one (Senadheera, Marecek, Hewage, & Wijayasiri, 2010), with the rates for girls increasing among older girls. Very few of these adolescents (only about 3 per cent) died. The same study showed that the number of adolescents admitted to hospital for self-harm increased by 91 per cent between 2001 and 2007; unpublished data for 2008 and 2009 show that the high rates have persisted. We have few explanations for this striking increase; we are currently studying this question.

Self-harm – in particular, nonfatal self-harm – among young people has become an urgent public health problem. I often lecture about suicide and self-harm to students of medicine, sociology and psychology, as well as to groups of lay counsellors and psychosocial practitioners. As I speak with these audiences, they invariably express the need to move beyond collecting information to making change. In this chapter, I describe a first attempt to design an action programme that is based on empirical evidence specifically from Sri Lanka. The programme draws upon research on the social, cultural and interpersonal dimensions of self-harm among Sri Lankan (primarily Sinhala) adolescents.

Every social group has a stock of narratives that its members draw upon to understand themselves and others and to organize their actions. In Western high-income countries today, the dominant narrative for explaining and responding to psychic suffering is the medical narrative. The medical narrative of suicide links it to mental illness, most often to clinical depression. Indeed, the suicide-depression link seems so self-evident to many Western mental health professionals that it is usually presumed to be universal.

The notion that suicide and nonfatal self-harm arise from mental illnesses (or even that they are forms of mental illness) – though it may seem self-evident in the United States or the United Kingdom – does not hold sway in the cultural imaginary of Sri Lankans. Neither ordinary people nor medical professionals in Sri Lanka regard suicide and self-harm as *ipso facto* indications of mental disorder or psychiatric illness. Nor are suicides and nonfatal self-harm closely linked to depression or any other psychiatric condition in actual practice. The conventional medical management of self-harm bears this out. In hospitals with psychiatric services, for example, very few self-harm patients (roughly 4 per cent) are referred for psychiatric evaluation or treatment (Kathriarachchi & Manadu, 2002). In a study of 97 patients hospitalized for self-poisoning, researchers diagnosed fewer than 14 per cent with a psychiatric condition (Hettiarachchi & Kodituwakku, 1989). Furthermore, episodes of self-harm – even those involving potentially lethal means

such as self-immolation – are brought to medical attention only when treatment for physical injuries is required (Marecek & Senadheera, 2008).

If suicide and self-harm are not understood and treated as psychiatric conditions in the Sri Lankan cultural context, what meanings do they have? Most previous studies have relied on the 'confessions' forced out of patients by hospital staff, survey-style questions with cut-and-dried response categories ('How many minutes did you spend thinking about self-harm before you did it?'), or generic symptom checklists developed for Western populations. With Sri Lankan colleagues and students, I have sought instead to understand young people's reasons for and experiences of self-harm and suicidal behaviour, as they express them in their own words, and to situate their actions in the context of their social relations and larger societal and cultural forces (Marecek, 2006; Marecek & Senadheera, 2008; 2009; in press; Senadheera, 2010; Senadheera et al., 2010).

The action programme described below rests primarily on a series of studies conducted by Chandanie Senadheera and me. In one study, we studied 60 adolescents hospitalized for self-harm and then separately interviewed each child's mother. In another study, we interviewed 50 self-harm patients in the hospital and then conducted follow-up interviews in their homes four to six weeks later. We made use of semi-structured interviews, with open-ended questions, a method that yielded rich, complex, and highly personal stories. Our analyses focused on the social ecology of self-harm. We looked closely at the conflicts, crises and relational impasses that preceded adolescents' self-harm, the organization of self-harming behaviour, the patterned ways that adolescents described the feelings and thoughts (or lack thereof) that accompanied self-harm, and the responses of others when adolescents were discharged from hospital and resumed their lives. Not surprisingly, the stories were often self-contradictory. Moreover, there were some characteristic disparities between the accounts given by self-harming adolescents and those given by their parents. Analyzing such narrative patterns offered further insight into the painful process of coming to terms with one's own self-harm and into the cascade of stresses, strains, and anxieties that self-harm unleashes on families.

Our research and others' research point to a cultural pattern of suicidal and self-harming behaviour that I have elsewhere termed a 'dialogue suicide' (Marecek, 2006). In Sri Lanka, nearly all self-harm episodes erupt amidst acute interpersonal conflicts involving close family members or spouses. Among the adolescents we studied, these conflicts were usually with their parents; occasionally an older sibling or an aunt or uncle was involved. In many of the conflicts, the adolescents were scolded harshly or beaten; sometimes their belongings (such books or cell phones) were destroyed. The feelings associated with self-harm included humiliation, shame, disappointment in others, frustration, anger mixed with sadness and a desire for retaliation. As with adults in Sri Lanka, the adolescents' self-harm was usually more or less unpremeditated. They typically reported that they had contemplated self-harm for only a short time (a few hours or even mere minutes). The adolescents usually made few efforts to conceal their actions. In fact, many directly informed others (including the person who had offended them) shortly before or immediately after taking action. In some instances, the self-harming act was carried out in the presence of parents, siblings, or other onlookers. To sum

up, the self-harm episodes of the adolescents we studied typically were precipitous acts undertaken in times of high negative emotion. They were directed towards specific others and served as a potent (albeit silent) expression of grievance and anguish, as well as an overt but silent way to blame and shame an antagonist.

What Next? Taking Action

How could the emerging research findings be put to practical use? Although there are many implications for counsellors or family therapists, there is little or no scope outside Sri Lanka's capital city, Colombo, for psychotherapeutic interventions following self-harm. Hospital stays for self-harm patients are brief, averaging about three days. Patients stay on medical wards, not psychiatric wards, and their care is strictly limited to biomedical treatments for physical injuries. Families of patients manage self-harm episodes in culture-specific ways. For example, they may mobilize the support of extended family members or force the patient to marry. Many families seek professional help from astrologers or soothsayers in order to learn more about negative forces (e.g. bad planetary influences or ensorcellment) acting on the patient. Buddhist families usually arrange for a ***Bodhi-puja***, a propitiatory ritual that includes lighting coconut-oil lamps to avert the negative influence of inauspicious planetary conjunctions. Neither patients nor their families see a need for professional mental health care or for Western-oriented counselling. Indeed, in our hospital-based sample, in the few instances in which psychiatric referrals were made, patients and their families refused them.

We turned our attention from psychotherapeutic interventions to developing an action programme focused on prevention. A number of avenues of prevention have been tried previously. Among them are programmes that endeavour to promote the safe storage of pesticides by providing rural households with double-locked boxes (e.g. Hawton, Ratnayeke, Simkin, Harriss, & Scott, 2009). Important though it is to limit access to pesticides, it seems doubtful that locking away pesticides is sufficient to deter self-harm. Our data and those of others indicate that many poisonous substances are ingested in self-harm episodes, many of which (e.g., toilet cleaner; washing powder; veterinary medicine) are in everyday use. Moreover, our data indicate a recent shift away from the use of pesticides to the use of overdoses of medicine, especially paracetamol. Paracetamol is readily available in village shops and many medicines can be purchased without prescription. Moreover, it is not practical to expect families to keep medicines in daily use (blood pressure pills, diabetes medication, or contraceptives) in a double-locked strong box. Another avenue of prevention has been an effort to establish centres staffed by volunteers who offer supportive listening to troubled individuals. Located in cities and large towns, the centres offer drop-in counselling, counselling by mail and counselling by telephone. Although these programmes meet important needs, they cannot address the needs of all. For example, they are unavailable to most rural dwellers, the group whose risk of suicide and self-harm is the highest. Nor can they reach those whose decisions to harm themselves are spontaneous. Yet another avenue of prevention involves 'suicide awareness' programmes conducted by lay volunteers who use materials imported from Western high-income countries.

These programmes centre on decision-making skills, self-esteem, depression, drug use and coping. But although these topics may be relevant to Western teenagers, there is no evidence of their relevance in rural Sri Lanka. Neither clinical depression nor illicit drug use, for example, is common among Sri Lankan adolescents. The notion of promoting high self-esteem garners little favour in Sri Lanka; in fact, Sri Lankans place more emphasis on cultivating *lajja* – modesty, self-effacement, reticence and a proper degree of shame – in their children, especially their daughters.

The programmes I have just described not only tend to be Western-centric in their content, but also focus narrowly on the individual and try to correct deficits that are presumed to leave individuals vulnerable to self-harm. In contrast, our aim was to develop an action programme that focused more broadly on changing the culture of self-harm. In addition, we sought to develop an action programme that was based directly on the knowledge we had gleaned from our empirical studies of the social ecology and culture-specific meanings of adolescent self-harm *in Sri Lanka*. We were also committed to respecting the sensibilities, norms and values of rural communities. This turned out to be more difficult than we had imagined, because we found that adolescents' self-harm touched upon an array of social practices, such as childrearing, gendered standards of conduct, and generational hierarchies of authority in the family. In addition, because we chose schools as the site for intervention, educational philosophies, pedagogical principles and norms governing teacher-student relationships also came into play.

Promoting Change through a School-based Action Programme

We had many reasons for choosing schools as sites for an action programme focused on adolescents. Schools are venues in which adolescents spend large amounts of time. In remote areas where television, newspapers, and books are scarce and cinema is non-existent, school provides the main window to social and cultural worlds outside the village setting. Moreover, although adolescents' self-harm nearly always takes place at home, we found that situations that students encountered at school or en route to and from school featured prominently in the accounts of self-harm that adolescents provided in our interviews. These situations included difficulties with peers (e.g. sexual innuendoes cast on girls; teasing, ragging and public humiliation based on caste, class or ethnicity; and sexual harassment) and with teachers (e.g. false accusations; public shaming about poor academic performance; and harsh scolding). The interviews also contained a good deal of information about the obstacles – both institutional and interpersonal – that adolescents and their families faced when a student who had engaged in self-harm wished to return to school.

In rural areas, teachers and principals – as educated and urbane outsiders – carry considerable moral authority in the eyes of parents and children and the village community at large. That is one reason why it seemed useful to enlist teachers in efforts to change the culture of self-harm among students. At the same time, however, this required considerable readjustment in most teachers' approaches to their work and their ideas of proper teacher-student relations. The pedagogical styles of teachers in rural schools differ dramatically from those of teachers in

Western, high-income countries. Although teachers are exposed to such methods as student-centred learning, group discussions and project-based learning during their training, these modes of teaching and learning are seldom implemented in rural classrooms. There, rote memorization continues to dominate the school day. Teaching styles are authoritarian, and teachers emphasize strict conformity to rules of behaviour and comportment. As is generally true of adult-child relationships in rural Sri Lanka, teachers maintain formality and distance from their students. Physical discipline of children is common and readily accepted. This might include caning children for what are considered 'serious' infractions (e.g. shouting in the hallway) and rapping children's arms and hands with a bamboo cane for minor infractions (e.g. fidgeting at one's desk or dropping a pencil during lessons). This authoritarian style set limits on how much teachers could be enlisted to reach out to distressed children. In extreme cases, this formality and authoritarian style placed self-harming students in jeopardy. For instance, in our interviews with adolescents, we learned of incidents in which a student had shown a bottle of poison to other students or had swallowed an overdose in full view of others. The onlookers did not inform the teacher because they feared that they would be punished for speaking out of turn.

School personnel are tasked with fostering children's development as well as teaching them academic lessons. Although there are only a few school-based counsellors in the country, the Sri Lankan Ministry of Education has placed priority on developing a cadre of such counsellors by identifying teachers who seem suited for such work and training them. In part, this initiative is an effort to address the psychosocial strains endured by much of the country's population as a result of the catastrophic 2004 tsunami and the civil war waged in the north and east for over 25 years. The workshop I describe below was designed as part of this effort to build the capacity of school personnel to promote children's psychological well-being. We had no illusions that a single workshop would radically alter long-standing and deeply embedded roles and practices. Nonetheless, we hoped to introduce alternative practices, model their use in an interactive format, and nudge the workshop participants towards trying them.

Workshop Design

Two sets of participants took part in the workshops. Both sets of participants held positions in which they were charged with developing and expanding teachers' competence to address children's psychosocial needs. The first set of participants consisted of teacher-counsellors who were posted in village schools in the war-torn northern and eastern provinces. These individuals had earlier been selected by a team of mental health professionals for training in counselling sponsored by the Ministry of Education. They had been part of an ongoing training programme for about two years, but their meetings had been sporadic because the armed warfare raging in the area often did not permit travel. We conducted two three-day residential workshops, one in Sinhala and one in Tamil, for these teacher-counsellors. These workshops were held in Trincomalee, a large coastal town with a multi-ethnic population. At the time, the town was heavily guarded by the government army and thus presumed to be safe from attack. Workshop members travelled from

their hometowns to Trincomalee. The second workshop was offered to members of the Educational Studies faculty of a major university in Colombo. These faculty members offer in-service training courses for teachers and principals from all over the island. In addition, they conduct a course of postgraduate study for unemployed university graduates who seek to be certified for teaching positions in the government schools. The university faculty members took part in a one-day workshop.

The goal of all the workshops was twofold. First, we intended to provide research-based knowledge specific to Sri Lanka about adolescents' self-harm. Second, based on that knowledge, we wanted to work with participants to devise practical strategies for school personnel to address the rising tide of self-harm among adolescents. The workshops used several modalities including didactic presentations, small group discussions, interactive role-plays and reflective practice. The didactic portions consisted of presentations of information regarding self-harm among Sri Lankan adolescents. Neither the teacher-counsellors nor the university educators had access to research-based knowledge concerning suicide or self-harm. What they knew about self-harm and suicide was drawn largely from sensationalist newspaper reports and portrayals of suicidal individuals in popular television dramas. Neither are accurate reflections of reality. Popular culture, for example, typically portrays adolescent self-harm as the result of 'love failure' (that is, a broken romance), a girl's loss of virginity (with suspicions about out-of-wedlock pregnancy) or drug addiction; however, none of these is a common antecedent of young people's self-harm.

Taking into account the limited time allotted for the workshop, our intuitions about which innovative pedagogical practices might be culturally acceptable to rural teachers and our desire to counter tendencies to blame self-harming children, we selected three areas for group work and developed a module for each. I describe them briefly below.

1. What messages about self-harm should adolescents receive?

The teacher-counsellors and the educationists both were in principle open to the idea of educating students about suicide and self-harm. Therefore, we created small groups that were assigned the task of brainstorming possible messages about self-harm that could be integrated into the school day. Overall, the outcome of these brainstorming sessions disappointed us. In all three sessions, the workshop participants proposed many possible lessons, but the lessons dwelt on deterring self-harm by fear, shame, blame and moral exclusion. For example, many proposed that science teachers should teach students that poisons and medicine overdoses could be lethal or lead to permanent injury. Others thought that students should be warned that the medical treatments for poison were extremely painful. Another set of proposed lessons involved rendering moral judgments about self-harm. For example, some participants advocated that suicide and self-harm be discussed in religion classes, where students could be admonished that suicide is a violation of religious precepts, sinful and morally wrong. (Religion is a compulsory subject in government schools in Sri Lanka.) Some wanted to inform students that suicide was a criminal offense (as indeed it had been until the late 1990s). Other

participants thought that students should be made to understand that self-harm was shameful. Examples included teaching students that self-harm is a 'low-class' behaviour, a behaviour that only 'uneducated' people engage in, or an indication of a 'bad' family background. Yet other proposals involved vague exhortations and moral platitudes, such as urging adolescents to 'strengthen their minds' or 'control themselves' or informing them that 'life is valuable'.

We had anticipated that the brainstorming exercise would be a springboard to critical reflection and debate. We were dismayed that participants made little use of the didactic presentation that had opened the workshop in which we had described the interpersonal crises, painful affects, and deteriorating family situations that were common among adolescents who harm themselves. Instead, participants had recourse to 'scare stories' and shaming. Moreover, although we had described in considerable detail how peer interactions in school (e.g. rumour-mongering, sexual harassment, bullying, or humiliating a vulnerable student) are often the triggers for adolescents' self-harm, no one proffered the suggestion that teachers might intervene in such behaviour or that teachers might encourage students to take responsibility for one another's well-being or to support to a classmate in distress.

The brainstorming sessions did not accomplish what we had hoped. The participants did not bring forward ideas for positive learning. Moreover, much of what they advocated seemed to foster ridicule and shunning of those who had engaged in self-harm. Therefore, we devised another exercise devoted to reflecting on the likely impact that specific lessons about self-harm would have on young students. From our dataset of interviews with hospitalized adolescents, we culled a list of specific verbatim examples. Some of the examples are as follows:

- 'We were taught in Science class that it is harmful to one's health if more than 24 tablets of Panadol [paracetamol] are taken.' (16-year-old boy)
- 'In Health Science class in year 9, the teacher taught us about death caused by hanging and consuming Panadol tablets and how to stay away from them.' (15-year-old girl)
- 'We were taught about suicide in Social Studies. Under Civil Rights, one cannot do any harm to oneself, another person, or a foetus.' (16-year-old boy)
- 'Our science teacher said that a student took poison because his mother switched off the TV. The teacher warned us not to be in a hurry like that.' (16-year-old boy)
- 'I was told that our life doesn't belong to us. Our class teachers asked us to be good.' (15-year-old girl)
- 'My Social Studies teacher said that suicide is a crime and people who do it will go to jail.' (16-year-old boy)

For this exercise, we divided participants into small groups and we asked the groups to reflect on each item on the list and to consider what goal the teacher might have had. We asked the groups then to discuss whether or not the teacher's approach was likely to have a good effect. We stressed that the issue was not whether or not the information was accurate, but whether it was likely to be helpful to students. That is, a message might convey accurate information, but nonetheless be inappropriate or unhelpful. Finally, we asked group members to discuss how each

message could be changed in order to teach students better lessons about self-harm. We did not have fixed ideas about what should or could be incorporated in the school curriculum. Instead, we wanted to facilitate an exchange among the participants, making use of their considerable knowledge of curricular matters, of the on-the-ground realities of local schools, and of the daily lives of children living in a zone of active military combat. Moreover, because teachers in government schools typically teach a tightly prescribed curriculum and rely solely on standard textbooks and materials, we wanted to present teachers with an opportunity to engage collectively in critical reflection on curricular content.

2. Storying the 'unstoried' side of self-harm using narrative practices

As episodes of self-harm have become more common, self-harm has touched the lives of more and more Sri Lankans. The adolescents we interviewed were no exception. They too had had abundant close encounters with others' self-harm and suicide prior to their own episodes. Most of them (68 per cent) knew personally at least one individual who had engaged in self-harm – an immediate family member, another relative, a fellow student, or a neighbour. Some knew two or three such individuals. The banality of self-harm and self-inflicted death in these young people's lives was sobering to contemplate. More sobering, however, was the often-articulated idea that self-harm was an effective means to resolve an interpersonal problem or force another person to change. For example, adolescents believed that a wife's self-harm would get her husband to stop drinking or hitting her; a teenager's self-harm would cause her parents to set aside their objections to a love affair; or a young man's self-harm might compel his ex-girlfriend to return to the relationship. For example, a 12-year-old girl whom we interviewed offered this anecdote:

> Aunty [a polite way to refer to an older woman] next door drank some medicine and she was in hospital. That uncle used to shout in the night after he was drinking. That was the reason. Even in the dead of night, he used to shout. Even we were unable to sleep.
>
> [What happened then?] That aunty is at home now. After that, uncle only shouts once in a way.

In contrast to adolescents' faith in the utility of self-harm, self-harm in real life has an array of unfortunate psychosocial consequences, as well as possible medical complications. The adolescents whom we interviewed reported that they were teased and ridiculed by others, as well as shunned. Sometimes their entire family became objects of ridicule and exclusion. Other consequences included increased surveillance by parents and dramatic restrictions on the adolescent's movements. Consequences for girls who had engaged in self-harm seemed especially severe. Some had been expelled from school. Some had been forced to move out of the hostels or boarding houses where they had been staying. Some families shunted their daughters off to a relative's home in a distant locale. In a few extreme cases, girls (and sometimes their sisters) were forced into hastily arranged marriages before news of the self-harm episode diminished the chances of finding a good

match. In short, the actual aftermath of self-harm was often far less rosy than the fantasy pictures that adolescents painted.

How could children be helped to arrive at more balanced appraisals of the interpersonal benefits and liabilities of self-harm? We hit upon an adaption of a technique used by narrative therapists that could be used as a classroom exercise. As narrative therapists point out, the stories that people construct about their lives are not veridical accounts of reality; they are highly selective and they leave vast amounts of experience unstoried. In the case of adolescents' remembered (or imagined) stories about others' self-harm, only positive consequences are featured in the narrative; the negative consequences are left unstoried. The narrative therapy technique helps clients re-story their experiences to include previously unstoried elements. It involves close listening to a client's story, carefully probing for detail and asking expansion questions to help the client add previously unstoried aspects of experience. This process both enlarges and changes the story. The therapist is especially alert for instances of 'unique outcomes' – that is, elements of experience that disconfirm the client's usual story and offer possibilities for constructing a different one. The therapist directs the client's attention to such unique elements, encouraging the client to elaborate them into a revised narrative.

We designed a module to introduce these narrative therapy ideas to the teacher-counsellors. The idea that our knowledge of the world is not grounded in a reality 'out there', but rather arises in the mind is a central tenet of Theravada Buddhism; it is common sense to most Sri Lankans. We built on this common sense by introducing the concept of storied and unstoried experiences and the practice of prolonged and detailed examinations of incidents of self-harm in search of unstoried outcomes. The participants worked in pairs, role-playing a conversation in which one participant recollected an incident of self-harm and the other participant helped the individual to enlarge upon and re-story the recollection. Then the partners switched roles. At the conclusion, we asked the participants to discuss ways in which such an exercise could be adapted for use in a classroom with groups of students.

3. Addressing the shaming, ridicule, and shunning of self-harm victims

In Sri Lanka, shaming and ridicule are common and accepted techniques of socializing children (Chapin, 2003; Obeyesekere, 1981). Shaming is a pre-eminent means of social control of adults in village life as well (Spencer, 1990). It is not surprising, therefore, that adolescents who had engaged in self-harm often reported that their siblings, neighbours and fellow students teased, ridiculed or poked fun at them once they came home from the hospital. Indeed, even in the hospital, several were subjected to ridicule and shaming by nurses and other staff. The hospital workers justified these interactions in terms of their beneficial effects: ridicule and humiliation would ensure that patients would think twice before engaging in self-harm again.

Teasing and shaming rituals constitute part of students' everyday lives. Children (like adults) use shame to police one another's behaviour and to establish or reaffirm social hierarchies. Children from towns ridicule children from small hamlets;

rich children poke fun at poor children; able-bodied children tease disabled or deformed children; children from high castes denigrate children from low castes. Likewise, adolescents who have harmed themselves are subjected to ridicule and avoidance. However, even if ridicule and exclusion are culturally approved practices, it seems counterproductive for schools to be arenas where students are victims of shunning and shaming. Anticipating such painful interactions might keep some adolescents from returning to school after a self-harm episode. In the worst case, such experiences might lead a vulnerable child to engage in further self-harm.

We developed two exercises to help participants consider how adults in school settings might avert such negative peer interactions. The first exercise asked participants to strategize about a hypothetical situation in which a class teacher (the equivalent of a homeroom teacher) learned that a student in the class had been hospitalized for self-harm. The usual practice, we knew, was for teachers to ignore such occurrences entirely and proceed with the planned lesson. However, this practice allows rumours to flourish, thus generating tension and uncertainty that disrupts students' ability to learn. In the exercise, we divided the participants into groups of five. We placed a chair in the centre of each group. The chair was designated as the place for the individual in the role of a class teacher. The 'class teacher' was tasked with informing students about a classmate's hospitalization following an overdose. Participants were to take the chair when they had something to say to the class or if they wished to add to or amend what the previous occupant of the chair had said. The participants were instructed to devise respectful ways of disclosing the information and to take care to avoid statements that would impugn a victim's character or reputation.

In a second exercise, we asked participants to consider how a class teacher could pave the way for a student to re-enter school after a self-harm episode. In particular, we asked how a teacher could ensure that such a student would not be ostracized or humiliated by others. Participants engaged in a role-playing exercise similar to the one discussed above. Following the role-play, we facilitated reflective discussions in which the 'teacher' described how he or she had chosen what to say, and the 'students' described what the 'teacher's' remarks had led them to think and feel. We intended this exercise to lessen the taboo on speaking about self-harm. We also wanted to demonstrate how teachers could help students deal with emotion-laden issues. Lastly, we wanted to introduce the idea that teachers have a stake in assuring the emotional well-being of all their students.

Beyond Peer Relations and School Culture

To be effective, intervention programmes must take into account local meanings and practices of self-harm, as well as the social context of which it is a part. The action programme tried to address some salient features of youth culture and school life. However, the spiral of adolescent self-harm is not solely a matter of youth culture, and this programme could be criticized for its limited focus. Indeed, in the interviews with hospitalized adolescents, distressing aspects of

family life loomed large. Adolescents often identified physical violence in their families as the immediate trigger for their self-harm. They received beatings as punishment; sometimes parents (or occasionally an older brother) destroyed the child's property (such as cell phones or school books). Some parents justified their use of physical violence to discipline children; one mother explained that hitting a child was an expression of love. For other adolescents, the triggering circumstances involved chaotic situations of fathers who drank to excess or violent quarrels between the parents. Among girls, much self-harm revolved around issues connected to sexual respectability. Girls told stories of receiving severe punishment when their behaviour appeared to violate their parents' stringent standards of sexual respectability. Others told of swallowing tablets or poisons rather than face accusations of sexual impropriety.

The preponderance of girls among adolescent self-harm patients points to the need for action programmes specifically addressing girls' issues. Among the girls we interviewed, most cases of self-harm involved family conflicts over what parents regarded as lapses in their daughters' sexual behaviour. In rural Sri Lanka, girls find that their freedom of movement, freedom of association and privacy become limited after they come of age. Parents, older siblings, neighbours and relatives monitor their actions and movements. Moreover, girls are punished if they receive sexual attention from boys and men. Moreover, they are held responsible even if such attention is uninvited and unwanted. Many feminist researchers (De Alwis, 1995; Hewamanne, 2008; Lynch, 2007; Marecek, 2000), both Sri Lankan and foreign, have written about how the double standard of heterosexual behaviour, as well as other patriarchal values and practices, diminishes the lives of women and girls. Our interviews with girls in hospital show an undeniable connection between stringent standards of sexual respectability and girls' self-harm.

Many local psychosocial practitioners in Sri Lanka have shied away from broaching such issues as intimate partner violence, men's drunkenness, and double standards of sexual behaviour when they work in rural communities. They fear that if they object to these practices, they may alienate themselves from members of the community and even be forced to leave the community. These practices are held in place by a web of traditional values, such as the premium placed on female virginity, patriarchal family relations involving male dominance and female subordination, and men's 'right' to excessive alcohol consumption and unfettered male sociality. Traditional or not, however, these values are not endorsed equally by all members of the community; there are dissenting groups. When psychosocial practitioners declare such issues to be undiscussable, this is not a neutral posture. By shrouding these issues in a veil of silence, they not only allow the status quo to prevail, but also tacitly condone it.

Conclusion

Modest though it was, this action project represents the first psychosocial intervention in Sri Lanka based on empirical evidence. To my knowledge, it was also the first effort to implement an action programme specifically for self-harming

adolescents. In nearly all respects, the project represented an excursion into uncharted territory. We did not know whether the substantive content would be acceptable to the participants. We also did not know whether the group processes (e.g. group work, role-plays and reflective practice) would be intelligible and acceptable to the participants. The residential workshop with the teacher-counsellors ended by asking the group to reflect on lessons learned that could be useful in their everyday work. Many of the lessons that the group identified concerned processes (such as strategies for conducting group discussions or for opening a conversation with a troubled student). The workshop disputed the widely shared understanding of children's self-harm as misbehaviour at worst and youthful foolishness at best. In so doing, it cast doubt on the customary prevention strategies of moral injunction, shaming and threats of punishment. All the workshop participants – teacher-counsellors and educationists alike – found it difficult to re-conceive self-harm in terms other than moral failing on the part of the victim. We had no means of assessing whether and how our participants might have made use of what they learned in their work; this glaring gap remains to be filled by future research.

We close with lessons for the future. Although school is a logical site for intervention programmes focused on youth, working in rural schools presents particular challenges. Our participants viewed school primarily as a site where transfer of information from teacher to student takes place and where children learn conformity, good comportment and obedience. The idea that teachers can promote children's emotional and social development in the course of academic learning was new. Moreover, the formality and distance that characterize proper teacher-student relationships in Sri Lanka hinder teachers from facilitating students' personal development. In future workshops, we would emphasize a conception of schools as not just sites of learning, but also psychosocial arenas where children negotiate identities and friendships, as well as relations of difference and hierarchy. We would also emphasize that teachers can play a key role in shaping this psychosocial arena, even if they cannot completely control it.

Finally, addressing adolescent self-harm cannot stop with efforts to change youth culture or family relations. The dramatic fluctuations in the incidence of self-harm over the past half-century indicate that self-harm is connected to the larger social context, albeit in complex and multiple ways. Financial hardship caused by the deteriorating economic conditions in the agricultural sector, for example, has had many effects on family life, including the large-scale labour migration of men and women to the Gulf States. Financial strains and demoralization no doubt contribute to men's alcohol abuse, marital difficulties and spousal abuse. Economic necessity has led girls to obtain advanced education and paid employment. As girls move outside the range of parental surveillance, however, traditional practices of modesty, segregation from men and circumspect behaviour are no longer possible. The stage is set for the parent-daughter clashes that so often precede girls' self-harm. In 1998, Sri Lanka decriminalized suicide. This was largely symbolic: Very few cases of self-harm had actually been prosecuted in recent years (Jansz, 1989). However, it acknowledged that suicide and self-harm are not simply private problems, but public issues that are embedded in broad societal structures.

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