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FEATURE ARTICLE

Cutting across boundaries: A case study using feminist praxis to understand the meanings of self-harm

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ABSTRACT: *Deliberate self-harm predominantly occurs in women under the age of 30 years. This qualitative case study using feminist methods explored the experiences of three women who each had a long history of self-harming behaviour. Psychoanalytical concepts are used to explore the meaning of the conflicts that these women experience. Emergent themes include: great expectations, I speak but no one hears, sexual naivety meets sexual violence, and redrawing the sexual map. This thematic analysis helps facilitate an insight into what these women are trying to communicate, and provides guidance for mental health professionals to more effectively respond to the challenges of working with women who self-harm.*

KEY WORDS: *mental health*, *psychoanalysis*, *self-harm*, *women*.

INTRODUCTION

Deliberate self-harm is an expression of extreme distress, which can consume an individual's very existence. Self-harm is predominantly a female behaviour (Clark & Whittaker 1998; Suyemoto 1998) and encompasses a variety of behaviours, which pervade destructiveness of the self. Globally, deliberate self-harm is the most common reason for female medical admission to hospital (Bennet *et al*. 2002; Hawton 2000). The most common self-harming behaviours are self-poisoning (predominately by drugs and alcohol misuse), misuse of food and/or self-mutilation. The average age of women who self-harm ranges from 22 to 28 years (Hawton 2000; Langbehn & Pfohl 1993; Schmidtke *et al*. 1996), while the mean reported age for the onset of this behaviour is 13–24 years (Hawton 2000). Reports of women self-harming have been documented in medical literature since the mid-19th century. The earliest relates to a 48-year-old woman described as a 'psychiatrically depressed guilt ridden widow who enucleated her eyes' (Bergman, 1846, cited in Favazza & Conterio 1989).

This paper seeks to explore how mental health practitioners can move beyond the pathologizing of such experiences resulting from the sometimes reductionist use of psychiatric diagnostic labelling. For example, the *Diagnostic and Statistical Manual 1V TR* (American Psychiatric Association 2000) includes deliberate self-harm behaviour as an essential feature of borderline personality disorder (BPD). However, the link between self-harm and BPD has been widely debated (Crowe & Bunclark 2000; Johnstone 1997) and highlights the tendency to associate self-harm with BPD, thus ignoring traumatic experiences and the social context of a person's life. Using a psychoanalytical approach to understand the experiences of three women who use self-harm, presented in case studies of the gendered nature of their experience, a more complex and complicated phenomenon is revealed.

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CONTEXT

While numerous hypotheses have been put forward as to the causality of self-harming behaviour, Favazza and Conterio (1989) suggested that family dynamics may be significant in the understanding of such behaviour. They identified that 34% of fathers and 33% of mothers of children who self-harmed had a psychiatric history, with alcoholism and depression, respectively, being the most common. Other research (Hawton 2000) links childhood sexual and physical abuse to deliberate self-harm. However, although such associations are largely identified in quantitative research studies, qualitative studies that explore why women feel the need to self-harm remain sparse (Harris 2000; Talseth *et al*. 1999). It is for this reason we turn to case study as a methodology and use psychoanalytical concepts to give meaning to the self-harming behaviour used by these women.

In psychoanalytical terms *per se* it has been suggested that deliberate self-harm equates to acts of masochism (Pattison & Kahan 1983), although underlying psychodynamic hypotheses also include: attempts at self-healing, rage towards the self or the internal bad object, symbolic castration, formation of ego boundaries, autoerotic gratification, mastery of menstruation, and procurement of the transitional object (Favazza & Conterio 1989).

Early female (arguably pioneering feminist) psychoanalysts (Deutsch 1925; Horney 1924; Lampl-de-Groot 1928) challenged the prevailing Freudian phallocentric theories, drawing on not only their professional experiences but also their personal experiences as daughters, mothers, and caregivers and in so doing, recognized the impact of the social world on the individuals psychic structure.

In the context of deliberate self-harm, Zweig-Frank *et al*. (1994) noted that it was problems of parental bonding that were important, while Rosenthal *et al*. (1972) and Favazza and Conterio (1989) suggest that deliberate self-harm is more likely to occur in response to separation. Gilligan and Rogers (1993) argued that for boys disconnection from the mother occurs in early childhood whereas for girls it does not occur until adolescence. This might account for why self-harming behaviour is more prevalent among young women.

During the 1960s and 1970s feminist writers viewed the theoretical models used to understand women as products of the same society that disempowered them (Chodorow 1978; De Beauvoir 1960; Greer 1971). In particular, they were critical of psychoanalysis, believing that its main concern was to socialize women into their role as wives and mothers. While some critics of psychoanalysis chose to ignore any useful insights that it might have to offer, from the mid-1970s onwards some feminist psychoanalysts (Eichenbaum & Orbach 1983; Mitchell 1974) were becoming more adept at incorporating feminism into their practice. Many contemporary feminist psychoanalysts readily acknowledge the importance of social context, and how the patriarchal discourse has been internalized by women (Sayers 1991; Taylor 1995; Ussher 1990). The early phallocentric view of women's psychology and sexuality continues to be challenged through an emphasis that is increasingly focused on the relationship shared by mother and daughter.

For the past 35 years this important developmental relationship has consistently been considered of major significance in understanding women's psychological development and especially in formulating women's psychological problems. For example, Eichenbaum and Orbach (1983) noted that a major aspect of the mother–daughter interaction that influences a daughter's psychology is their shared gender and the strong identification. However, this mirror image may create a blurring of boundaries, giving rise to conflict in terms of separation and individuation. The more a parent seeks oneness with a child, the likelihood is the child's strivings for a more differentiated 'self' becomes the source of severe conflict and guilt (Socarides & Stolorow 1984–5). For some, this will obstruct the process of boundary formation and will become an enduring source of guilt, which can often manifest through high anxiety and self-punishment. Rosenthal *et al*. (1972) and Shapiro (1991) identified that, prior to acts of self-harm, women experience depersonalization, an emotional state that results from extreme anxiety and tension.

The close shared sense of identity experienced in the mother–daughter relationship is likely to result in such guilt and conflict being more intensified for the female child. For some women the lack of boundary formation means that they are never able to separate sufficiently; their personal identity never becoming distinct from that of their mothers'. Studies such as these, can for some mental health practitioners, provide a glimpse of the possible personal, emotional, and psychological struggles experienced by women who self-harm. However, we readily acknowledge that for many mental health practitioners, this view of the self-harm context might remain an impenetrable one. Current mental health policy perpetuates a more bounded approach to practice, with for example cognitive behavioural therapies being the current treatment of choice in the UK for so many conditions. This paper aims to challenge the limitations of such policy-driven boundaries to practise through the

exploration of the three case studies presented in this paper.

METHODOLOGY

The studies methodology is informed by feminist praxis, an approach that connects experience and action (Burman 1994a). Feminist research is focused on the gendered nature of 'experience' and through accurate representation, this experience is validated through the research process. Generally, three types of feminist critique can be employed: (i) feminist empiricism (Eichler 1988) using women's experience to improve and/or supplement existing knowledge; (ii) cultural feminism (Squire 1989), which goes beyond discussing the exclusion of women's experience from dominant knowledge paradigms to emphasizing how the experiences differ; and (iii) feminist postmodernism (Harding 1987) or feminist poststructuralism (Hollway 1989), which explores women's experience in the context of the social realities in which they live.

Implicit in feminist research is the attention given to power as being both an intrinsic and an extrinsic factor. As power is inherent within the research process, in this case, the coming together of the interviewer and interviewee, reflexivity is central to feminist research (Stanley 1990). Feminist research recognizes that power is an ever-present dynamic just as it is for women who live their lives in a patriarchal society. A case study approach was utilized to provide the opportunity for participants' stories to be heard in a manner that acknowledges this dynamic.

The case study methodology satisfies the three tenets of the qualitative method: describing, understanding, and explaining. Case studies can be single or multiple case designs. Single-case studies are used to confirm or challenge a theory, and they are also useful in gaining access to a phenomenon that was previously seen to be inaccessible. However, in both approaches, case study is done in a way that incorporates the views of the individuals in the case under study, and therein lies the methodological dilemma. A frequent criticism in terms of limitation is that case study methodology is dependent on a single case, which results in difficulties regarding the generalizability of findings. In response, Yin (1994) notes that generalization of results, using case study as a methodology, is made to theory and not to populations.

However, the value of using case study as a methodology is it's quintessential characteristic, which strives towards a holistic understanding of cultural systems of action (Warne 1999). Cultural systems of action refers to interrelated activities engaged by individuals in a social situation, and for this reason, the case study must be bounded (Stake 1995). The unit of analysis is a critical factor in the case study. It is typically a system of action rather than an individual or group of individuals. Case studies tend to be selective, focusing on one or two issues that are fundamental to understanding the system being examined.

In addition to the above, case studies can provide multiperspective analyses. The researcher must consider not just the voice and perspective of the actors, but also the relevant groups of actors and the interaction between them. This is salient point in terms of the case study methodology as case studies can give a voice to the powerless and the voiceless.

Semi-structured in-depth interviews were used for data collection, allowing for further exploration of specific topic areas that had emerged from a review of the literature. Each individual interview lasted approximately 90 min. All interviews were audiotaped and transcribed, and each transcript was subjected to a thematic content analysis to identify emergent themes.

Ethical approval for the study was gained through a university research ethics committee governing the work of one of the authors. The three participants for each of the case studies were recruited via an advertisement placed on the Internet. Written information and the opportunity to clarify any questions they had about the project were provided. Written consent was obtained from each participant. Participants were assured that they could opt out at any point during the study and that their contributions would remain anonymous and confidential.

BRIEF BIOGRAPHICAL OVERVIEW OF EACH PARTICIPANT

The three case studies revolve around the experiences of women who have self-harmed and have come into contact with mental health services. Each had been given a differential diagnosis following this contact, which appears to have inhibited them in telling their stories and having their needs met. For example, Margaret said that *they* (doctors, psychiatrists) had told her she was schizophrenic. Margaret herself said that she did not believe that she was schizophrenic, but had experienced a very mixed-up and confusing life and that this was her problem. Several years ago, Margaret was admitted to hospital following an act of deliberate self-harm under the care of a female psychiatrist. Margaret risked telling her story but was ignored. It was dismissed as a consequence of her delusional beliefs and her medication was increased. She has not told her story to both her current

psychiatrist and community psychiatric nurse both of whom are male.

Rose is 28 years old, currently living alone and working in a voluntary capacity for mental health services. She grew up in a middle-class Jewish family consisting of mother, father, and brother. She was sexually abused by both parents from an early age, having a specific memory of her father fondling her genitals when she was 4 years old. Another childhood memory for Rose was that of 'waying up her mother's mood and learning what to say and what not to say at these times'. She remembers not being allowed to cry and if she did her mother would take her into the kitchen where she would 'slap her until she stopped crying'. At 10 years old Rose remembers being 'bashed up badly' by her brother. When she turned to her mother, who was present and could hear her screaming, she was ignored. At this point, Rose said that she was 'overwhelmed with frustration and put her arm through a pane of glass'. Today Rose still has a recurrent dream whereby her head is 'being smashed open' and remains afraid of her brother. Rose is brought up believing that men have the right to have power over women. She is repeatedly told by her mother, who she describes as hysterical, that men 'rape women'. At 15/16 years old she starts to 'test men out' engaging in sexual experiences with numerous men to 'see if they would rape her'. At 17 years old she leaves home and stays with friends. At 18 years old she goes to Israel where she eventually joins the army. At the same time she learns martial arts and start having sexual relationships with women as she wants to 'identify with men'. When she is 24 years old, Rose makes her way to New York where she is admoitted to psychiatric hospital after she attacks a man who she has had sex with and following the attack she tries to hang herself. Rose was given electroconvulsive therapy and after discharge from hospital has to return to the UK. Rose has no contact with her family and is fearful that they might find out where she is living. Since her return, Rose has had numerous admissions to psychiatric hospitals in response to her self-harming behaviours and on occasion to her attempts to harm other people. Rose uses her cutting to dissociate herself with these early traumatic experiences. She has been given a differential diagnosis of schizo-affective disorder, depression, and BPD.

Angela is 44 years old and lives alone in an inner city area. Angela has had involvement with mental health services since she was 15 years old. Her mother was a single parent who felt unable to look after Angela. Aged 2, she was put into care and grew up in a children's home. At 6 years old Angela was sexually abused by a member of staff and then physically abused by the matron when she 'told her what the man had done'. At 15 years old she had to leave the home and was found living accommodation and work at a local boarding school for girls. There she suffered further physical abuse and eventually she ran away. At 15 years old Angela was gang-raped at knife point by five men. Following this she cut her wrists and took an overdose to try and 'get rid of the pain'. At this point, Angela was returned to her mother's house where she was hoping to be 'loved, looked after and cared for'. However, this did not happen and she was ignored. Angela could not cope with being ignored by her mother and brother and after they had gone out on day, she 'burnt the house down'. She received a 6-year sentence and spent 4 years of her life in prison for arson. After her release, Angela married and had three children. Her first born was a girl but she died at 10 days old. Angela spoke about this for the first time during the interview. She subsequently had two sons but the marriage was an abusive relationship with Angela's husband being physically abusive towards after he had been drinking. The marriage ended when Angela was detained in psychiatric hospital after she retaliated by attacking her husband. She has had several admissions to psychiatric hospitals and has differential diagnosis of schizophrenia, depression, and BPD. Angela does not know if her mother is dead or alive and has no contact with her brother. She uses cutting to relieve the 'emotional pain that often overwhelms her'.

Margaret is 47 years old and lives with her 21-year-old son in an inner city area. Margaret has had contact with psychiatric services since the birth of her son. She grew up in a working class family with her mother, father, and four siblings (Margaret was the youngest). As a child Margaret always felt close to her mother but was frightened of her father. At the age of 9 years old Margaret was raped on her way home from the pictures where she and a friend had gone instead of going to Brownies. Margaret was not able to tell anyone about the rape as she blamed (and still does) herself for the rape. Following the rape she took some medicine that her mother had told her 'not to touch as it was poisonous'. Margaret said she 'drank some thinking this will kill me this is what I need'. From 10 years old she starts inserting poles and other obstacles into her vagina as a way of 'disguising what had happened and trying to get rid of being a girl so her mother wouldn't find out what she had done (not going to Brownies)'. During adolescence she continued to try and dispense with her femaleness by dressing and identifying with boys. At the age of 19 Margaret married but this was an abusive relationship. She has a son from the marriage and following the birth she started expressing ideas that 'he is born of sin because I am sinful'. It was at this point that

she had her first admission to psychiatric services. Shortly after her discharge from hospital, she 'bundled up her 8-month-old son and left in the middle of the night'. She moved as far away as she could and changed her name and has had no contact with her husband since that time. She has had several admissions to psychiatric hospitals and has differential diagnosis of schizophrenia, depression, and BPD.

EMERGENT THEMES

There were four emergent themes arising out of the stories that these women had to tell: (i) great expectations (which was further subdivided in to fantasy, disenchantment, and the mirror image); (ii) I speak but no one hears; (iii) sexual naivety meets sexual violence; and (iv) redrawing the sexual map: if only I were a man.

Great expectations

Fantasy

The fantasy of the mother–daughter relationship relates to the participant's expectations of 'mothers who are caring and who will care for them by being there for them'. The data suggest that women do have preconceived ideals of nurturing, caring mothers who by social expectation and the virtue of being a 'mother' will care for them.

Burman (1994b) describes the notion of 'preconstituted individuals' and how in a patriarchal society, women and especially mothers, are both overtly and covertly ascribed to the role of carer. This is reflected in the way that each of the participants was able to readily verbalize their personal expectations of their mothers, although none was able to directly verbalize their disenchantment when their mothers did not live up to expectations.

Disenchantment

After Margaret was raped [raped is our description of what happened to her, she never uses the word] she 'wants her mam' yet is never able to tell her mother what had happened. Her disenchantment is conveyed in the statement that she makes: 'and this is when I must of somehow lost touch with me mam'. This is reflective of a child's bewilderment when losing something of great importance. She takes on the responsibility for disconnecting with her mother. There is a readiness for self-blame for what Eichenbaum and Orbach (1983) described as the 'missing connection', the part that would fulfil the little girl's nurturing needs. Margaret is disenchanted with herself, believing herself to be unworthy of love and care, and this in itself is a way of protecting the expectations she has of her mother. Margaret blames herself for the rape, she should have been at Brownies, but instead she and a friend went to the cinema. At the age of 9 years old, rather than being disillusioned with the person she loves, Margaret uses rationalization and projection to adopt the stance that she is the one to blame if her mother does not live up to her expectations.

The mirror image

All three participants had and still have strong identification with their fantasy mother figure. However, their expectations were not met, and perhaps generated 'feelings of isolation, depression and even despair' (Eichenbaum & Orbach 1983). Their need for nurturance was not satisfied. They projected their expectations and then introjected these expectations, leaving themselves no option but to take the caring role (protecting and defending a fantasy image of their mothers) when they themselves still needed to be cared for. The merging of ego boundaries made it very difficult for them to separate themselves from their mothers, although Kanter (1993; p. 31) warns, 'it is important for female development to recognize the mother's mirror image is that of woman'.

I speak but no one hears

The participants' experience of trying to communicate but no one hearing their voices only condemns them to a position of powerlessness. At 16 years old Angela had been returned to her mother's house by social services. This was despite being gang-raped at the age of 15 (after being in the care of social services up to the age of 15, which at that time, was when adolescents were deemed no longer to be in need of care). No one in her family spoke to her and her frustration with this situation grew. This frustration resulted in her setting fire to the family home. At the time she reported being extremely disillusioned and unhappy, and taking extreme action was the only way she felt that she could communicate her frustration.

Margaret reported that psychiatrists had told her 'she was schizophrenic'. During her interview she ***did*** talk about hearing voices, believed herself to be evil, had strange thoughts, and expressed odd ideas:

> if a fella comes in here now I would chat to him and so on, very out-going, but deep inside I'm hurt with them and I want to murder them inside my head. Deep inside I hate them and I want to murder them and cut them up in my head and ram things into them . . . but that's all in your head.

Understanding what Margaret is saying about wanting men to feel the same pain and hurt that they have caused her, is made easier when her history is considered. She still blames herself for being raped and 38 years later is still not yet able to call it rape, suggesting her unconscious has locked this traumatic event into her childhood. Margaret reported that she did not believe that she was schizophrenic but that she had experienced a very mixed-up and confusing life, which had caused her problems. Her contact with mental health services offered only male input to Margaret and, therefore, she has never been able to tell her story. Eventually, she was admitted to hospital under a female psychiatrist and risked telling her story. She was ignored. Her story was attributed to her delusional beliefs. The covert message being communicated to Margaret is that at times, even women do not want to listen to women. Margaret spoke and still no one listened. The message 'you can speak but no one will listen' has had a major impact on the lives of each participant. Each has taken desperate measures to communicate their story, but the sense of powerlessness resulting from consistently not being heard is still a dominating part of their felt experiences.

Sexual naivety meets violent sexual experience

Sexual naivety and being the victim of violent sexual experiences were strong emergent themes of each interview. We argue such experiences will resonate with those of many women who self-harm. All three participants were sexually naïve until their late adolescent years and/or early adult life, despite their early experiences of childhood sexual abuse. Each had been the subject of violent sexual encounters perpetrated by men (apart from Rose who was abused by both her mother and father), and each blamed themselves for the sexual violations that they had encountered. Mistrust of self and significant others, in particular of the women who were perceived as their caregivers, was evident. Van der Kolk *et al*. (1996) note that a child who has been abused may not be able to develop a stable sense of trust in their caregiver, resulting in the child learning that the world is an unstable place where love is conditional and sometimes painful. The child may then introject this and start believing themselves to be untrustworthy. Sociologically, the overt and covert message is one of acceptance that men do this sort of things to women. According to Olivier (1989), women are brought up with the understanding that sex is something that is predominantly male and not openly accessible to women.

Redrawing the sexual map: If only I were a man

Angela appears to have difficulties with regard to her sexual identity. During her marriage she again succumbed to male domination by becoming victim to her husband's physical abuse, for which the police cautioned him on several occasions. She had learnt from a very early age that boys are more desirable than girls, men can do what they want to women, and women cannot be trusted. Angela demonstrates her desire to be male when she talks about retaliation and on one occasion abusing her husband. Angela associates male behaviour with violence, internalizes this and then tries to use this behaviour herself. In a patriarchal society, aggressiveness or violence in women is often viewed as unacceptable. Angela was made aware of this when because of her aggressive behaviour she was arrested by the police, her behaviour was pathologized and she was taken to a local psychiatric hospital where she was detained under the *Mental Health Act* (1959).

Margaret, in relating the first incident of her self-harming behaviour (where she impaled herself on a scaffolding pole) said:

> I know what I will do to stop this . . . I don't know cos I just don't want this fanny (points to her vagina) here . . . I just didn't want to know what sex I was . . . and I swung . . . swung on the poles and I went like that and dropped over the poles and something went between my legs like that [mimics jumping on the pole and it impaling her vagina] . . . and it was killing us and I couldn't walk and I thought that's got rid of that.

This part of the story explicitly illustrates the conflict Margaret has in being female. Possible psychoanalytical interpretations of this event might include: (i) the forcible acquisition of a penis; and (ii) ridding herself of the internal bad object. Whichever interpretation is used, both accounts serve to demonstrate the extreme behaviours that women use to address their extremely distressing intrapsychic conflict.

It is not surprising that each of the participants have a desire to identify with the male gender. All have encountered male power and domination, and all have learnt from their female contemporaries, in particular their mothers, that what is not permissible for them as women is often expected and accepted of their male counterparts.

DISCUSSION

The participants in this study shared commonalities with previous research studies (Favazza & Conterio 1989; Greenspan & Samuel 1989; Hawton 2000). All used a variety of self-harming behaviours, the onset had

occurred between the ages of 9 to 15 years, and all at some point had a diagnosis of BPD. Far from attaching blame to mothers when things go wrong, it would appear that the absence of such a relationship seems to give rise to more complex problems. The personal consequences for the participants included: experiencing sexual and physical abuse in child and early adulthood; having little sense of their own identity; problems with sexual identity and confusion regarding which gender they belong to and which will be accepting of them; an inability to trust; a need to engage in self-destructive behaviours due to the guilt and hatred of themselves; loneliness; humiliation and emotional and physical pain.

These women have very little self-esteem and in Kleinian terms, they believe themselves to be the 'bad object'. In offering care to such women, it is important to give credence to this fundamental belief. Self-harming behaviour is about releasing the 'bad' in themselves. Psychodynamically, the 'bad' can be interpreted in numerous ways. According to McAllister (2003), self-harm could be considered as a form of anger turned inwards, a way of demonstrating psychic distress without talking about it, a mechanism for dealing with repressed guilt in relation to sexual conflict or a form of catharsis for emotional extremes. The desire to rid themselves of the 'bad' may go some way to account for there being no pain when inflicting self-harm. The behaviour enables the overwhelming emotional pain to be localized physically. The sight of the blood and being able to look inside themselves allows affirmation of the self, that is, they are a real person. Because of these positive effects of self-harming, coupled with the paucity of positive early life experiences, health-care professionals should not expect those who use self-harming behaviour to accept social and more importantly, professional norms.

IMPLICATIONS FOR PRACTICE

Although the study involved a very small cohort of women, and is therefore limited in its generalizability, useful insights were gained from the unfolding stories. The gender bias of those being referred to mental health services for their self-harming behaviour is a major issue that cannot be ignored. Often women who deliberately harm themselves are labelled as 'attention seeking' whereas we, similar to a number of other authors, argue that a better description might be 'attention needing'. As mental health professionals attempting to meet the needs of these individuals, it is imperative that we are able to effectively listen to and understand the complexities implicit in these women's life stories. Part of this complexity results from many women's experiences being set in a context of a predominately patriarchal ordered society, which promotes an unequal distribution of power, often leaving women feeling powerless.

In the UK, a recent independent review into the death of a young woman, 22-year-old Sarah Lawson, accused mental health services of being dysfunctional and fragmented, perhaps for many it was a frightening mirror image of the lives of the people whom we profess to serve (Frith 2004). Similarly, other global research (Agar & Read 2002; McAllister 2003; Talseth *et al*. 1999) is suggestive of mental health professionals not feeling competent or confident to address the emotional turbulence, which is many of our service users' experience.

In recent years, there has been a welcome resurgence of psychoanalytic approaches used to facilitate greater understanding of many aspects of mental health work (Crowe 2004; Yegdich 1999). We argue that to effectively meet the complex needs of people who self-harm, a twofold strategy is imperative. First, the limitations inherent in short-term fixes, for example cognitive behaviour therapy, brief intervention therapy and pharmacology, should be more fully acknowledged. These approaches are not a new panacea, and therapeutic approaches, which allow for the mediation of intrapsychic distress accumulated by the individual over a number of years, should also be available. The evidence presented identifies that those who deliberately self-harm often have long traumatic life histories. To attempt to deal simply [sic] with the here and now problems and disregarding the history is akin to sticking a plaster on wound to stop the bleeding while disregarding the bacteria that lie beneath the surface, which can continue to fester and destroy what otherwise could be healthy tissue. Second, while ensuring that service users are listened to in a sensitive manner (often comforting to the service user) helping them move beyond simply being heard requires the nurse to be cognizant of psychodynamic understanding. Thus, those offering care to people experiencing such emotional turmoil need to be appropriately educated, skill trained and supported in working in longer-term therapeutic approaches through adopting the guiding principles of the psychoanalytic encounter (Gallop & O'Brien 2003).

CONCLUSION

We, as mental health nurse, welcome the return to recognizing the value of psychoanalytic theory in providing an alternative, and perhaps greater understanding of how to meet the needs of those women who use self-harming behaviour. The resurgence of using psychoanalytic theory

allows the mental health nurse to take account of the person's history while giving credence to the social context in which they have and do exist. However, our contention is not that psychoanalytical theory and practice should be seen as the panacea for this client group and/or that it should replace other theory-based therapeutic interventions. Doing so would be an indictment of our naivety as the decision to use a particular therapeutic intervention has to be made with the client and in relation to their preferred way of working. However, in a world increasingly driven by economic exigencies and professional performance management, we are concerned that there is a risk that some individuals will be unable to have their story heard and mental health needs met due to the way mental health care is provided. This paper has argued that it is in harnessing psychoanalytical concepts by those concerned with working with alleviating the distress resulting from the type of experiences explored here, that the stories of other similar women might be heard and responded to in more appropriate ways in the future.

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