ARTICLES

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Shifting Conversations on Girls' and Women's Self-Injury: An Analysis of the Clinical Literature in Historical Context

Through a historical review of girls' and women's episodic and repetitive self-injury – scholarship focusing primarily on white, middle-class women in North America and Britain – in the clinical literature from 1913 to the present, the author identifies four shifts over time. These are: 1) varying degrees of clinical interest in and numbers of publications on self-injury, 2) changing conceptualizations of self-injury, 3) changing treatment approaches for self-injury, and 4) changing characterizations of women who self-injure. Moving from research studies which indicate that self-injury typically presents in females during adolescence, this article elucidates how self-injury may reflect girls' developmental struggles within a patriarchal culture and embody a narrative of women's experiences of violation. Bringing together the history of self-injury and a feminist, relational analysis, it is argued that the historical discourse on self-injury mimics women's experiences of objectification and violence by silencing and distorting their self-injury.

Key Words: *adolescence, female development, relational psychology, self-injury, self-mutilation*

INTRODUCTION

Tracing the study of episodic and repetitive self-injury in girls and women – a body of work focused primarily on white, middle-class women in North America and Britain – from the first publication in the early 1900s through the year 2000 reveals that self-injury repeatedly appears and then disappears in the clinical literature. Beginning with a single case study in 1913 (Emerson), scholarship on self-injury proceeds in fits and starts over the course of the 21st century with distinct periods of publications in the 1930s, between the mid-1960s and the mid-1970s, and then from the mid-1980s to the present. Examining these periods of

interest in self-injury illuminates a series of perplexing shifts in how this behavior has been conceptualized and treated, and how girls and women who self-injure have been portrayed.

Grounded in a feminist and relational reframing of self-injury, and predicated on the empirical research which indicates that self-injury is a gendered and developmental phenomenon (Simpson, 1975; Doctors, 1981; Conterio and Lader, 1998), I illustrate how the shifting historical discourses[1] on self-injury, as well as the alternating presence or absence of discourse, may shed light on the act itself. Specifically, I propose that self-injury reflects girls' and women's experiences of relational and cultural violations, silencing and objectification. I further argue that the history of this literature at points replicates this process by ignoring and distorting girls' and women's self-injury.

I use a sociocultural analysis, drawing on a relational reframing of self-injury (Rogers, 1996a; Machoian, 1998) and Kleinman's (1988a) work on illness narratives. Illness, here self-injury, is understood as inextricable from a larger culture of values and social relations that 'shape how we perceive and monitor our bodies, label and categorize bodily symptoms, interpret complaints in the particular context of our life situation; [and how] we express our distress through bodily idioms' (Kleinman, 1988a: xiii). By the same token, culture shapes how we conceptualize, give meaning to, and understand clinical phenomena. In Kleinman's words: 'Psychiatric concepts, research methodologies, and even data are embedded in social systems' (1988b: 3–4). Thus, self-injury has meaning on individual, social and cultural levels. The bodily idiom through which women express their psychological distress is meaningful, and self-injury reflects women's experiences of distress in this culture. Furthermore, how self-injury is conceptualized and treated, as well as how women are portrayed, is socially and culturally embedded.

Episodic and Repetitive Self-Injury

Episodic and repetitive self-injury (Favazza, 1996) refers to behavior that occurs in the absence of psychosis, organic intellectual impairments and incarceration. Self-injury is described by Walsh and Rosen as 'the deliberate, non-life-threatening, self effected bodily harm or disfigurement of a socially unacceptable nature' (1988: 10). It is understood as distinct from suicide attempts and other forms of self-injuring behavior such as self-poisoning (Farberow, 1980; Schwartz et al., 1989; Sonneborn and Vanstraelen, 1992; Safer, 1997; Deiter and Pearlman, 1998) in terms of intent, physical damage, frequency, prognosis and methods (Walsh and Rosen, 1988). It has even been characterized as 'anti-suicide' (Simpson, 1975: 432).[2] Distinguishing episodic and repetitive self-injury from other forms of self-harming behavior is critical to this analysis, because the shifts I document in the historical discourse are particular to this behavior.

Although there are no comprehensive prevalence studies of episodic and repetitive self-injury in the general population, some authors characterize it as

common, underreported and on the rise (Ferrence et al., 1975; Pipher, 1994; Patton et al., 1997). Given the limitations of available studies, it is unclear whether there are prevalence patterns in terms of class, race and ethnicity. The historical literature, and therefore my analysis to follow, is based almost exclusively on samples of white women. Despite these skewed samples of past years, more current publications have noted working-class black and south Asian young women in Britain who self-injure (Babiker and Arnold, 1997, in Smith et al., 1999; Marshall and Yazdani, 1999). In addition, a US study with an inpatient sample at a state facility reported high rates of self-injury among Latina girls (Lipschitz et al., 1999).

Studies based on self-selected samples of the general population (Favazza and Conterio, 1989; Patton et al., 1997), college student samples (Favazza et al., 1989) and clinical samples (Phillips and Alkan, 1961a; Graff and Mallin, 1967; Pao, 1969; Rosenthal et al., 1972; Simpson, 1975; Bennun, 1983; Ghaziuddin et al., 1992; Langbehn and Pfohl, 1993; Herpertz, 1995) indicate that the vast majority of individuals who self-injure are female. Episodic and repetitive self-injury is documented in males, but this work (for example, Johnson, 1978; Ross, 1980; Rosen et al., 1990; Shea, 1993) primarily documents self-injury in institutional contexts where the behavior may be attributable to institutionalization. Clendenin and Murphy (1971), Weissman (1975) and Kaplan and Fik (1977) have been credited with refuting studies and clinical wisdom that depict self-injury as peculiar to women because each of these studies reports 'wrist-cutting' in men. What seems to have been overlooked is that these studies were based on samples of suicide attempters and thus may not be comparable to studies based on samples of individuals who cut their wrists in the absence of suicidal intent.

Acts of self-injury tend to begin in adolescence and peak between the ages of 16 and 25 (Favazza and Conterio, 1988; Arnold, 1995). Cutting on the forearms predominates and the physical damage is typically minimal but in some instances may require medical attention (Bongar et al., 1990; Langbehn and Pfohl, 1993). Methods less frequently reported include burning, hitting and interference with wound healing (Favazza and Conterio, 1988).

Studies abound linking childhood sexual and physical abuse and emotional neglect to the later development of self-injuring behavior (De Young, 1982; Darche, 1990; van der Kolk et al., 1991; Romans et al., 1995; Zlotnick et al., 1996; Dubo et al., 1997a). In addition, self-injury is associated with early parental loss, illness or surgery, marital violence, and familial impulsive self-destructive behavior, as well as loss, peer difficulties, body alienation and impulse disorder in adolescence (Walsh and Rosen, 1988).

Women who self-injure are commonly diagnosed with personality disorders (Walsh and Rosen, 1988; Casey, 1992; Zweig-Frank et al., 1994; Brodsky et al., 1995; Dubo et al., 1997b). The behavior also frequently presents in diagnoses relating to eating, dissociation, mood, anxiety and substance dependence (Garfinkel et al., 1980; Schwartz et al., 1989; Darche, 1990; Favazza, 1996; Zlotnick et al., 1996). However, not all girls and women fit neatly into diagnos-

tic categories (Hawton and Catalan, 1987; Herpertz, 1995). Suyemoto and MacDonald's study found that many girls cut themselves in the wake of 'temporary stressors and difficulties' (1995: 168).

Favazza et al.'s study (1989; cited in Favazza and Rosenthal, 1990) of psychology undergraduates found that 12 percent self-injured. Lena and Bijoor (1990), Orenstein (1994), Pipher (1994) and Levenkron (1998) all describe case studies of middle- and high-school girls and college women who function well in many domains yet self-injure. Fennig et al. (1995), investigating self-injury in a public high school, found the behavior was practiced primarily by 'popular' girls who excelled academically. This apparent phenomenon of self-injury in the general population has recently captured a wider audience as evidenced by media coverage (Todd, 1996; Egan, 1997), advice columns (for example, Ask Beth, 1996), novels (for example, McCormick, 2000) and personal narratives (for example, Kettlewell, 1999).

Many women who self-injure never disclose their behavior due to stigma and shame over their behavior (Turner and Morgan, 1979; Simpson, 1980). Such barriers to treatment may be especially accentuated in localized cultural communities that perceive '"sharing" problems outside the family as inappropriate' (Marshall and Yazdani, 1999: 425), as research conducted with south Asian, self-harming women in Britain found. Those who do seek treatment have been reported to present in emergency rooms, psychiatric hospitals and therapists' and primary care physicians' offices (Johnson et al., 1973; Whitehead et al., 1973; Morgan et al., 1976; Favazza, 1996). Women who receive professional help (Favazza and Conterio, 1988, 1989; Arnold, 1995) indicate a high rate of dissatisfaction with treatment.

TRACING THE HISTORICAL STUDY OF SELF-INJURY

Self-Injury Enters the Clinical Literature: 1913 and the 1930s

Emerson makes the first contribution to the clinical literature on episodic and repetitive self-injury with a case study in 1913 and, in 1935 and 1938, Menninger provides the first systematic, and most widely cited, discussion of self-injury. Emerson's (1913–14) account of Miss A. reveals an approach to understanding self-injury grounded in her subjective experience. Miss A. articulates that her self-injury is related to a number of factors: the need to relieve headaches and nightmares of incest she experienced; distress over past romantic relationships, especially an incident in which her ex-fiancé called her a 'whore' and left her because she was not a virgin; and 'bitterness' over her thwarted desire to have a child because of her unmarried status. In an empathic discussion, Emerson concurs with Miss A. and suggests that cutting represents the tension between Miss A.'s difficulty in bearing psychic pain and anger as a result of the abuse she suffered and her unrealized longing 'to live a full life' (1913–14: 53).

In line with Emerson and his emphasis on Freudian concepts, a psychoanalytic perspective forms the basis for early understandings of self-injury. Menninger (1935, 1938) posits that 'self-mutilative' acts are on a continuum wherein all people engage in some form of non-fatal bodily self-destructive behavior. He theorizes that in all cases 'self-mutilation' symbolizes a struggle between the life instinct and the death instinct whereby a compromise is 'struck' through the act between 'instinctive' and 'repressing forces' (1935: 450). As such, self-injury is 'the choice of the lesser evil' (1938: 406) and 'an attempt at self-healing, or at least self-preservation' (1935: 450).

Although Dabrowski (1937) also sees all acts of 'self-mutilation' as sharing a common underlying dynamic, his vision of the motivations and causes behind self-injury are much less benign and therefore in contrast to Emerson and Menninger. Dabrowski (1937) differentiates between 'self-mutilation' in 'states of psychomotor hyperexcitability' (1937: 7), 'acute psychoneurotic conditions' (1937: 12), 'neuropathic dramatization and hysteria' (1937: 16), 'feelings of inferiority, guilt, or the need to be in the spotlight' (1937: 22), and 'emotional hyperexcitability and lack of mental balance' (1937: 29). Similar to Dabrowski's less forgiving vision of self-injury, Ackerman and Chidester (1936) hypothesize that adolescent self-injury represents a need to self-hurt or punish arising from guilt over sexual fantasies, a ploy for attention and sympathy, and an expression of anger toward others.

Menninger is the only author to put forth general treatment recommendations. He urges the need for a holistic approach, involving psychoanalytic psychotherapy and attention to family dynamics and the social environment. Psychotherapy centers on the physician–patient relationship and seeks to 'reduce the self-destructive trend, and increase the capacity for living and loving' (1938: 446). He observes that treatment and acknowledgement of the phenomenon of 'self-mutilation' may be challenging for clinicians because it is a 'taboo' subject, one that most would prefer to, and do, deny. Menninger cautions his audience to take this into consideration:

> I must warn the reader that what follows in this chapter is not very pleasant subject matter. Our experience with pain makes the thought of self-mutilation even more repugnant than the thought of suicide, in spite of the great reality differences in favor of the former (Menninger, 1938: 231).

Both Menninger and Emerson conceive of self-injury as a meaningful phenomenon that presents in 'normal' and 'pathological' populations. Individuals who self-injure are portrayed as complex and fully human, possessed of subjectivity. In the case of Miss A., Emerson makes considerable effort to illustrate this, describing her as 'completely amenable, showing excellent judgment' (1913–14: 42) and 'natural intellectual ability' (1913–14: 44). In contrast, what is apparent in Dabrowski's choice of language (for example, 'the need to be in the spotlight', 'neuropathic dramatization and hysteria' and 'emotional hyperexcitability') and, in Ackerman and Chidester's view, is a less sympathetic

portrayal of self-injury, and a tendency to assign pejorative characteristics to those who self-injure.

Early Clinical Literature: The Mid-1960s to the Mid-1970s

After Menninger's foundational works in the 1930s until the mid-1960s, I found no publications on episodic and repetitive self-injury, only scattered accounts of self-injury as manifest in psychosis, pervasive developmental disabilities, incarceration and other distinct psychological disorders. This absence of publications has not been previously noted because it has been assumed that the study of self-injury was simply subsumed in the suicide literature (for example, Graff and Mallin, 1967). This, however, is an erroneous assumption that not only conflates self-injury and suicide but also fails to look carefully at the literature in question. My examination of the suicide literature reveals that what is actually investigated in this scholarship is primarily self-poisoning, not self-injury (Kreitman, 1977; Pierce, 1977; Hawton and Catalan, 1987; Demoore and Robertson, 1996; Hall et al., 1998). Thus, I feel confident in making the claim that episodic and repetitive self-injury at points drops out of the clinical literature.

During the mid-1960s to the mid-1970s, a cluster of articles emerge on women's episodic and repetitive self-injury in psychiatric facilities. It is described as 'common' (Lester, 1972), underreported (Phillips and Alkan, 1961a, 1961b; Siomopoulos, 1974), and a 'major psychiatric' problem 'frequently seen both on mental hospital wards and in general emergency rooms' (Nelson and Grunebaum, 1971: 81).

These articles share with the work from 1913 and the 1930s a psychoanalytic framework while enlarging their vision to incorporate relationships and environmental context (Podvoll, 1969; Crabtree and Grossman, 1974). The dominant understanding links self-injury to early maternal deprivation, an inability to express feelings and the interpersonal context of the hospital ward (Graff and Mallin, 1967; Rosenthal et al., 1972; Herzberg, 1977). Self-injury is seen as an attempt to re-establish ego boundaries when faced with 'loss or abandonment . . . or an impasse in interpersonal relations' (Simpson, 1975: 432). It is depicted as a sequence of events wherein women, unable to verbally articulate their feelings surrounding a loss of connection, feel increasingly numb, and self-injure 'as a direct means of achieving reintegration and repersonalization' (Simpson, 1975: 432). In this way, self-injury is viewed as 'adaptive' (Novotny, 1972: 510), tension-relieving and self-soothing (Rosenthal et al., 1972; Waldenberg, 1972; Gardner and Gardner, 1975).

Self-injury is framed in a larger cultural context as a behavior that arises within interpersonal relationships and social environments that may perpetuate it (Matthews, 1968; Roback et al., 1972). Podvoll (1969) asserts that self-injury is an expression of 'feelings and experiences' (1969: 217) that 'to a greater or lesser degree, remain unarticulated in most of us' (1969: 219). 'As such', the woman who self-injures may 'perform a service to her culture in dramatic

expression of those patterns which are felt to be intolerable within the self' (1969: 219). Offer and Barglow (1960) show how this phenomenon has 'hospital-wide repercussions' (1960: 204) as staff divide over how to respond. The 'resultant personnel confusion, guilt, and anxiety further undermine superego controls, resulting in propagation of self-mutilation' (1960: 203) and epidemics of the behavior. Several authors (Offer and Barglow, 1960; Podvoll, 1969; Simpson, 1976) note that rigid controls instituted to manage self-injury may fuel the behavior. Indeed, Crabtree and Grossman (1974) found that restructuring a closed psychiatric unit into an open unit decreased self-injury by 94 percent.

Treatment in this period centers on individual psychodynamic therapy (Kafka, 1969; Pao, 1969) 'directed at fostering more mature methods of giving and receiving love' (Graff and Mallin, 1967: 36). The therapist's job is to facilitate meaning making as 'slashing contains a message not recognized by others in the patient's life' (Graff and Mallin, 1967: 39). Other approaches include building relationships with role models, relaxation, community responsibilities, family and group therapy and assertiveness training (Grunebaum and Klerman, 1967; Roback et al., 1972). Medication alone is discouraged, as is psychotherapy focused solely on insight (Crabtree, 1967; Grunebaum and Klerman, 1967; Simpson, 1976). Nelson and Grunebaum's (1971) follow-up study found that more than half of the patients 'were well or improved' six years after their original contact with the hospital.

During this time from the mid-1960s to the mid-1970s, there is a call for honest engagement with women. Psychiatric staff are encouraged to voice their responses to self-injury and to negotiate hospital policies and conflicts in relationship with women (Crabtree, 1967; Nelson and Grunebaum, 1971). There is acknowledgement of positive as well as negative feelings toward patients and recognition that clinicians may become overwhelmed by self-injury, and consequently respond punitively (Battle and Pollitt, 1964; Ballinger, 1971; Kroll, 1978). There are lengthy discussions of counter-transference and the challenges posed by working with women who self-injure (Crabtree, 1967; Kafka, 1969). For example, Simpson (1975) reports an 'epidemic' of self-injury in which 12 patients and two nurses, 'so disturbed by the sequence of events . . . felt compelled to cut themselves' (1975: 432). Clinicians express a mixture of fear, anger, guilt, frustration, fondness, helplessness, wishes to save the patient and perceived threats to their competence.

In a likeness to Emerson's portrayal in 1913, women in this period tend to be portrayed with socially valued qualities (for example, Simpson, 1975). For instance, Burnham (1969) describes women who self-injure as 'really committed to treatment' and capable of 'highly collaborative' treatment relationships (1969: 225). Grunebaum and Klerman characterize women who self-injure as: 'young, attractive, intelligent, even talented, and on the surface socially adept . . . . They appear "normal" except when periodically overwhelmed by inner emotional tensions . . . . They are usually people who at one time acted responsibly on their jobs or at school' (1967: 113–14).

MORE RECENT CLINICAL LITERATURE: MID-1980S TO THE PRESENT

While the mid-1970s to the mid-1980s evidence few articles on episodic and repetitive self-injury, the mid-1980s to the present show dramatic growth in publications. Resembling the earlier literature, self-injury is proclaimed common and underreported (Conn and Lion, 1983; Favazza, 1998).

I have divided this period into two bodies of work. The first comprises literature published in conventional academic journals. The second and smaller body of work exists on the margins of traditional scholarship and has grown out of dissatisfaction with the dominant discourse in conventional journals. This work includes articles in journals focused on trauma, or with feminist sensibilities, as well as literature from psychiatric consumer advocacy organizations, personal narratives and dissertations.

Conventional Discourse

There has been a surge of explanations to understand self-injury since the mid-1980s. For brevity, I summarize psychologically based conceptualizations which, in varying degrees, draw on earlier conceptualizations. I then highlight significant contemporary developments based on diagnostic classifications, increased emphasis on the impact of trauma, and advances in neuroscience.

At the risk of oversimplifying, I have categorized psychological conceptualizations into psychodynamically oriented models and behavioral models. Psychodynamic approaches offer several rationales, envisioning self-injury as inward-turned aggression, primitive functioning, perceived alienation and body image distortions. The self-injury punishes the self and others, expresses psychic pain, gratifies repressed sexual feelings, regulates affect and organizes the internal object world (Bennun, 1984; Figueroa, 1988; Suyemoto, 1994; Favazza, 1996).

Behavioral models underscore a communicative purpose of self-injury, a 'contagion' effect whereby self-injury is a function of peer influence as in hospital epidemics, and self-injury as an operant response to the environment. Other behavioral models – as well as psychodynamically orientated models – attribute women with less benign motives such as attention-seeking and manipulation (Bennun, 1984; Feldman, 1988; Favazza, 1996). Although behavioral explanations of self-injury are not unique to this period, they have gained prominence and serve to buttress pejorative portrayals of women who self-injure.

The first contemporary development in the conceptualization of self-injury entails constructing self-injury as a syndrome of impulse dysregulation (Kahan and Pattison, 1984; Favazza and Rosenthal, 1993; Evans et al., 1996; Favaro and Santonastaso, 1998). Here, the behavior is viewed as addictive; interpersonal and environmental factors are de-emphasized; and the pathology is located within individual women and in their inability to resist self-destructive impulses.

A plethora of research on trauma since the mid-1970s has led to increased

emphasis on the role of childhood sexual and physical abuse, neglect and other manifestations of trauma in self-injuring behavior. This second contemporary development illuminates how self-injury may be a coping strategy as trauma survivors attempt to manage feelings of powerlessness, dissociation, intrusive memories, compulsions to re-enact the trauma and punish the body, and bodily alienation (Shapiro, 1987; van der Kolk, 1989; Young, 1992; Miller, 1994).

Last, neurobiological research made possible only in recent times shows that self-injury has physiological antecedents and consequences which may fuel the behavior, making it especially difficult for those who self-injure to stop (Winchel and Stanley, 1991; Simeon et al., 1992; Stanley et al., 1992; Haines et al., 1995).

Despite the different conceptualizations of self-injury from the mid-1980s to the present, there are commonalities, and many authors understand self-injury in terms of more than one model. There is agreement in the literature that self-injury is a response to symptoms of psychological distress such as dissociation, feelings of helplessness and anxiety. The act provides relief and a sense of control (Simpson, 1980; Favazza, 1996).

The more recent literature does depart from earlier conceptualizations in de-emphasizing interpersonal and environmental factors. Any mention of inter-personal elements is within the context of epidemics wherein patients are held responsible for the spread of self-injury (Walsh and Rosen, 1985; Rosen and Walsh, 1989). Most prominently, with only a few exceptions (for example, Hart-man, 1996), the roles culture, social structures, hospital environments, relation-ships and clinicians may play in fostering conditions conducive to self-injury have been omitted from current discourse. Contemporary developments in con-ceptualizing self-injury – particularly the identification of biological factors and a greater appreciation of the pervasiveness and profound consequences of trauma – would seem likely to facilitate a move away from behavioral and blame-orientated understandings of self-injury and toward increasingly sympathetic treatments and portrayals of women who self-injure. However, this has not been the case.

There has been a remarkable shift in the discourse on treatment which reflects more general changes in the mental health profession, including a shift away from psychodynamic therapy, and a push toward pharmacological treatment and short-term approaches (Grob, 1994; Shorter, 1997). In spite of the remnants of a psychodynamic orientation (for example, Cross, 1993; Waska, 1998) that persists today in understanding this phenomenon, current treatment models focus pre-dominantly on symptom removal, cognitive-behavioral techniques, medications and contracts (Conn and Lion, 1983; McEnany and Tescher, 1985; Moyes et al., 1985; O'Brien et al., 1985; Linehan, 1987). This is a shift from the historical literature, which demonstrates clinicians' philosophy of treating women in a holistic and engaged fashion with a focus on intrapsychic dynamics, interpersonal and environmental relations, the clinician–patient relationship, and meaning making. Current treatment is characterized by disengagement with women who self-injure.

To be sure, there is evidence in the recent literature of a diversity of treatment options including psychodynamic therapy (Kernberg, 1987; Rockland, 1987), group therapy (Conterio, 1985; Marziali and Munroe-Blum, 1987), cognitive-behavioral therapy (Rosen and Thomas, 1984; Kaminer and Shahar, 1987), hypnosis and relaxation (Malon and Berardi, 1987), art therapy (S.A.F.E., 1996), medications (Liebowitz, 1987; Favazza, 1996), inpatient (Pawlicki and Gaumer, 1993) and eclectic approaches (Keane, 1997). However, relationship-oriented approaches that facilitate empowerment and empathic exploration of women's internal and external worlds are in large part given lip service relative to other approaches. To give justice to the minority of clinicians writing in the conventional clinical discourse who articulate the need for authentic engagement with women, I refer readers to Kroll (1988), Tantam and Whittaker (1992), Noshpitz (1994a, 1994b) and Alderman (1997).

The literature in the 1960s and 1970s poignantly speaks to clinicians' fears, puzzlement and, at times, anger and punitive responses in working with women who self-injure. These women are undoubtedly seen as presenting a formidable challenge; however, the prevailing attitude is of engagement and care. In contrast, current discourse reflects a spirit of antagonism and powerfully speaks to the pervasiveness of pejorative attitudes (Aldridge, 1988; Favazza, 1989a; Blessing, 1990; van Moffaert, 1990, 1991).

Current discourse frames the behavior as 'treatment resistant' (Valente, 1991: 19) and a management problem (Feldman, 1988; van Moffaert, 1990, 1991; Allen, 1995). The challenge of working with women who self-injure is a theme that recurs with startling regularity throughout the literature. Authors note clinicians' troubled responses including distress, anger and powerlessness (Frances, 1987; Zerbe, 1988; Favazza, 1996). Unlike earlier literature, however, the discussion ends here, with little effort to analyze how these responses impact on treatment. Often, treatment that began with the premise of developing a trusting relationship evolves into a power struggle around terminating the behavior (Conn and Lion, 1983; Rockland, 1987; Haswell and Graham, 1996). Clinicians seem to lose sight of the widely supported conceptualization of self-injury as primarily an attempt to reduce symptoms of psychological distress and begin to view the behavior as 'emotional blackmail' (Kwawer, 1980: 214).

As clinicians' frustration and distress grows, treatment can take on elements of coercion and blatant mistreatment (Conn and Lion, 1983; Frost, 1995; Haswell et al., 1996). Women are physically restrained and threatened with abandonment by therapists if the self-injury does not cease (Arnold, 1995; Favazza, 1996; Spandler, 1996; SHOUT, 1998a, 1998b). There are examples of women sutured without anesthesia, scrubbed with wool surgical sponges on open wounds as a deterrent, told they do not deserve medical treatment because their injuries are self-inflicted, and locked in quiet rooms for days (Favazza, 1989b; Blessing, 1990; Pembroke, 1996; SHOUT, 1998a, 1998b).

In contrast to early descriptions of women who self-injure as 'attractive', 'intelligent' and 'talented', these adjectives virtually disappear. Moreover, they

have been replaced by pejorative adjectives such as 'manipulative' (Lion and Conn, 1982: 782) and 'attention-seeking' (Hartman, 1996: 7).

Aldridge succinctly speaks to this attitude toward women:

> Both the medical and nursing staffs of the hospital ward saw these women as difficult patients who presented a management problem. The patients were described as unresponsive to treatment, hostile, manipulative, aggressive, illegitimate in their claims, difficult, uncooperative, and seeking control . . . they were not seen as mentally ill, but as disorderly. If the patients did not respond as staff expected once the staff had implemented treatment strategies to manage the patients' behavior, their behavior was not regarded as legitimate (1988: 10).

Feminist Contributions and a Relational Reframing

A feminist and relational reframing of self-injury echoes the 1960s and 1970s in its emphasis on empathy and engagement, as well as intrapsychic, interpersonal, environmental and cultural factors. Work from that early period is extended in this contemporary literature by introducing an analysis of gendered development, power relations, a critique of psychiatry and women's subjective experiences. Feminists and psychiatric consumer advocates argue that self-injury has been 'misrepresented and distorted' (Himber, 1993: 207; Johnstone, 1997). Girls' and women's articulation that self-injury is 'self-sustaining' (Himber, 1993: 155), effective in literally keeping women alive, and that self-injury is primarily a means to manage distress (Connors, 1996a; Solomon and Farrand, 1996) is high-lighted.

These works, grounded in research on women's experiences of self-injury, challenge the conventional discourse of the contemporary literature and contest the view that self-injury is an act intended to manipulate. Self-injury may be a communication to others or to the self, but manipulation or 'emotional blackmail' (Kwawer, 1980: 214) is not the goal. Rather, the goal is to communicate over-whelming psychic pain (Himber, 1993; Frost, 1995; Collins, 1996). Indeed, women report tremendous shame over self-injury, shame that may be exacerbated by clinicians' accusations of manipulative intent and coercive treatment. Consequently, many women go to great lengths to hide their behavior (Favazza, 1996; Pembroke, 1996).

This feminist-infused scholarship delineates that women may self-injure not only because they feel unable to articulate their experiences, but also when 'language fails' (Himber, 1993: 174). Self-injury is a last attempt to have others take them seriously. McLane eloquently elucidates that self-injury, in cases of child abuse, may be the only form of communication that adequately speaks to the experience:

> 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 her pain (McLane, 1996: 114).

Self-injury is understood as a means for women to gain control when they feel
they have no control in other realms of their life (Burstow, 1992; Spandler, 1996).
Bringing in an analysis of power relations, Smith et al. (1999) hypothesize that
such a lack of perceived control and powerlessness is linked to broader systems
of gender, class, racial and ethnic based oppression which play a contributing role
in the emergence of self-injury. For women who have experienced trauma, self-
injury may induce a sense of efficacy and relieve feelings of victimization
(Himber, 1994; Solomon and Farrand, 1996). Paradoxically, self-injury can also
feel frightening when women feel unable to control the behavior. Here, prohibi-
tions against self-injury may be experienced as particularly punitive.

Rogers (1996a) and Machoian (1998) offer an understanding of self-injury
grounded in a model of relational psychology. By bringing in research on girls'
and women's development, they offer an explanation for why this behavior is
predominantly seen in females and typically presents in adolescence. A relation-
al reframing of self-injury shifts this behavior from one that is located in the indi-
vidual woman's pathology to one that is a symptom of a larger relational crisis
for girls and women in western culture.

The basic premise of a relational orientation posits that humans are 'funda-
mentally relational', and 'born with an innate capacity for, and desire to engage
in, relationships' (Spencer, 2000: 2). Emotional connections are assumed to be
necessary for psychological health, growth and a sense of self (Spencer, 2000).
From this perspective, authentic or genuine relationships are those that provide
emotional sustenance and allow for open disagreement. Such relationships create
a space to be heard and validated, and an experience that facilitates the ability to
act in and beyond the relationship (Jordan et al., 1991). False relationships are
those marked by a need to cover over one's knowledge, feelings and experiences,
and lead to an increasing inability to act and emotional disengagement (Gilligan
et al., 1991; Rogers, 1996b, Spencer, 2000).

Research based on girls and women in the US indicates that adolescence is a
risk period for girls who struggle to stay in relationship with themselves and their
relational worlds. Girls may feel torn between what they think and feel internally
and what the external world puts forth as reality (Jordan et al., 1991; Brown and
Gilligan, 1992). There is a 'coming not to know what one knows, the difficulty
in hearing or listening to one's voice, [and] the dissociation between mind and
body, thoughts and feelings' (Gilligan, 1982/1993: xxi). This struggle to find a
voice that is legitimated in the culture and at the same time maintain relationships
in the external world may paradoxically result in the loss of voice or resistive
strategies to maintain voice. This dilemma can lead to the consequent appearance
of psychological symptoms such as self-injury, eating disorders and depression.

According to Rogers, acts of self-injury are 'culturally unacknowledged
forms of self knowledge and self expression for girls' (1996a: 2) where 'what
cannot be known or named in girls' experience finds a new language – a know-
ledge written on her body' (1996a: 7). Similarly, Machoian (1998) delineates
how girls' need for authentic relationship is impeded by their discovery that

preserving relationships may require capitulation to cultural norms of feminine behavior. This capitulation results in false relationships where girls struggle to be known and to know others authentically. Here, self-injury may arise as girls learn to use the cultural 'language of violence' (Machoian, 1998: 112) against themselves in the hope that self-injury will open the possibility for genuine relationships.

This literature advocates long-term supportive therapeutic relationships where women can co-construct meaning of their self-injury in the context of their lives (Arnold and Magill, 1996; Connors, 1996b; Sapsford, 1997). Therapy may take a variety of forms including individual psychotherapy, creative therapies, mutual support, self-help, and community activism (Trautmann and Connors, 1994; Parker and Lindsay, 1996; Pembroke, 1996; Rogers, 1996a; Sapsford, 1997).

Feminist and psychiatric consumer advocates' vision of treatment is similar to Emerson's (1913–14), Menninger's (1938), and the discourse from the 1960s and 1970s. The approach adheres to research that concludes that authentic relationships in therapy are necessary for healing. This research also suggests that efforts to eradicate self-injury through strict controls are ineffective, may escalate self-injury, and may be more reflective of clinicians' needs to allay their discomfort about self-injury than the needs of women who self-injure (Offer and Barglow, 1960; Crabtree, 1967; Connors, 1996b).

Harsh criticism is leveled against prevailing treatment. This literature argues that condemnation from mental health professionals, punitive approaches and failure to engage with women and recognize the ways in which self-injury helps women cope may lead to lowered self-esteem and can be the catalyst for women to terminate treatment (Arnold, 1995; Pembroke, 1996; Johnstone, 1997). Some writers frame treatment as another form of self-abuse (Blessing, 1990) and traumatic re-enactments (Spandler, 1996; Johnstone, 1997). Rigid contracts demanding the cessation of self-injury are seen as destructive to the therapeutic alliance, taking control from women, and may lead to the emergence of less overt forms of self-injury (Himber, 1993; Arnold, 1995; Mazelis, 1997).

Girls and women who self-injure are neither idealized nor denigrated in this work. Their behavior is seen as an adaptive response – albeit with serious consequences – (Frost, 1995; Solomon and Farrand, 1996) to experiences of trauma, violations and silencing in a culture that fails to provide adequate opportunities for women's development, healing and expression.

MAKING MEANING OF THE SHIFTS AND ABSENCES: A HISTORICAL RE-TELLING

The preceding review of the study of self-injury over the past century illuminates a series of shifting discourses punctuated by absences of discourse. Bringing together this historical perspective with a feminist, relational analysis of the behavior itself, the remainder of this article argues that the clinical literature

on self-injury reproduces the very distorting and violating experiences in a patriarchal culture that facilitate the emergence of women's self-injury.

In detailing the discourses on episodic and repetitive self-injury from the first appearance in the clinical literature to the present manifestations, two persisting themes are striking: 1) contrasting descriptions of self-injury in terms of conceptualization, treatment and the characterization of girls and women; and 2) clinicians' intense distress in the face of self-injury. The first theme becomes apparent by contrasting the accounts of self-injury put forth by Emerson (1913–14) and Menninger (1935, 1938) with the accounts put forth by Dabrowski (1937) and Ackerman and Chidester (1936); by contrasting the discourse in the 1960s and 1970s with the conventional discourse in the 1980s and 1990s; and by contrasting feminist and psychiatric activist accounts in the 1980s and 1990s with the conventional discourse.

These contrasts illustrate that the discourses oscillate between the inclination to understand self-injury as a meaningful expression of women's intrapsychic, interpersonal and cultural experiences and the understanding of self-injury as illegitimate, and a form of 'emotional blackmail' (Kwawer, 1980: 214). The inclination to authentically engage with women in treatment and make meaning of the behavior vies with treatment directed toward eradicating the behavior regardless of women's protestations that the behavior serves a 'self-sustaining' function (Himber, 1993). Last, the inclination to portray women as insightful and 'good candidates for psychoanalytic psychotherapy' (Burnham, 1969: 225) contrasts with their portrayal as manipulative and 'unresponsive to treatment' (Aldridge, 1988: 10).

Looking at these contrasts, what comes into focus is that shifts occur as soon as self-injury begins to be conceptualized as meaningful and related to women's experience in the world, as soon as women engage in treatment founded on genuine relationship, and as soon as women are portrayed as possessed of subjectivity and in legitimate pain. There is then either an abrupt shift to counter this understanding with pathologizing conceptualizations, clinicians' disengagement from women, and disparaging characterizations, or the subject drops out of the literature. This occurs despite recognition at each historical period that the behavior is common and a pressing concern.

The second theme – of clinicians' intense distress in the face of self-injury – is apparent from Menninger's (1938) observation that because self-injury is perceived as 'taboo', it is often misunderstood and is a phenomenon which many clinicians would prefer to, and do, deny. Clinicians in the 1960s and 1970s repeatedly assert that self-injury is unsettling and the cause of disturbing countertransference (Crabtree, 1967). Again, in the 1980s, self-injury is cited as distinctly unnerving. As Frances writes:

> Of all disturbing behaviors, self-mutilation is the most difficult for clinicians to understand and treat. Most of us have a much greater immediate empathy for a patient's depression or anxiety, and even for violent impulses and psychotic

> thinking, than we do for the relief some patients feel when they hurt and scar themselves. The typical clinician (myself included) treating a patient who self-mutilates is often left feeling some combination of helpless, horrified, guilty, furious, betrayed, disgusted, and sad (Frances, 1987: 316).

Bringing together these themes, the shifts in the discourse and the puzzling absences of literature at points begin to make sense. It is as if there is something so disturbing about this behavior that clinicians feel the need to preclude the possibility of deepening their understanding of self-injury, to move away from in-depth explorations of the phenomenon, or to ignore the presence of the phenomenon. In other words, clinicians, as evident in the absence of discourse at historical points, pull back from the investigation of self-injury as they come closer to making meaning of the behavior and potentially grasping its significance. They do so by failing to document and explore the phenomenon in the clinical literature, dismissing the behavior as the willful manipulation of deviant, pathological women, or alternatively by disengaging from women in treatment.

The question then that arises is: What is so unsettling about self-injury that clinicians feel the need to pull back from the behavior? Given the consensus in the literature that self-injury is 'life-preservative' (Kahan and Pattison, 1984: 17), an effective means of reducing symptoms of psychological distress, and typically results in superficial physical damage, the degree to which self-injury arouses distress and the extent to which such distress deflects attention from women's own understanding of their behavior is curious.

The catalyst for clinicians pulling back from the discourse on self-injury and authentic engagement in treatment seems to revolve around what it means for girls and women to cut, burn and hit themselves. Following Kleinman (1988b) that, in understanding 'illness' it is critical to locate the cultural context in which it emerges, the ensuing discussion examines possible meanings of self-injury in North American and British contexts as this is where it is centered in the clinical discourse.

Specifically, why is self-injury the bodily idiom through which girls and women express and manage psychological distress? What does it mean within this western culture for girls and women to self-injure? And why, given the pervasive culturally sanctioned ways in which women's bodies are objectified and violated and the presence of cultural conditions that encourage women to hate their bodies, is there such alarm when these women bring violence on themselves by their own hand?

In exploring the cultural context in which self-injury emerges, it is immediately transparent that episodic and repetitive self-injury is not socially sanctioned. It is constructed as pathological and typically experienced by outsiders as unsettling. On the basis that self-injury involves a deliberate destruction of body tissue and is perceived as causing pain (although many women do not report pain during the act [Favazza, 1996]), these interpretations follow logically and intuitively. However, the logic and intuitive nature of such interpretations come

into question when self-injury is considered alongside other behaviors which also involve the deliberate destruction of body tissue and cause pain.

Women voluntarily undergo culturally sanctioned procedures which are painful and physically destructive for the sake of western beauty ideals. Such behavior is not interpreted as pathological or deviant. Women pluck, cinch, inject toxic substances, and have cellulite vacuumed out of their thighs. As Dworkin asserts: 'not one part of a woman's body is left untouched, unaltered. No feature or extremity is spared the art, or pain of improvement' (1974: 113). 'Pain is an essential part of the grooming process . . . no price is too great, no process too repulsive, no operation too painful for the woman who would be beautiful' (1974: 115).

Even the image of girls and women diagnosed with eating disorders who admittedly are labeled pathological when the behavior goes beyond the culture's tolerable limits, and who starve, binge and vomit, does not unsettle as self-injury does. On television, in magazines and on the internet, women are contorted into uncomfortable positions, painted, and sometimes enslaved and in pain. Yet, although not acceptable to all, these images are understood as pleasing and sexually gratifying. Boys and men break bones by punching walls and playing football in the name of frustration, masculinity and sport. Professional athletes perform amazing feats that push the body beyond its natural capacities and they are revered for their strength.

In comparing behaviors such as those noted above to episodic and repetitive self-injury, what becomes startlingly clear is that self-injury involves women taking control of and objectifying their own bodies in ways that transgress cultural norms. Self-injury is women's self-inflicted objectification and destruction of their bodies in the service of reducing symptoms of psychological distress. It is this which is not culturally sanctioned. What is remarkable is that it is culturally tolerable for women's bodies to be objectified and destroyed if it is inflicted by others, and when it is in the service of western beauty ideals and men's sexual gratification. What is not culturally tolerable is for women to objectify and destroy their own bodies in ways that do not serve western aesthetics.

In the case of eating disorders, women's pursuit of thinness is seen somehow as understandable as it enacts cultural prescriptions for what women's bodies should look like, and what is culturally tolerable for women to do with their bodies. In this interpretation of eating disorders, women are 'forgiven' for their pathological behavior as it can be distilled to women's narcissism. To wear the scars of self-injury, however, is to make oneself ugly in this culture and to violate sacred beauty standards for women.

Looking at self-injury from a relational perspective (Rogers, 1996a; Machoian, 1998) clarifies my questions. If acts of self-injury express 'what cannot be known or named in girls' experience' (Rogers, 1996a: 7), is it possible that what is so unsettling about this behavior is that it speaks to a lived reality for many women that the culture would rather deny? If acts of self-injury are girls' protestations

against the pervasive female image of a 'false appearance of being unscathed, smooth-skinned and "plastic," like dolls' (Machoian, 1998: 185), and if this 'language of violence' (Machoian, 1998: 112) re-enacts girls' experiences of relational and cultural violations, perhaps self-injury's power to disturb lies in the act itself as a symbol of struggle against the dominant cultural story of what it means to be female.

Harrison's description of her self-injury poignantly delineates this experience:

> Once in hospital I remember being physically dragged into the charge nurse's office, where . . . He told me that I'd look prettier if I plucked my eyebrows and put on make-up. Is it any wonder that I went on to slice up my face? I was visibly saying 'fuck off' to my abusive keepers . . . I had survived my family's denial. Their silence had been a powerful defence. Self harm was the only defence I had – there, in my own space, I could punish or scream at my perpetrators. Sometimes my wounds were light because I felt too undeserving to express anything. At other times, cutting was an act of defiance and anger. I was trying to reclaim my own territory, my body, my power, something which had been taken from me, rendered numb, silenced (1997: 438–9).

Several ideas are presented simultaneously. To begin, the emergence of self-injury in adolescence becomes understandable from a developmental perspective. As Erikson describes, adolescence brings the 'search for something and somebody to be true' (1968: 235), abstract thinking and the task of identity formation. In Gilligan's words, 'the adolescent becomes the truth teller' (1988: 143) as s/he seeks out connections between an inner truth and larger truths in the community and culture. If, in this process, the community does not permit the requisite environment for self-expression that conforms to the adolescent's burgeoning truths, the adolescent will resist through 'deviant . . . self-destructive tendencies' (Erikson, 1968: 236).

With enhanced cognitive capacities, physical maturity, and new societal expectations to capitulate to adult feminine conventions, girls begin to grasp what it might mean to be women in this culture. As Brown's (1998) work on girls' anger elucidates, girls come to see 'the impossibility of bringing their rich and varied life experiences into relationship with such a narrow social construction' of 'woman' (Brown, 1998: 8). Using 'the subversive power of body' girls 'challenge conventional meanings and expectations of femininity' (Brown, 1998: 9). In self-injury, girls urgently speak to this impossible developmental dilemma to express the truth of their experience within a culture that does not permit them to forge an identity that reflects their truths.

In line with Kleinman's (1988a) view that we express our distress through culturally distinctive bodily idioms, and Machoian's view that girls learn to use the cultural 'language of violence' (1998: 112), girls and women express their distress through self-injury because girls learn that they are valued for their bodies and also that their bodies may be objectified as they mature physically. They come to grasp that what will bring attention to their experiences of violation is the destruction of their bodies in ways that simultaneously re-enact their

experiences and transgress cultural norms. Self-injury is a brilliant maneuver in the sense that girls and women turn the cultural and relational objectification of their bodies on its head. In one powerful act, they replicate what has been done to them by objectifying their own bodies. In so doing they appropriate the relational and cultural methods through which they have been violated.

Self-injury is uniquely distressing because it reflects back to the culture what has been done to girls and women. Whether or not it is a conscious process, by refusing to remain silent, by literally carving, cutting and burning their experiences of violation and silencing on to their arms and legs, girls and women claim ownership of their bodies and their subjectivity. They refuse to relinquish what they experience as true. This is a radical and threatening act because part of what holds patriarchy in place is girls' and women's silence.

To truly dialogue with women who self-injure and ponder the meaning of such acts through treatment relationships entails asking questions about self-injury (why is self-injury a predominantly gendered phenomenon and why does it emerge in adolescence?) which threaten the status quo and the dominant cultural story of what it means to be female. I suspect that clinicians, as bearers of our culture, would rather not ask such questions. So, as clinicians come closer to grasping the significance of self-injury, they pull back. Possible conversations about the meaning of self-injury are not broached, or if they are, it is for a brief moment in time, only to vanish. Later, when it reappears, women are dismissed, pathologized and characterized as manipulative. In other words, when the disturbing psychological truths of women's lives surface through the act of self-injury, the girls and women who speak these truths through their bodies are discredited or simply ignored through termination of the discourse on self-injury.

In a parallel to Bordo's analysis of what she calls the 'bodies of disordered women' (1993: 169), exemplified, for instance, in the phenomena of eating disorders and hysteria, I am also suggesting that women's bodies 'offer themselves as an aggressively graphic text for the interpreter – a text that insists, actually demands, it be read as a cultural statement . . . about gender' (1993: 169). Like Bordo in her attention to eating disorders, by framing one meaning of self-injury as a symbol of protest, I do not intend to imply that this process is necessarily conscious nor that it is an effective vehicle of political resistance for women's liberation. What I am suggesting is that the notion of self-injury as meaningful has been neglected – most strikingly in the contemporary literature – and that the question of girls' and women's self-injury as rooted in their experience as females in this culture has not been, but needs to be, accorded a legitimate space in this discourse.

Just as embodied experiences of gender must be granted a rightful place in the dominant discourses on self-injury, so too must other dimensions of culture and the diversity of their individualized expressions. As my argument rests on the broader notion that culture is enacted through and reproduced on the body, clearly, gender intersects with other embodied experiences such as race, ethnicity and class. In the historical study of self-injury, this phenomenon has been

studied within samples of, and framed as peculiar to, white, middle-class women. Some recent studies (for example, Lipschitz et al., 1999; Marshall and Yazdani, 1999) have documented self-injury in communities of women of color and across class lines, and current research suggests that self-injury may be on the rise (for example, Pipher, 1994). If this is a prediction of what lies ahead, the challenge will be to develop more inclusive discourses that can hold both the commonalities and differences across women.

Self-injury is a complex phenomenon with multiple meanings, which take on nuances of new meaning with individual women, as a woman self-injures over time, and with cultural transitions. Self-injury is not only protest or resistance. It is a product of culture as well as physiology, unconscious processes, traumatic experiences, life events and environmental triggers. Paradoxically, self-injury may at once be a symbol of protest, a marker of violations, a catharsis and a behavior through which women unwittingly engineer their own incarceration as they become entrapped in an isolating cycle of self-abuse. In the end, self-injury undermines women's freedom, limits their possibilities and may blaze a trail toward suicide attempts.

CLOSING REFLECTIONS

Contending with self-injury is similarly complex for clinicians and psychological theorizing. There are a multitude of obstacles – namely, a problem of language and human vulnerability and the need to preserve the self in the face of one's own and others' seemingly unbearable pain – which make it immensely challenging to think about self-injury in relationship to this culture. The hallmark of self-injury is that it touches us profoundly. As Lauren Slater states in her memoir, 'wounds . . . reach out to rasp us all' (1996: 179) – patient and clinician alike. Moreover, if self-injury is an indicator of what can and cannot be culturally known and spoken, then how is it possible for girls and women who self-injure and those who come face to face with the behavior to speak about it? In a void between experience and narrative, the relationship between culture and self-injury becomes a nebulous thing indeed.

In the end, whether clinicians' failure to listen to women who self-injure and the culture's distortion of stories of women's lives is intentional or unintentional, the effect is the same: girls and women are silenced. Practically, girls' and women's developmental struggles and experiences of violation are unacknowledged and de-legitimated. When they narrate these experiences through self-injury, they are dismissed and pathologized. In a tragic irony, the history of the study of self-injury mimics girls' and women's experiences in the world as the dominant discourses again suppress girls' and women's lived realities.

This is not merely a theoretical debate; rather, clinical discourse on self-injury, and in particular, current conceptualizations of self-injury, treatment approaches and portrayals, have real implications for girls and women. Not only does self-

injury remain poorly understood, but treatment is problematic with few helpful approaches available to clinicians. Girls and women are subject to humiliating and sometimes abusive treatment, which may ultimately dissuade them from getting care they need and want. The consequences of current characterizations of women who self-injure are that these women are in a double bind. Women who self-injure can stay in the proverbial closet and not get much-needed treatment, or they can disclose their self-injury and risk being labeled manipulative and attention-seeking.

My hope is that this historical re-telling will serve as a reminder that there are choices of interpretation and action. We can choose to see self-injury as a reflection of women's hyper-excitability and as emotional blackmail, or we can choose to see self-injury as meaningful. We can engage with girls and women in treatment and create spaces where they can know and be known in their complexity, or we can disengage and preclude the possibility for meaning making and wholeness.

Reckoning meaningfully with this behavior demands the creation of new frameworks for understanding which traverse history, culture, social relations, biology and embodied experience. In self-injury, I see confusion, pain, violation, protest and desperation, but also perseverance, a yearning for connection, a struggle to hold on to what is real and a moment primed for intervention.

NOTES

1. I use the term discourse to refer to the general body of scholarship on self-injury and to denote particular ways of conceptualizing, speaking about and working with women who self-injure as represented in the clinical literature. My purpose in identifying multiple discourses which emerge as dominant within specific historical periods or which emerge to challenge the dominant discourse – as is the case in the 'Feminist Contributions and a Relational Reframing' section – is to illuminate the shifting and particular meanings of women's self-injury as socially and culturally constructed.
2. For a discussion of other variants of self-injuring and self-destructive behaviors and how these behaviors differ from episodic and repetitive self-injury, see Arensman and Kerhof (1996), Diekstra (1996), Favazza (1996) and Shaw (1999).

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