

How is self-mutilation constructed? An examination of discourses of gender, the
body and risk in the DSM and by psychiatrists.

By

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ABSTRACT

My research is concerned with the production of knowledge and how the process of knowledge production might shape how we view and understand people's bodies. In particular, this research sought to understand the construction of knowledge about self-mutilation, how discourses of gender, the body and risk shaped how self-mutilation was perceived and whether or not these dominant knowledge(s) re-produced inequalities. The aim of my research was to explore the various ways of thinking that surround self-mutilation and to map the connections and disconnections between the diagnostic criteria used to diagnose self-mutilation and psychiatrists' understandings. Using a post-structuralist critical discourse analysis approach, I conducted a longitudinal analysis of the Diagnostic and Statistical Manual (DSM) versions 1 through 5 (spanning 1952-2013) and in-depth interviews with ten psychiatrists practicing child, adolescent and adult psychiatry. The results illustrate that knowledge produced in the DSM does impact how psychiatrists make sense of self-mutilation. Drawing on multiple theoretical perspectives, such as the work of Deborah Lupton, Michel Foucault and Dorothy Smith, I show that self-mutilation discourses reflect larger dominant ideas surrounding gender, the skin, healthy bodies and risk; that self-mutilation is gendered and is linked to a diagnosis of borderline personality disorder; and that there are multiple ways in which DSM language is taken up, reproduced and resisted by psychiatrists. In sum, this thesis has outlined the intersections between gender, power, and psychiatric knowledge.

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List of Symbols, Nomenclature or Abbreviations

BPD	Borderline Personality Disorder
DSM	Diagnostic and Statistical Manual of Mental Disorders
ICD	International Classification for Disease
NSSI	Non-Suicidal Self-Injury
PTSD	Post Traumatic Stress Disorder
SM	Self-Mutilation
WHO	World Health Organization
APA	American Psychiatric Association
DBT	Dialectical Behavior Therapy
HMO	Health Maintenance Organization
SI	Self-Injury
CDA	Critical Discourse Analysis
DID	Dissociative Identity Disorder

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Chapter 1 – Introduction

1.1 Purpose and Overview

“Knowledge is power. We live in a world in which knowledge is produced and used to make change, inform others, support a perspective, or justify an action. Hence, the question of who provides knowledge is central to understanding how power is created, taken or maintained. Being able to produce knowledge then is a route to power, empowerment, and influence” (Kirby et al., 2006, p.1).

Research, put simply, refers to the process of uncovering new knowledge. My research creates new knowledge by critically examining knowledge production itself. It is about highlighting the ways in which official medical knowledge is created and how medical practitioners take it up. It attempts to answer the questions: What are the differences between text and practice? What are the similarities and differences or contradictions in what psychiatrists say and what they say they do in practice? Overall, it is an inquiry into seeing how psychiatric knowledge is produced and recreated by the actors (psychiatrists). It explores the intersections between gender, power and psychiatric knowledge. In particular, this research seeks to understand the construction of self-mutilation knowledge and will examine how it is produced in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and is understood by psychiatrists who have experience with patients who self-mutilate. For convenience, I focus on the practice of psychiatry within my home province, Newfoundland and Labrador (NL).

This work is sociological in scope, therefore not addressing concepts such as social influence and modeling from a psychological perspective. I should also note that I am not exploring the physical health effects of self-mutilation (e.g., infection) or any

association with suicidal behavior. I am examining the dialectical relationship between the production of self-mutilation knowledge and already existing, dominant knowledges about gender, the body and risk. In addition, I examine whether or not certain ways of talking about disordered behaviors are gendered thus making a certain pathology or behavior masculine or feminine. I believe that it is important to highlight how taken-for-granted knowledge(s) affects peoples' experiences and ultimately their health. In highlighting these taken for granted knowledges, I am employing a critical, feminist, sociological approach. A critical feminist approach emphasizes the ways in which the body is the site of power relations and how discourses influence how we see and relate to others' bodies as well as our own (Bordo, 2003; Martin 1987; Lupton, 1999). A feminist standpoint is crucial for examining the construction of psychiatric discourses and, in particular, the impact such discourses have on how healthy or ill bodies (and minds) are identified.

In examining complex relationships between power and the body, the Foucauldian concept of the body as the site of surveillance, regulation, and discipline is useful (Foucault, 1977). This conception can also be useful when trying to understand the ways in which hospitals and medical authority act as powerful institutions that in turn shape either normalized or marginalized ideas about bodies. In other words, Foucauldian theory helps us to understand how framing somebody as "sick/ ill" comes from larger, authoritative understandings of health and often affects peoples' day-to-day relationships with both the people and institutions around them. For example, part of my inquiry concerns the concept of stigma attached to people who deviate from what is regarded to

be normal/normalized. This occurs in my later discussion of Borderline Personality Disorder (BPD). A study by Camp, Finlay and Lyons (2002) concluded that women with chronic mental health problems made negative comments about themselves and avoided disclosure of their diagnosis out of fear of others' potential reactions (such as rejection). Thus, stigmatized attributes are deeply discrediting in particular contexts and often become the dominant identities by which the person is seen and also how they see themselves. It is not hard to see how discourses and larger ideas about bodies, health and illness have real world effects (Bendelow, 2009). Violation of any social norm is likely to result in negative reactions and social marginalization. Thus, the norm is powerful because to go against it results in negative implications. Psychiatric diagnoses are strong examples of how deviations from social and psychological norms are understood and how diagnoses with pejorative labels negatively impact individuals' lives.

1.2 Rationale

Given that medicine is an extremely powerful institution and one we rely on when we are most vulnerable, understanding how medical knowledge is constructed and understood is essential. Both personally and academically, I am interested in how power works within medicine. The impetus for this research came from a desire to understand how medical knowledge shapes how we understand bodies and, specifically, the ways psychiatric knowledge positions bodies that are considered disordered. It is important to note that when I refer to bodies I am, in essence, also referring to the mind. The relationship between the mind and body is dialectical: a "disordered" mind affects behaviors that in turn affect the body and, conversely, what is seen on the "disordered"

body emanates from the mind. My focus is on “the body” because self-mutilation is corporeal. In addition, given that purposeful harm to one’s body often evokes strong, perplexed reactions from others, I decided this would be my main focus of inquiry. I chose the term self-mutilation because it sounds barbaric and extreme. This was purposeful because I believe the connotations of that term have contributed to the extreme reactions surrounding the behavior. Related terms that are widely used include: self-injury, self-harm, non-suicidal self-injury, and self-inflicted injury. I refer to self-mutilation and self-injury most often and use them interchangeably depending on the context I am writing in. I mostly use the term “self-mutilation” but, when referring to research or the DSM-5, I mirror the term used by the authors (such as the term NSSI—non-suicidal self-injury).

Although there are no statistics for the prevalence of self-mutilation in NL, one quantitative study examining the overlap between non-suicidal self-injury (NSSI) and disordered eating behaviors suggests that NSSI is indeed a serious concern in the province and one warranting further investigation. The study surveyed 1639 undergraduate students (response rate 80%). The study found that 6.52% of participants engaged in NSSI at least once in their lifetime and that both females (6.5 %) and males (6.5%) engaged in self-mutilation as a coping mechanism (Duggan, Button, Heath & Heath, 2010). These numbers are consistent with other studies that suggest prevalence rates for college and university populations: 11.68 % (Heath, Toste, Nedecheva, & Charlebois, 2008) and 7.2 % (Gollust, Eisenberg & Goldberstein, 2008) of students report engaging in NSSI. Furthermore, these numbers reflect higher prevalence rates than many

other mental health conditions including eating disorders (1.7%, Statistics Canada, 2002), schizophrenia (0.5-1.5%, DSM IV-TR, 2000) and bipolar I (0.4-1.6%; DSM-IV-TR, 2000) which have been the subject of closer study. Further exploration into self-mutilation (and its many synonyms) is needed.

Historically, in Euro-American societies outside of a religious context, purposeful self-injury has often been trivialized, misidentified, and misrepresented; is also a behavior that millions of people have engaged in but often has been considered so unnatural and offensive that it has not been considered appropriate for public discussion or scientific inquiry (Favazza, 2011; Strong, 2009).¹ Although, self-mutilation has gained much attention over the past decade, the reasons why some people feel a need, desire or urge to damage their own physical body is no doubt a very complicated phenomenon in need of further examination. While I am concerned with the reasons for and function of self-mutilation, this is not something I take on at length in this research project. Rather, I think it is also important to examine larger ideas about bodies and gender and risk and how they influence how we talk about and think of self-mutilation – and how these knowledge(s) (re) create inequality and marginalization for those who self-mutilate. Bodies express what words often cannot articulate; scars, bruises, and burns have their own language that tells stories about the complicated relationship with the body.

What is self-mutilation? Definitions of self-mutilation depend on how both self and mutilation are defined culturally and historically. For the purposes of my research,

¹ I must note that varying forms of self-mutilation are common and culturally accepted practices around the world. For example, bodily mutilation as a form of religious ecstasy is not uncommon around the world. Those broader comparisons and examinations of the symbolic meaning of mutilation – for example, the meanings of blood in relation to the inscription of power on the body -- are beyond the subject of this

when I refer to self-mutilation I am referring to mutilation/ injury to oneself without the intention of suicide. Essentially, this is the same definition as non-suicidal self-injury, which is defined as a purposeful infliction of injury to oneself, without suicidal intent, that results in immediate tissue damage and is not socially/ culturally sanctioned, therefore excluding tattooing and piercing. It includes, although is not exclusive to, cutting, scratching, carving, burning and hitting oneself (Heath & Nixon, 2009).

Marilee Strong (2009) maintains that the experiences that often act as underlying stressors prior to self-mutilation include: sexual abuse, physical abuse, emotional abuse, other forms of trauma (e.g., hurricanes, death in the family, serious illness, school bullying, body image issues), instability in childhood and perfectionism (or any combination of the previously mentioned). Similarly, when women institutionalized in a psychiatric hospital were interviewed about past and present reasons for self-harm, they cited natural disaster, death, illness and various forms of trauma as the driving force behind their engagement in self-harm behaviors (Liebling et al., 1997). These experiences often led to tremendous difficulty in being able to tolerate painful or upsetting emotions and thus the struggle for the use of something to soothe the emotional pain (Strong, 2009; Adler & Adler, 2011). Women are thought to self-mutilate in greater numbers than men; the way in which self-mutilation is described is also gendered feminine (Alder & Adler, 2011; Strong, 2009; Brickman, 2004), something that will be discussed in detail later in this work. A study examining the epidemiology of attempted suicide and self-harm visits in U.S. emergency rooms from 1993-2008 found emergency department visits for attempted suicide and self-inflicted injury have increased dramatically over the past two

decades. In addition, they noted that numbers of self-inflicted injury and attempted suicide were higher for women than men, however numbers for both sexes were increasing overall (Ting et al., 2012).

In addition, self- injurious behaviors often provoke strong, negative reactions from others. Purposeful injury of one's body is often puzzling because it is difficult to understand why someone would willingly injure their body without the intention of dying. In line with this, many medical and mental health professionals find self-injuring behaviors very challenging to understand and treat (Heath & Nixon, 2009; Walsh, 2006). Furthermore, beyond finding self-injuring behaviors challenging, some therapists and physicians find dealing with patients who self-injure leaves them feeling helpless, guilty, sad and angry (Favazza, 2011). Walsh (2006) examines the various responses of mental health professionals' to self-injury and argues that the reactions can be conceptualized as a psychosocial phenomenon. He maintains that therapists, physicians, nurses, and other mental health professionals respond to self-injury physically, psychologically, and interpersonally. He asserts it is important for mental health professionals to manage their negative reactions through self-monitoring. Taking this into account, there is still a lot that needs to be understood about self-mutilation.

1.3 Study Objectives

The aim of my research is to highlight the various knowledge(s) and discourses that surround self-mutilation and to map the connections and disconnections between the diagnostic criteria used to diagnose self-mutilation and psychiatrists' understandings of and experience with dealing with self-mutilation.

The specific objectives of my research are:

- 1) To examine the construction of expert medical knowledge of self-mutilation by examining mentions of self-mutilation in the DSM (editions 1 through 5).
- 2) To examine how psychiatrists describe and understand self-mutilation.
- 3) To better understand how knowledge(s) of gender, the body and risk shape how self-mutilation is understood and further to critically interrogate whether or not these dominant knowledge(s) re-produce inequalities.

1.4 Thesis Organization

This thesis is organized into 7 chapters. Chapter 2 will provide a review of literature broadly on medicalization moving on to risk, the body and the production of medical knowledge and then to the psychiatric response to self-mutilation. Chapter 3 explains the methodology that influenced my research, what methods I used to collect my data, how I went about analyzing the data and the theoretical works that helped make sense of my findings. Chapter 4 is an overview of the DSM from its inception in 1952 to the DSM-5 just recently published. I also provide an overview of all references to self-mutilation over the span of all five versions, the current proposal to include non-suicidal self-injury (NSSI) as a separate diagnosis, important changes to the DSM-5 and discussion of the discursive link between self-mutilation and BPD as well as a discussion of how self-mutilation has evolved over time. Chapters 5 and 6 provide results and analysis of interviews with psychiatrists. Chapter 5 focuses on how psychiatrists understand and describe self-mutilation. Chapter 6 discusses how psychiatrists deal with self-mutilation in their practices and the relationship between the DSM and practice.

Chapter 7 summarizes my findings, discusses possible clinical implications and outlines areas for future research.

Chapter 2 – Literature Review

2.1 Introduction

The purpose of this literature review is to position my research in relation to what is already written and to ask questions not yet considered. This literature review focuses on the literature that helped define my research questions. Feminism belongs to an overarching critical paradigm concerned with understanding how societal structures and power relations play a role in promoting inequalities by attempting to explain underlying structures that influence phenomena (Kirby, Greaves, & Reid, 2006). A review of the literature concerning knowledge production, gender, the body and risk is necessary to a sociological feminist inquiry into how self-mutilation is understood, how bodies are gendered and how risk itself is understood as gendered. A review of the literature on gender, the body and risk highlights how dominant ways of thinking and talking construct healthy/ normal and unhealthy/ abnormal bodies. These constructions are shaped predominantly by larger medical / scientific epistemologies which also means that a discussion of knowledge production and the objectification of knowledge must be included. The parameters of this literature review include a discussion of risk, gender, bodies, knowledge production and self-mutilation. Gender is a thread that runs throughout my research. It is intricately intertwined with understandings of bodies as well as how we understand risk.

2.2 Gender, Medicalization and Mental Health

First, I think it is important to answer why is gender a useful point of analysis in general. Gender is useful for understanding positioning within social structures and subsequent inequalities that result (Young, 2005). Access to resources (for example, health care, education jobs, housing) is often based on structural positioning; material factors such as class, age, gender, and race affect one's positioning within social structures and inequality. Young (2005) maintains that women are positioned within structures where they are unfairly constrained by regulative bodily norms and understandings of the female body. The division of labor, normative heterosexuality, child care and housework responsibilities are some of the ways in which women are positioned and constrained, thus being not afforded the same opportunities as men (Hochschild, 2003). Gender heavily influences the experiences one has in life and for women, this can be evidenced quite clearly within the discourses that surround their bodies (fluctuating hormones and moods) and their socially prescribed gender roles (feminine, not masculine) (Martin, 1987; Lupton, 1999). Social and institutional structures often also have implicit rules and norms that offer benefits and freedoms to some and not others. For example, gender and sexuality are often regulated by normative heterosexuality and those who do not fall within these prescribed rules are often marginalized in various implicit and explicit ways. All of these things influence peoples' health directly and their experiences within health care systems (e.g., isolation and discrimination). Young (2005) argues that the experience of giving birth is often alienating for women due to power differences in doctor- patient relations (the ways in

which the doctor has power over knowledge and thus bodily processes) but also the ways in which medical discourses define healthy bodies (Martin, 1987; Martin 1994, Lupton, 1999).

The act of self-mutilation, beyond the fact that the opening up of one's skin offends the senses of what is normal or stable, when women engage in it, also threatens how society sees feminine beauty (Brickman, 2004). There are differences in how tattoos on men and women are perceived or how scars on men and women are viewed. Ideal female bodies are understood to be beautiful, with soft and unblemished skin (Ahmed and Stacey, 2001). Damaging the skin physically and the urge to do it indicate mental instability. Psychiatrists understand self-mutilation as a coping mechanism used to regulate intense, upsetting moods. It is also considered an expression of those emotions (Heath & Nixon, 2009).

As Clarke (2004) has argued, medical science became increasingly influential along with urbanization, secularization and industrialization. In the 19th century, medical institutions gained power as agencies of social control and human behaviors became subject to medical explanation like never before. Behaviors that may have been historically viewed as sinful or criminal could now be categorized as illnesses in need of treatment (i.e., alcoholism, depression, and homosexuality up until the 1970's). Zola (1972) described the process by which human conditions and problems come to be defined and treated as medical conditions as *medicalization*. It has been said that the social and sexual control that male doctors exerted over women in the 19th century has shaped the gendered character of contemporary medicine, particularly the medicalization

of emotion (Woodlock, 2005). The term “medicalization” emerged with the foundational works of Illich (1975) and Zola (1972) who expressed concern that medicine seemed to be taking over areas of life that were previously under moral, legal, or religious jurisdiction. For example, the processes of birth and death now took place in hospitals (Bendelow, 2009). Similarly, the medicalization of emotions and behaviors started to take place with the rise of psychiatry as a discipline that had authority and power to label a range of everyday reactions (Young, 1995).

Medicalization is both conceptual (in that medical vocabulary is used to define the problem) and institutional (in that the problem is legitimized when diagnosis and treatment occurs) (Bendelow, 2009). The process of medicalization is a critical piece in my research when examining how the DSM participates in the process of medicalization both conceptually through texts and institutionally in practice. In addition, the concept of medicalization is key to recognizing the influence medical knowledge has on the body and vice versa. As Foucault noted in *The Birth of the Clinic* (1973), changing ideologies of disease can be seen as an outcome of the changing perceptions of the body.

2.2.1 The Medicalization of Women’s Unhappiness and the Gendering of Emotion

The medicalization of women’s unhappiness as “depression” has had a large impact on women today (Bendelow, 2009; Woodlock, 2005). Labeling this distress as an “illness” and as something in need of treatment is problematic. The medical model does not take into account the social and historical context in which women have lived or have come to understand their experiences. Feminists have long considered women’s distress and unhappiness as resulting from their social positions and psychiatric discourses have

often recast women's subordination to men as disorder, hysteria or madness (Blum and Stracuzzi, 2004). How gender is represented, conceptualized and researched in psychology and medicine has a powerful influence on how we understand ourselves and make sense of our life experiences (Stanley, 1993). Distress is a social as well as a personal event but the problem is that the psycho-medical approach views distress and emotional reactions as solely having a biological basis and therefore in need of medical attention and treatment (Cosgrove, 2000). Critics argue that we should look at the social and historical conditions that have contributed to women's location in specific diagnostic categories. For example, we need a more in depth understanding as to why the DSM (editions three, four and five) cite women as comprising 75% of the Borderline Personality Disorder (BPD) population (DSM-5, 2013).

How certain behaviors are understood, for example aggression and crying, are also gendered (Young, 2005). Psychiatry has a "double power" of sorts where it has the power to marginalize "inappropriate bodies" but also the power to regulate and medicalize women's embodiment through discourse. For example, Blum and Stracuzzi (2004) found that most psychiatric illnesses are implicitly gendered; they are constructed and understood in terms that convey femininity and/or masculinity. This sort of medicalization of women's lives and experiences only intensifies the oppressive world in which they live, maintaining the power of men and submission of women by reinforcing the dualisms that separate them in the first place. Psychiatry/ psychiatric discourses can be seen as the central point at which institutional power, bodies, discourses, and gender intersect. Both the works of Elizabeth Grosz (1994) and Michel Foucault (1973) are

useful in understanding this intersection; Foucault for his understanding of how discourse regulates bodies and how power is inscribed on our bodies and Grosz for her discussion of how knowledge production shapes the perception of bodies as well as her call for a new understanding of bodies outside of the constraints of existing dichotomies. As Grosz has put it:

“The body has thus far remained colonized through discursive practices of the natural sciences, particularly through discourses of biology/ medicine. It has generally remained mired in presumptions regarding its naturalness, its fundamentally biological and precultural status, its immunity to cultural, social and historical factors, its brute status as given unchangeable, inert and passive manipulable under scientifically regulated conditions. The ways in which bodies, men’s and women’s bodies, are understood by the natural sciences is however no more accurate than the ways social sciences and humanities understand them: in all cases, how bodies are conceived of seem to be based largely on prevailing social conceptions of the relations between the sexes” (1994, p. X)

While Foucauldian theory provides useful concepts from which to understand how power and knowledge shape bodies, Grosz (1994) argues that Foucault’s discussion has not left a space for the inclusion of women’s differently sexed corporeality and thus lacks attention to the ways in which power and knowledge may work differently for men and women. She calls for a more nuanced way to relate to bodies, one that does not rely on the concepts and dichotomies that currently exist, as dichotomous thinking ranks one while subordinating another, keeping them unequal and constructing them as opposite. For Grosz, a new understanding of corporeality would avoid mind/ body dichotomies, avoid normalizing one type of body by which all others are judged, and understand the body as the site of social, political, cultural and geographical inscription.

2.3 The Body

The body and its complexities have long been at the center of the nature/ nurture debate. When exploring how people think about and use their bodies in everyday life, it is important to look at the sociology of the body and feminist literature. Although the body is not exclusive to the domains of sociology and feminist literature, both sociology and feminism highlight the various ways in which the body is often the site of power relations and discourses that shape how people view, use, and relate to their bodies (as well as other people's bodies). In other words, both sociological and feminist theories have deconstructed taken for granted assumptions surrounding the conceptualizations of the body and gender, for example, by exploring the intersection between gender and the body as the site of the production of various masculinities and femininities (Connell, 2009). Taken for granted assumptions are embedded in discourse and reproduced in the ways that the discourse is interpreted and used. Discourses are dynamic, change over time and differ in the way they are taken up.

Beyond prevalence rates and the reasons that lead people to engage in self-mutilation behavior, it is also important to understand how self-mutilation and dominant ideas about gender, the body and, risk are produced through everyday talk and interaction. We use our bodies every day in everything we do; we work with our bodies, move our bodies in particular ways, clean and groom our bodies, exercise our bodies and we sometimes superficially or physically alter our bodies. Bodies can also be a kind of capital or tool used in everyday interactions within institutions and with other people, but

how we (re) negotiate our bodies depend on contextual factors such as gender, class, race, age, status, and (dis) ability.

Ideas of what constitutes a “healthy body” have changed over time and so have ideas about individual responsibility for health (Martin 1994; Lupton, 1995; Youll & Meekosha, 2013; Turner, 1984). Part of this shift resulted from changing perceptions of risk as well as shifts in power (Lupton, 1999; Martin, 1994; Harwood, 2009).

Medical/scientific discourses have tremendous influence and are constantly used to justify various types of inequality and serve to naturalize power. We live in a culture of individualization where we often attribute what society views as negative qualities, such as weight gain, eating disorders, and drug addiction, as things one has individual, personal control over, therefore eliciting less sympathy than something biological in basis like Type 1 diabetes, hyperthyroidism, or psoriasis. Medicalization works because there is often a push to identify things as ‘diseases’, like alcoholism or sex addiction because it takes blame off of the individual and results in less stigma. As long as things are thought to be “natural” and “scientific fact”, there is less blame directed toward the individual resulting in less stigma and little motivation for change at a social level. If poor eating habits, drinking too much, or purposely throwing up food were seen as biologically rooted things and therefore not within the direct control of the person, then societal attitudes might be more compassionate. Youll and Meekosha (2013) have noted how a focus on “positive thinking” (the idea an individual’s positive attitude can alter health outcomes) may allow people disillusioned with the dominant health care system to exert some control by taking personal responsibility. Paradoxically, even though positive

thinking could be seen as a form of “resistance”, people are still complying with neo-liberal ideals of individualism and responsibility for self. This sort of self-responsibility can clearly be seen in discourses surrounding obesity and the excessive focus on the self-regulation of diet and activity (Rail & Beausoleil, 2003). Dominant health discourses often reflect ideas of both healthism and individualism that positions the body as the centrality of health- bodily practices and disciplines are used to attain the ideal, healthy body. Rail and Beausoleil (2003) employ Foucault’s reference to the panopticon to illustrate the shift from external punishment to a self-imposed form of control or bodily discipline; the desire to achieve health has become a new corporeal self-control.

Scientific knowledges of what constitutes healthy bodies are mediated by larger ideas about gender, race, class, ability, education, and sexuality (Rail & Beausoleil, 2003; Martin, 1994). Anthropologist Emily Martin (1994) explored the effect that healthy/ sick discourses and associated types of views had on people. She claimed that health was becoming a medium by which people’s value could be judged (Kirschner, 1999). She noted the intersection between health and structural positions during her research where she spent time at immunology grand rounds. She noticed that the patients being discussed with immune system “deficiencies” were most often black, elderly, women, foreign or working class that Martin contrasted to the structural position of the white male doctor.

It is important to consider that the advertising and media industries are also exceptionally influential in shaping cultural attitudes and discourses. The altered body is seen in the media constantly; plastic surgery, weight loss programs, advertising aimed at altering/disciplining bodies, gym culture, tanning sessions, hair removal and the

purchasing of particular brand names and hence particular identities. Ideas of health and healthy are embedded in this sort of advertising as well; the skinny, good looking, exercised, groomed, well dressed body is the ideal that is for sale.

2.3.1 Risk and the Body

A consideration of the concept of “risk” and risk discourse is also important for framing my own research work for two reasons: (1) I am seeking to understand how self-mutilation is understood in terms of risk; and (2) I intend to establish whether or not the relationship between self-mutilation and risk is gendered. In her text *Risk* (1999), Lupton explores the ways in which people in Euro-American societies understand, assign meaning to and manage risk in their everyday lives. She argues that the use of the risk concept is an attempt to deal with uncertainty but often does quite the opposite and creates more uncertainty through its prevalence in everyday media and discussion. The effect of the intense concern and preoccupation with risk finds its way into governments, institutions, and organizations and subsequently into how we think of and conduct ourselves. Health knowledge and practices are embedded and justified within larger socio-political contexts. Knowledge about risk is bound to sociocultural contexts and scientific knowledge, or any other knowledge, is never value-free but rather a product of a way of seeing; experts often do not acknowledge the situated nature of their claims, preferring to represent them as objective, universal truths (Lupton, 1999).

Lupton (1999), importantly, also recognizes the dialectical approach to the body—bodies as physical, biological beings in nature and also the ways in which discourses act to shape bodies and the experiences of bodies; in other words she recognizes how bodies

are transformed by social relations and power and, most notably how bodies are regulated by medical/ health discourses. She contends that many of the risks in the past, as well as the present, were seen to threaten the health or integrity of one's body. Lupton explicitly builds on Michel Foucault's work by highlighting how risk discourses are used as a way to regulate uncertainty and by extension people's bodies in everyday talk and interaction. She highlights Foucault's notion of the "inscribed body written on by discourse" as a central point from which to understand bodies and what she phrases, "is the nexus between anatomy and society" (Lupton, 1995, p. 6). In other words, Lupton is employing Foucault's notion of biopower (where power relations work in and through the body) as another way to understand how discourse, most notably risk discourse, is used to monitor and regulate bodies. Grosz (1994) claims that for Foucault, the body is the field on which the play of powers, knowledges, and resistances is worked out; "the body is that materiality, almost a medium, on which power operates and through which it functions" (Grosz, 1994, p. 146).

"For Foucault, power deploys discourses, particularly knowledges, on and over bodies, establishing knowledges as the representations of the truth of those bodies and their pleasures. Discourses made possible and exploited by power, intermesh with bodies, with the lives and behavior of individuals, to constitute them as particular bodies. Power is a condition of possibility of these true discourses, the motivating force behind their profusion and the energy which inscribes them on bodies and pleasures" (Grosz, 1994, p. 149-150).

The act of self-mutilation is a very clear example of how power both operates *on* and works *through* bodies and is truly a literal inscription of the body. First, the reasons that led to engagement in self-mutilation were likely shaped by the unequal ways that power is inscribed on the body; the act itself is an obvious, visible representation of such

inscriptions and second, it is an explicit inscription in itself. Furthermore, the production of self-mutilation knowledge and discourse perpetuates unequal power relations—the body is both a product of normative discourse and also a material to be re-inscribed by normative discourse.

For Foucault, “knowledge is what is socially recognized as knowledge” (Grosz, 1994, p. 147). Knowledge is major instrument and technique of power and is made possible by and functions through regimes of power where power and knowledge are both made (Grosz, 1994). Knowledge is the channel through which power can seize hold of bodies. In addition, inscription techniques are not only imposed but are sought out actively; this is what Foucault might have called “techniques of self-production” (Grosz, 1994). Biopower works through what Foucault refers to as technologies of the self where individuals engage in practices, surveillance, and regulation in order to transform themselves in some way (Wright, 2009). Wright (2009) argues that knowledge and power are intricately linked and particular techniques of power affect individuals through certain systemic practices (e.g., pedagogical practices) where certain “truth” discourses are produced; certain pedagogical practices are used to produce normalizing, regulating and surveillance effects. While Wright (2009) is referring to the use of healthy weight and physical activity discourses in schools, the same connection can be made with the practices of psychiatry, the DSM and its normalizing, surveillance effects on individual behaviors to produce discourses of the disordered body. The DSM is a technology of power that determines the conduct of individuals by objectivizing the subject. Certain types of knowledge produce a code of conduct and accordingly a particular body/ mind.

The internalization of risk discourses leads people to regulate and monitor their own, as well as other people's, bodies and behaviors. Lupton claims that most risk discourses in contemporary popular and expert culture portray risks as negative: to take unnecessary risks is seen as careless and irresponsible, therefore evidence of an individual's lack of ability to regulate the self (Lupton, 1999). Purposeful self-injury violates the expectation that all people seek to avoid pain and instead pursue pleasure (Walsh, 2006). Self-mutilation could be considered an example of a failure to regulate oneself, or rather a failure to regulate intense emotions appropriately. In addition, uncertainty and fear about cutting, and the symbolic opening of one's body/skin not only threatens normative ideas about beauty and the body but also blurs the boundary between what is considered public and private. Emotions (like anger or extreme sadness), sexual activity, certain body parts (genitals), and bodily fluids (like blood and urine) are seen to be private and when they enter the public realm are often seen to be "inappropriate", "problematic" "bad" or "risky". This sort of separation between public and private is sometimes kept in place physically by clothing (underwear) and/or the designation of private space (washrooms, bedrooms, hospital wards), but also by normative ideas and discourses that regulate what is socially acceptable and unacceptable.

Anthropologist Mary Douglas (1969) has written about ideas that surround purity, danger, and the body and has argued that bodily control is an extension and expression of social control. She upheld that symbolic meanings have been applied to material bodily practices. The body and its openings are symbolic of boundaries around stability and order, constructed by ideas of "inside" and "outside", "dirty" and "clean," and policed by

the processes of marginalizing those who engage in what is considered taboo. Lupton also refers to the divides between acceptable and unacceptable bodies/ behaviors but instead uses the terms “civilized” and “uncivilized” bodies.

To complicate the relationship between the body and risk even further, the dichotomies of public/ private intersect with the gendered dichotomies of masculine and feminine. What is publically or privately acceptable or what is seen as “risky” is also gendered. For example, Brickman (2004), challenging the pathologization of female bodies through what she terms “authoritative medical discourses”, examines popular discourses and contends that they frame cutting as a passive feminine behavior whereby women are constructed as too passive to “act out” but are still overly emotional and are “acting in” their immature frustrations through cutting their “delicate” skin, therefore, also threatening normative ideas about ideal feminine bodies. Furthermore, she argues that the continuance of seeing the female cutter myth within popular and medical discourses only serves to reproduce dominant gender and psychiatric discourses which in turn creates docile bodies by ensuring the internalization of disciplinary individuality through the careful observation of the self and others.

Lupton (1999) also writes about the intersection of risk and gender and argues that risk-taking behavior is gendered. Lupton argues that risk taking behavior is often a (celebrated) part of proving one’s masculinity, especially in adolescence, and activities such as excessive drinking, drug taking, speeding in cars are considered to be heroic behaviors located within the sphere of danger and violence and contrasted to the feminine life characterized by production and care. Men engaging in risky activities often reflect

control (regulation) over their emotions and vulnerability (Lupton, 1999). This gendering of risk-taking constructs women as “safe”; therefore women who engage in anything considered risk-taking behavior (such as cutting) face a sort of doubled edged marginalization due to the fear and uncertainty that surrounds risk and the norms that construct who can take risks. Women are supposed to attempt to prevent risks and take care by “being responsible for the well-being of others” (Lupton, 1999, p. 159). Furthermore, women’s bodies are often culturally represented as chaotic compared to men’s; and the regulation and surveillance of the self may be more sought after. The avoidance of risk and the act of risk-taking are both examples of control and agency but, more than that, show that the body is often the site of power struggles that are managed and regulated via discourse.

The difference in how expert knowledges are understood and taken up is also worth mentioning. Some lay people rely upon experts for their knowledge base about certain topics; yet sometimes they question or actively resist “expert” knowledge. In *Risk and Everyday Life*, Lupton and Tulloch (2003) explore how lay people understand and describe risk in everyday life, and argue that conversely, even though risk discourse sets risk up as something to be avoided and something to be in control of, some people engage in risk-taking behavior (e.g., extreme sports like sky diving, or hurting one’s self purposefully) as a way of taking up agency or attempting to control the mundane and strictness in one’s day-to-day life. In terms of self-mutilation, it would be useful to understand how mutilating oneself may indicate internalized control/regulation or active resistant agency (or perhaps both regulation and resistance at the same time).

2.3.2 Foucault: Experts, Discipline and Shifts in Power

Foucault made an immense contribution to the discussion of institutionalized power, knowledge production and the sociology of the body. In doing so, he also conceptualized new knowledges as extensions of institutionalized power, particularly through discourses and practices of psychiatry, criminology and penology (Turner, 1984). This institutionalization of the body made possible new practices of quantification and producing statistics. This resulted in the rationalization of the body and (as described in Foucault's later work), of populations, by new forms of power and knowledge (Turner, 1984).

In *Discipline and Punish: The Birth of the Prison* (1977), Foucault provides a historical account of how discipline and punishment shifted from the public (explicit) to the private (implicit) over time. This new shift, Foucault noted, gave rise to new experts and authorities (lawyers, doctors, police), resulting in shifts in power as well. Foucault maintained that this shift in power led to a whole new set of diagnostic criteria and tools (e.g., psychiatrists, categories like "unstable" or "unfit") and new forms of power and authority (experts who had the power to make decisions about who was guilty or innocent and who had the power to allocate punishment). This meant that now knowledge, techniques, and scientific discourse also had the power to punish. Essentially, Foucault was arguing that modern day "quartering" still happens but it is just implicit and subtle (e.g., sexism, racism or the disciplining of knowledge).

In his discussion of "docile bodies," Foucault explores the development of rigid, precise forms of discipline which influenced how bodies are thought of and used, which,

he argues, developed an entirely new body politic. Foucault claims that disciplined and docile bodies are ideal bodies that function in certain institutions (such as schools and militaries) but in order to construct a docile body, one must: (1) constantly observe/record bodies and (2) ensure the internalization of the disciplinary individuality within the bodies being controlled. Foucault argues that this must come about not by excessive force but through the molding of bodies by careful observation. Foucault illustrates this type of careful observation by using Jeremy Bentham's model of the panopticon. The panopticon is an architectural model that became an important conceptualization of power relations for 19th century prison construction. The panopticon allowed for constant observation that was characterized by an "unequal gaze" (i.e., the constant possibility of being observed but never knowing for sure). This constant possibility of observation subsequently resulted in the *internalization* of disciplining individuality which meant that people were less likely to break rules if they thought they were being watched, which subsequently meant they "policed" (watched) themselves and conducted their bodies accordingly. A docile body was one that could be subjected, transformed, and improved-- the human body became a political economy with power relations of its own. The true magnitude was not in the scale of control as a whole but through the disciplining of gestures, movements and attitudes. The history of punishment can be seen as a series of technologies of the body, and procedures for the control and subjugation of the body. This makes clear how transformations in the conception of the body are a consequence of changing investments in the power of the body (Grosz, 1994).

The significance of this for analyzing the construction of self-mutilation can be better understood through reference to Foucault's notion of "biopower." Grosz (1994) defines biopower as a power that regulates the minute details of daily life and behavior in individuals and populations. Biopower focuses on life and populations rather than the focus on disciplinary power and death, as death is power's limit. Biopower works both on and through bodies— it has the power to shape understandings of the body, but bodies are also vehicles that reproduce power in various ways. One of the ways that power is reproduced is through normalizing mechanisms. Biopower normalizes the behaviors of the subject, through the normalization and internalization of discourses and what Harwood (2009) has termed biopedagogies. Biopedagogies are a sort of "how-to" on health and a marriage of the concepts biopower and pedagogy, stemming from a larger discussion of biopolitics. The concept of biopower helps shed light on the ways in which knowledge is produced across multiple sites. Biopedagogies teach life, shaping the identities and desires of life. Although Harwood is referring to the ways in which obesity discourses shape how we understand healthy bodies, the same concept can be extended to psychiatry and beg the question of who is producing the knowledge of the healthy regulated mind and psychiatric truths about who and what is disordered. Normalizing mechanisms can be seen in mental health discourse and practice in terms of what is regarded as normal, which is often understood through juxtaposition of discourses of what is abnormal and disordered.

These normalizing mechanisms are internalized through the policing of the self. The self is not governed centrally but rather by a complex array of technologies of power-

which utilize experts such as social workers, psychiatrists, psychologists and other professionals (Dean, 1999). These technologies of power prescribe standards towards which individuals can strive (e.g., healthy weight, active lifestyle, balanced mind). Even engaging in self-help practices constitutes a technology of the self and is still responsible for the management of individuals, shaping them toward certain ends. In this sense, resistance or agency through taking control of the self is not total resistance because the process is still a shaping, guiding and correcting or self-conduct (Dean, 1999).

2.3.3 Lupton, Foucault and Self-mutilation

Lupton explicitly builds on Foucault's work by highlighting how risk discourses are used as a way to regulate uncertainty and also people's bodies in everyday talk and interaction. She highlights Foucault's notion of the "inscribed body written on by discourse" as a central point from which to understand bodies and what she phrases, "the nexus between anatomy and society" (Lupton, 1995, p. 6). In other words, Lupton is employing Foucault's notion of biopower as another way to understand how discursive practices, most notably public health risk discourses, are used to surveil and regulate bodies. As I have noted in the previous section, biopower works by normalizing the behaviors of the subject through the internalization of discourses through what Harwood (2009) has termed, biopedagogies and argues that risk biopedagogies (instructions on how to understand risk, manage risk and avoid risk) are ever present in society. She claims that most risk discourses in contemporary popular or expert culture portray risks as negative, taking unnecessary risks is seen as careless and irresponsible, therefore evidence of an individual's lack of ability to *regulate the self* (Lupton, 1999). Moreover, Lupton and

Tulloch (2003) claim, over the span of the 20th and beginning of the 21st century, there has been an intensification of risk discourses emerging from various fields of expertise such as law, medicine, science and social science in an attempt to regulate risk.

Put simply, when we think of risk, thoughts about danger, negative events or illness most likely come to mind. We live in a world where there are “risks” involved in our day-to-day lives and our awareness of risk is heightened and is often part of everyday conversation (Lupton & Tulloch, 2003). How risk is conceptualized has gone through several iterations over time (natural, genetic or human fault). The argument that risk was something that was within human control and was calculable meant that it was then seen as controllable and something to be avoided (Lupton, 1999).

The notion of risk as a socially constructed and changing category is pertinent to my research topic when looking at how risk is described and understood and how the concept of risk intersects with how self-mutilated bodies are conceptualized in the DSM and by psychiatrists. Reflect on the term self-mutilation. First, the word mutilation in itself implies there is something wrong or bad with altering the physical state of one’s body as mutilate/ mutilation is synonymous with “maim”, “disfigure”, “butcher”, “desecrate”, “violate” etc. But is there anything “wrong” with altering the physical state of one’s body? People often tan, shave, wax, pluck, receive botox or lip injections, build muscles, get tattoos, and pierce themselves. Such practices have been accepted, and sometimes even encouraged, bodily practices in Euro-American culture. So what makes self-mutilation different?

2.4 The Objectification of Knowledge

In “The Conceptual Practices of Power”, Dorothy Smith critiques sociology in terms of sociological methods of inquiry and makes a strong case for sociology from the standpoint of women. Her arguments are relevant for a further inquiry into how, and which, knowledge(s) become important, how social phenomena get constructed and how knowledge(s) shape which concepts are used and, in turn, how concepts reproduce knowledge(s). Smith elaborates on each of these arguments and illustrates these points by highlighting how mental illness statistics are produced and constitute objectified forms of knowledge. She argues that objectified forms of knowledge conceal the lived actualities of people, particularly women. I draw on Smith’s discussion of the production of mental health statistics to illustrate how the DSM contains diagnoses that obscure the complexities of people’s lives that then become objectified forms of knowledge upon which we rely and produce statistics.

In line with thinking about the objectification of knowledge and the production of statistics, it is important to consider classification and its relationship with diagnosis. Jutel (2011) has written about classification and contends that in medicine, diagnosis is an important classification system—a way to organize knowledge. Classification is the attempt to categorize things that are more similar than different by reducing disorderly mess to something more orderly. “Classification also seeks to create meaningful juxtapositions between groups and objects. It can only be about isolated, bounded boxes if there is something beyond the boundary part of a system where one category sits in relation to what it is not” (p. 192). Classification shapes medicine and defines practice

because the assignment of particular disease labels is linked to both therapeutic and social responses. In this sense, classification cannot be divorced from the social because in order for something to be classified as a disease, there has to be some recognition of its undesirability. Jutel (2011) maintains that once classification is established, however, it reproduces itself in an intuitive way that silences debate. Jutel's work coincides with Smith's notion of the objectification of knowledge in terms of the ways that classification participates in producing objectified forms of knowledge that subsequently lead to the production of statistics.

2.4.1 Critique of Sociology and Women's Standpoint

Smith posits that sociological methods of inquiry are problematic, maintaining that the universe that sociologists encounter is already ideologically structured (Smith, 1990, p.57). She argues that sociological research methods often overwrite and interpret the site of experience by transposing an experience-based writing and speaking; sociology then provides an objectified version of reality that neglects the version of what people tell about themselves. She argues that sociological concepts such as "gender" or "the family" are concepts that are constructed and then imposed back onto a reality; they are concepts that are worked up from the actualities of people's lives as if they existed outside of people's realities. Often times sociologists (or professionals in any discipline for that matter) conducting research come up with new concepts removed from the actualities of people's lives or elaborate on already existing concepts. The problem for Smith exists in the data because the data being used or created have already been worked up and

formulated to fit objectified forms of knowledge that do not access lived experience and thus obscure complicated relations of people's day-to-day lives.

Thus, Smith proposes an alternative sociology starting from the standpoint of women. A sociology starting from this place re-organizes social investigation by beginning with local knowledge and tracing it back to extra local relations. She claims that starting from people's everyday lives demystifies what happens in people's lives subject to ruling relations. An alternative sociology, from the location of women, makes the everyday world problematic and in doing so we also problematize everyday localized practices of objectified knowledge that organize our everyday worlds. The standpoint of women exposes the alienated knowledge of the relations of ruling by highlighting the everyday practices of individuals (e.g., care work done by women). With this we can then confront that sociology that is written outside of experience (Smith, 1990). Smith proposes an inquiry that produces a way of knowing that can be relied on in an ordinary way where sociological statements can refer back to the practices of actual people. Therefore, starting inquiry from the standpoint of women enables us to question the social relations constitutive of an objective knowledge of society.

2.5 A Sociological Examination of Self-injury and the Complex Continuum

Patricia and Peter Adler conducted research on self-injury (SI) and argue that what is revealed through the online self-injury subculture marks an important shift in the use(s) of self-injury and how it has been understood. Their longitudinal research charts the evolution of self-injury from the early 1990's to the early 2000's, noting the shifts that have occurred at various points and in particular the rise of self-injury cyber populations.

They argue that this may highlight a shift (much like the shift in ideas around tattooing and piercing) from a behavior on the fringe to an acceptable mainstream practice. Interestingly, they chose not to use the term self-mutilation as they felt the term “mutilation” had a negative connotation and chose “self-injury” instead as they felt it more adequately described the acts people engaged in. They initially began recruiting exclusively for face-to-face interviews but became intrigued when searching the Internet using terms such as self-harm and self-injury and finding sites where people were sharing their thoughts and reflections on self-injury. Their study population included men and women ranging in age from 16 to the mid 50’s, although the majority were women (85% women and 15% men). Their study drew on 135 in-depth life history interviews. While some of the participants interviewed may have been hospitalized in the past, none were institutionalized at the time of the study, therefore highlighting an important segment of the self-injury population moving away from the view of self-injury as psychiatric pathology (Alder & Alder, 2011).

The Adlers’ work forces us to realize that with both the increasing awareness and practice of self-injury, the question of whether or not the behavior is psychological or social (or both) remains. Much of what has been written on self-injury comes from research carried out by psychologists or psychiatrists studying self-injury from the perspective that views it as a problematic or maladaptive behavior indicative of a pathological problem or psychiatric disorder. Common themes surrounding self-injury include traumatic life experiences (particularly early childhood experiences that were upsetting or damaging to one’s emotional development and sense of security), impulse

and emotion control problems that lead to subsequently use of self-injury as a method to control, or a mechanism to soothe distressing thoughts and emotions. Adler and Adler (2011) make clear that there is still a place for psycho-medical models of self-injury as they help define the severity and scope of the behavior and argue that it certainly does seem to adequately explain reactions to severe trauma. They have noted in their research that out of those interviewed, the people who often did not “grow out” of self-injury behaviors were precisely the people who have experienced trauma and/ or psychologically upsetting childhoods. However, the psycho-medical model still fails to explain why it is that seemingly “normal” people without traumatic histories engage in such practices; here the line between pathology and mainstream practice is becoming increasingly blurred. The result is the shift of self-injury from a strictly psychological phenomenon to a broader sociological one.

Adler and Adler (2011) posit that the different places where people were situated on the psychological/ sociological self-injury continuum depended on factors such as the main reasons for engaging in self-injury, the age of the person self-injuring and the duration of the self-injury career (how long the person has been engaging in self-injury). For example, those who engaged in self-injury for reasons such as high school stressors and stopped self-injuring in early college or shortly after graduation were more likely to have been engaging in self-harm as a trendy social fad and were more likely to hear about it from others or through the media (Adler & Adler, 2011). Those who engaged in self-injury as a way to deal with the stress resulting from abuse or neglect, who continued to do it for long periods of time (even if at points they took hiatuses from self-injuring) into

their adulthood were more likely to fall on the psychological end of the continuum. Nonetheless, a sociological examination is critical because often self-injurers, regardless of where they fell on the continuum, were part of structurally disadvantaged, disempowered groups (such as those with lower socioeconomic status). Adler and Adler (2011) contend that when behavior spilled beyond psychiatric bounds, it took on sociological dimensions that could not be addressed by the clinical frameworks. Perhaps this was, and still is, part of the impetus for the DSM to include self-injury as its own disorder in future editions of the DSM-5 (it is not listed in the current edition of the DSM-5 but it is still listed under conditions requiring further study for future editions). A critical sociological examination highlights that there are increasing numbers of the population who engage in self-injury and do not exhibit symptoms or criteria associated with a psychiatric disorder. This also provides insight into the response of the psycho-medical community and the creation of new psychiatric disorders.

The Adler's study population included the following: people who associated with alternative subcultures (punk, goth, emo), trendy offshoots, adolescents dealing with "typical" stressors, and people who were most often younger, most often women and most often occupied structurally disadvantaged positions in either race or social class (Alder & Alder, 2011). The population, with the exception of a few, used self-injury as a way to manage intolerable feelings and emotions. Furthermore, the commonalities found among those in the self-injury population likely suggest positions of powerlessness rather than individual psychological or psychiatric pathologies. The experience of being disempowered likely results in an emotional distress that can then come to be (mis)

understood as symptomatic of a cognitive, behavioral, or medical problem. Alder and Adler (2011) note the shifts in self-injury in the early 1990's, from the hidden practice of the psychologically disordered to a cult youth phenomenon dealing with typical teenage angst to a wide range of socially disempowered groups. People engaged in self-injury careers for various reasons: some had trauma or mental illnesses, others engaged in it for rebellion, comfort, or as a way to deal with everyday upsets. Others self-injured in effort to relieve emotional tension and maintain a "normal" emotional social appearance. For whatever reason, most people still engaged in it as a way to deal with emotional distress. Cutting often was a way to control one's body or take back power when they felt they were in a power struggle between their bodies and minds or the world around them (Adler and Adler, 2011).

2.5.1 Gender and Self-injury

Adler and Adler identified the gendered component of self-injury in terms of the distribution of the population but also in how these behaviors were understood. They note early on that their research supports the assertion that there is a greater prevalence in women (85% of their participants were women). They touch on the discussion of women's bodies as micro-regulated (through patriarchal, oppressive appearance practices such as skin and weight maintenance etc.) and argue that bodies that are not in line with these norms may be defined as deviant and are subsequently pathologized, medicalized and criticized harshly. Alternatively, they argue, one might see gendered self-injury as actively resisting through agency.

More importantly, they also underlined how gender was taken up and understood by the participants they interviewed. The Adlers (2011) argue that intentionally injurious acts committed by men are not always perceived and interpreted into the same categories as women; a broader spectrum of acceptable risk-taking behavior exists for men. Participants were also aware of the ways in which self-injury was gendered, citing how the practice of self-injury and subsequent scarring was outwardly perceived differently for men and women. Men tended to repress emotion and exhibit obvious outward expression (through harsh injury) that was often understood as typical masculinity. Women by contrast internalized their emotions, not expressing their discontent outwardly (especially when it came to expressing anger). Participants noted that men tended to cut deeper and have bigger scars or that they injured themselves as part of masculine culture.

One female participant noted how self-injury was constructed as a gendered behavior because she felt men had more acceptable outlets for expressing their anger (such as punching walls). Many women felt that it was not acceptable for them to outwardly show anger through SI so instead they turned their anger inward; others felt SI was a way to symbolically externalize wounds they felt were initiated on them (Alder & Adler, 2011). Some also cited that the use of masculinity rituals involving SI (risk-taking behaviors to demonstrate pain tolerance), to prove one's toughness or masculinity was common, particularly among high school boys. Here risk taking was normalized. One participant when asked about his scars explained to his mother that it was masculinity ritual he was engaging in with his guy friends and was permitted to continue (Adler & Alder, 2011, p.13).

Much has been written about self-injury and gender from a feminist perspective concerned with patriarchy and oppressive practices; the feminist cultural/ structural approach stands in stark contrast to psycho-medical explanations and explores the various ways power is inscribed on the body (Brickman, 2004; Kilby, 2001; Liebling et al. 1997). The Adlers' work was a major sociological contribution to literature on self-injury. Adler and Alder (2011) also touched on some of the theoretical works written about gender and SI but also highlighted the ways in which participants understood self-injury as a gendered practice. Gender, like social class and race, shapes one's position within larger social structures and thus makes some people more likely than others to be in powerless situations and experience feeling powerless, and lacking control. Some participants viewed SI as being gendered because women and girls often found themselves in disempowered situations (Alder & Adler, 2011, p. 74). Whereas hyper masculine culture often celebrates, or at the very least normalizes, certain risk-taking behaviors, women who engage in risk-taking behaviors are more often heavily stigmatized.

2.6 Reactions and Responses to Self-mutilation

Intentional infliction of pain to one's body often provokes strong, negative reactions from others. Purposeful injury of one's body is often puzzling because it is difficult to understand why someone would willingly injure their body without the intention of dying. Medical and mental health professionals find self-injuring behaviors very puzzling and difficult to understand and treat (Heath & Nixon, 2009). Some therapists and physicians found dealing with patients who self-injured left them feeling helpless, guilty, sad and angry (Favazza, 2011).

Self-mutilation is perplexing and the ways in which it is understood often do not reflect or do justice to the underlying distress that is experienced or to what message the act itself is intended to convey. One might argue the misunderstanding that surrounds self-mutilation only serves to perpetuate and reinforce the very sort of invalidation that might lead to purposeful injury of oneself in the first place—Liebling et al. (1997) note that feeling invalidated is a trigger for some people who self-mutilate. Strong (2009) maintains that cutting is a language written on the body and in order to understand this language one really has to listen to what self-injurers say about what they do and why they do it. It is useful to consider the reasons for self-injury, the different ways self-mutilation is read and the psychiatric response to self-injury. I will argue that the way self-mutilation is read and made sense of is ultimately not helpful to those who engage in it; how self-injurers are treated by medical professionals only exacerbates the struggle for one's pain to be heard. I am referring mostly, although not exclusively, to women's experiences throughout this section because much has been written about women who self-harm.

2.6.1 The Reading of Purposefully Damaged Skin

What is the function of purposeful injury, what purpose does cutting (or other forms of self-mutilation) serve? Ultimately, self-mutilation is used as a self-soothing tool in an attempt to feel relief. People who self-mutilated reported feeling grounded or re-integrated afterwards; some say they feel whole, real, alive and human again, others say they use it to break out of feeling numb or conversely report engaging in self-harm because they feel too intense and want to feel numb (Strong, 2009). Another explanation

given for self-harm is the issue of control, some people say engaging in self-mutilation is a way of taking back control of one's body, a body that has been controlled by past traumatic experience and is now controlled by intense distressing thought and emotions (Liebling et al., 1997). This would make sense given that the experience of trauma or abuse leaves one feeling invalidated, powerless or out of control. However, taking into consideration the reasons cited above, many professionals still mistake self-injury, particularly cutting, as a suicide attempt (Strong, 2009; Kilby, 2001). These explanations fall under the dominant psycho-medical explanations of the reasons for and function of self-mutilation. However, there is room for alternative understandings of self-mutilation. This is not necessarily to replace the current understandings but to add a more nuanced and complicated appreciation that takes into consideration social positions and structural factors aside from the psychological/ personality and biological/genetic perspectives.

The type of treatment self-injurers receive is influenced by the ways in which people read or understand larger ideas about the body, gender, risk, pain, death and damaged skin (Ahmend & Stacey, 2001). Jane Kilby (2001), in her chapter on bearing witness to self-harm, contends that the act of self-harm is a plea for social recognition and it would seem that the simple response would be to listen. However, she argues, self-harm is difficult to bear witness to precisely because of *how it is read* and interpreted by others; the act of self-harm gains significance because of its break with verbal language, which means that others often want to define it in a desperate attempt to make sense of it. Consider the terms: non-suicidal self-injury, deliberate self-harm, self-injury, and self-mutilation. All of these references are attempts to describe a similar act but are reflective

of the different ways the behavior is read. For example, self-mutilation indicates desecration, self-harm indicates mistreatment, and non-suicidal self-injury divorces the behavior from suicidal intent. Nonetheless, no matter which term is used, self-mutilation is still poorly understood. As Kilby (2001) maintains, self-harm is often viewed by medical professionals as attention seeking or playing around with death thus wasting their time either because they do not truly want to die or because they are spending time where they could be treating someone else. Similarly, Strong (2009) goes on to say that self-injurers are seen widely as a problematic and hopeless group, particularly in a medical system where time is limited and resources are scant and compassion is already stretched to the limit.

An alternative way to view the cut skin, as opposed to understanding it as a desire to end one's life, is a desire to live out past trauma. Armando Favazza (2011), well known for his research on self-mutilation, calls self-injury a morbid act of self-help that is used to feel okay again, a way to save oneself (quite the opposite of feeling suicidal). Psychologist Scott Lines has argued that cutting is an expression through blood and scars similar to the emotional expression of tears; others have proposed that self-mutilation acts as a mothering substitute in distressing times (much like food, drugs or sex) in an effort to fill a void and soothe and comfort oneself (Strong, 2009). Kilby (2001) maintains that the testimony of the cut skin is often a means to search for the affirmation and validation denied by trauma. As McLean (1996) maintains, self-mutilation represents a language of past trauma but also represents a breaking with language, thus the act becomes a language itself, a language of pain. Cut skin threatens the boundaries of inside and outside, sane

and insane. How others, and more importantly, medical professionals, read the skin and in particular, the cut skin, largely impacts those who want their voices heard and there is a disconnection between what self-injurers say they need when they seek help and what sort of treatment they report receiving from medical professionals (Liebling et al., 1997). Reading the cut skin as either attention seeking or an attempt at suicide obscures the complexities of women's lives and reduces their bodies to time spent or wasted (Kilby, 2001). The cycle of speaking through the skin in order to be validated and the sort of treatment that self-injurers receive often reinforces unequal power relations and subsequently, further invalidation. For example, women hospitalized in psychiatric institutions reported feeling misunderstood and powerless which meant their desire to cut often became stronger. The desire to cut was an attempt to regain power and thus creates a cyclical pattern of cutting and feeling invalidated (Liebling et al, 1997).

2.6.2 The Psychiatric Response

Hospitalization in any context shifts power dynamics regardless of the reason for admission, considering that most day-to-day life responsibilities are removed and patients are under the care and control of the hospital staff and the larger organization of the institution itself. Power relations in psychiatry play out in a number of ways. Beyond the physical constraint of being hospitalized, power is also enacted through the use of diagnoses and the criteria used to diagnose. Diagnoses separate and order corporeal states, affording higher status to some than others. Diagnoses also organize illness, give permission to be ill, and influence the course of treatment and predict outcomes (Jutel, 2009). The way self-mutilation is often seen, labeled and treated by medical professionals

poses another concern. How self-mutilation is read and understood in a medical context often means that patients, in an attempt to speak through body language, lose their voice once again. In other words, there is the initial pain or distress that leads to the mutilation and then the subsequent losing of one's voice when it comes to seeking out treatment and being invalidated as someone who is attention seeking or suicidal, not taken seriously, and being further silenced. Unfavorable staff attitudes shaped by the larger medical-psychiatric ideas influence the type of treatment patients receive. This is seen most acutely in women admitted to psychiatric hospitals.

In a study by Liebling et al. (1997) exploring past and present reasons for self-harm, women admitted to psychiatric hospitals found that the experiences of excessive institutional control and the resulting power imbalance and negative reactions from staff often lead women to self-harm while in hospital as a way to regain control. The women listed reasons for self-harming behaviors while in hospital as feeling locked in or powerless. The same women reported experiencing reactions from staff that were unhelpful and at times punitive. They suggested alternative ways in which they would prefer to have their self-harm responded to rather than the invalidating comments staff made. Their suggested alternatives included: feeling like they were in a more caring environment, feeling less locked in; having access to group therapy (particularly for sexual abuse survivors); and having someone understanding to provide them with company (Liebling et al., 1997).

All too often however, the focus in hospitals is on medical treatments and certain types of distress are ignored or staff may lack adequate training. Liebling et al. (1997)

noted that because staff attitudes were seen as uncaring or punitive, this often meant that the women would not ask for help when they felt they needed it. In line with this, Johnstone (1997) argues that despite efforts made to inform staff of self-mutilation from the perspective of lived experience, the standard psychiatric approach has remained unhelpful and even damaging. Women who were institutionalized often times experienced negative reactions from medical staff and found it (re) traumatizing. These reactions were largely due to the assumptions embedded in medical psychiatry that are often based on the notions of diagnosis, illness, hospitalization and treatment (Johnstone, 1997).

2.7 Conclusion

This chapter focused on the literature necessary for framing my research and pointed to gaps in the research. I began by outlining a discussion of gender, medicalization and mental health, shifting to literature on the sociology of the body and the relationship between risk and the body. A review of the literature on gender, the body and risk highlighted how dominant ways of thinking and talking construct ideas about normal and abnormal bodies and behaviors. I have shown how these constructions are also shaped by larger medical/ scientific epistemologies and incorporated the writings of Foucault, Lupton and Smith to show how their work is valuable in helping make sense of self-mutilation knowledge production. I also highlighted the importance of sociological readings of self-mutilation by showcasing Adler and Adler's sociological inquiry into self-mutilative behaviors. Lastly, I emphasized how the psychiatric response to self-mutilation paints a clear picture of the intersection between knowledge and practice and a

need for change. Through an examination of knowledge production in the DSM and by psychiatrists, my research is both an original and important contribution to the literature on knowledge.

Chapter 3 – Methodology and Method

3.1 Introduction

This research is a critical study that seeks to understand the construction of knowledge about self-mutilation and examines how knowledge is produced in psychiatric texts and it is taken up and (re) produced by psychiatrists. This research is a post-structural feminist analysis of health, deconstructing scientific/ psychiatric knowledges by examining how self-mutilation language is produced and taken up. I examined how self-mutilation knowledge was produced and taken up by reviewing all editions of the DSM for references to self-mutilation and how they have changed over time. As well, I interviewed psychiatrists about their perspectives regarding self-mutilation, exploring their understandings and use of self-mutilation language.

Qualitative research attempts to answer the how and why of phenomena and its goal is to explore and uncover the complexities of such phenomena. Qualitative methods of social inquiry are often used within the domain of the social sciences to increase understandings of what constitutes health, health behavior and health services (Green & Thorogood, 2009). Green and Thorogood (2009) maintain it is useful to characterize qualitative research not by the kind of data produced but rather by the objectives of the study; the aim of the study guides what are appropriate methods of data collection. Since my primary concern is to understand how knowledge about self-mutilation is produced, I used two different methods that are most suitable to answer this question: document analysis and one-to-one interviews.

In terms of data analysis, there are some difficulties in articulating how qualitative data will be analyzed given that themes often emerge and the research process can change. Qualitative research processes are often fluid and require an ongoing redefinition and adaptation. I decided to use critical discourse analysis to analyze my data. Put simply, discourse analysis is looking at language use and patterns in language use (Wright, 2009). Critical discourse analysis focuses on the relationship between power and discourse, studying the way in which “social power, abuse, dominance, and inequality are enacted, reproduced, and resisted by text and talk in the social and political context” (van Dijk 2001: 352). A discourse consists of a set of common assumptions that may be so taken for granted as to be invisible or assumed (Cheek, 2004). Therefore, the goal of critical discourse analysts is to “make visible the “common-sense” social and cultural assumptions (or ideologies) which, below the level of conscious awareness, are embedded in all forms of language that people use” (Fairclough, 1995).

Discourse analysis can be considered in numerous ways from post-structural approaches to those more concerned with linguistics. A post-structuralist discourse analysis is the process of capturing regularities of meaning (Wright, 2009) and can promote the critical examination of “health” and “the body” as objects of inquiry (e.g., Beausoleil, 2009). A central concern of a post-structural approach is with the relationship between power and knowledge given that power relations are always implicated with knowledge and no knowledge is objective or disinterested. Power relations are seen as operating through social institutions, are productive and are present in any social relation (Lupton, 1999). Post-structuralism raises questions about how selves are constituted and

how power and knowledge relations change over time in different places and in social, political and cultural contexts (Wright, 2009).

Discourses both enable and constrain the production of knowledge by allowing and excluding certain ways of thinking about reality, including ideas about who can speak and what can be spoken about. Analyzing the discourses that the DSM and psychiatrists use to describe self-mutilation is one way of uncovering social and cultural assumptions about gender, the body, and risk and how they influence the language of mental health. “Language is how social organization and power are defined and contested and the place where ourselves, our subjectivity is constructed” (Hesse-Biber, 2004, p. 475). Phillips and Hardy (2002) argue that without discourse, we cannot understand our reality, our experiences, and ourselves. As Wright (2009) has argued, the notion of discourse provides a means to understand what resources are available to individuals as they make sense of the world and themselves in the world. However, it does not explain why some, rather than others, are taken up or how the same discourses are taken up in different ways. She contends that part of this answer lies in the relation between power and discourse.

I focused on uncovering and examining references to self-mutilation and related terms in all published editions of the DSM (DSM I through IV) as well as the recently published DSM-5 (2013). In addition, I conducted one-to-one interviews with psychiatrists to gain their perspectives on self-mutilation and how they understand the behavior.

Green and Thorogood (2009) contend that whether we are cognizant of it or not, theoretical knowledge about how the world works informs the kind of questions we ask,

how we answer them and the type of interactions we have. My training in sociology and my reading in feminist theory shape my way of knowing the world and what I see as worthwhile research questions. This project is a feminist project in that I believe the legitimization of knowledge is heavily tied to social structures of domination and that this is the case when it comes to how self-mutilation knowledge is constructed. Knowledge is a process and although it is often organized and represented in a way that it reflects the standpoint of those who produced it, it is often presented as objective or true (Kirby, Greaves, & Reid, 2006). Some feminist research differs from the positivist paradigm in that the goal is not to discover an “objective” reality that exists waiting to be discovered but rather to challenge the very concepts of objectivity and universality altogether. As Hesse-Biber (2007) notes, “Feminists ask new questions that place women’s lives and those of the ‘other’ marginalized groups at the center of social inquiry” (p.3). Feminist research is a relational process rather than an objective product and demands a critical self-reflectivity, dialogue, and interaction. The goal here is not to find objective truth but rather to explore how self-mutilation knowledge is produced by the DSM and by psychiatrists. I will show how the production of self-mutilation knowledge, and its use in practice, largely reflects the perspectives of one dominant community (mental/ medical health professionals) or one dominant paradigm (medical-psychiatric-disease-illness-model), such that ways of producing and knowing knowledge go unheard.

3.2 Ethical Considerations

Research projects typically have various stakeholders such as researchers, the institution(s) for which they work, the participants, and those who are affected by the

research results. The question of *who* the research is for will, of course, shape the research process. *What* the research is for will also imply different ideas about the proper responsibilities of the researchers (Green & Thorogood, 2009). Responsibilities of the researcher may also vary according to the discipline or paradigm; nonetheless specific ethical guidelines (such as, in Canada, those outlined by the Tri-Council Policy Statement) must be followed when undertaking research that involves human participants. Respect for human dignity forms the foundation for the guiding principles of the Tri-Council Policy, this includes: respect for persons, and concern for welfare and justice (TCPS2, 2010). Consideration of these guiding principles also means recognizing that researchers and research participants may not see the possible harms and benefits of the research process in the same way, but it is essential to minimize potential harm for the research participants. This is ensured by a series of requirements such as a proportionate review by a research ethics board for any research involving human participants (TCPS 2, 2010).

The issues that may arise from my proposed research design (my second method, one-to-one interviews) center around: free and informed consent, privacy and confidentiality, conflict of interest and inclusion in research. Informed consent is essential in research involving human participants. Research participants must be informed of the intent, purpose, and expected outcomes of the research and voluntarily consent to participate in the research (Green & Thorogood, 2009). Participants were required to sign consent form that explains the purpose(s) of the research, that ensures all personal identifying information is kept confidential and that they have the right to withdraw from

the interview/ research process at any time (Appendix E). Permission for the interview to be digitally recorded was also outlined in the consent form.

Confidentiality was ensured by assigning a random pseudonym (e.g., Dr. A, Dr. B) to each research participant. I also made certain that there were no personal identifiers located within the data, either written or recorded. Names, employment information, office location or any other identifying information was not used in the transcripts or in the thesis. The master list of pseudonyms and the interview data were digitally password protected in separate folders and other related documents were locked in a file cabinet located in my academic department. Privacy and confidentiality of both psychiatrist and patient information were at issue in my research. Psychiatrists have a code of ethics they follow regarding privacy and confidentiality, so it was unlikely that patient information would have been divulged. However, in the case that identifying information was shared on record (which in one case it was), it was deleted from the written transcript and the recorder. If psychiatrists expressed a desire to say something off record, I turned off the tape recorder and made no recorded notes of the conversation. All of this was also outlined in the consent form signed by psychiatrists before the interview (Appendix E).

The concept of *minimal risk* research is defined by the Tri-Council Policy Statement as “research in which the probability and magnitude of possible harms implied by participation in the research is no greater than those encountered by participants in those aspects of their everyday life that relate to the research” (TCPS, 2010: Page 23). My research posed minimal risks to participants involved in the research project. Having said that, I considered that one-to-one interviews with psychiatrists did pose two separate

confidentiality issues (as I have outlined above), first making sure that neither psychiatrists nor their practices are identified and second, ensuring that any information divulged by the psychiatrists regarding patient information would be deleted from both the digital recorder and transcription records.

3.3 Data Collection

3.3.1 The DSM

My research seeks to understand the construction of knowledge about self-mutilation and examines how knowledge is produced in psychiatric texts and is taken up and (re) produced by psychiatrists. Since my primary concern is to understand how knowledge about self-mutilation is produced, in part through psychiatric texts, I focused on uncovering and examining references to self-mutilation and related terms in all published editions (DSM I through IV) of the DSM, the proposed criteria for the DSM-5, and any important changes in the recently published DSM-5.

My aims were to:

- 1) Examine DSM editions I through IV, the proposed criteria for the fifth edition of and any noteworthy changes in the published DSM-5.
- 2) Compare and contrast how the editions have changed over time particularly with reference to self-mutilation.

I took a longitudinal approach to document analysis of the DSM. This means that I conducted a document analysis of the DSM over time, between 1952 (DSM-I) and 2013

(DSM-5). The DSM is a widely used psychiatric diagnostic tool and it determines the official medical criteria to assess and diagnose self-mutilation. A longitudinal document analysis demonstrates how knowledge has changed throughout the different editions.

According to Green and Thorogood (2009), using pre-existing documents can be an efficient way to answer qualitative research questions. There are a number of ways in which public records can be used as data for qualitative research as the topic of analysis. They maintain that public records can be a rich source of data for researchers interested in exploring the ways health categories are constructed and how political and social factors shape the types of data collected (Green & Thorogood, 2009, p. 178). Documents can be read in a number of ways and Green and Thorogood (2009) propose that social constructionists make the most out of document resources as they provide an important longitudinal record of official classifications of health and medicine. What is of interest is how categories are constructed and how they change over time. However, I undertook a slightly more nuanced approach to document analysis. I conducted a discourse analysis of the DSM (taking into account how the DSM has changed over time) and also considered how the DSM is taken up (used, understood, reproduced, and resisted) in practice. Understanding how documents are used in real life can be done by repositioning documents from the more traditional view of documents as passive and static to documents as active social agents where the focus is on function rather than the content alone (Prior, 2008). Dorothy Smith (2001) claims it is not enough to use texts alone as sources of information about institutions. Instead she reasons that what remains important is to examine how texts enter into people's practices of everyday writing and mediate

everyday practices. She contends that sociology in some regards has failed to see how texts are implicated in social organization but emphasizes how central texts are to understanding ruling relations as ruling relations are textually mediated. Texts are active and their words and images are produced and re-produced over time in many different contexts, by many people all of whom are situated differently.

I re-positioned the DSM to show how the DSM influences interaction and knowledge production. The DSM is not an ahistorical, unaffected document that just came into being, it is an incredibly powerful diagnostic tool that shapes interaction and is also shaped by interaction. Thus an exploration into how it informs psychiatrists' viewpoints on self-mutilation is key.

I accessed DSM editions I through IV through Memorial University's library health database and Psychiatry Online (the online newspaper of the American Psychiatric Association). This online newspaper houses a historical DSM library where all published versions of the DSM are available to download in PDF format for viewing.

For editions I through IV, I downloaded the PDF from the online database, noted the version, year of publication, any revisions made, number of pages, and references to self-mutilation (and its various synonyms) as well as any other additional observation notes, and how it may have changed from another version. In order to include various combinations or different endings, I used asterisks (*) at the end of terms in order to find all variations in the document. Using the "find" function in the PDF reader I searched the PDF using the following search terms: self-harm, self-mutilati** (to include self-mutilation, self-mutilating, self-mutilative), self-injur** (to include self-injury, self-

injurious), NSSI, non-suicidal self-injury, self-inflicted injury, purposeful injury. I then noted results that the search terms produced and took note of what diagnosis/ disorder the term self-mutilation/ self-injury was associated with along with the page number. I ran the search terms through each edition a second time to make certain the same results were produced. Because the search returned multiple results for each edition, I organized the results into a series of tables.

For the proposed fifth edition², I examined the website and the published hard copy. Before DSM-5 publication, using the website, I searched ‘self-mutilation’ in the search bar on the DSM-5 website and under the proposed revisions section. I noted the proposed change for the inclusion of a new disorder: V-01 Non-suicidal self-injury under the category “other disorders” and the APA’s rationale for the inclusion of the diagnosis.

In the spring of 2013 I was able to access a hard copy of the published DSM-5 to review mentions of self-mutilation. While I was not able to download a PDF version and perform the same find function as I did with versions I through IV, I was still able to gather some important information on any deviations from the previous DSM-IV. I took note of whether or not non-suicidal self-injury was included as a separate disorder and

² Only versions I through IV were available through the psychiatry online database. At the time I was carrying out the analysis of the DSM, the DSM-5 was not yet published, but I had access to the proposed criteria. The proposed criteria for the fifth edition were available publically through the APA website for the development of the DSM-5: (available at <http://www.dsm5.org/Pages/Default.aspx>; accessed August 2012). While not the same as a published text, the DSM-5 development website contained the proposed revisions for the fifth edition of the DSM, ongoing research, links to publications, frequently asked questions, and opportunities for public comment on available drafts. Furthermore, during the time I was writing my thesis, the DSM-5 was published (spring 2013) at which time I was able to access a hardcopy for review.

any changes to borderline personality disorder criteria where self-mutilation is listed as one of the criteria.

3.3.2 Interviews

My goal was to examine the relationship between textual medical knowledge of self-mutilation and psychiatrists' understandings of self-mutilation based on their professional experience. The focus of this section is the use of one-to-one interviews as a data collection method. The aim of conducting one-to-one interviews was to produce detailed accounts from the perspective of the interviewee. How psychiatrists understood and subsequently treated self-mutilation was part of the answer in examining how self-mutilation knowledge was constructed.

3.3.2.1 Recruitment

I interviewed psychiatrists located within the largest health authority in the province in St. John's, Newfoundland. For psychiatrist recruitment I sent an email outlining my research and my request for participation to the head of Psychiatry (Appendix B). The head of Psychiatry agreed to help in my recruitment efforts by discussing my research at a faculty meeting, and then forwarded along to me the names and email addresses of the psychiatrists who were interested in participation. I subsequently contacted those who indicated an interest in my study via email to set up appointments (Appendix C). In a few cases, I wrote follow-up reminder emails. All 9 psychiatrists who originally indicated interest responded and were available for interviews. A tenth psychiatrist was recruited using snowball sampling and was sent an

information sheet about my study (Appendix D). Recruitment began in December 2011 and was completed by the middle of February 2012. Ten interviews were conducted between January 2012 and March 2012.

3.3.2.2 The Participants

The psychiatrists I interviewed came from different educational backgrounds and worked at different sites, and specialized in treating different populations (e.g., adult or child and adolescent). I interviewed 10 psychiatrists in total and out of those I interviewed, there were 6 male and 4 female psychiatrists, 6 of which were child and adolescent psychiatrists and 4 who were adult psychiatrists³. The psychiatrists worked at three separate hospital sites with both inpatient and outpatient populations. The three hospital sites are located within the same health authority that comprises the largest health authority (of 4), in the province and serves a population of approximately 290,000 people. There was only one psychiatrist I interviewed who worked in psychiatric emergency. A greater number of psychiatrists with this type of experience/ perspective would have been useful to interview, however they did not indicate interest in my study. Future research could perhaps look at the perspectives of psychiatrists who work in psychiatric emergency and see and treat self-mutilation patients, as the presentation may be more acute and different than the experience of psychiatrists who treat patients in practice.

³ Child and adolescent psychiatrists see people until age 18 after which they fall under the realm of general (adult) psychiatry.

3.4 Qualitative Interview Method

Interviews are the most widely used method of conducting social inquiry. The qualitative interview is different from everyday sort of interviews in that researchers are exploring people's accounts in order to develop some sort of theoretical understanding of underlying beliefs and structures; it opens up responses not assuming there is one truth but multiple truths and realities (Green & Thorogood, 2009). Rapley (2004) understands interviews as social encounters where speakers collaborate in producing retrospective (and prospective) accounts or versions of reality of their past (or future) thoughts, feelings and experiences. Holstein and Gubrium (2009) suggest simply that interviewing provides a way of generating data by asking people to talk about their lives. It has also been suggested that the interview is essentially a conversation directed towards the researcher's need for data, but how much of the interview is directed depends on how rigidly or freely the interview is structured.

There are different types of interview methods ranging from structured to semi-structured to informal interviews. Green and Thorogood (2009) see the semi-structured interview as a method where the interviewer sets the agenda in terms of the sorts of topics covered but the interviewee's responses determine the kinds of information produced and the importance of them. For my research, I decided to use a semi-structured interview format as it best suited my data collection needs; it was free enough to elicit a relaxed conversation between myself and the psychiatrists I was interviewing but still remained directed toward the topic I was exploring.

I developed an interview script where I ordered my questions in what I thought was a logical flow, but given the flexible changing nature of the interview process this was not always the case. Sometimes I did not adhere rigidly to the order of the questions as the conversation flowed naturally and so I let it flow, and if there were unanswered questions I went back afterwards and asked them. After I conducted a few interviews, I realized that some of my questions were not clear to the participant, so I re-arranged them according to the themes, training, experience and perspective to make them more coherent (See Appendices F and G for the original and revised interview scripts).

I began with general questions about education and choice of psychiatry as a profession to lead into the more detailed questions around self-mutilation. Open-ended questions were key in my interviews for obtaining the most detailed and rich accounts of psychiatrists' experience. I used "tell me about" type of questions (e.g., "tell me about your experience in treating those who self-mutilate?"). When I felt it was necessary to get further information or that the information was not clear and I needed clarification, I used prompts and probes and mirrored back what I thought they said. There was a delicate balance between appropriate silence and knowing when to follow up on a particular question or to move on to the next. This was something that I became more comfortable with as time went on and I conducted more interviews. Occasionally, in addition to digitally recording the interviews, I jotted down a few brief notes during the interview and always wrote down more detailed notes and thoughts after each interview. I also kept a methods/ reflexivity journal organized according to the categories defined by Richardson (2004), in her chapter 'Writing: A method of inquiry'. The notes were

organized under the following headings: observation notes (what I saw, heard, smelled), methodological notes (what to wear, what approach worked, what did not work, how I collected data), theoretical notes (connections, critiques, early themes) and personal notes (non-censored thoughts and feelings, doubts, and exciting moments). I found this to be very useful for organizing my thoughts throughout the whole research process. It served as a way to de-brief with myself, keep track of how my research evolved and helped make sense of how my own subjective position shaped my research. Richardson (2004) also maintained that keeping detailed notes like this was a way to understand how feelings were affecting what the researcher was laying claim to knowing.

Holstein and Gubrium (2009) maintain that all interviews are *active* interactions instead of one-way exchanges. Furthermore, they contend, “treating interviewing as a social encounter in which knowledge is actively constructed suggests the possibility that the interview is not so much a neutral conduit or a source of distortion, but rather a site of, and occasion for, producing knowledge” (p.141). Similar to Prior’s (2008) argument that documents are not just passive receptacles of content but instead active agents in interactional processes, the same is true of the creation of data in the interview process.

Considering that language is the primary way in which we make sense of the world, communicate understanding to others and shape the world, it is an essential site of analysis. Language becomes a central feature as both method and data. First, because interviews rely on an exchange of words between the interviewer and interviewee and second, the data generated from the interaction consists of a sample of spoken and written words. As I conducted my interviews I kept in mind that the types of questions I was

asking were shaping what answers I might receive. I kept it uppermost in mind that I was part of the interactional process of the interview and the creation of data (Holstein & Gubrium, 2009; Kirby et al., 2006). Listening to the words psychiatrists used to describe those who self-mutilate was important in understanding how they make sense of the behavior and how they take part in (re) producing psychiatric knowledge. Understanding how language shapes categories and by extension, the world, is important in uncovering meaning, people's everyday lives and how their experiences shape their health. I was concerned with how psychiatrists interpret, organize and make sense of self-mutilation and how the knowledge produced in the DSM around self-mutilation is taken up, interpreted, and adapted.

However, language is only part of the inquiry; understanding the larger structural processes of interaction is also important. How language is taken up, by whom and in what context and how it affects interaction is dependent on many larger structural influences and factors. Language does not contain one meaning but multiple meanings. So my focus was not only on what psychiatrists *say* but rather what they *say they do* in practice.

Given the interactional nature of the interview process, interviewers are also unavoidably implicated in meaning making. This is in part created by, as I have said before, the questions that are asked, but also by body language and non-verbal cues by both participants. The use of non-verbal cues are also important and something to be aware of. I tried to be aware of how I sat and made sure to have what Holstein and Gubrium (2009) call an "active listening stance," sitting with my posture posed slightly

forward on my chair, nodding my head, and allowing for appropriate silences and break in between questions and responses.

3.4.1 Reflexivity

Taking meaning making, question asking and interaction into consideration, it is not hard to see that reflexivity in any research process is also essential because the position of the researcher will affect the kind of relationship established and the interactions that follow. Green and Thorogood (2009) define reflexivity as a reflection process whereby the researcher considers and critiques their position within their research practice in the same manner they would critically analyze their own data. It is essentially a process of self-reflection about how one's own subjectivity affects their research. Hesse-Biber (2007) argue that reflexivity is a dynamic, reflective, learning process in which there are constant negotiations with one's self and their relationships with participants in terms of one's own positionality, assumptions about the world, personal biographies and concepts of what constitutes as an insider or outsider. Furthermore, she argues that reflexivity is a process that takes place along all stages of the research from the research question through to interpretation and writing. However, she also notes "the boundaries between self-indulgence and reflexivity are blurred as there will always be a struggle with how much to reveal or keep silenced (Hesse-Biber, 2007, p. 507). Thus, my position as a 27 year-old, white, female, master's student, feminist, sociologist engaged in interviewing psychiatrists in various positions, undoubtedly affected the dynamics of the interaction and thus the data generated. My desire to understand the relationship between power and the construction and use of diagnostic categories came from my own

experience navigating the politics of the mental health system. I have witnessed first-hand the complex ways that power is used and reproduced in interactions among staff, among patients, and between staff and patients, and how that use of power shapes, and is shaped by, the politics of psychiatry and its use of diagnostic categories. While talking about power and interaction might seem very abstract or unimportant, the effects are very real for the people who exercise power and for those who experience its effects. The ways my positionality affected my research was documented in a methods/ reflexivity journal that I kept throughout the research process. I kept this reflexivity journal as a parallel process to identify the ways in which I was implicated and positioned in my research so that I could be conscious of how my position was affecting the research.

Consideration of different power/ social positions are noteworthy while conducting interviews, as power shapes the data. “An array of interlocking identities such as race, gender and class, influence the research process and insider/outsider positionalities become more complicated as the researcher ventures into relationships across difference” (Hesse-Biber, 2007, p. 499). Often times, past advice concerning conducting interviews and power differentials assumed the researcher would have more “power” but neglected the different ways in which power can be negotiated. In much health research, the opposite is often true where the interviewee often holds the more powerful position (Green & Thorogood, 2009). This was the case with my research where in terms of career status, age, educational level, and psychiatric language proficiency, I was in the less “powerful” social position. Considering, though, that power can be negotiated differently, I also had power in the research process given that I chose the

research question, came up with an interview script and ultimately organized and interpreted the data according to what I saw as important themes.

3.4.2 The Interview Process

The interviews took place in psychiatrists' offices except for one that took place in the psychiatrist's home. Initial recruitment was relatively easy but, due to time constraints and responsibility to patients, being able to schedule appointments was difficult, moreover interruptions during the interviews (e.g., phone calls, knocks on the door, pagers that needed prompt reply) were common. Some interviews were easier than others; some people were talkative, some were not or seemed to be pre-occupied (this was the case when interviewing one psychiatrist in particular).

The number of interviews I chose to conduct was, in part, dependent on the number of people who indicated interest in participating, which in total was ten. For each interview I reviewed the consent process and, with the participants' permission, I digitally recorded the interview. At the beginning of each interview, I introduced my research and myself. Some psychiatrists at this point had further questions, and some did not. I also asked if there were any questions at the end of the interview. I jotted a few notes during the interview and, once the interview was over, I recorded detailed notes on how I thought it went, and any initial themes I thought might be evident. I listened to the taped interviews once completely without transcribing to become familiar with the data and made note of different themes that seemed to be emerging. I then listened to the taped interviews a second time while transcribing the interviews and noted different themes that

seemed to be emerging. I transcribed the interviews myself, verbatim, including technical terms, slang, improper grammar, long pauses, and so on.

3.5 Data Analysis

Data analysis is an ongoing, emerging process and multiple readings of data can uncover different things. I have employed what Thomas (2003) has termed “a general inductive approach” to uncover important themes. The purpose in using this approach is to condense extensive raw data into brief summary format, to establish links between research objectives and the findings from the data and to make theoretical sense of the underlying structure of the experiences or processes that are evident in the data. The model of analysis is the development of themes from raw data into a framework that encompasses what is considered important by the researcher. Inevitably, the findings are shaped by the assumptions and experiences of the researcher conducting research and analysis.

Coding involved an initial reading of the transcripts followed by a close reading of the text and the creation of broad categories and themes (and subthemes). I then identified un-coded or overlapping categories, while identifying contradictory points of view. Transcripts were used to identify themes and, when no new themes were identified, I concluded that that all relevant themes were recognized. I then organized data into separate theme-based Microsoft word documents.

The general inductive approach provides an efficient way of analyzing qualitative data (although it is often confused with grounded theory approach) (Thomas, 2003). However I am not claiming that the data “spoke” to me and revealed themes that were

somehow already organically there. The themes I uncovered were of course influenced by my research question and the methods I employed and my particular way of knowing the world. But a general inductive approach helped sort out a very detailed, large amount of data in order to identify relevant important themes. Within this general approach, after identifying themes, I looked for particular discourses within the DSM or used by psychiatrists and took note of how discourses were embedded in certain knowledge constructions. The term *discourse* has many different definitions depending upon the discipline in which it is used, but for the purposes here, I am referring to *discourse* as the use of language that is based on particular knowledge constructions. For example, there are biological discourses, political discourses, gendered discourses, and medical discourses and some discourses are dominant and others marginal. I employed critical discourse analysis to uncover implicit assumptions surrounding gender, the body, and risk found in the language of the DSM and in how psychiatrists spoke about self-mutilation. I was also concerned with how these discourses affected practice. I then linked the themes/ findings back to some of the writings I have outlined in the literature review chapter.

3.6 Theoretical Framework

Both documentary and interview data can be analyzed from multiple perspectives. My research is multi-disciplinary and works in and between the disciplines of sociology, anthropology, psychology and medicine. Within these disciplines, I draw on the writings and work of Michel Foucault, Deborah Lupton, Dorothy Smith, and various other post-structuralist, materialist and feminist approaches. I found the work of Dorothy Smith and

her discussion of the objectification of knowledge to be particularly useful in theoretically making sense of self-mutilation knowledge construction.

As I have noted above, above all I am most influenced by feminism. There are many different types of feminisms within feminist theory and I define feminism as an inquiry into “common sense” assumptions, discourses and behaviors are often reflective of deeper-rooted inequalities such as sexism and heterosexism and are based on gendered dichotomies of masculine/ feminine, strong/ weak, rational/ emotional. These inequalities, whether implicit or explicit, are the product of power differentials and have real world effects and implications for the health of women and men. From motor vehicle accidents to domestic violence to mental health issues, to war-related injuries, health is gendered and gender is often a contextual factor that affects people’s lives in very serious ways. I believe it is important to use a feminist lens when looking the health broadly, and specifically, in my own research in what ways gendered dichotomies shape how the body— or rather how self-inflicted damage to the body— is produced and understood.

3.7 Conclusion

Both Green and Thorogood (2009) and Fossey et al. (2002) argue that qualitative research aims to address questions that explore the meaning and experience of people’s lives and worlds. This research is aimed at gaining a richer, deeper understanding of how self-mutilation knowledge is constructed and understood. Given the flexible qualitative methodology I have employed, themes and alternative approaches have inevitably emerged and changed throughout the research process. I think the methods of data collection I have chosen complement one another in understanding how self-mutilation

knowledge is produced/constructed. The methods enable me to map the connections and disconnections between knowledge produced in the DSM and how knowledge is (re) produced/ taken-up by psychiatrists.

Chapter 4 – The Diagnostic and Statistical Manual of Mental Disorders

4.1 Introduction

The DSM is an American based classification of mental disorders used by psychiatrists around the world and is incredibly influential in the production of the language of mental disorders (Cooper, 2004). It is the primary handbook used by mental health professionals for providing consistent, standardized diagnoses when communicating about patients. Given that the DSM is tremendously influential in the production of the language of mental disorders, an analysis of the DSM is part of the logical flow in mapping out self-mutilation knowledge production in the DSM itself but also in psychiatric practice. In this Chapter, I will only briefly highlight how the DSM came into being and the changes it has undergone in its 60-year history. The DSM and its complex history is the subject of a much broader inquiry.

This chapter will provide the necessary background to have an elementary understanding of how the DSM was produced, followed by a more in depth discussion of the DSM in relation to self-mutilation. I include an overview of how the DSM came into being, its diagnostic system, critiques of the DSM and the search results pertaining to mentions of self-mutilation in the editions I have examined. Although the DSM-5 was not yet out at the time I conducted the analysis of versions I to IV, this did not significantly alter my findings. I will address these changes in the DSM 5 later on in this chapter.

4.1.1 Background of the Diagnostic and Statistical Manual

According to the American Psychiatric Association (APA, 2012), the DSM is defined as:

The standard diagnostic tool used by mental health professionals worldwide to promote reliable research, accurate diagnosis, and thus appropriate treatment and patient care. Each psychiatric disorder with its corresponding diagnostic code is accompanied by a set of diagnostic criteria and descriptive details including associated features, prevalence, familial patterns, age, culture, and gender-specific features, and differential diagnosis. (APA, 2012)

As the title and description suggest, the DSM is a text containing criteria and guidelines used to define, diagnose, communicate about and guide treatment for various mental disorders to medical or mental health professionals. This need for classification has been evident throughout the history of medicine. Classification systems are developed to organize information and aid in the diagnosis and treatment of medical conditions; agreement on classification categories however is contentious. What led to the development of the DSM? In the United States, prior to World War II, the need to collect statistical information was the preliminary impetus for the categorization and classification of mental disorders. What might be considered a first attempt to gather information on mental illness, noted by the APA, was recording the frequency of “idiocy/insanity” in the 1840 census. Forty years later, the 1880 census listed seven different categories of mental illness (APA, 2012).

The period after WW II marked a fundamental shift in psychiatry, recognizing the impact of environmental stressors associated with combat and the effect stressors had on soldiers. This subsequently marked a significant change in thinking surrounding

psychiatric disorders and treatment (Grob, 1991). Taking this into consideration, a broader nomenclature was developed by the United States Army to better encompass the outpatient populations of World War II service people and veterans. At the same time, in 1948, The World Health Organization (WHO) published the sixth edition of the International Classification for Disease (ICD), which, for the first time since being published, included a section on mental disorders. Subsequently, the APA Committee on Nomenclature and Statistics developed a variation of the ICD-6, which became the first edition of the DSM (DSM-I). The DSM-I contained a glossary of descriptions of diagnostic categories (APA, 2012). The development and publication of the DSM and the ICD were often concurrent and shared the goal of diagnostic agreement and congruency so that mental health professionals would be able to communicate diagnoses and disorders consistently.

4.1.2 Editions I through IV and the DSM-5

The DSM has evolved over the past 60 years, changing significantly, reflecting both changes in society as well as understandings of psychiatric disorders. As is the case for most texts, the Diagnostic and Statistical Manual is not exempt from the influence of the social/ historical/ political period in which it was published.

The impetus for the development of the first DSM was an increase in patients' mental suffering from fighting in WWII and the need for a standardized diagnostic measurement. The DSM-II was an attempt to better organize the previous version, but still failed to produce clear diagnostic categories. This subsequently led to the development of the DSM-III. DSM-III represented a major shift in the DSM. For the first

time, the DSM made the move from descriptive paragraphs to a criterion based, multi-axial diagnosis system that attempted to address the problem of diagnostic agreement among physicians; it was a radical change from the DSM-II, which was oriented toward psychoanalytic concepts (Martin, 2009). The DSM-III included new diagnoses, such as Post Traumatic Stress Disorder (PTSD) and Borderline Personality Disorder (BPD), and homosexuality was removed as a mental disorder (DSM-III, 1980). Explicit, operationalized criteria meant that diagnostic agreement among mental health professionals was better than before (Bernstein, 2011). However there were number of inconsistencies in the new criteria. The APA appointed a work group to revise the edition and make corrections that led to the development and publication of the DSM-III-R in 1987 (APA, 2012).

The DSM-IV came out in 1994. Compared to the DSM-III and DSM-III-R, numerous changes were made to the classification, the criteria and the text description; some disorders were added and some deleted (APA, 2012; DSM-IV, 1994). There were no major changes to DSM-IV-TR (2000) other than changes to the text portion.

The much anticipated, highly controversial DSM-5 was published in the spring of 2013. This edition changed from using roman numerals DSM-V to DSM-5 to make revisions easier e.g., DSM-5.1, 5.2. The DSM-5 included fifteen new diagnoses (e.g., caffeine withdrawal, cannabis withdrawal and skin picking disorder) while eliminating others completely (e.g., Asperger's Disorder) and made changes to some of the already existing criteria and specifiers.

4.1.3 Revisions

The APA maintains that the DSM serves as an important educational tool and that it is essential that information within the text be recent. A revision to the manual usually reflects the need for incorporating new evidence from ongoing research (APA, 2012). For the most part, each edition has undergone a revision either of the entire manual, denoted by “R” (e.g., DSM-III-R) or a revision to the text denoted by “TR” (e.g., DSM-IV-TR). Sometimes revisions are necessary to incorporate new research (either statistical, clinical or both); other times revisions are made to change, include, or delete certain diagnoses.

4.2 The Use of the DSM by Professionals

It is important to understand how the DSM is used, in other words how diagnoses are made. The DSM does just what the title says: its intended purpose is to convey statistics about mental disorders and to provide clinicians with directions about how to code, report and diagnose mental disorders. The priority of this sort of manual is to create a helpful clinical guide to assist mental health professionals with how to diagnose and report psychiatric disorders (DSM-IV-TR, 2000). The major advancement of the DSM-III was the introduction of the systematic criteria sets and a multi-axial diagnosis system. This organizational structure continued in the DSM-IV (1994) and DSM-IV-TR (2000).

According to the DSM-IV-TR (2000)⁴, the purpose of the manual is to provide characteristic descriptions of diagnostic categories in order to enable clinicians to

⁴ Throughout this section, I will refer to the DSM-IV-TR. As described in the Methods section of this thesis, this analysis was conducted prior to the publication of DSM-5. The analysis remains salient; it is

diagnose, communicate, and study people with various mental disorders. The DSM does not contain information regarding treatment, although the goal is accurate diagnosis leading to appropriate treatment (APA, 2012). However, it is important to note that the influence of DSM diagnosis still shape treatment and treatment outcomes. The explanations of diagnostic procedures begins with a cautionary statement on making diagnoses, stating that diagnostic criteria are offered as guidelines for making diagnosis, and that the proper use of these guidelines requires specialized clinical training (DSM-IV-TR, 2000, p. xxxvii).

So how are the diagnoses made? The DSM-IV-TR is grouped into 16 major diagnostic categories, each of which has various diagnosis contained within the corresponding category. For example, Borderline Personality Disorder (BPD) is found under the heading Personality Disorders and Bipolar Disorder is found under the heading Mood Disorders. Each disorder has a name and corresponding diagnostic number/ code. The coding system in use in the United States at the time of DSM-IV-TR (2000) publication was the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). Most disorders that appear in the DSM appear with a numerical code that appears preceding the name of the disorder, at the beginning of the text section and at the beginning of the list of criteria (e.g., “301.7- Antisocial Personality Disorder”). For some diagnoses, the appropriate code depends on further specification and often times subtypes (e.g., Delusion Disorder, Jealous Type) and/or specifiers (e.g.,

consistent with DSM-5. Therefore, I have chosen to retain my original language here, referring to DSM-IV-TR rather than revising in keeping with DSM-5.

296.21 Major Depressive Disorder, Single episode, mild) are provided for increased specificity. The APA declares the use of this code is important for medical record keeping and is often required for insurers and government agencies. Each diagnosis is followed by a text section outlining the diagnostic features of the disorder accompanied by epidemiological information and diagnostic criteria for the disorder. As the DSM clearly indicates, the diagnosis usually applies to the individuals' current presentation at the time of seeking medical help (DSM-IV-TR, 2000).⁵

After a diagnosis is made, often a multi-axial assessment system is also used to ensure a comprehensive, systematic evaluation has been made. Attention is paid not only to mental disorders, but also to the various physical or general health concerns and environmental and psychosocial factors. Because of the complexity of some presentations, most diagnoses also have a "Not Otherwise Specified" (NOS) category to be applied in cases when the diagnostic criteria do not cover all clinical situations and presentations (e.g., Eating Disorder NOS). Some have criticized NOS categories as being a catch all diagnosis when a diagnosis is not necessary (Davis, 2006).

It is worth mentioning that the DSM-5 eliminated the 5 axes, multi-axial assessment system. The new system combines the first three axes outlined in past editions of DSM into one axis with all mental and other medical diagnoses. The APA maintains that the impetus to shift to a single axis system was to remove artificial distinctions among conditions (DSM-5, 2013).

⁵ A more detailed description of coding and reporting procedures can be found on page 1 of the DSM-IV-TR (2000).

4.3 Critique of the DSM

As with any text whose goal it is to organize, categorize and label the complexity of people's lives, the DSM is not exempt from much criticism and contentious debate. It is often considered the "bible" of psychiatry and when used has the power to label an individual's behavior, which can have positive or negative consequences for an individual's life (e.g., stigma, internalization of the label, denial or acceptance of treatment coverage from insurance agencies). Although the DSM is an incredibly powerful diagnostic tool, the validity and reliability of diagnoses have been called into question. The APA recognizes the possible problems in using diagnostic categories and lists the limits of using a categorical approach: "DSM-IV is a categorical classification that divides mental disorders into types based on criteria sets with defining features, however, there is no assumption that each category has absolute boundaries" (DSM-IV-TR, 2000, p. 24).

4.3.1 Moral Judgment

The development of the DSM, its politics and the effect of its (mis)use has been the source of much debate within various disciplines. Thomas Szasz in the *Myth of Mental Illness* (1974) holds that psychiatric interventions are directed at moral, not medical, problems. Extending this, Miller (2004) writes about the implicit moral judgments that are found in the treatment of human suffering and argues that the extent to which our culture approaches the moral dimensions of human character in a de-moralized manner is evident in the DSM-IV. In particular, he argues that Axis-II, Personality Disorders, is not a list of symptoms but rather a description of lifelong patterns of

thought, feeling and behavior that are characterized as being disordered. Miller argues that this sort of classification is invalidating and harmful to the people who experience these thoughts and feelings. He also questions whether psychiatry and psychology have taken on the responsibility of enforcement and control of moral standards of behavior. He questions whether this enforcement is seen in domains that do not fall within the jurisdiction of the law, such as intimate relationships and personal tastes where therapists often act as wardens in the sense that they are employed to “do something” about correcting what is seen as problematic ways of being in the world (Miller, 2004). Others have argued that while all diagnoses in the DSM house some implicit moral evaluations, the moral judgment is hardly disguised when it comes to personality disorders (Caplan, 1995; Kirk and Kutchins, 1992).

4.3.2 Politics and the Myth of Objectivity

Cooper (2004), in her critical assessment of “what is wrong with the DSM,” concludes that while the DSM is of practical use, it is not necessarily the best classification of mental disorders. Questioning what constitutes a “natural” mental disorder, she argues that naming a condition a “disorder” is partly a value judgment. She cites the diagnosis of homosexuality as a classic example of how political issues shape what conditions count as diseases/ disorders and which do not. The debate surrounding homosexuality as a psychiatric disorder listed in the DSM was contentious and was later changed in 1973 when Robert Spitzer (chair of the DSM-III) put together a new definition of mental disorder that was both politically useful and seemed to appease both sides of the debate. He proposed that a “condition can only be a mental disorder if it causes

distress or disability” (Cooper, 2004, p. 7). He did this by defining mental disorder and removing the diagnosis of “homosexuality” from the DSM but replacing it with “sexual orientation disorder” instead. Spitzer created a subtly different definition of mental disorder that managed to still pathologize sexual orientation in a way that did not seem overtly homophobic. Second, Cooper (2004) questions objectivity and theory-laden perception in psychiatric theory. “For the most part, the descriptions of conditions included in the DSM are based on psychiatrists’ observations of psychiatric patients. Thus we must ask whether perceptions of people are affected by theoretical beliefs” (p. 15). She concludes that inquiries into how knowledge is produced are crucial considering classification is theory-laden.

4.3.3 The Relationship between Diagnosis and Treatment Coverage

Another major criticism of the DSM is the relationship between which diagnoses are included in the DSM and various financial pressures. While this is specific to the United States and is not directly connected to my research, in an effort to highlight the incredible far-reaching power of the DSM, it is imperative to underscore the power a DSM diagnosis has on treatment coverage. As I have mentioned earlier, while the DSM does not provide guidelines for treatment, it is important to note that DSM diagnoses shape treatment and treatment outcomes. One way this affects individuals is through denial of treatment coverage. Anthropologist Emily Martin (2009) maintains that since insurance companies or federal programs require DSM codes on their bills, many people have become familiar with the language of the DSM. It could be argued that people are somewhat forced to take up the vocabulary of the DSM, particularly if they need

coverage. In the 1960's, insurance companies began to cover part of the cost of psychotherapy and it soon became required by medical insurance companies that DSM diagnoses be provided in order to obtain coverage for treatment (Martin, 2009; Cooper, 2004). The pressure for reimbursement manifested itself in different ways. First, doctors' interests were affected and those who wished for their patients to be reimbursed may be inclined to exaggerate a patient's diagnosis (in order to justify treatment and obtain coverage) or may record less severe diagnosis (in an attempt to reduce or avoid stigma and socially unacceptable diagnosis) (Martin, 2009; Cooper, 2004). Not only does it become clear that diagnoses have real world effects for people (stigma, insurance coverage) but also that diagnoses may be somewhat arbitrary and can be easily manipulated by financial pressures. Second, there is pressure to include "new" diagnoses in the DSM as a result of patients and psychiatrists lobbying for treatment and insurance coverage. For example, Cooper (2004) has argued that when lobbying is successful, new diagnosis are included in the DSM, citing the introduction and inclusion of PTSD in the DSM-III (1980) as the result of lobbying efforts by Vietnam veterans and programs aimed at treating the disorder.

The DSM is quite powerful; it has the power to label and marginalize, but also to help and treat. It provides the vocabulary that shapes how individual behaviors are understood and categorized, particularly when they do not fit what is seen as normal, appropriate behavior. The DSM also provides psychiatrists, other health professionals and lay people with the language to define mental illness. Inquiry into how the DSM produces diagnostic knowledge and specifically knowledge surrounding self-mutilation is key in

understanding how experts both take up and understand what is considered self-mutilation.

4.4 Historical References to Self-mutilation

The DSM has changed considerably since its inception, going through many revisions as well as changes to the overall organizational structure. References to self-mutilation, and related terms, have also changed over time since the first edition of the DSM-I in 1952.⁶ Some noteworthy observations stand out: first, the DSM has grown in terms of number of pages and the number of disorders over time, from 132 pages and 106 disorders in DSM-I in 1952 to 947 pages and 297 disorders in DSM-5 in 2013. The 2013 edition contains the same number of disorders as did the DSM-IV-TR in 2000. This is because complaints about the ever-increasing number of disorders led the Chair of the DSM-5 task force to announce that the number of disorders in the DSM-5 would not increase (Rosenberg, 2013). However, as Rosenberg (2013) has pointed out, due to the major re-structuring of the DSM-5, new disorders can be subsumed under existing disorders thus appearing as if the number of disorders did not increase. This explains why both the DSM IV-TR and the DSM-5 list 297 disorders.

Table 4.1 DSM overview editions I through V

DSM Edition	Year Published	Number of Pages	Number of Disorders
DSM-I	1952	132 pages	106 disorders
DSM-II	1968	119 pages	182 disorders
DSM-III	1980	494 pages	265 disorders

⁶ See Appendix H for a detailed breakdown of references to self-mutilation and related terms seen in DSM editions I to IV.

DSM-III-R	1987	567 pages	292 disorders
DSM-IV	1994	886 pages	297 disorders
DSM-IV-TR	2000	943 pages	297 disorders
DSM-5	2013	947 pages	297 disorders*

4.4.1 Terminology

4.4.1.1 Term Use and Intention

It is necessary to discuss the issue of DSM terminology as a foundation to understanding how self-mutilation is constructed in the DSM and how it evolves over time. I originally started out thinking I would examine only references to self-mutilation as that was my object of inquiry; however, there are so many related terms that something might have gotten lost in my analysis if I had proceeded with this narrow inquiry.

Therefore, in addition to self-mutilation, I included in my analysis three related terms: self-inflicted injury, self-injury, and self-harm. This broader inclusion was useful for highlighting how different synonyms are used with certain disorders and not others.

The terms self-mutilation, self-injury, self-inflicted injury, self-harm and non-suicidal self-injury have all been included in the DSM over the course past four editions⁷. Different terms are associated with different disorders; some disorders are associated with the term self-mutilation and others with self-harm or self-injury. I chose to include all of the variations of self-mutilation for two reasons: first, to ensure I did not overlook anything by limiting the search to looking only for references to self-mutilation. Second, I

⁷ An in-depth analysis of differences in terminology is beyond the scope of this inquiry.

thought the use of different terms highlighted something worth exploring: some disorders used terms like self-harm and others used self-mutilation, when essentially they referred to the same type of behavior—a purposeful injury to oneself. Some interesting questions come up: why the difference in self-mutilation, self-inflicted injury and self-harm as terms? Do they refer to something different? Is there is a judgment implicit in the differences in terms? For example, perhaps the term self-harm is the term associated with autism, but is it with the assumption that it cannot be helped because the disorder is considered organic? Head banging, self-biting and self-hitting are part of the diagnostic criteria Stereotypic Movement Disorder, but is not considered to be part of self-mutilating behavior in the criteria: is this because it is understood as something else? Perhaps the term self-mutilation is seen as intentional on the part of the individual, reflecting a lack of control, or failure to regulate oneself, thus garnering negative attention?

For DSM editions II to IV, the APA was not explicit about the rationale for the particular use of one term over another. The DSM-5, however, in the proposed revision to include non-suicidal self-injury (NSSI) as a separate disorder in future editions, maintained the rationale for the use of the term NSSI as opposed to the terms self-mutilation or self-harm. The APA argued that self-mutilation is the term used in the existing borderline literature and that “mutilation” refers to the physical loss of, or loss of use of, a body part, whereas NSSI involves superficial damage without loss of power or autonomy and is the term most commonly used in the more recent research (p. 6, Shaffer and Jacobson, 2009). It remains unclear why the term self-mutilation is still used in the context of borderline personality disorder (BPD) when the term “mutilation” refers to loss

of, or loss of use of, a body part. This is an extreme, and some would argue rare, case of self-mutilation. In addition, self-mutilation in the context of BPD can, and most often does, refer to superficial damage to the body. However, it does seem that the introduction of the term NSSI serves to dissociate self-mutilation from BPD.

While all of the terms related to purposeful self-harm in the DSM refer to damage to the self in some way, I suggest that particular terms used seem to depend on the intention of the individual engaging in the behavior. For example, the terms self-inflicted injury, self-harm and self-injury are often associated with developmental disorders (e.g., Stereotypic Movement disorder, Autistic Disorder) or disorders where it seems the behavior is a consequence of suffering from the disorder (e.g., Catatonic Type Schizophrenia, Dissociative Amnesia Disorder) and therefore might be understood as less intentional. In other words, self-harm is an outcome of being disordered but not necessarily *what* makes them disordered to begin with. Self-mutilation, I argue, is often seen in the DSM as part of *what* makes one disordered (i.e., being listed as a criterion more often than an associated feature or complication). Perhaps it is both the perception of the individual's intention as well its connection with BPD that plays a role in the negative view of self-mutilation. The relationship between intention and disorder becomes blurred and it becomes arduous to decipher what comes first, the behavior or the disorder.

4.4.1.2 Self-mutilation and Related Terms in the DSM from 1968 to 2013

When I conducted a term search of the different DSM versions, the results highlighted the terms wherever they were listed in the DSM. Sometimes this meant that a

particular term was listed as a central feature of a disorder (i.e., explicit diagnostic criteria), but the same term may have also been listed, peripherally, under the course, associated features, complications or prevalence sections. For example, self-mutilation is listed explicitly as part of the diagnostic criteria for BPD but self-mutilation is also listed under associated features for Dissociative Identity Disorder (DID). The former is one of the defining criteria by which professionals diagnose an individual with BPD and the latter is a behavior that may possibly occur in people who have the disorder but is not a defining feature of the disorder itself. Appendix H includes the detailed breakdown of the DSM search results. In the following table, I outline where references to self-mutilation and related terms were first seen in the DSM.

Table 4.2 highlights the introduction of self-harm related terms over time. Given that NSSI is currently being considered to be included as its own separate disorder in future versions of the DSM-5, we can begin to also see the evolution and introduction of a new disorder and thus appreciate how knowledge (diagnosis) gets produced. It is also important to note the term self-mutilation has been associated with a number of different disorders over the course of DSM editions three to five. The disorders included: Sexual Masochism, Childhood Onset Pervasive Developmental Disorder, Multiple Personality Disorder, and Stereotypic Movement Disorder. For these disorders, self-mutilation was listed under associated features, course, or complications or explicitly as diagnostic criteria. Consistently, however, self-mutilation has been listed as a diagnostic criterion for BPD since the DSM-III in 1980 to the current DSM-5. I will return to this point in the discussion at the end of the chapter.

Table 4.2 Introduction of self-mutilation and related terms into the DSM

Term	DSM Version	Associated disorder(s)
“Self-inflicted injury”	DSM-II	Suicide and Self-Inflicted Injury (E950-959)
“Self-mutilation”	DSM-III ⁸	<p>299.9x Childhood Onset Pervasive Development Disorder (Listed under diagnostic criteria)</p> <p>302.83 Sexual Masochism (Listed under course)</p> <p>319.0(x) Unspecified Mental Retardation (Listed under diagnostic criteria)</p> <p>301.83 Borderline Personality Disorder (Listed under diagnostic criteria)</p>
“Self-injury”	DSM-III-R	<p>307.30 Stereotypy/ Habit Disorder (Listed under prevalence)</p> <p>Pervasive Developmental Disorder (Listed under features)</p>
“Self-harm”	DSM-IV	295.20 Catatonic Type (Listed under description)
“Non-suicidal self-injury” (NSSI)	DSM-5	Part of proposal to include NSSI disorder in future DSM-5 editions)

⁸ The DSM-III was also the first time BPD was included as a new disorder and “self-mutilation” was listed as one of the diagnostic criteria.

4.5 DSM-5: Pre-publication and the Proposal to Include NSSI as a Separate Diagnosis

The term non-suicidal self-injury (NSSI) was not seen in any of the previous editions of the DSM; the proposal to include NSSI disorder as its own diagnosis in the DSM-5 was a significant proposed change. Due to what some argued was the lack of diagnostic recognition, there had been several unsuccessful attempts to include NSSI as a separate disorder in previous editions of the DSM. Prior to the publication of DSM-5 in spring 2013, the task force proposed the inclusion of NSSI as a separate disorder (Selby et al., 2012). This was a major shift because NSSI had not been previously listed in the DSM-IV or the ICD-10 in itself or as part of any anxious or depressive disorder (Wilkinson and Goodyear, 2011). According to the APA, the rationale for the creation of a new diagnosis includes that the “new” disorder either has not been or was insufficiently represented in the DSM-IV, the diagnosis must have clinical value, must improve accurate identification and treatment, and be prevalent, impairing and distinctive (APA, 2012). The APA extended this to support the argument for the inclusion of NSSI as a diagnosis in the DSM-5. There was a limited representation of NSSI in the DSM-IV and the closest representation was found in criterion # 5 of BPD, where “self-mutilation” was found in “recurrent suicidal behavior, gestures, thoughts, or self-mutilating behavior” (DSM-IV-TR, 2000).

4.5.1 Renaming and Re-conceptualizing Self-mutilation and its Association with BPD and Suicide

Shaffer and Jacobson, (2009) maintain that previous attempts to include NSSI in the DSM were rejected because it was regarded as a defining feature of BPD. This, however, was changing at the time the DSM V was being drafted; self-mutilation was becoming understood to be evident outside of BPD populations. Recent research had shown that there are both adults and adolescents in inpatient and outpatient populations who engage in NSSI behaviors but do not exhibit any of the other criteria for BPD (Nock et al., 2006; Selby et al, 2012). In addition, Selby et al (2012) found that NSSI occurs without BPD symptoms and is associated with higher levels of stress. Wilkinson and Goodyear (2011), in their review of whether or not it is appropriate to include NSSI as a diagnosis, concluded that adding NSSI disorder to the DSM-5 could have a number of positive consequences including: improved communication among mental health professionals and patients, as well as improved treatment and management decisions.⁹

In their proposed revision to include NSSI as a separate disorder in future editions of the DSM-5, the APA clarifies the rationale for the use of the term NSSI (non-suicidal self-injury) as opposed to the terms “self-mutilation” or “self-harm”. They argue that self-mutilation is the term used in the existing borderline literature and it refers to the loss of or use of a body part; self-harm refers to a broad range of behaviors including gambling, and suicide attempts whereas NSSI involves superficial damage without loss of power or autonomy and is the term most commonly used in recent research, thus is the most apt to

⁹ The authors only refer to adolescent populations in their discussion.

describe the new disorder (DSM-5, APA, 2012). Furthermore, associating NSSI with BPD can lead clinicians to make an automatic assumption that those who self-mutilate have BPD, furthermore, NSSI had to be distinct from BPD (Selby, 2012). Shaffer and Jacobson (2009) argue that the failure to distinguish terms affects research activity and renaming and recognizing purposeful self-harm as NSSI will provide new ways of understanding the disorder apart from BPD. Taking this into consideration, what does that say about self-mutilation and its association with BPD? Is the proposed divorce from BPD in part an attempt to have NSSI taken seriously without the negative associations of being “difficult” to treat? The DSM-5 still uses the term “self-mutilating behavior” in the section on BPD but under Conditions Requiring Further Study; Non-Suicidal Self-Injury Disorder (p.803) uses the terms “intentional self-inflicted damage” and “self-injury” (DSM-5, 2013).

Beyond being associated with BPD, self-mutilation is also commonly confused with suicidal behavior by both the general public and by health professionals (Liebling et al., 1997; Walsh, 2006). The association between self-mutilation and suicide is also argued by some to be a public health concern in that it contributes to the over-utilization of treatment resources (i.e., restrictive surveillance and management such as emergency room resources, hospitalization, and/or long-term therapies) (DSM-5, APA, 2012). Shaffer and Jacobson (2009) suggest that the mistaken association between suicide and self-mutilation is the foremost motivation for the inclusion of NSSI as its own separate

disorder. However, how NSSI as a diagnosis will lead to different management and treatments is not clear in the rationale provided by the APA.¹⁰

4.5.2 DSM-5 Post- publication: NSSI and Other Important changes

NSSI was *not* included as a new disorder in the DSM-5, although the possibility of including NSSI as its own disorder in future editions of the DSM-5 (DSM-5.1, 5.2) is not totally out of question. It is not clear why the inclusion of NSSI as a new disorder was not made. NSSI is still listed under *conditions requiring further study* in the DSM-5. The new **proposed criteria** for NSSI as its own disorder include:

“In the last year, the individual has, on 5 or more days, engaged in intentional self-inflicted damage to the surface of his or her body of a sort likely to induce bleeding, bruising, or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing), with the expectation that the injury will lead to only minor or moderate physical harm (i.e., there is no suicidal intent).

Note: The absence of suicidal intent has either been stated by the individual or can be inferred by the individual’s repeated engagement in a behavior that the individual knows, or has learned, is not likely to result in death.

The individual engages in the self-injurious behavior with one or more of the following expectations:

To obtain relief from a negative feeling or cognitive state.

To resolve an interpersonal difficulty.

To induce a positive feeling state.

Note: The desired relief or response is experienced during or shortly after the self-injury, and the individual may display patterns of behavior suggesting a dependence on repeatedly engaging in it.

The intentional self-injury is associated with at least one of the following:

¹⁰ A more comprehensive listing of the rationale to include NSSI as a diagnosis is included in the APA’s discussion of proposed revisions to the DSM5
<http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=443#> (Accessed August 2012)

Interpersonal difficulties or negative feelings or thoughts, such as depression, anxiety, tension, anger, generalized distress, or self-criticism, occurring in the period immediately prior to the self-injurious act.

Prior to engaging in the act, a period of preoccupation with the intended behavior that is difficult to control.

Thinking about self-injury that occurs frequently, even when it is not acted upon. The behavior is not socially sanctioned (e.g., body piercing, tattooing, part of a religious or cultural ritual) and is not restricted to picking a scab or nail biting.

The behavior or its consequences cause clinically significant distress or interference in interpersonal, academic, or other important areas of functioning. The behavior does not occur exclusively during psychotic episodes, delirium, substance intoxication, or substance withdrawal. In individuals with a neurodevelopmental disorder, the behavior is not part of a pattern of repetitive stereotypies. The behavior is not better explained by another mental disorder or medical condition (e.g., psychotic disorder, autism spectrum disorder, intellectual disability, Lesch-Nyhan syndrome, stereotypic movement disorder with self-injury, trichotillomania [hair-pulling disorder], excoriation [skin-picking disorder]).” (DSM-5, 2013, p.803)

Even though NSSI was not included in DSM-5, the existing proposal to include NSSI as a diagnosis points to some important considerations. It means that self-mutilation outside of BPD may eventually become recognized as a separate entity which emphasizes an important shift in recognizing the diversity of issues related to non-suicidal self-injury. It is essential to note, given the link between self-mutilation and BPD since the DSM-III in 1980, that the criteria for BPD in the DSM-5 remained unchanged from what was seen in DSM-IV-TR (2000) and still included self-mutilating behavior as a criterion. Therefore, self-mutilation is not yet divorced from BPD altogether. It is likely that, while NSSI may be included as a separate disorder in the future, self-mutilation will still remain a fundamental characteristic of BPD. This is due to the connection between self-mutilation and impulsivity with difficulty regulating intense emotions, particularly in

times of real, or feared, rejection or abandonment, which does not seem to be in evidence in the proposed NSSI diagnosis.

While there were no major changes to personality disorders per se, other changes in the DSM-5 included changes to Axis II disorders by eliminating the Axis II category altogether and moving Personality Disorders to the main disorders section. This reorganization could have a positive effect for the treatment of personality disorders. It has been suggested that many insurance companies have not covered treatment for personality disorders because Axis II diagnosis (e.g., personality disorders) were defined as pervasive and enduring, thus are considered time and resource intensive requiring mostly talk therapy, consistently over time. Importantly though, the DSM-5 included an alternate diagnostic model for personality disorders and encouraged its use among clinicians (Wakefield, 2013). The alternate model was the result of original efforts to overhaul personality disorders entirely in order to provide a dimensional (vs. the traditional categorical approach) diagnostic model. While it is listed only as an alternative model, it still made its way into proposed changes to future DSM-5 editions and is a step toward a more complex understanding of personality variations, behavioral patterns and emotional reactions. Rather than relying on categorical criteria, the alternate approach provides more detailed criteria that more take into account multiple areas of an individual's functioning. For example, the proposed alternate (dimensional) model for BPD has two major A and B sections where two or more of four have to be found in section A and four or more found in section B to warrant a diagnosis. Section A includes the headings: Identity, self-esteem, empathy, and intimacy. Section B includes the

following headings: emotional lability, anxiousness, separation insecurity, depressivity, impulsivity, risk-taking and hostility. This is different from the previous and currently used categorical list of nine criteria where five or more have to be met to warrant a BPD diagnosis.

Interestingly, ‘Skin Picking Disorder’ was included as a new diagnosis under the umbrella of Obsessive Compulsive Disorder. This is interesting because it illustrates how ideas around intention and responsibility contribute to the distinction between what is considered within and outside of the control of an individual. In other words, skin picking disorder refers to damage to the skin yet is not considered self-mutilation or non-suicidal self-injury because it does not relate to the *intention* of harming oneself. Skin picking, rather, seen to be the result of fixation or preoccupation.

The DSM-5 also underwent major changes to the diagnostic procedures that were originally created in the DSM-III (1980). The DSM-5 has eliminated the multi-axial system implemented in the DSM-III, restructured the entire document into three sections with different chapter headings. The elimination of the multi-axial system was an attempt to be congruent with other general medical diagnostics (that do not require multi-axial assessments) as well as co-ordination with ICD, which was a major concern (Wakefield, 2013).

4.5.3 Critique of the DSM-5

Wakefield (2013) argues the DSM-5 places into question the state of knowledge in psychiatry and in mental health in general and poses the question of whether or not we can expect continuous revisions of psychiatric classification (Wakefield, 2013). Defining

and categorizing mental disorders has always been controversial. The controversy surrounding the DSM-5 is argued to be unprecedented; some criticize the DSM as pathologizing far too many variations of human behavior, but particularly so in the DSM-5 (Wakefield, 2013). Mainly it is criticized for diagnostic inflation, the relationship between the APA and drug companies and the possible loss of insurance benefits due to diagnostic restructuring (i.e., coverage for therapy being denied due to change in diagnoses). Considering the overhaul of the DSM-5, Smoyak and Halter (2013) argue that it still does not depart significantly from previous diagnostic systems and may not provide information that better informs treatment.

Alan Frances, the editor of the DSM-IV, objected to the ways in which he thought DSM-5 was participating in turning normal into disordered:

“DSM-5 will turn temper tantrums into a mental disorder....Normal grief will become Major Depressive Disorder....The everyday forgetting characteristic of old age will now be misdiagnosed...creating a huge false positive population of people....Excessive eating 12 times in 3 months is no longer just a manifestation of gluttony and the easy availability of really great tasting food. DSM-5 has instead turned it into a psychiatric illness....DSM-5 has created a slippery slope by introducing the concept of Behavioral Addictions that eventually can spread to make a mental disorder of everything we like to do a lot....DSM-5 obscures the already fuzzy boundary between Generalized Anxiety Disorder and the worries of everyday life....Many millions of people with normal grief, gluttony, distractibility, worries, reactions to stress, the temper tantrums of childhood, the forgetting of old age, and ‘behavioral addictions’ will soon be mislabeled as psychiatrically sick.” (Frances 2012)

In sum, the proposal to include NSSI as a disorder underlines how understandings of self-mutilation have evolved over time. This poses some interesting questions: Are more people presenting with self-mutilating tendencies to psychiatrists or is it that that people are finally recognizing the disorder and seeking help? If in fact self-mutilation

behaviors are increasing, why is this so? Is this due to cultural or psychological factors — and can these be separated?

4.6 The DSM, Medicalization and Obscuring Contextual Complexity

Broadly, a look at the DSM from a critical point of view illustrates how individual complexities are condensed into numbered criteria and coded diagnoses. The DSM is a diagnostic tool and, in order to diagnose, certain criteria need to be met. These criteria are also supposed to be part of an “objective” system of categories in accordance with a scientific model that is compiled of clearly defined disease categories (Martin, 2009). Psychiatrists do not have biological or medical tests to determine mental illness and they rely upon the self-reported symptoms from patients, which are interpreted through the patient’s experience, then through the psychiatrist’s own experience, shaped by their academic training, and the diagnostic criteria listed in the DSM. The checklist criteria serve a way to code behaviors, the result being that the DSM oversimplifies the complexities of people’s lives. Saying an individual meets 5 of 7 criteria ignores the possible range and presentation of people’s behaviors. Consider this example, listed on DSM-5 website under the section “sexual dysfunctions”: N04- female sexual interest/arousal disorder and N05 – male hypoactive desire disorder. The criteria of these disorders lack contextual and social explanations and are devoid of the complexities that surround relationships and sexualities. Take into consideration the names of the disorders themselves, which are reflective of dominant ideas surrounding gender and heterosexuality and the problematizing and pathologizing of oversexed and undersexed

behaviors, which are socially constructed concepts based on what is deemed appropriate desire and drive for each of the sexes— which are constructed as dichotomies.

It is not the goal of the DSM to provide a nuanced, complex view of the reasons contributing to individual psychological manifestations and the DSM does not go beyond a medical, individual centered model to explain larger social relations and their individual effects. The DSM is not all bad either, it is a tool used to organize, code, and document behavior; a way to produce knowledge about mental illness and a way of structuring, ordering knowledge with the intention of giving a name to the pain and suffering of people and treating mental illness. What becomes problematic then is how these knowledges get produced and taken up, because this has implications for people's everyday real lives. The removal of context surrounding certain behaviors and the effects that diagnostic labels have on individuals' lives are significant, particularly if the diagnosis has a negative connotation (Camp et al, 2002). Take for example, Axis II diagnoses, personality disorders, defined by the APA as “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture” (DSM-IV-TR, 2000, p. 685). Being diagnosed with a personality disorder might consequently result in negative treatment from health professionals because clinicians often regard these patients as difficult, high risk (in terms of suicide) and untreatable (Davis, 2006). As I have pointed to earlier in the chapter, Miller (2004) also contends that there is an inherent judgment when it comes to personality disorders because it does not just serve as a list of symptoms but rather a description of lifelong patterns of thought, feeling and behavior that are characterized as being disordered.

4.7 The DSM and the Gendering of Self-mutilation

Although Smith is critiquing the practices of sociology in *The Conceptual Practices of Power*, she extends this to the practices that produce objectified knowledge(s) in any discipline where the data has already been worked up and formulated to fit objectified forms of knowledge. I am drawing on the arguments Smith present in her text, “the statistics on women and mental illness and the ruling relations they conceal” in connection with my own research on the construction of self-mutilation, where self-mutilation is listed as one of the symptoms/ diagnostic criteria of BPD. I am extending her argument to highlight how the criteria for BPD listed in the DSM-IV are gendered and thus conceal what goes into the making of the statistics. This is further solidified in Smith’s article, “K is Mentally Ill”, where she highlights the difficulties in creating alternative accounts of an individual’s behavior when the set of instructions (objectified forms of knowledge) on how to understand someone as mentally ill have already been formulated; this is the process of diagnosis. Behaviors that that fall outside of that framework then have no place to belong or at the very least few other avenues to be interpreted through (Smith, 1978).

Smith investigates the statistics on gender differences in mental illnesses and questions the procedures that produce the statistics, exploring the ruling relations underlying their production. Her main argument is that often what goes into the making of the text is not explicit and available, suggesting that the statistics on mental illness conceal the ruling relations that go into their making. Smith (2001) defines ruling

relations as various forms of bureaucracy, administration, media and discourses (scientific, technical and cultural), which, she maintains, are textually mediated.

Furthermore, the process of becoming mentally ill (or rather being diagnosed as such) is a process in which psychiatric agencies participate (Smith, 1990). It goes something like this: an individual is recognized as not fitting appropriate social norms and thus is seen to exhibit “symptoms”, this individual is then diagnosed by a professional relying upon “objective” diagnostic criteria and is then subsequently counted in mental health statistics. However, “objective” criteria, apart from symptoms that are absolutely physically observable, are difficult to find. Seeing what people do as symptoms of mental illness comes about in a process of social interaction (without interaction, symptoms are not observable by others). The process of diagnosis is done through interaction between individuals (patients) and experts (psychiatrists) drawing on objectified forms of knowledge (DSM). Even if the position of the professional (e.g., psychiatrist, psychologist) is one of detachment, this still constitutes as interaction. Furthermore, once someone is labeled as “mentally ill”, he or she is not expected to make sense and is treated as if they do not, thus the process of “making” crazy (Smith, 1978), creating a situation where one’s behaviors can only be observed and understood as crazy and nothing else. As Jutel (2009) has argued, diagnosis is both a process and a label and guides medical practice. It provides structure to narratives of disorder and deciphers real from imagined while serving to also impact the relationships between doctor and patient. Understanding diagnoses provide insights into how we understand health and illness and the energies that shape our knowledge (Jutel, 2009).

Obscuring the complexities of people's everyday lives also means obscuring their social positions. The work of sociologist Dorothy Smith is useful here as she argues that objectified forms of knowledge conceal the lived actualities of people, particularly women. The DSM is a diagnostic tool used by psychiatrists and serves as a way to order individual behaviors and, depending on the number of behaviors/ symptoms that fit the objective criteria, also serves as a method to produce diagnosis. Smith's discussion surrounding the production of mental health statistics is useful to illustrate how the DSM contains diagnoses that obscure the complexities of people's lives that then become objectified forms of knowledge upon which we rely and produce statistics. For example, consider that the diagnosis of BPD is more frequently given to women than men. BPD is a personality disorder characterized by unstable moods, behavior and relationships; the DSM-IV states that 75% of patients diagnosed as BPD are women, without any further discussion as to why this might be (DSM-IV-TR, 2000). This statistic has not changed in the recently published DSM-5 (DSM-5, 2013). This poses an interesting question, are the criteria for BPD gendered? I posit that some of the criteria for BPD are inherently gendered thus producing a gendered (feminine) patient.

Consider the following criteria for BPD from the DSM: “# 4: Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating) and # 8: Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)” (DSM-IV-TR, 2000). Both criteria include behaviors that in men are seen as part of normal masculinity and are often celebrated. Sex, substance abuse (excessive

drinking), reckless driving, frequent displays of temper and physical fights are behaviors associated with the type of normalized risk-taking behavior in line with dominant constructions, and performances, of masculinity. Risk taking is a gendered performance and for men testing the boundaries of fear and endurance proves one's masculinity (Lupton, 1999). This is contrasted to the constructed ideals of femininity that emphasize safety and caretaking. Women are often marginalized for behaviors that are regarded as incongruent with ideals of femininity (i.e., risk taking behavior or displays of behavior perceived as masculine) and, in essence, are pathologized for behaving like men. It is this type of transgression from social norms (gender roles) that results in social marginalization and the policing of gender roles that act to keep gender roles intact and constructed as opposites. Because BPD is largely characterized by risk-taking behaviors and risk taking behaviors are often an accepted part of masculinity it is not hard to see how women would comprise the majority of those diagnosed with BPD. The criteria listed in the DSM-IV for BPD are gendered and thus conceal what goes into the making of the statistic: "75% of patients with BPD are women". The factual story that is produced from the individual is forced to fit an already formulated abstraction of psychiatry in the form of checklists that exist in the DSM.

I contend that because of the strong discursive link between self-mutilation and BPD, self-mutilation is also gendered (feminine). Self-mutilation is also one of the nine criteria for BPD (# 5: Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior DSM-IV-TR, 2000) and thus, through the gendering of the criteria for the disorder, self-mutilation becomes gendered (feminine) as well. The relationship between

self-mutilation, BPD criteria and the statistic that women comprise the majority of BPD patients may be a self-fulfilling prophecy, cuing the psychiatrist to look for certain behaviors and finding them. Put simply, BPD is gendered (feminine) through the construction of the diagnostic criteria (and the statistic that 75% of people with BPD are women). Self-mutilation is gendered (feminine) because of its strong link with BPD. This shapes how both self-mutilation and BPD are understood, treated and how ideas about both may be reproduced in psychiatry. To clarify, my argument that self-mutilation is gendered is not based on the prevalence rate: I am arguing that the prevalence statistic is a construction that comes from the fact that borderline personality criteria are gendered, therefore skewing what we think is the prevalence rate (because psychiatrists are finding what they are looking for).

The DSM criteria contain a set of criteria that when the patients say things that do not fit they are simply left out. Thus, the factual story that is produced from the individual (in the case here, cutters or women who present with distress) is forced to fit an already formulated abstraction of the discipline (psychiatry). The text (in the case here, the DSM) organizes social relations that transform the local experiences of actual people and works them up into this stripped down representation of them (Smith, 1990, p. 108). Thus it neglects the adequate examination or explanation of the ruling relations that shape people's everyday actualities. For example, when a woman has experienced traumatic sexual abuse, the complex problematic intersection of gender inequality and power relations is stripped down to fit nine criteria (in the case of BPD) resulting in a diagnosis and a statistic. The woman's voice and the reality of her distress get lost in the label.

The DSM contains diagnoses that obscure the complexities of people's lives that then become objectified forms of knowledge upon which we rely and from which we produce statistics. The DSM does not consider the actual experiences people have had that have shaped, and continue to shape, their lives and behaviors. Starting from the standpoint of women (or those marginalized and deemed others) real lived actualities will offer a very different version of the local than what is presented in the DSM. As Smith (1990) claims, how knowledge is mediated becomes problematic because we do not necessarily know the ways in which that knowledge was organized for us prior to our participation in it, it is not totally available to us in its original form. The DSM is one such example. Beyond obscuring the complexities that have shaped people's lives, what goes into the making of the DSM is not made explicit. Any processes prior to its finished product are not explicitly apparent, even if information on task force and work groups seems to be transparent in the making of it. Ruling relations and the social organization of society is textually mediated. Smith maintains that a knower's access to the object of knowledge is through its textual presence, which is often hidden but effective. "Knowing is still an act, knowledge discards the presence of the knowing subject" (Smith, 1990, p. 66).

The DSM constitutes knowledge but the subjects behind its production have disappeared and has obtained the taken for granted status of objective, scientific finding and the reader often interprets it as a given. To qualify a statement with "I know" is to lose factual standing thus to achieve factual standing is to eradicate historical, specific and subjective sources (Smith, 1990). The objectification of knowledge is a feature of

ruling relations. Through an examination of the DSM and a closer look at self-mutilation, BPD criteria and its relationship to gender, the process of self-mutilation knowledge production and its discursive link to BPD and women becomes clearer. This is significant because uncovering how self-mutilation knowledge is constructed makes clear how gendered inequalities are perpetuated and reproduced in psychiatric knowledge and practice.

4.7.1 Evolution of a Disorder

Self-mutilation has been associated with different disorders and has changed over time. In DSM-II it was associated with suicide; in DSM-III it was first listed in association with BPD, Childhood Onset Development Disorder and Unspecified Mental Retardation; in DSM-5, self-mutilation underwent a name change (NSSI), which was also a shift from solely being associated with BPD; and most recently, a proposal is in place to have self-mutilation be a separate disorder from BPD in future editions of the DSM-5. Here we can see how self-mutilation appeared as a symptom of a disorder and essentially has transformed into a (proposed) new, separate disorder over time.

It is worth examining this shift in detail, particularly the APA's rationale for divorcing self-mutilation from BPD in order to have self-mutilation gain independent and separate status as NSSI disorder. From DSM-III (where both self-mutilation and BPD were first seen) to DSM-5, self-mutilation was listed either as a central, specific diagnostic feature (i.e., as part of the diagnostic criteria) or peripherally as an associated feature or complication (its inclusion in the category of "associated features" highlights the fact the self-mutilation was being seen in other clinical presentations). Below is a

table outlining where self-mutilation was listed as a defining feature of a disorder as part of the explicit diagnostic criteria.

Table 4.3 Self-mutilation listed as explicit diagnostic criteria

DSM-I (1952)	None
DSM-II (1968)	None
DSM-III (1980)	299.9x- Childhood Onset Developmental Disorder 319.0x- Unspecified Mental Retardation 301.83- Borderline Personality Disorder
DSM-III-R (1987)	301.83- Borderline Personality Disorder
DSM-IV (1994)	301.83- Borderline Personality Disorder
DSM-IV-TR (2000)	301.83- Borderline Personality Disorder
DSM-5 (2013)	301.83 –Borderline Personality Disorder

What might be the implicit rationale for divorcing self-mutilation from BPD in order to have self-mutilation gain independent and separate status as NSSI disorder? For example, what happened in DSM-III-R (1987) to the references to self-mutilation in the other two diagnostic categories? This is important in terms of understanding how BPD has become so stigmatized. What does that transformation in terminology say about self-mutilation and its association with BPD? Is the proposed divorce from BPD in part an attempt to have NSSI taken seriously without the negative associations of being “difficult” to treat?

Smith (1990) argues, in relation to the production of knowledge through sociological research, that researchers often come up with new concepts removed from the actualities of people’s lives; that is, that data are merely formulated to fit or elaborate on already existing concepts and forms of knowledge, in ways that do not access lived

experience and that therefore obscure complicated relations of people's day-to-day lives. Smith enables us to extend this critique to other practices and disciplines that produce objectified knowledge(s). Objectified forms of knowledge get written into DSM in subtle ways and get taken up in practice, and this is where understanding the DSM as a document that is an active social agent becomes useful. The process of becoming mentally ill (or rather being diagnosed as such) is a process in which psychiatric agencies participate (Smith, 1990). An individual is recognized as not fitting appropriate social norms and thus is seen to exhibit "symptoms"; this individual is then diagnosed by a professional relying upon "objective" diagnostic criteria and is then subsequently counted in mental health statistics. However, "objective" criteria, apart from symptoms that are absolutely physically observable, are difficult to find. Seeing what people do as symptoms of mental illness comes about in a process of social interaction (without interaction, symptoms are not observable by others). The process of diagnosis is done through interaction. Even if the position of the professional (e.g., psychiatrist, psychologist) is one of detachment, or the diagnostic tool is a document (DSM), this still constitutes as interaction. The DSM, then, is not simply a passive document but acts as an active agent in an interactive network.

Once a diagnosis makes its way into the DSM, the text then becomes a cue to the practitioner to know what to look for, thus creating more examples of what they were looking for in the first place; a self-fulfilling prophecy. This is part of the process of the production and evolution of a disorder. Smith calls this the objectification of knowledge and argues this is not a true reflection of reality but how texts produce reality and

knowledge about it. Smith's work is particularly fitting when asking how knowledge is produced. A longitudinal analysis of the DSM has highlighted the textually mediated objectification of self-mutilation knowledge.

4.8 Discussion

Psychiatry as a discipline holds incredible power to be able to make diagnostic and treatment decisions about people's lives. The main diagnostic tool that provides the language to define disorder holds part of this power. The influence of the DSM is far reaching. Beyond its obvious labeling power, the terminology in the DSM is taken up by practitioners to be able to characterize someone as disordered but also is taken up by the general public and used to surveil both others and themselves.

Power can be exercised in many ways. Discipline is a mechanism of power that regulates the behavior of individuals in the social body. This is done by regulating the organization of space, of time and people's activity and behavior— which is enforced through complex systems of surveillance (e.g., psychiatry, diagnostic criteria). Foucault emphasizes that power is not discipline; rather discipline is simply one way in which power can be exercised, through the disciplining of knowledge but also of attitudes and gestures as well. Foucault also understood the shift from disciplinary power to modern forms of power in terms of relations of power that were constantly being produced and reproduced (Foucault, 1994). This power is exercised through the management of life via biopower and various technologies of power. The DSM is a technology of power. The DSM acts to normalize disorder by pathologizing the normal. Understanding how the DSM constructs disorder helps to understand the connection between how such

discourses are taken up and reproduced. Consider the discursive link between BPD and self-mutilation: this is a clear example of how psychiatrists link behavior with discursive references from the DSM and corresponding disorders.

Chapter 5 – Psychiatrists’ Understandings of Self-mutilation

5.1 Introduction

In this chapter I will “introduce” the psychiatrists I interviewed¹¹, and then proceed to the first major theme: how do psychiatrists talk about self-mutilation. In the next chapter I will discuss the other two themes: how psychiatrists deal with self-mutilation in practice and whether or not they reproduce the language of the DSM.

5.2 The Participants

5.2.1 Dr. G

Dr. G is a female psychiatrist specializing in child and adolescent psychiatry. She chose to go into child and adolescent psychiatry because she was interested in both pediatrics and psychiatry. Unlike general adult psychiatry, child and adolescent psychiatry has the added layer of having to include parents in the treatment process in order to understand the whole picture (which she argued was a challenge and a benefit). Dr. G could not recall learning much about self-mutilation in her training but what she did learn was the differentiation between self-mutilation and suicidal behavior. She also noted that since her training, knowledge around self-mutilation has changed. She maintains that each person’s cutting was about something different (e.g., acceptance as part of an in-group in a school, trying to feel pain when they felt numb, trying to feel when numb when

¹¹ Pseudonyms were randomly assigned to each psychiatrist.

overwhelmed). People often cut because of a history of trauma or emotional neglect and it functioned as a coping mechanism to deal with the pain. She believes that genetics played an important role in temperament and subsequently how people deal with life stressors, and that environment and experiences compound the mix. Dr. G treats more girls than boys. She believes that self-mutilation is less visible in men. She believes that self-mutilation behavior can be a trait of BPD but is not necessarily a defining trait of the disorder. She maintains that self-mutilation has both increased and is also more acceptable because it is less hidden. She was the only psychiatrist I interviewed to mention sensory profiles (e.g., high registry, low sensory or low registry, high sensory), arguing that people who self-mutilate have high sensory function and thus need strong sensations to deal effectively with overwhelming registries; these difficulties could be the result of trauma which has significantly impacted particular pathways in the brain and responses to external stimuli and internal anguish.

5.2.2 Dr. H

Dr. H is a child and adolescent psychiatrist. He explained that his interest in both pediatrics and psychiatry is what had steered him into practicing child and adolescent psychiatry. He did not think self-mutilation is a major concern in psychiatry today but is nonetheless of importance because it is an “epidemic among teenage girls”. While he does treat boys who self-mutilate, he emphasized that girls self-mutilate far more. Dr. H could not recall learning much, if any, about self-mutilation in his training. He defines self-mutilation as burning and cutting, but not hitting oneself. He is adamant about not paying too much attention when his patients tell him about their practice of self-

mutilation or show him their scars; he believes paying attention to the behavior might reinforce it and lead them to increase their activity. He was careful to distinguish self-mutilation from suicidal threats/ thoughts, noting the two are not the same.

Dr. H believes many patients (almost always girls) self-mutilate to make a statement, to ease tension at home or to relieve tension after a relationship has ended. Other patients hurt themselves because they are frustrated and angry; the endorphin release has a positive, reinforcing effect. He strongly cautioned against equating self-mutilation with depression because he has seen several patients who self-mutilate and are not depressed. Often times, those who self-mutilate have the diagnosis of BPD but this is not exclusive. Other patients include adolescents who see self-mutilation as a viable option for coping with stress. Dr. H believes that teaching alternative ways to experience pain without damage to the body (e.g., pinching the Achilles tendon or holding ice cubes) is key to treatment. He cautions his patients about how scars may affect how people are treated in the future. He did not think self-mutilation is more acceptable socially, but has seen an increase over the past number of years.

5.2.3 Dr. F

Dr. F specializes in child and adolescent psychiatry. She remembered learning about self-mutilation in residency and that self-mutilation was associated with people with personality disorders (mostly BPD) and had nothing to do with wanting to commit suicide but rather is a way to regulate emotions. She also noted that self-mutilation is looked at negatively in the mental health community. In her practice, she has seen a lot of adolescents who self-mutilate and argues that in this population in particular, self-

self-mutilation goes through phases and periods of trendiness. She also observes self-mutilation behaviors in patients with personality disorders (mostly BPD) and argues that people have very little tolerance for people with BPD because of patients' difficulties with abandonment.

Dr. F thought there was no typical patient, she sees more girls who self-mutilate more than boys, although she noted that boys do engage in the behavior (albeit in different ways) and that boys who are troubled are more likely to fall towards the correctional system than the mental health system. The goal for her in practice is to figure out what distress precedes the action. In her opinion self-mutilation is not "treatable" per se, but understanding the context of the situation is important.

She also mentioned not paying too much attention to patients showing their scars, because doing so might reinforce the behavior. She cited self-mutilation as a major concern in psychiatry because of its prevalence. She has seen an increase, but suggested that this is not necessarily because the behavior has increased, but that people perhaps talk about it more openly. She thought the openness in celebrity culture/ reality television could be a possible contributing factor to people engaging in self-mutilation or at least talking about it more freely, because it has become more acceptable or even 'cool'. Dr. F thought one of the long-term consequences of having self-mutilation scars was that it served as a constant reminder to the patient.

5.2.4 Dr. E

Dr. E specializes in child and adolescent psychiatry and enjoys the thinking aspect of psychiatry and highlights self-mutilation as one of her areas of interest. She was also

drawn into psychiatry because of her cross-interest in pediatrics and psychiatry. She did not remember learning about self-mutilation until her residency training, where she learned that self-mutilation was: (1) often a coping skill that helped regulate emotions or (2) about turning anger inwards. She also learned that it was part of the diagnosis of personality disorders (mostly BPD), which she cautioned, is not the same as having BPD but tends to be more common in those with BPD. She also sees it in the absence of a BPD diagnosis and in connection with other diagnosis. The typical or stereotypical patient who presents with self-mutilation tendencies is the adolescent female who has difficulty with mood regulation. She understands self-mutilation as an attempt to self-soothe and manage moods. She believes Dialectical Behavior Therapy (DBT)¹² is an effective treatment in addition to other types of therapy and supportive relationships. She maintains that self-mutilation is a major concern in psychiatry because of the underlying distress. She contends that celebrity culture is influential and a place where teenagers learn about practices such as self-mutilation. Dr. E believes that scars serve as an outward expression in the short- term but long-term as a reminder of the painful past.

5.3.5 Dr. D

Dr. D specializes in adult emergency psychiatry. She remembers learning about self-mutilation in her residency training and that it was largely a coping strategy employed for those with affective dysregulation. That is when people feel very distressed and have no other method to soothe their moods/ emotions; self-inflicted pain is effective

¹² Dialectical behavior therapy (DBT) is a form of psychotherapy developed by Marsha Linehan, and is often used to treat people with BPD and/or those who are chronically suicidal. The approach combines mindfulness and cognitive behavioral approaches focusing largely on distress tolerance and acceptance.

and helps ease the emotional distress. Further, self-mutilation is most often associated with BPD.

Dr. D most often has seen people in crisis and then for short-term follow-up. In her clinical evaluation of self-mutilation in the emergency department, she feels it is important to judge whether or not the behavior is a chronic problem or short-term problem because it means different interventions are necessary (i.e., inpatient or outpatient treatment). In terms of who presents more, she cited the stereotypical younger woman and noted that, often times, people hear about self-harm practices from others. She maintains that patients do not always have to fit the criteria for BPD but do often have very dysregulated emotions, and that strong sensations seem to help them manage emotions effectively.

In her experience as an emergency psychiatrist, she has seen an increase in transient self-mutilation (i.e., people trying it) but she does not see self-mutilation as a major concern in psychiatry. She cited suicide attempts and aggression toward others as a more pressing concern. She regards scarring as physically stigmatizing because people often judge what they do not understand and, for the patient, knowing this may physically inhibit what they do in the future.

5.2.6 Dr. A

Dr. A specializes in child and adolescent psychiatry. He recalls learning very little about self-mutilation in medical school. In residency, some of his training in treating self-mutilation was academic and some of which was through clinical exposure. He always

thought of self-mutilation as a symptom, much like a cough or a headache. He learned of it in the context of depression, personality disorders and unhealthy coping skills.

He referred to self-mutilation as being on a continuum spanning from a social phenomenon to an indication of severe mental illness. He noted that the emergency staff threshold for self-mutilation has increased and he thought this maybe was due to it being more common, making staff less uncomfortable with it. He contended that it was not necessarily that self-mutilation was more “acceptable” but, like anything in society, was gradually introduced and therefore drastic changes were less noticeable.

He also acknowledged that seeing “cutting” behaviors in adolescents was often different than seeing it present in adults. In terms of who presents more, he most often has seen women but cautions that this may not reflect reality outside of practice. Cutting and self-mutilation is often seen in Cluster B disorders-Personality Disorders (BPD most often). He cited BPD as one of the best examples of nature plus nurture, because these patients are more vulnerable to doing poorly in the face of trauma and often are the ones who have experienced trauma. He noted self-mutilation occurs with other diagnoses as well, but as a consequence of being ill rather than a feature of an illness. He did regard self-mutilation as a major concern of psychiatry today because it is (1) a common symptom of a time consuming and resource intensive disorder (BPD) and (2) a symptom of another mental health concern.

5.2.7 Dr. I

Dr. I specializes in child and adolescent psychiatry and spent most of his career working as an inpatient psychiatrist. He did not remember specifically learning about

self-mutilation in his training, but argued that medical learning and training is always ongoing and is largely clinically driven. In his experience, he has mostly seen adolescents who had self-mutilated, most often in the form of cutting extremities, although sometimes burning and head banging. While females presented more, he thought boys were likely engaging in self-mutilation but in less visible ways. He thought that the commonality in those who self-mutilated was some sort of suffering connected to some kind of trauma more often than not, was severe trauma or emotional neglect. The experience of trauma shakes the foundation of their worlds and severely affects their sense of security, confidence and stability. This manifests in trust difficulties, how they relate to others in the world and their ability to form connections and attachments, which when healthy and intact, serve to significantly help people get through life with ease. Ultimately, trauma changes how individuals relate to themselves, and Dr. I understands self-mutilation to be some form of body message -- a communication and expression to both the self and the world. He also pointed out that it does not have to always be trauma based, it could also be associated with anxiety. Even if people are engaging in it as part of an in-group school trend, it still speaks to a pain and is worth inquiring about. Dr. I thought validation was a crucial part of treatment for those who have self-mutilated and have experienced trauma.

5.2.8 Dr. C

Dr. C specializes in adult psychiatry. He remembers learning about self-mutilation in his training mostly referring to the adolescent population, and to individuals with particular personality qualities. He also remembers learning that self-mutilation was not necessarily related to wanting to commit suicide. He differentiated between self-

destructive and self-mutilating behaviors, noting that behaviors involving drugs and sex can be self-destructive, but self-mutilation usually caused physical harm damaging the integrity of the body structure. Dr. C cited the most common self-mutilation patient as the stereotypic female between the ages of 15 and 40, who usually possessed BPD traits and had difficulties in tolerating distress where self-mutilation acts as a temporary relief. He notes having seen self-mutilating behaviors in men in the same age range (citing men can also suffer from BPD), but believes that in men it is more about expression and less about self-soothing. Most self-mutilation he has seen is in the form of cutting the extremities but noted that it can include other methods and locations of mutilation.

Dr. C does not think self-mutilation is a major concern in psychiatry because he does not consider it an epidemic and is not sure that there has been an increase; rather, he suggests that people are possibly more open and forward about it, which means psychiatrists have less difficulty obtaining that information from patients.

5.2.9 Dr. B

Dr. B is a general adult psychiatrist who became interested in psychiatry during one of his medical school rotations. One of the biggest changes in his time practicing psychiatry has been the changes in medications as well as changes in the DSM. He remembers learning about self-mutilation in his training but only in connection with BPD. Yet, over time he has learned that people do it for different reasons, mostly to relieve some sort of tension.

He noted that self-mutilation in adolescence is not uncommon in his experience, but the ones who persist into adult life tend to have personality disorders (most often

BPD). In his experience, “Borderlines” are most often women and are the ones who have most often experience sexual or physical abuse. BPD can also exist in men, but he admits that this disorder is poorly understood. He considered self-mutilation to be aggression turned inward and thought of it as a dysfunctional, immature response to anger of frustration. Dr. B has not seen an increase in self-mutilative behaviors but does think that self-mutilation is a major concern insofar as it usually means “Borderline” patients which, he argues, do worse in hospital, do not respond medications and are often difficult to treat.

5.2.10 Dr. J

Dr. J is a general adult psychiatrist. He remembers in his training learning that those who self-mutilate have disturbed psychodynamics that can lead to a number of illnesses, most often BPD. He also noted that mentally handicapped people employed self-mutilation as an expression tool because they have great difficulty expressing their emotions. He admits that when he sees patients who self-mutilate, he is often suspicious of an Axis 2 diagnosis (i.e., personality disorder). Dr. J understood self-mutilation as aggression directed inward toward the self, and an expression of disapproval or anger. He has seen this most often in patients with BPD, Histrionic Personality Disorder and the mentally handicapped. He mentioned psychotherapy as most appropriate modality to deal with past issues or the distress underlying self-mutilation. He believes self-mutilation has increased in the past few years because of the increased awareness and recognition of the issue.

5.3 Findings

The goal of this chapter is to highlight how self-mutilation knowledge is understood and constructed by psychiatrists. The next chapter tackles if and how psychiatrists reproduce self-mutilation knowledge found in the DSM. Conducting interviews with psychiatrists resulted in rich, vast data. The data speaks to the complexity of how self-mutilation is described and understood by psychiatrists. There were some commonalities among psychiatrists in their perspectives on self-mutilation, but there were also differences and contradictions. Three main overarching themes came out of the interviews: how psychiatrists talk about self-mutilation, how they deal with it in practice and whether or not they reproduce the language of the DSM. Some themes or quotes contain multiple cross themes. For example, the section on “the skin” contains ideas about appropriate bodies and scarring, the social consequences of scarring, gender and risky behaviors. The section on “self-mutilation as language” contains other themes pertaining to gender, the skin, and bodies.

5.3.1 How do Psychiatrists Talk about Self-mutilation?

Psychiatrists talked about self-mutilation in a number of different ways: self-mutilation as an expressive body language, self-mutilation as a trend, self-mutilation as a symptom of a disorder, self-mutilation as not connected to a disorder at all, and at times all of the above. Most psychiatrists agreed that self-mutilation often has very little to do with wanting to commit suicide but rather is used as a coping mechanism to tolerate distressing emotions (that is, a way to create physical pain to distract from or bring one back from intense emotions or thoughts they were experiencing as overwhelming).

Almost all psychiatrists equated self-mutilation with cutting or, at the very least, damage to the skin. Rarely were any other methods mentioned (e.g., burning, picking) and even when other methods were mentioned, it was usually only when I prompted them to define what they considered self-mutilation. When I asked Dr. H to define self-mutilation, he immediately spoke of cutting. He also referred to other methods of self-harm but still only those that involved damage to the skin.

INT: How would you define self-mutilation?

DR H: I guess anyone who mutilates themselves, anyone who [wrist/ arm slashing gesture and slightly twisted facial expression mimicking someone cutting their arms].

INT: What would you define as mutilation, cutting or hit themselves?

DR H: Hitting themselves is not mutilation. Some kids actually burn themselves, some dig pins through their face, or wrist pins through their face. Some of them get something and keep burrowing into the skin until it hurts. And I have seen them use everything, glass, razor blades, coke cans.

Dr. I also referenced cutting as the most frequent method of self-mutilation, and extremities as the most frequent location he has encountered in his experience.

DR I: Cutting, mostly arms. Or you know, most extremities. Mostly arms. Sometimes legs. Sometimes abdomen. Sometimes burning oneself with cigarettes. Sometimes banging their head against whatever. Much less commonly but still sometimes, various insertions or injections of things in bodies.

5.3.1.1 Self-mutilation as Language

Self-inflicted injury as a form of expression or language was one of the more common themes described by psychiatrists. Psychiatrists understood self-mutilation as an expression of pain, a literal body language intended to make clear the internal suffering. Either self-mutilation was as a form of communication or expression to the outside world,

or a physical sign of internal anguish or anger directed toward the self. There were, however, differing opinions about the reasons underlying the desire to hurt oneself and this is highlighted by the different ways psychiatrists read and understood the patient's literal body language. Some psychiatrists argued that every person's reason for cutting may have been different but still had to do with the difficulty with regulating emotions and, as Dr. G maintained, difficulties communicating in relationships were part of this. Dr. G's explanation also houses a common idea among psychiatrists that self-mutilation is an abnormal response because "most of us" communicate or deal with things differently.

DR G: So one of the things we always do when we see a patient is we try to formulate them into that whole bio-psycho-social understanding. Everybody's is different and your understanding of the act is also different depending on the person so for many it is because they don't have the emotional regulation but I think it is for many as well the difficulties they have relationship wise, it doesn't allow them to use verbal kinds of interactions. Which is what most of us do. We talk it out, write it down, and go for a run.

Dr. I believed self-mutilation was often a message to others. He told the story of a young patient trying to use the skin as a canvas on which he was conveying a message to his mother.

DR I: Totally, I'd say it does. I think that with each body, um, action there's as part of that a communication, there is a message there that if you can understand it as a friend or family member or a treating clinician, you have gone a long way towards getting aligned with the point of view of the person you are caring for. Um, and so that message can be anything. I am thinking of um, a young teenage boy I saw whose mother was a dermatologist [laughter] who you know was going after his skin in you know really visible ways while his mother was making her career [in dermatology] so that's again a sort of simple but um, that there is some message there. In that case it was telling the mother you know [hesitant].

INT: Pay attention?

*DR I: F*** off.*

Dr. F similarly felt the self-mutilation was an outward expression of what was going on inside of the person and noted that long-term self-mutilators often times change their method of pain infliction by shifting to tattoos or piercings. Despite the shift, she still sees the underlying motivation for controlled pain as the same—a desire to have an outward representation of internal feelings.

DR F: The scarring, um in, the short term, I find people like it [the scar], its sort of um a badge of honor or its an outward expression that they have been suffering, it's a way to tell the world there is something going on here with me. I think in the short term, people like their scars. I have had patients who have stopped cutting and once their scars faded they had to do it again, they had to have some mark there as an outward representation of what they have been through. It's probably on a continuum with things like tattoos and piercings and those sorts of things. Um and a lot of people who self-mutilate long term will have a lot of tattoos and piercings and will try to shift it to that. But they need some outward marker of what's going in with them on the inside.

Self-mutilation was also seen as manipulative or used for attention seeking. Dr. H explained that self-mutilation was often employed by young teenage women in an effort to diffuse tense situations in their homes, most notably those with their parents. He also cautions against equating self-mutilation with depression.

DR H: A lot of them do it to make a statement and say if you a daughter who was a teenager and the mother sees that she has cut her wrist or arm or body some place, the red flags go up and so it sometimes brings a whole lot of attention and eases the situation at home. There is a reward for some of these kids so if you just skipped off school and your mother is rip roaring mad or you are doing drugs and your mother is absolutely mad at you and then you go cut your wrists that diffuse the whole situation and eases the chaos in the house and all of sudden instead of being mad at you, mom is totally concerned about you so I would think a lot of cases are like that. They're mad at some family situation or some personal stress that they have in their lives. They are failing or are on drugs or their boyfriend has left them and they are getting depressed, but don't equate self-mutilation with depression because I would think most of the kids I see who self-mutilate are definitely not depressed.

Similarly, Dr. F felt that self-mutilation was also sometimes used as a manipulation tactic to ease tension at home, knowing that their parents would fear that self-mutilation was a precursor to suicide. The response had come from a discussion between us centering on parents' (mis)understanding and fear of self-mutilation.

DR F: The main thing initially is are they suicidal and the next thing is how stressed are they to be chopping their bodies up and sometimes they're doing it to manipulate: if you don't give me this or let me do that I'm going to cut and it's your fault. There is a lot of blame and, you know, it can't be a tool for manipulation because it increases the risk for further behavior so it becomes reinforcing. It worked for me now so it will work for me the next time and a lot of parents are put off by it and they are just like why can't you come talk to me, it is hard to understand.

Self-mutilation as an expression of anger was another theme that came up.

Interestingly, some psychiatrists also noted both the act as well as the placement of scars as a particular expression of anger, either toward oneself or directed to the external world.

DR E: Our understanding of it would sort of be as a form of mood regulation or affective regulation whereas some people project their anger outwards, might sort of punch walls or fight with other people but some people project their anger inward and that can be through cutting or self-mutilating. The wrists or outside we think of as more anger to the outside and inner on your body sort of maybe your breasts or abdomen or thighs is anger toward the self. Um, it's sort of a coping skill in a way as some people might use drugs or drink alcohol when they feel overwhelmed, um young people sometimes self-mutilate, more so girls but sometimes boys as well. So that was my understanding of it or what I learned about it.

Furthermore, Dr. E thought expressions of anger were also gendered and that girls were often socialized to internalize intense emotions.

DR E: Personally, I think girls are socialized to turn their anger inward so they are more likely to cut, that's more acceptable coping. It's less likely that a girl would go punch another girl, although it does happen. The boys will be more socialized to turn their anger outward so they might sort of, they might hit

somebody, they might start a fire, they might steal something, throw rocks at cop cars. They have other things to do to express their anger, that's my opinion why it's a little bit different but you can see either activity in boys and girls, its not, ah, a perfect correlation.

Dr. E's observations of anger as a gendered expression were in line with Young's (2005) thoughts on gendered bodily comportment. Young contends that women in society typically comport themselves differently than men do. For example, she argues that the different ways in which men and women are socialized to express anger are connected to particular bodily comportment styles that are either internalized or externalized where women take up passivity and men take up activity. Because men and women are socialized to take up space differently, they act accordingly to the space they feel they have available to them.

Self-mutilation as language was one of the many ways psychiatrists described self-mutilation. Although, their experiences may have differed, most agreed self-mutilation was a message or cry for help indicating something was going on internally that needed attending to. The message was clear, how the message was read and dealt with was complicated.

5.3.1.2 Self-mutilation as Dysfunctional Response

Self-mutilation was also described as a dysfunctional or immature response to negative emotions or thoughts. Most psychiatrists talked about self-mutilation as a dysfunctional response to emotional distress, yet some also argued that while it is an unhealthy, dysfunctional response, it serves a function for those who engage in it: mood

regulation, tension relief, creating a numbing effect, attempting to feel strong sensations when numb (i.e., grounding), or dealing with feelings of guilt and shame.

Some psychiatrists argued that self-mutilation serves a function at the basic physiological level due to the endorphin release that follows the pain. Many psychiatrists talk about self-mutilation as mood management and an attempt to self-soothe. Dr. F notes the difference between self-mutilation and suicide and highlights the function of self-mutilation for people experiencing too many emotions.

Dr. F: Um, its more often than not, not to do with wanting to be dead, more to do with emotional regulation either because you have no feelings or because you have too many feelings and you can't get rid of them.

Self-mutilation was also described as a poor coping mechanism. One psychiatrist thought self-mutilation was a result of what she termed “shitty life syndrome”, a combination of social, environmental, and psychological factors. In addition to these factors, she thought there were just some people who had poor coping mechanisms and found that self-mutilation was useful.

DR G: I think, um, income, poverty, relative neglect, and emotional, physical neglect. I think for some, there's the group that—the sexually abused group and the severely traumatized and one could argue that it's partly social and partly psychological, and then there are those who have, I think, just innately poor coping mechanisms who discover that this works for them. So I think that there's multiple groups, but I have a number of people who have really horrible life stories and losing parents, being put in foster care, parents that are incarcerated, parents who are substance abusers and maybe never quite meeting the level where child youth and family services would remove them. I really truly believe there is an endorphin release piece and it becomes almost addictive for some kids so I think that for some kids, in and of itself, for some reason they do something that they realize gives them that release, that sense but the vast majority of kids that we see that cut or self-mutilate, sorry, more chronically have significant mental health issues. They have significant social problems. I call it SLS, shitty life syndrome.

The underlying emotional distress causing people to self-harm was regarded with concern, but the expression of distress via self-mutilation was sometimes viewed as immature or inappropriate. Dr. B read self-mutilation as an expression of outward frustration, but also noted it as a dysfunctional response.

DR B: Yeah I think it's, a lot of it, it is, we will talk about distress, aggression turned inward, response to frustration, and it's a learned response. It's a dysfunctional response. It is an immature response.

In conversations about self-mutilation, BPD came up frequently. Psychiatrists cited this disorder for numerous reasons: first, where self-mutilating behavior is seen as a criterion of BPD and second, because several patients that they had seen in adult psychiatry had the diagnosis of BPD and often had great difficulty in regulating intense emotions. Dr. A argued that for people with BPD self-mutilation often functions as a useful grounding technique.¹³

INT: So that's the Borderlines, and you see them self-mutilate more often because of the chronic difficulties?

DR A: Um, yeah, well but also because of the dissociation. Hurting yourself is a powerful grounding technique. So, like I say, why do they self-mutilate? Because it works, the basic reason is why does it work? It works for all kinds of reasons. It works because it might be the most healthy coping mechanism they have, as sad as that is, because it might stop the voices in their head, so you know on and on it goes.

Furthermore, Dr. D agreed that self-mutilation was most often employed by BPD in an effort to soothe emotion. She highlights here, the connection between self-mutilation and BPD.

¹³ I will return to a more detailed discussion of BPD later in this chapter.

DR D: Ah, I learned that it was, a, um, largely a coping strategy they would employ, you know, for what we call affective dysregulation, so when they felt very distressed and they had no other way of dampening down their emotions, this was something they could do to ease that. And it was associated with, you know, in terms of our diagnostic system; it was mostly often associated with borderline personality traits or disorder.

5.3.1.3 Self-mutilation as Trend

Self-mutilation was also described as a trend, almost exclusively among child and adolescent psychiatrists who have seen self-mutilation in their practices. It was thought that while some people engaged in it because of significant underlying mental health stressors, others tried it either because it was a fad or part of accepted junior high or high school culture. Dr. E wondered whether or not the influence of celebrity culture had an effect on the increase in self-mutilation behaviors. Another psychiatrist, Dr. H, thought self-mutilation was seen as an available option to youth now to deal with their pain.

When I asked Dr. G if she thought self-mutilation had increased in the past 10-20 years, she noted an increase but thought there were important factors involved: that it *seems* to have increased, but it might seem that way because people are more open to talking about it and it is less hidden. In addition, she noted it does seem to be a more mainstream practice and therefore more acceptable and more common, particularly as part of school risk-taking in-group dynamics. Psychiatrists also thought that there are those who are engaging in what they termed “transient self-mutilation” where they try it once.

DR G: There’s actually schools where the whole culture is unless you can show that you have self-mutilated, you can’t be a part of a certain social group, high schools. I think it’s really prevalent and I think there is a group that goes on to continue to use it as a form of coping or whatever else they are using it for. I would say that, teachers would tell you that 10 to 20 percent of the kids are self-

mutilitating in high school or doing self-mutilative kind of gestures in high school and a lot of them just try it once.

Dr. F also noted this kind of behavior in high schools, the trend of self-mutilation and the influence of celebrity culture.

DR F: I see a lot of the because of the group I see. It can be trendy. We have gone through periods where it is very trendy to now, where it is not very trendy, it seems to have settled down a bit. Um, like so it's a teenage thing I guess, where one is doing it so all of their friends are doing it so it becomes legitimate because everyone is at it. There was a period two or three years ago where they are having wussy tests, what they used to call it in school, where they would burn or cut, that's sort of gone now. Everything comes and goes in phases. The people we see now are more likely the people with the personality disorders or are heading that way as opposed to a couple of years ago when it was a popular thing, just like dressing in black went through a period right?

Dr. F also noted the paradoxical effect celebrity culture had on engaging in and understanding behaviors like self-mutilation. While it was a place where young people could see and reproduce these behaviors, it also meant that those who engaged in self-harm could have their feelings validated.

DR F: I think that it has become more acceptable to talk about and to seek help about it and there has been a bunch of movies and it was trendy, I don't know if you saw the movie 13? If you didn't I recommend you watch it. It was written, ah the person who plays the bully was actually a victim in real life. It is a really interesting movie about a 13-year-old girl who moved and didn't fit in and fell in with the wrong people; it's all about self-abuse. They all get together and beat each other up and slap each other for fun. It's really and you know that for a while was the movie that everybody, it wasn't have you seen 13? It was when did you see 13, you know?

INT: You saw an increase in it because of the movie?

DR F: Plus, yeah, and then you have the Hollywood stars come out, like Megan Fox has come out and acknowledged that she used to cut, and Demi Lovato, she was in some fancy rehab, there's others that admit that they used to do it so that becomes sort of role modeling in a negative way for some people, so they will pick it up but it also legitimizes it for people already at it so you're more likely to go get help, right?

Dr. E cites similar experiences and adds that there are youth out there who have traumatic backgrounds and that self-mutilation appeals to them for many reasons.

DR E: I don't know. I don't know if it's always been there and we are seeing it more or if its become more acceptable or more talked about and I do think that with the rise of social media and the internet, if someone is doing something it is easier to convey that to a wider audience, so people are more aware of some of these things. Some of this is a positive in that people can get help with coping or that they are not alone but it can be a negative because if people are not doing well and they read someone else's blog about cutting and how it makes them feel, I think they might be more likely to try it. There are a lot of youth who are disenfranchised who don't belong anywhere and if they can find a place where they belong, especially the invalidated youths with traumatic backgrounds, I think that's really appealing. So I think this whole subculture, it's appealing to them on a whole bunch of levels.

Dr. I contended that whether or not some self-mutilation behaviors are part of a trend or not, it is still a concern that is in need of inquiry. This was in response to our discussion of self-mutilation as a trend or being influenced by pathological celebrity culture.

DR I: I would be weary of that as an explanation to dismiss a large amount of behavior as something not rooted in the person themselves or in the space between the person and others in their world so, yeah maybe it would allow something to be more visible, but I would be surprised if it would be like some other culturally driven behavior. I would say there is something going on at least worth inquiring about.

5.3.1.4 Adolescent Versus Adult Self-mutilation

Following the discussion of self-mutilation as a trendy behavior, it is noteworthy to focus some attention on how psychiatrists understand the difference between adolescent and adult self-harm. Self-mutilation in adolescent populations is read as a phase or something that will mellow out, and likely stop completely, as the individual matures. It is interesting to note that the adult population is understood and labeled

differently; for adults, self-mutilation tends to be understood in the context of personality disorders. Dr. B held the idea that self-mutilation is often the result of common adolescent turmoil, but those who continue to self-mutilate into adulthood frequently have personality disorders.

DR B: Well, I think with adolescence you start off as a child, and you wind up as an adult and there is a whole bunch of turmoil in between where all of your values are turned upside down and challenged so there is a great deal of distress in the best of us, so a lot of things happen in adolescence that we grow up from, recover from and settle down, so its certainly very common in adolescence. Most adolescents are of course—most of that falls into child and adolescent psychiatry, but the ones who persist into adults tend to be people with personality disorders.

Given that self-mutilation is a criterion associated with BPD, which is a diagnosis given to those usually over the age of 18 due to the fact that many of the symptoms could be misread as normal adolescent reactions, child and adolescent psychiatrists are hesitant to give the BPD diagnosis to adolescents, although they do note whether or not the individual display BPD traits. Similarly, DR. F argues that these sorts of behaviors can be restricted to the particular life phase.

INT: I know you have mentioned it before that there is no typical self-mutilation patient, but you mentioned it was often associated with BPD, so—most often?

DR F: It's hard for me to say in my population, 9 times out of 10, because I would say in the adult population 9 times out of 10, but in the adolescent population they sometimes go through difficulties that are kind of restricted to that phase of life.

An extension of the argument surrounding adolescent versus adult self-mutilation was the consideration of where self-injury is located along a continuum (social phenomenon to pathological). Some psychiatrists thought that regardless of where self-mutilation was on the continuum it was a concern because of the underlying distress or reason that preceded the act. Others were not sure what they would deem pathological

versus normal life phase expressions or a cultural phenomenon. Dr. A spoke about how complex he thought this continuum was.

DR A: Very complex, and I always think about stuff in continuums. So you know, define the two ends and everything else is in the middle. On the one end, self-mutilation is not at all related to mental illness. It is some form of coping or a social phenomenon. There's many possible explanations. Taking mental illness as an axis upon which to measure it. Um, you know. No mental illness on one end and severe mental illness on the other end and, big continuum in the middle.

Dr. E also discusses self-mutilation on a continuum (but refers instead to an expression continuum), arguing that some people shift from certain expressive skin markers to others.

DR E: I find people like [the scar], it's sort of um a badge of honor or it's an outward expression that they have been suffering, it's a way to tell the world there is something going on here with me. I think in the short term, people like their scars. I have had patients who have stopped cutting and once their scars faded they had to do it again, they had to have some mark there as an outward representation of what they have been through. It's probably on a continuum with things like tattoos and piercings and those sorts of things. Um and a lot of people who self-mutilate long term will have a lot of tattoos and piercings and will try to shift it to that. But they need some outward marker of what's going in with them on the inside.

5.3.1.5 The “Typical” Patient

Some psychiatrists would agree that there was a “typical” self-mutilation patient or a stereotypical patient and others would say there was not a typical self-mutilation patient. Yet, others would not explicitly describe a typical patient, but would cite common characteristics that seemed to be congruent with the ways in which other psychiatrists described self-mutilation patients.

Common themes that came up in discussions of the typical patient were trauma, gender and BPD. Most of the references to the typical patient were references to women.

In the interviews, I heard numerous times that women cut more and women are more often BPD patients. The DSM, in fact, stated that 75% of those with BPD are women (DSM-5, 2013). The typical patient section describes what psychiatrists either explicitly discussed as the typical self-mutilation patient or implicitly referred to by talking most often about a certain type of person or a common experience.

Dr. H thought self-mutilation was “an epidemic among young teenage girls” and that this is not surprising because women genetically are more predisposed to affective (mood) disorders. Dr. G thought the typical patients were those who had significant social problems. In her experience, Dr. D felt women presented more often with cutting behaviors and this was because women chose cutting as an option more often.

DR D: Ah, well in my experience, it would be the classic sort of younger women. um. [Pensive look]. Why do I think that is? [laughter] um, [pause]. I think, ah, that women with affective dysregulation in my experience seem to gravitate towards, for example, cutting self-harm whereas men with affective dysregulation might gravitate towards more anger outbursts, drug use, that sort of thing. That's gross generalizations, but in terms of emergency presentations, that would probably be more of my experience. I think there is a certain amount, what I always ask people when they come in, if they have been cutting is, in what way did they start because there is a certain amount of, um, you know ah, mirroring or people hear about it from friends or you know there seems to be in a younger cohorts a little bit more discussion of cutting. It is bit more an acceptable behavior right. So it's not uncommon, you know, for me to see a 19 year old who says oh yes, my friend did it. I am not sure men have the same dialogue around cutting.

Discussion of the “typical patient”, particularly with psychiatrists specializing in adult care, usually meant a discussion of the typical BPD patient, which were most often women. Dr. C also noted that men can also have BPD although men with BPD tended to have effeminate qualities and/ or be homosexual.

DR C: Yeah. Of course that applies to women as well, but generally it's almost as a self-soothing strategy. And again if you look at statistics, if you're talking about borderline patients, I mean the majority are female, um, and it's not just a bias, a sex bias, or gender bias, I think it actually it is a difference maybe, with part of a neurobiology, and all that kind of stuff and the child/mom relationship which is different obviously in women than to a man. But in the men that you see with similar traits, we'll say borderline, they usually are more effeminate. We do know that. Usually are more homosexual in orientation. Again, um, just seems to be things, seem to always kind of be there, you know, always comes out.

Conversely, Dr. G was the only psychiatrist who understood typical self-mutilation patients as having particular sensory profiles.

DR G: Our OT would tell you that there are people who have low sensory profiles; she is very interested how sensory profiles fit with different behaviors.

INT: What do you mean by sensory profile?

DR G: So, she'll look at whether a person has kind of normal responses to sensations so like you're sitting there, a fire alarm goes, and it may be a nuisance whereas another child may go ballistic so they may be high registry, low tolerance whereas people with high registry or low tolerance: people with high registry or low tolerance logically to me would be the people more likely to self-mutilate. Because they have low registry or low sensory things. Perhaps because they haven't learned touch or other things so that pain is what actually gives them the fulfillment that they need. So I would suspect that it is that group, we have talked about it before, that it would make sense.

Dr. I was not convinced that there was a typical patient per se but rather believes there is a commonality in experience of suffering or trauma among those who self-mutilated.

DR I: I think what's in common is some kind of suffering, some kind of pain of some sort, um that often times, and I think that this would go to typical. Um, is rooted in and you know it could be way deeper, there is not necessarily a direct connection here but rooted in or connected to some kind of trauma and I say that in terms of typical, just with the sense of most commonly occur. That's what I mean by typical. I don't think that is the case with everyone that is doing self-destructive behavior or self-mutilation. Ah, but I think that more often than not.

Dr. C describes the typical adult self-mutilator that he sees in his practice, both female and borderline, with difficulty tolerating distress. He is aware, though, that this is the stereotype.

Dr. C: I know it's gonna sound like a stereo...well, I guess some stereotypes are true so it's not a stereotype, but it would be female, between the ages of [little pause] fifteen to about [little pause] early forties usually. Usually possesses what we would term as borderline personality traits, or borderline personality disorder, you've probably already heard all of this before. Um...Tends to coincide with someone who has difficulty with distress tolerance and coping, usually there is a lot of crises on the go. The crises might not necessarily be apparent to the individual, so it's almost like a situational anesthesia, that they can't really see the chronic issues, or chronic to acute to chronic issues that are exacerbating the distress. However, they are quite well adept at telling you that they'll engage in certain behaviors, at least temporary relief with long-term consequences and one of the things is self-mutilation. That would be the kind of classic, but that being said, you know...

Dr. B, in speaking about the typical self-mutilation patient, referred to what he thought the typical BPD patient was. His response contained ideas about gender, heterosexuality and normal, stable behaviors.

DR B: Well they tend, BPD for some reason tend to be more often female, males tend to be anti-socials. They tend to have very high rates of childhood physical and sexual abuse. Uh, they tend to have instability all over place, so intense unstable personal relationships, they get [umpteens? unclear] usually boyfriends [laughter] or other relationships which are very intense, and then of course crash and yeah. So what you are looking at most commonly in adult psychiatry would be your BPD.

5.3.1.6 Self-mutilation as Symptom

Self-mutilation was also understood as a symptom, an indication that something else was going on. In addition to it being an indicator of distress, it also served as a reminder to screen for BPD. Dr. D understands it as an index of symptoms that helps direct the treatment required.

DR D: Well, I think you see it as, I look at it is as an index of symptoms and an index of a person's emotional state and dysregulation and then you try and get a sense of how chronic it is versus acute, um, because it does sometimes point to different interventions.

Dr. A regarded self-mutilation as a symptom much like a headache, where it could indicate something minor or something major. He did however see self-mutilation as a major concern in psychiatry because it is a sign of something “not right” and because it's a sign of BPD which is a very time consuming and resource intensive disorder.

DR A: Um, I guess because coming at this from two sides. One because it is a common symptom of a common condition that occupies a lot of resources and time, i.e., BPD and on the other side it is a sign or symptom, like a canary in the mine shaft, that it is, um, it is highly suggestive that there is something not right here and can point to mental illness and it is certainly indicative of some sort of mental health concern. Differentiating that from mental illness. It is certainly cause for concern and question.

Dr. B viewed self-mutilation as important clinical information and also as an indication of a BPD patient, which to him meant another “difficult” patient.

*DR B: I have long since gotten to the point where it is just more clinical information. Well you look at it and you tend to think well uh-oh [laughter]
INT: why do you think uh-oh, another borderline?*

DR B: Yup. You certainly suspect a borderline in adults. I mean there are times you can be mistaken. Well, your borderline patient, your personality disorder patient by definition, are more difficult patients. Your straightforward psychotic patient, your straightforward clinical depression, or mild anxiety...well they are people [laughter] you know people like you and I. Well, so are people with BPD they tend to be a lot more unreasonable.

5.3.1.7 Borderline Personality Disorder

BPD, a disorder characterized by emotional instability, warrants significant attention here because it was the most mentioned disorder in interviews with psychiatrists, it has a negative connotation in the psychiatric community and is said to

affect women more than men. The link between self-mutilation and BPD was highlighted in previous sections; discussions of the typical self-mutilation patient often led psychiatrists to speak about the typical BPD patient. Speaking with psychiatrists about BPD elicited mixed reactions: some were weary of the diagnosis altogether, some were compassionate and, for others, the very mention of it was frustrating. The interviews often led to the question of why people with BPD engaged in self-mutilation, what led to the development of the diagnosis and what did the diagnosis mean over the life course. The following section highlights the “why” of BPD and provides some insight into the relationship between trauma, invalidation and purposefully hurting oneself.

Dr. F spoke of BPD in terms of emotional dysregulation and impulsivity and the inability to tolerate emotions.

DR F: They have trouble regulating their emotions. They love you, they hate you. It could all be five minutes apart. They are super happy or super angry or super fed up. A lot of trouble with stuff like that, idealize, devalue. So on any given day they are running into all kinds of trouble because of their dysregulation. They are very impulsive, so often times they will do something in the heat of the moment because they don't take the time to think. They are almost sometimes pseudo-psychotic in the way they believe things and experience things. The identity disturbances are the ones who have no feeling and they don't feel anything, they often cut because they are numb. Most of them, it's because of the fact they are unable to tolerate the feelings/ emotions they have.

Dr. G mentioned sensory profiles in the previous section on the typical patient but she elaborated on why she thought patients with BPD self-mutilated, arguing that often times due to their particular sensory profile, they needed stronger physical sensations, particularly if they had a background of trauma where over time they have learned how to tune sensations out.

Dr. G: For some of these kids, it's because over time they have learned to tune out their registry. If you are repeatedly smacked, hit you may start to tune out that physical sensation to a certain extent so you need a much stronger physical sensation in order to elicit a response.

Dr. A claimed that people with BPD are often very vulnerable and are also likely to do poorly in the face of trauma but that self-mutilation is a useful way for BPD patients to self soothe their emotions.

DR A: Ultimately these people are more vulnerable to more poorly in the face of life's traumas. Truly terrible things happen um, there is hypersensitivity where they are more likely to perceive life's difficulties as being traumatic. Um, but in addition to that there is also something specific to these people that put these people in harm's way more often. Whether that's, there's all kinds of reasons for that. Their history of relationships, they are more likely to be in these impetuous impulsive relationships so you think of the people that they are with, they tend to have their own sets of problems, personality disorders. Um, so to be in abusive, unhealthy relationships or just to be in dangerous situations if they are attracted to, if there is thrill seeking, attracted to dangerous situations, they will be in dangerous situations. So there is that and there's um, I often think of the, have you ever seen the wildlife show and you'd see the lion stalking the wildebeest. You'll often hear the narrator say, the lion knows which wildebeest to get; they stick out somehow. Borderlines are like the wildebeest. Yes, so as a diagnosis, they are highly likely to do bad.

When I asked psychiatrists what caused BPD, the responses ranged from genetics, to environment, to trauma, to invalidation. Many noted that the old literature pointed to a strong link between sexual abuse or childhood trauma and BPD but recent research speaks about the link between an invalidating environment and BPD. While sexual, physical and emotional abuse are all forms of extreme invalidation, psychiatrists maintained that sometimes invalidation could take the shape of a bad parental fit between the emotional needs of the child and parent even if the parent was well meaning.

Dr. C understood BPD as a combination of distinct temperamental qualities and experience with invalidation. He believed BPD people were more sensitive and outlined some of the ways that type of sensitivity could play out.

DR. C: Someone who [pause] has distinct temperamental qualities and possibly a level of invalidation um, um, throughout their life experiences... It's a horrible way to live... I've never met a patient with borderline personality that wasn't sensitive. They can cover it up by being external or very tough and assertive, but deep down they are very sensitive and they invalidate their own sensitivity by, you know, ridiculing it or discounting it. Right? Some people are born with thick skin; they can take a lot of crap, they can dish out a lot of crap, and if they are in an environment that's invalidating, so the worse form of invalidation, let's say for example sexual abuse or some kind of horrific event, they might be able to handle it and move on and adapt and grow. While someone who is very sensitive, they could be paralyzed by that, right? And they develop their own ability to invalidate their own experiences, they are not important enough to themselves to, they don't love themselves enough to genuinely appreciate anything with themselves. So they invalidate themselves as being crazy or unstable or abnormal and they're trying the best they can and they can't regulate, they can't sooth themselves, it takes longer, [unclear] mentally, it takes longer for distress to reach baseline or stabilization. So as a child, the child may cry for a longer period of time than another child who is much more able to settle down. For example, support fit between a parent and a child, I'm not saying a bad parent. A good parent who's really, really attentive to the needs of the child, but still doesn't understand why the child can't sooth themselves. They say, "everything's ok, nothing's going on, nothing's wrong, nothing's wrong", and the child's like "what the hell? I'm feeling like crazy, I'm exploding out of my mind here and you're telling me everything is fine. What the hell", you know. And you don't know what it is right? Because you just can't get it as a parent. You can be the best parent in the world you know, God's gift to parenting, just not a good fit because...our classical invalidating parent would be a parent like "Look what you're doing to me. Look at you crying there, making a fool of yourself in front of...look what people are thinking of me". That's invalidation right there. You know, the ultimate form of invalidation is when someone takes your body and does what they want with it and doesn't respect your thoughts about it or your personal space or whatever, you know. Or your emotions. Or your experiences. And their priorities come...anyone with sexual abuse, I mean, their priorities need to be met before that other person. So that's the ultimate form of invalidation. Invalidation can happen in many ways, shapes and forms.

Dr. D also thought BPD was a result of temperament and environment and sometimes a poor fit between parent and child. She thought this was a useful way to explain it to patients.

Dr. D: The core, the core of the theory behind BPD is that there is a, people have a temperament, temperament is very sort of biological explanation. People will talk about temperament a lot in pediatrics, babies that are easy to sooth etc. so um, you know in about 10 percent of the population, there seems to be sort of an intense temperament where you are more predisposed to affective dysregulation but only about 1-2 percent of the population meets criteria for BPD so then they sort of think there's something about an environment as you grow up where a person either learn strategies or not around recognizing and dealing with their emotions right so that's sort of how I talk about it to patients...Invalidating environment is the term used. So certainly, you know the most invalidating environment you are ever going to find is emotional neglect, sexual abuse, these sorts of things but it doesn't always have to be that and sometimes parents can be very well meaning you know but is just they have got this child who is really intense and they are trying to help he or she deal with it but they just you know, it's hard right. I find that sometimes helpful when I am talking to patients so that they don't feel like its necessarily pointing fingers right?

In addition to an invalidating environment, Dr. E thought people with BPD who self-mutilated and had difficulty regulating their emotions likely struggle because of early life experiences where parental comfort and attachment was absent.

Dr. E: I think more likely they have had some sort of trauma. More likely they haven't learned to manage their emotions, um I personally think that some of that comes from very, very early life and um you know I am a big advocate of sort of Bruce Perry's work and your brain developing within the first couple of years And he wrote the boy who was raised as a dog and other um, I forget the rest of the title but he writes a lot about children needing to be picked up, held, comforted, learning to manage their emotions in the first couple of years and if that's not done then you don't learn to control your emotions and if your emotions are overwhelming you are more likely to present as being Borderline. Um, people with family histories of a lot of mood disorders or trouble regulating their moods are more likely to have it. It's more typically girls than boys although can be either or and we also talk a fair bit about families who are invalidating. So where the person's feelings are not respected so they have to really act up or act out in order to get their needs met or to get attention so if they are sitting quietly not bothering anybody and they just say I need whatever, they don't necessarily get it

but if they kick and scream and yell then they do so that sort of parenting probably encourages it.

Many psychiatrists expressed frustration with people with BPD because of their self-sabotaging behaviors. Dr. F explains her mixed experience of frustration and compassion.

DR F: Because they are always are self-injuring, they don't listen to what you want them to do, they sabotage themselves, you know they don't, they are perceived sabotaged by someone else, it goes back to abandonment. If you are getting close and things are working, they will reject you so you don't have a chance to reject them. If they are in a relationship that they are enjoying, they will think it is not going to last so they will do something that will precipitate the break up subconsciously. Not even consciously, they are always their own worst enemy. I always say be grateful you are not in their skin. When people get frustrated with them. It's a lot easier to be on the other side of the table trying to help them than to be in their skin. Their skin is a horrible place to be.

Because of therapy interfering behaviors, such as self-sabotaging as described in the previous quote, in addition to BPD patients being considered difficult or high risk, patients with BPD are often regarded pejoratively. Dr. I, however, expressed that because of this there is often hopelessness associated with these patients and finds other ways to make sense of the pain to ensure they get the care they require.

DR I: Right again, most people to my thinking, most people who have what others would call BPD, have likely some either disclosed or undisclosed, aware of or not aware of um, trauma that is driving most of the signs and symptoms and unfortunately, there is a kind of hopelessness that gets generated as soon as someone is identified as having BPD that my concern is leads to that person not getting the kind of care that would be beneficial...I can't think of the last time I have described borderline as having borderline personality disorder. I will always find a different way to make sense of it that speaks to some more of the nuance of what's going on with the hope of having anybody else involved in their care, family members or friends or some of the staff or the group home worker or the child protection service social worker have a more nurturing sympathetic approach to the kid instead of, "it's just a borderline" which basically means the she or he pisses someone off and the way to approach them is with a kind of more harsh and distancing.

5.3.1.8 The Skin

“The skin is an outer covering of the body that both protects us from others and exposes us to them.” (Cataldi, 1993, P. 145).

The skin becomes meaningful through how it is read, and it can be read in multiple ways. As Ahmed and Stacey (2001) have noted, if skin is read differently, then consider the ways in which various techniques for reading *produce skins* in specific ways. They argue that this is especially true with reading the feminine skin, because it is read in terms of anti-aging techniques, being smooth, soft and shaven, covering any trace of surgery or illness.

“Indeed surfaces of the skin will always fail to be smooth, whether that failure is upon the deliberate markings of the skin or upon the unwanted traces of bodily changes or medical interventions, or upon the impossible desires produced by consumer culture.” (p. 2).

The marking of the skin is also temporal and spatial, temporal in that it is affected by the passage of time (wrinkles, signs of time, or records of biographies on the skin) and spatial in the sense that it expands and contracts. The skin is a canvas and cuts turn into lasting scars that serve as an outward reminder to both the world and the person who put them there. Self-mutilation was most often understood in terms of cutting oneself, or purposefully damaging the skin in some way. Ideas about the skin also reflected dominant ideas about beauty and gender.

Discourses of risk were evident with the words of the psychiatrists I interviewed in that damaging one’s body, one’s skin on purpose was seen as risky because of its

consequences (e.g., infection, scarring). Dr. D thought cutting was damaging to the integrity of the body.

DR D: I think we just have this feeling that, society, that we are supposed to maintain the integrity of our skin unless it's in a planned purposeful way and even so, people have problems with that. But you know. It just, I guess people have this inherent feeling that it is disrespectful you know. I don't know.

Dr. D went on to say that because society is often offended when people engage in risky behaviors that reflect lack of appropriate self-control (e.g., weight, exercise, alcohol use); there is often a judgment when people do things to themselves. Because of this assumption, scars are often physically stigmatizing to those who have engaged in self-mutilation.

DR D: I think people judge people who do things to themselves or perceive that they do it to themselves. I think people— that with eating disorders, self-mutilation, I think people experience it with drugs and alcohol. Anything where it's a behavior that the person is technically doing, I think it is very hard for people to understand and have the same empathy for that.

Gender was extremely significant when it came to discussion of the skin and scarring. Almost all references to the consequences of scarring were female references. This was likely because psychiatrists stated that women cut more and therefore all of their references to women were reflective of what they saw in their practices. However, in talking about the consequences of visible physical damage to the skin, psychiatrists may have been invoking taken for granted discourses of culturally acceptable beauty and femininity.

Not only were the references to scarring gendered but they also reflected ideas that were heteronormative. For example, Dr. F refers to life events such as graduation and motherhood.

DR F: Scarring is a problem and sometimes I will say you're gonna have to stop that one of these day, you're gonna want to put on a pretty grad dress and people are gonna be saying what's that all about, or you're gonna have a kid who says but mommy you cut. But I don't say that unless it's early in and I think they can stop without too much effort and because otherwise you are just giving them something else to feel bad about themselves. You have to be very, very careful with that.

Dr. G Similarly refers to wearing a wedding dress and motherhood.

DR G:I think the big ones are the ones I always say to people, how are you going to explain that to your 14-year-old daughter when she sees your arms or do you want to walk down the aisle, are you going to wear long gloves when you go to your wedding? Um...

5.4 Discussion

In this chapter, I offered a summary of each of the psychiatrist's backgrounds and perspectives, to help provide a contextual picture of each psychiatrist apart from only knowing them by their quotes. In the next chapter, I will explore two themes: how psychiatrists deal with self-mutilation in their practices and how self-mutilation is connected with the DSM. Emphasis will be placed on linking what the psychiatrists said to my analysis of the DSM.

Chapter 6 – Psychiatric Practice, Self-mutilation and the DSM

6.1 Introduction

This chapter focuses on how psychiatrists experience and treat self-mutilation in their practices and what influence the DSM has on psychiatric practice. First, I will describe how psychiatrists deal with self-mutilation when it presents to them and what sort of treatment or advice they offer. I will then move to the ways in which the DSM influences practice, in terms of how psychiatrists take up and resist DSM knowledge.

6.2 How Psychiatrists Deal with Self-mutilation in their Practices

Previously in Chapter 5, I discussed how psychiatrists described self-mutilation, how they understood the behavior and the reasons behind it, and what type of patient they believe is likely to engage in such acts. In this section, I am outlining what psychiatrists say they do about self-mutilation.

Psychiatrists most often cite their major concern with self-mutilation to be the underlying distress of the patient. While there is no necessary treatment for self-mutilation, the implicit goal is for the behavior to stop. When I asked Dr. G about how those who self-mutilate are treated by mental health professionals, she provided some important insight into understanding doctors' frustration. She thought that self-mutilation is both puzzling and frustrating because it is not necessarily "fixable".

INT: Mm hmm, and would you see a severe reaction or a reaction in general in psychiatry amongst your colleagues, when someone presents to emergency and they are covered in scars, are they treated differently. You have a little smile there. What's the smile about?

DR G: [knowing smile] I would like to say no, but I think that ...long pause...even as a resident I remember people that were coming in with repeated episodes and you are thinking “do they really want to kill themselves?” Again that was 26 years ago and I have a very different understanding now its sometimes it’s just, it’s just maybe its frustration on our part because we can’t fix it because we are doctors and that’s what doctors do, they fix things. You go through helplessness and are frustrated by not being able to fix it.

Dr. F, in response to a discussion about what she has learned about self-mutilation in her training, speaks in part to the negative connotation surrounding self-mutilation.

DR F: About self-mutilation? Um, it’s mostly associated with people with personality disorders, borderline personality disorder. Um, its more often than not, not to do with wanting to be dead, more to do with emotional regulation either because you have no feelings or because you have too many feelings and you can’t get rid of them and its looked on very pejoratively by many people in the community and in health care matter of fact.

Dr. F believes self-mutilation is maladaptive coping and that the best course of action is to understand the context and help them to stop. According to her, sometimes understanding the underlying reason is futile because not much can be done about underlying stressors.

DR F: Yes because it is maladaptive coping and that’s how to talk to them about it. The feelings you have are real and genuine. Sometimes there is nothing you can do about the underlying reason so the best thing is to focus on understanding the illness and the circumstances in which they do it and how we can help them stop doing it. Because it sounds more like aggression but you need to ask the questions. Why did you do it? Were you mad? Were you really frustrated or wanting to feel hurt because lots of times they will say they had to feel something. Yeah, so yeah it needs to be clarified. Context is the big word in psychiatry. Get context instead of just ticking off sheets.

Dr. G thought getting at the underlying reason was an important start to sorting out where to go from there.

DR G: Well, I think it’s relatively common, one of the things we do is try to sort out is this a kid who tried it for a reason, sometimes it’s a social reason,

sometimes it's an accepted reason, sometimes they just heard that it works to relieve pain.

Dr. I did not feel stopping the behavior was necessary but thought self-mutilation presentations were a type of communication and that his goal was to help make meaning of them. He spoke about the common goal to stop the behavior but cautioned that for a group that is likely already feeling misunderstood, this may set up struggle.

DR I: yeah, right and I think it always is you know it's like some kind of communication and um, some kind of expression. Maybe expression is better. Um you know so I think that um, if you, like, notice what it is the person is doing and aim to make some meaning of it, ideally in concert with them, then um, you can learn a lot. They can potentially learn something and that potentially offers that shared understanding, that shared meaning making, um, offers a potential approach to shifting something so that they are not doing it anymore if that is what people decide. I think it depends on the person, the context, you know. I there are a lot of clinicians who would say you know, "this is bad, it must be extinguished at any cost with any sort of degree of intervention", and often times that sort of approach sets up more struggle unfortunately which leaves someone experiencing again usually that people aren't with them. People don't get them. I will touch a patient and touch that scar or that wound as a way of making contact and also as a way of diffusing some, some of the what most of time I experience as shame, or being frightened by it or disgusted by it. It's like kind of, this is your body, I can deal with it, I can deal with it this way you know.

Similarly, Dr. C sees the presentation of self-mutilation in his practice as an opportunity to explore the patient's pain.

DR C: Well, concern, but I wouldn't be like, oh my God, we gotta do something about it. I would actually say, because it is a choice, right? And therefore a choice to validate someone you have to validate that they chose to do this and a bigger validation is to let them to express it and to not see it as a horrible thing or 'look what you did', you know, 'oh my God, now we got to go clean this up'. I would use it as an opportunity to explore. Because clearly it's a choice, it's not like automatically you start doing this, right?

Self-mutilation often serves as a cue to look for BPD. It is hard not to make that connection when in DSM versions 3, 4 and 5 it was the only disorder that explicitly and continuously listed self-mutilation as a diagnostic criteria.

Dr. B sees the presentation of self-mutilation in his practices as clinical information pointing to BPD, although he acknowledges this is not always the case. He sees self-mutilation as a symptom of a major concern.

DR B: I have long since gotten to the point where it is just more clinical information. Well you look at it and you tend to think well uh-oh [laughter]... You certainly suspect a borderline in adults. I mean there are times you can be mistaken. Well it's a symptom of a major concern. It's a symptom [of BPD].

Dr. A similarly sees self-mutilation as a symptom of a major concern (one of which is a BPD diagnosis).

DR A: um, I guess because coming at this from two sides. One because it is a common symptom of a common condition that occupies a lot of resources and time i.e., BPD and on the other side it is a sign or symptom, like a canary in the mine shaft, that it is um it is highly suggestive that there is something not right here and can point to mental illness and it is certainly indicative of some sort of mental health concern. Differentiating that from mental illness. It is certainly cause for concern and question.

6.2.1 Alternative Options for Pain

While there is no necessary treatment for self-mutilation, the implicit goal is for the behavior to stop. This is done either by addressing the underlying distress, by substituting something else in place of permanent body damaging practices, or by a combination of these. The intervention is closely tied to ideas surrounding the skin and the integrity of the body because the alternatives still cause pain enough to distract from uncomfortable emotions without lasting damage or scarring to the skin. Implicitly, psychiatrists are not saying purposeful pain is wrong; rather they are concerned about

infection and aware of the stigma surrounding self-injury scars. Often their goals were to provide alternative strong sensations. Dr. H's approach involves teaching other ways of dealing with distress.

DR H: I might add that some kids come in here and say they'd rather feel the physical pain over the psychological pain. That line has been presented to me many times. Must be extraordinary. Some of the stresses that these kids have are extreme, anything they could do to distract themselves could be positive. We teach them other options, press on their Achilles tendon or hold an ice cube. That doesn't leave scars or do much damage. Run for 10 minutes as fast as you can.

Dr. F's goal is to help stop self-mutilation through various methods by providing alternatives that do not damage the skin permanently in the form of scars.

DR F: we usually come up with some things they can do, it's better if they come up with it. When you read all of the things like snap a rubber band, they find that trite and insulting. I usually pass out things that other patients told me will be helpful. one of my patients that was really bad used to have to feel something so she would hold ice cubes and they would burn but don't leave marks but is just as discomforting when you are doing it she felt more so than cutting. Still have pain.

Dr. D suggests painful sensation alternatives as well that that are part of

Dialectical Behavior Therapy (DBT).

DR D: I think there's something about just the extreme um intensity of what they are experiencing that this seems to or on the other hand, emptiness is the other feeling that people feel and say they cut in response to. But whatever it is, it is so profound that I think that they, this is some sort of tangible way or it's for some reason helps. But sensory, sensation seems to help with dysregulation. So for example, I don't mean to keep harping on this but with DBT they try to give other things that people can do. So they will suggest ice packs, people will even do really extraordinary things like stick their heads in water, like cold water as an alternative to cutting. Because it's a big physical sensation that at least is not destroying the skin right? So there seems to be something that having an intense physical sensation helps but I don't pretend to understand it because I don't have that experience.

Dr. H sometimes uses the fear tactic of talking about scar infection as way to get a patient to stop the behavior.

DR H: I have seen some girls rip their faces, their chest their arms, their legs, and what I tell them all now is I try I say to them go ahead if you want to do that, sometimes they take out something right in front of me and will start cutting. And I will say go right ahead if you want to do that. But I give them two medical facts. Number one, of you cut yourself like that it will leave scars and one of these days you will be in a sleeveless dress at graduation and as you walk down the stage people are gonna see those scars and say, what's wrong with her. That's one. Secondly, I tell them look the skin is like a coat of armor and if you break it, germs and bacteria can get in there and if it gets in too far, and antibiotics are of no use and if its starts to travel way in there then the only treatment is amputation and their eyes open, usually open like that. And then I tell them true story about who that happened to.

A second psychiatrist also mentioned using a fear tactic such as telling patients that cuts can lead to possible infection. Both psychiatrists admitted they have not seen any cases of infection resulting from self-mutilation in their practices.

Beyond providing advice around alternative options, psychiatrists thought therapy and teaching problem solving skills were also useful. Dr. B spoke to the importance of preventing recurring crisis and teaching patients skills that can lead to independence.

DR B: I think we need to try to avoid drugs unless there is a very specific reason there and we are really looking at psychotherapy/ counseling and I think really the emphasis is in the here and now in terms of recurrent crisis intervention, a little bit of encouraging them to stand on their own two feet and assistance in problem solving, it is very important not to take over.

Dr. C talked about the importance of therapy for people with BPD more specifically but also the establishment of clinical therapeutic relationships.

DR C: We don't have a full good repertoire, but dialectical behavioral therapy, if you're talking about borderline personality disorder specific, it's one of the psychotherapies, there's also schema-based psychotherapy, mentalization-based psychotherapy. Always sounds really good on paper, but in terms of practical, or in terms of availability, not always the best. Especially in our province. But it's

changing I understand. We're supposed to be getting a DBT group coming in, or be trained. I was part of the initial, kind of, one day workshop. But there is a training of sorts happening, some staff... to do that. So those would be the prominent ways, evidence, I mean there is some equivocal evidence about the long term effectiveness and all that, but one would say that, and there's also arguments saying even the standard clinical follow-up where you see somebody and create a therapeutic relationship is sufficient to keep someone stable. I find that is relevant, but certainly it doesn't make anyone grow. Right? It just keeps things the way it is right? Um, but it works better than nothing. Um, medications are sometimes used for some properties like impulse control and for mood regulation where some people don't have a big emotional fluctuation in check, but it's not fool proof of course.

Dr. G also talks about the importance of a therapeutic relationship and the values of consistency.

DR G: I have a group of kids, a number of young women who have shitty life syndrome who at various times would have met criteria for depression, borderline personality disorder who at times would have had medication. Some of them I have seen every two weeks for years and years and years and sometimes we would just sit here and all we do, I would say "it really sucks that your dad is in jail again". Sometimes I am the most consistent person in their life for a period of four to five years.

6.3 DSM Knowledge and Psychiatric Practice

As I have outlined in Chapter 4, the DSM strongly aligns self-mutilation with BPD. While self-mutilation is seen as a characteristic of other disorders, it has been explicitly listed as a diagnostic criterion of BPD since the DSM-III-R (1987). Most psychiatrists made self-mutilation synonymous with cutting, referred almost exclusively to women when speaking of cutters, and often made the connection between self-mutilation and BPD. This highlights part of the construction of knowledge of self-mutilation. Of course knowledge production is complicated and is influenced by many

factors. I am concerned with the relationship between the knowledge production in the DSM and psychiatrists' experience in practice.

Psychiatrists drew on different forms and sources of knowledge in their practices. Occasionally they referred to other texts or sources of information, seen in the ICD or academic literature pertaining to self-mutilation, DBT or BPD, and specific texts such as Kaplan and Sadock's (2007) *Synopsis of Psychiatry*.

6.3.1 Uptake of the DSM

The DSM is the language of psychiatric communication and, taking that into consideration, it would be nearly impossible not to expect that DSM terminology or references would not come up during interviews. This section highlights the particulars of my participants' use of DSM language in reference to self-mutilation or BPD. Their words illustrate that the DSM shapes psychiatric practice and that psychiatrists both reproduce and resist the language of the DSM.

Dr. E spoke of the DSM as a tool of communication with other mental health professionals, a way to have a common language to report what they were seeing so everyone in the treatment team could be on the same page.

DR E: Okay, so the texts that I use... my DSM. I mostly use that because it's a tool of communicating so when I say somebody has something, if another psychiatrist, psychologist or social worker sees that patient, in my diagnosis accurately portrays the problem, then we are all speaking the same language. A tool for communicating. Um that's the primary thing.

Dr. H draws on DSM categorization by differentiating certain mental disorders. In the following example, Dr. H is noting the difference between Bipolar Disorder and BPD, referring to the DSM categorizations of what constitutes a "true" mental illness. He refers

to what is in the DSM as a form of diagnostic truth. He adds that he understands BPD as a “defect” in personality.

DR H: Bipolar is a totally different diagnosis. A totally different illness. Everything gets in high gear their affect, mood, speech and it doesn't just shut off just like that. Borderline personality disorder one second can be in the depths of depression and two seconds later bang they are high as a kite, so, they do everything. Making people worry. Repeatedly cutting up or overdosing [screwing up face when speaking] or just causing a big bunch of chaos.

INT: And why do you think it is that they are doing those things? Like repeatedly overdosing?

DR H: We don't know the answers to that. We don't know, they don't handle stress well and we talked about the emotional lability they have already, emotional dysregulation, they react to the extreme, no middle ground, unfortunately not. We try to teach them a middle ground I suppose.

INT: And that's not, so you said bipolar was an “illness” and that's not the case with borderline?

DR H: It's in the DSM so it's not up to me to call it an illness or not. It's a defect in personality and if you want to include that as an illness go right ahead.

Distinctions between “real” or “true” mental illness or disorders affect patients not only in terms of what seems to be a less empathic response for those with personality disorders, as I have shown in the previous quote, but also in terms of treatment coverage, particularly in the United States. Dr. F puts into perspective the power that diagnostic labels have for some. While she has never practiced in the United States, she talks about some of her colleagues' experiences with Health Maintenance Organization, HMO, and coverage. In an effort to obtain treatment for the patient and to get paid for practice, some psychiatrists will classify those with BPD as Bipolar Disorder because they can loosely fit the criteria for emotional lability and risky behaviors. We can see how the distinction between certain DSM diagnosis is understood and used by insurance companies to accept

or deny treatment coverage and may also be bent by psychiatrists to obtain payment. It is also interesting to note how BPD patients are set up as risky, time-consuming patients in the mental health community.

DR F: I enjoy the teenagers generally, right? But a lot of people won't take them for different reasons, they are risky patients, which will put anybody off, but they are also very time consuming. So if you are out in the community, you can only bill so much time. In fact, in the United States, there used to be a lot, of literature on borderline but there isn't anymore because the HMO's won't pay for many sessions with patients with personality disorders, so everybody now is classified as bipolar because if you look at the criteria, loosely they can fit because of the emotional lability and the dysregulation and some of the risky behaviors.

INT: So they pay for bipolar because—?

DR F: It's chronic true mental illness and they don't look at personality disorders as so, and it's for psychotherapy and so a lot of the research is kinda flipped around. Just like there are a lot of children with bipolar disorder which is all nonsense really because it's just a bunch of kids with temper problems, but you cant get paid for temper problems? Plus you add the drug companies on top of it who are trying to get their mood stabilizers and anti-psychotics to market and this is a lovely market because they are always on pills. Both of that pushing in that direction so the literature has shifted. I don't know how to look it up but there is a way to look how many sessions you can have for personality disorder treatment as a psychiatrist in the States and how many sessions you can have for bipolar disorder and you will see why there's a switch.

INT: It is funny how labels have power.

DR F: Yeah but at the end of the day, we all like to get paid. So if you are in the community and they are very labor intensive and on any given day, they are very unstable and you are trying to plan a clinic and ah, a lot of people will not be particularly interested in having this population, just like if you are a family doctor you wouldn't want to take a person with chronic diabetes, a 50 year old diabetic with cardiovascular, renal and respiratory problems. They are just one of our more complex problems but we take people here off a list and they come off a list. So we don't pick and choose and if we see them in the emergency department, they are ours. So again, we don't pick and choose who we see.

6.3.2 Ambivalence or Resistance Toward the DSM

Psychiatrists did not always take everything in the DSM at face value. Dr. E remembers learning about self-mutilation as part of personality disorders (that is, as related to BPD), but in her experience it is not always linked to BPD.

DR E: We also learned about it I guess as part of personality disorders, specifically borderline personality disorder because it tends to go with that.

INT: I'll get back to that because it keeps coming up, its something now that I have to consider, it comes up so much.

DR E: Because it is part of the diagnostic criteria. My experience is that it isn't sort of one and the same as borderline personality disorder especially now you see it much more. It is much more common than just in BPD. But in thinking of what I was taught, that would have been what I was taught, that it goes with BPD. My experience is that it's more than that.

However, she does note that self-mutilation serves as a reminder to screen for BPD.

DR E: My experience is that anybody who had distress can have self-mutilation; anybody who had identity issues can have self-mutilation. It's really multifaceted as you said before and can occur in almost any diagnosis or without a diagnosis, it isn't exclusive to BPD. When I see it, it reminds me to screen for BPD to see if people have the other symptoms or not but not necessarily.

Dr. A was not critical of the DSM per se but was critical of its potential for misuse. First, he thought that DSM criteria could be followed too blindly, thus ignoring important clinical observations. Second, problems could also arise if psychiatrists only relied on clinical observations without taking into consideration the DSM criteria. He cites Bipolar Disorder as an excellent example of ignoring criteria and creating new diagnoses that do not yet exist in the DSM.

DR A: Because um, not just the fourth edition but just as a thing. It's like being mad at guns you know, because it's the people using it. It is a tool that has the

potential to be misused. Any tool can be misused, I have no illusions about that but um, as someone who has spent a considerable amount of his life learning how to use it properly, um, it is a certainly a source of frustration to see it misused or mishandled either, the two broad ways we see this done is um, the extremes. Whether just blindly following the criteria without any regard for the reality in front of you or the other side of blindly applying diagnoses from the hip just entirely instinctual perspective without any regard for the criteria. [laughter] probably some, we have to keep both things in mind at the same time. Bipolar serves an excellent example of the erosion of the criteria and how people sort of constructed new diagnoses from the, you know. Ah, you must have, in fact this relates to BPD. Because you'll have people say you must have ultra-rapid cycling Bipolar disorder. Look it up in the DSM, it's not there! What's this ultra-rapid cycling? Oh they have mood swings. How long do they last, oh a few minutes to a few hours. Well that is really rapid cycling! It is both a scientific document in the sense that it is supposed to be based on epidemiological data but it's also a political document.

He is also referring to the bending of criteria to loosely fit another disorder. Dr. F mentioned this previously in her discussion of diagnosing people with Bipolar Disorder when they have BPD. In fact the description of ultra-rapid cycling Bipolar Disorder sounds like the criteria pertaining to the emotional instability outlined in BPD criteria.

When I informed Dr. C that NSSI was proposed to be included as a new disorder in the DSM-5, he voiced his concerns about the DSM being pharmaceutically driven and cited concerns about the inclusion of new disorders.

DR C: Ahh...I think they are using it for a political tool. It's mainly, it's taken advantage of by researchers. It gives them a research direction to use, which is fine, but, you know, sometimes I find that you can't create a clinical syndrome to do research on, that's an issue. And I also think there's a lot of them that are pharmaceutically driven. Again, case in point, anxiety disorders, all of them are supposed to have a sub-component, or a subtype called delusional, delusional level of poor insight which might trigger anybody to use anti-psychotics in that population, which is big money for drug companies. So, that's an example, that's my opinion again. Certainly, it's up for debate. It's a controversy but I've talked about this with my colleagues. This is just an example. I don't put a lot of stock into new syndromes. Stuff like Olfactory Reference Syndrome becoming a stand-alone condition. You know and as an anxiety disorder. Certainly there are syndromes in psychiatry or psychological experiences that people do, that have a

lot of symptoms black and white but there's a meaning behind it. You know, self-mutilation stand-alone to be honest with you I never knew it was gonna be there. You informed me of that.

Dr. B cites the criterion system to be useful but cautions against the over-reliance on diagnostic checklists. I thought it was particularly interesting that he also spoke about how the DSM was taken up by the public.

DR B: [pause, thinking]. I think changes are coming fairly slow; there have been huge changes in medications. Unfortunately the changes in medications have been more driven by drug companies than by reality. So that there is a [unclear] the Prozac's were much, much better than the tricyclic's, the new anti-psychotics were much, much better than the old ones. It's all smoke and mirrors, its nonsense. Unfortunately, the Americans have done 3 or 4 DSMs—well we have DSM 3, which was clearly a major advance because it took us to a criterion-based system which I think was helpful. So that's the advantages and disadvantages of that but it was overall helpful. They also introduced multi-axial diagnosis. Um, so not only in illness but also in personality. That came out in three, it went from three to three-revised to four. Um, [long pause] they have chopped things more and more and frankly they have, I think in fact things are in fact deteriorating from that point of view. I think there are some advantages but they are certainly making some retreats and I think one of, we are not, we are tending to look at checklists as opposed to taking and listening to patients and unfortunately the checklists become known to the public so if you wanted to walk in and tell me that you have Bipolar disorder, you know exactly what to say, [heavy laughter] and if I sit and look at a checklist I can be dumb enough to follow it.

6.3.3 Self-mutilation, BPD and the DSM

As I have outlined in Chapter 4, the relationship between self-mutilation, BPD and the DSM is very clear. BPD was a strong theme that ran through all ten interviews with psychiatrists. Dr. E noted that self-mutilation can be seen in the absence of a diagnosis, or seen with the diagnosis of BPD. However, she remembers learning about self-mutilation in connection with BPD, and the presentation of self-mutilation cues her to screen for the disorder (recurrent suicidal behavior, gestures or threats or self-mutilating behavior is listed in criterion #5 for BPD in the DSM). This was not an uncommon response from

psychiatrists. Adult psychiatrists almost always associated self-mutilation with BPD because they were less likely to view it as a trend or phase, as child and adolescent psychiatrists did.

Discourses around gender and instability were also taken up in talk about self-mutilation and BPD. Dr. B describes what he sees as a typical self-mutilation patient, and reproduces DSM language in terms of Cluster B disorders, sex, sexuality and instability.

INT: Okay, so is there a typical self-mutilation patient within these people with personality disorders?

DR B: Well, you're gonna be more likely to see patients, well it's one of the characteristics, one of the criteria of Borderline Personality Disorder which is actually the ICD-10 does a better term than the DSM, it uses emotionally unstable character disorder which is a much better term. You'll see it to a lesser extent in the other cluster B personality disorders but the big one is Borderline.

INT: Ok, and who is the typical BPD?

DR B: Well they tend, BPD for some reason tend to be more often female, males tend to be anti-socials. They tend to have very high rates of childhood physical and sexual abuse. Uh, they tend to have instability all over place, so intense unstable personal relationships, they get usually boyfriends [laughter] or other relationships which are very, very intense, and then of course crash and yeah. So what you are looking at most commonly in adult psychiatry would be your BPD.

Dr. A reproduces DSM language when referring to the ABC cluster of disorders (personality disorders), claiming cluster B disorders are often people in society who we would label as bad; BPD falls in this category.

INT: So would say self-mutilation occurs along with a particular psychiatric diagnosis more often than not?

Dr. A: We can look at this from two different sides, um, what illnesses, if you have a particular diagnosis will you commonly see cutting in that diagnosis, your cluster B personality disorders, is that something you have come across so far? They call those, the way we teach is that is ABC, which is mad, bad, sad. Cluster B is bad. Not judgment bad but those are the ones that society or people would

consider bad. They are your Borderlines, your histrionics, and your narcissists. Um, they tend to cut more than say your other personality disorders and specifically mostly we see the cluster B personalities, the BPD um and not necessarily that we see the full blown diagnosis at this stage but we see traits of BPD. Now we certainly see some patients who absolutely warrant the full diagnosis. Um, but we apply so much care because the personality is not finished forming. [Child and adolescent psychiatrist]

Dr. J argued when someone with self-mutilation presents, he becomes suspicious of an AXIS II diagnosis (the axis where Personality disorders was located in editions 3 and 4, but was changed in the recently published DSM-5) and although he notes the over-reliance on BPD as a diagnosis, he associates self-mutilation with personality disorders.

INT: Is there a typical self-mutilation patient?

Dr. J: Those especially who are having personality disorder traits. For example, histrionic personality traits, borderline personality traits, and a combination of a number others like if the person is like a handicap who is intellectually challenged. [pause] or a personal abuse as a child. They would also express their disapproval or anger in the form of self-mutilation. Some of my colleagues are very much fond of BPD because whenever a person comes to the unit with suicidal ideation, they get an axis 2 diagnosis very easily because they feel that if a person is doing this, there is something other than normal depression. Normal depression means clinical depression they have some personality component and it most often fits into borderline because they get other characteristics. So sometime, it's an overgeneralization. As a matter of fact, it is not only BPD. It is other traits as well.

Although, the presence of self-mutilation does not necessarily mean a BPD diagnosis will be made, Dr. E said self-mutilation reminds her to screen for BPD to look for other symptoms. This highlights how self-mutilation cues the practitioner to look for a collection of other symptoms linking the presentation of self-mutilation with BPD.

Dr. E: My experience is that anybody who had distress can have self-mutilation; anybody who had identity issues can have self-mutilation. It's really multifaceted as you said before and can occur in almost any diagnosis or without a diagnosis, it isn't exclusive to BPD. When I see it, it reminds me to screen for BPD to see if people have the other symptoms or not but not necessarily.

6.3.4 Bodily Damage and control

Interviews really brought out normative ideas about damage to bodies, the skin and the lasting effects of scarring. Given that the alternatives psychiatrists provided still somewhat satisfied the patient's desire for temporary bodily pain, it is important to ask why it is that opening the skin and scarring is seen as something that is offensive and needs to be stopped. Psychiatrists, while they may not condone it, clearly acknowledge purposely inflicted pain is a useful tactic for some people who have great difficulty dealing with intense emotions. In my discussion around the skin in Chapter 5, it was obvious that scarring was regarded both as a reminder to the self-mutilator of their past pain and as a sign of instability to the outside world. These were seen as adequate motivations to avoid damaging the skin. Psychiatrists discussed the long-term impact of scarring and proposed alternative ways to regulate emotions, such as holding ice cubes tightly in the palm of the hand, pinching the Achilles tendon or placing one's hand in ice-cold water. They provided alternatives because they saw self-mutilation as damaging to the integrity of the skin and body. What does skin, and the opening of skin, signify then?

As I outlined in the literature review chapter, the opening of one's body/ skin not only threatens normative ideas about beauty and the body but also blurs the boundary between what is considered public and private. The skin is seen as the boundary between the blood and organs and the outside world. When what is considered to be private enters the public realm it is often seen to as "inappropriate" and/or "risky". This sort of separation between public and private is kept in place by normative ideas and risk discourses that regulate what is socially acceptable and unacceptable. Anthropologist Mary Douglas

(1969) has argued that bodily control is an extension and expression of social control. The body and its openings are symbolic of boundaries around stability and order and are constructed by ideas of “inside” and “outside”, “dirty” and “clean,” policed by the processes of marginalizing those who engage in what is considered taboo. Purposeful injury is bewildering on a number of levels. Self-mutilation threatens not only social order but also normative ideas about bodies and gender (scars and ideas about smooth feminine skin), pain and pleasure, the ability to appropriately regulate emotions, the symbolic boundary of the skin (keeping the inside and outside separate), and ideas about mental stability

6.3.5 Bodily Expression and Gender

While there are mixed reactions to BPD patients and to what BPD even is, when I asked psychiatrists if they see self-mutilation occur frequently with a particular diagnosis, they routinely mentioned BPD; further, they emphasized women as the majority of both BPD patients and self-mutilation patients. The descriptions around the expression of anger were also interesting to note. Some psychiatrists either explicitly or implicitly thought girls who show anger tend to cut whereas boys who show anger tend to express it outwardly through aggression. For instance, Dr. E’s observations underlined how the gendering of anger steered more girls toward psychiatry and boys towards correctional systems. Gender and anger are both inscribed on bodies and perceived differently. I think part of understanding the relationship between self-mutilation and gender is understanding how we think of female and male bodies and what we think appropriate gendered reactions are supposed to look like.

6.4 Summary

The data presented in this chapter highlighted how the DSM influences and is taken up or resisted in practice. While the DSM is the main communication tool among psychiatrists and does influence diagnosis and decisions making, psychiatrists seemed to make up their own mind about the role of the DSM in their practice and often relied upon their clinical experiences and other literature bases. The DSM is taken up as a tool of communication, a diagnostic guide to look for certain things, a language to describe and explain what is observed, a document to use with patients and a political document that is sometimes misused.

Chapter 7 – Discussion and Conclusion

7.1 Introduction

This thesis has outlined the intersections between gender, power, and psychiatric knowledge. My goal was to examine the relationship between textual medical knowledge of self-mutilation and psychiatrists' understandings of self-mutilation based on their professional experience. To my knowledge, there has been nothing written to date on how self-mutilation knowledge is constructed in the DSM and understood by psychiatrists. Taking that into consideration, this project is an original contribution to the literature on self-mutilation. The impetus for this research came from a desire to explore and examine psychiatric understandings of self-mutilation. This, of course, was only one window of insight into the DSM and psychiatric descriptions of self-mutilation and the interaction between the two. I do, however, think it provided important insights into how self-mutilation knowledge is constructed and taken up. What this project can speak to is the common descriptions and discourses among psychiatrists and the DSM and how these discourses reflect dominant ideas about gender, risk taking and bodies. Deconstructing the ideas embedded within self-mutilation knowledge opens up the possibility of understanding its nuances and complications and subsequently understanding self-mutilation differently. If the language provided by the Diagnostic and Statistical Manual limits psychiatrists' perceptions of particular behaviors, it is possible that self-mutilation will continue to be mainly influenced by the DSM and dominant discourses. This is not to say that psychiatrists are not attentive to the difficulties and complexities in people's lives and cannot have their own nuanced ideas about why someone does something, but rather

if their knowledge base comes largely from a place that obscures complexities and is inherently invalidating, maybe we need to consider alternative ways of understanding the phenomenon.

The objectives of my research were: 1) To examine the construction of expert medical knowledge through an examination of self-mutilation references in the DSM (editions 1 through 5), as well as how psychiatrists describe and understand self-mutilation; and 2) To better understand how knowledge(s) of gender, the body and risk shape how self-mutilation is understood and whether or not these dominant knowledge(s) re-produce inequalities.

7.2 Self-mutilation Knowledge Production

Self-mutilation was described in many different ways but the common thread that ran through most descriptions by psychiatrists was discourses surrounding unstable, dysregulated, minds and bodies. Embedded within those discourses as well were ideas about gender and risk, but also conceptions of what is disordered. These are the areas I would like to focus on most in the following discussion, as they are foundational pieces to self-mutilation knowledge construction.

Larger, dominant ideas about bodies, gender, and risk are reflected in the interviews regarding psychiatric practice as well as implicitly embedded in the statistics and descriptions in the DSM. The DSM is not an ahistorical, apolitical document; it is a reflection of the cultural, social and political context in which it is written and influenced by the individual and collective politics represented by the working groups. Given all of this, it is reasonable to suggest that the DSM also reinforces dominant ideas about

normative minds and bodies, which are of course gendered, raced and classed. The DSM has become the universal language of psychiatry and is a very influential document that has very real effects for the people who are labeled with the diagnoses it contains. Being considered a “301.83 BPD” (DSM-5, 2013), which may look like a harmless combination of letters and numbers, often has very harmful effects if it is understood as a pejorative label. Many mental illnesses have a stigma attached to them, some more than others. “BPD”, for psychiatrists, often connotes a difficult, unstable, impulsive, time intensive patient. If self-mutilation is tied up with BPD, it could be argued that self-mutilation, too, comes with a set of ideas and explanations that reflect some of what is embedded in the negative discourses surrounding BPD.

The discursive link between self-mutilation and BPD is evident in the DSM and is also reflected in interviews with all of the psychiatrists. The association of BPD patients with being difficult and time-consuming patients was most often reflected in interviews with psychiatrists who practice adult psychiatry. Furthermore, part of the impetus to rename some self-mutilating behaviors NSSI is a push to divorce it from the negativity associated with BPD. This has both problematic and positive effects. It is problematic insofar as the proposal to create a separate NSSI disorder legitimizes self-mutilation in a way that is not the case for those who self-mutilate and are diagnosed with BPD. Conversely, this type of recognition can have positive effects for individuals who do not have BPD, find it distressing and would like to seek help.

Self-mutilation can also be understood in terms of risk in a number of ways. First, the opening up or damaging of one’s skin can be understood as physically risky due to the

chance of infection and, albeit rare, is a risk that still exists. Second, cutting or damaging one's skin purposefully can be understood as "social" risk-taking because the behavior falls outside of social norms and is often associated with impulsivity and instability; scars and cuts serve as external markers of internal chaos. Self-mutilation and scarring are risky insofar as they incur the risk of stigma, especially for women where expectations of beauty are, in part, tied to ideals of flawless, smooth skin. Third, because BPD is often connected with impulsivity and is understood as a "risky" disorder, self-mutilation (because of its strong link with BPD) is, by association, also understood as "risky". Self-mutilating means you are "at risk" of having BPD. There is a difference between individual intention and public perception of self-mutilation. The function of self-mutilation for the individual who engages in it is often for the purpose of sensory intensity, I see this as separate from how self-mutilation is understood and argue that self-mutilation is still viewed as a risk-taking behavior by society in general.

Foucault's work was useful insofar as his notion of the clinical gaze of disease demonstrates how changing ideologies can be seen as a product of different perceptions of the body. The concepts of biopower and technologies of power were also useful in understanding the role of the DSM, the construction of psychiatric truths, and the discipline of psychiatry in general. The DSM can be understood in Foucault's concept of a technology of power as it determines the conduct of individuals by submitting them to certain ends through the objectivizing of the subject. Through discourse of the body and mind, choices are made when defining what constitutes unstable or disordered, inappropriate or dysregulated. Knowledge, power and practice are intimately connected.

The DSM acts to normalize disorder and understanding how the DSM constructs disorder helps to understand how such discourses are taken up and reproduced and influence practice.

Smith's work is also useful in understanding knowledge production and the production of mental health statistics. She provides insight into the ways that objectified forms of knowledge are produced, are a result of ruling relations and obscure the complexities of people's everyday lives; but also how texts are mediated-- all of which apply to the consideration of the DSM as a social agent.

7.2.1 Discourse and Interaction

Language is powerful and discourses reflect and reinforce power relations. How people talk about others' bodies reflects ideas around morality and risk and often reinforces inequality. Popular mental illness discourse often leads to stigma. Mental illness discourse is part of larger normative discourses surrounding stability so that when individuals deviate from normative behaviors, they are marginalized and often viewed as ill, dangerous and unpredictable. In society, unpredictability and uncertainty are regulated by risk discourses and are kept in place by surveillance and regulation. Furthermore, the structuring of knowledge around gender, the body and risk contribute to the discourses about self-mutilation.

The language used to reflect and reinforce ideas about bodies in turn reflects inequality. The production of diagnosis leads to the production of certain kinds of bodies, healthy or ill, stable or unstable. Everyday discourses reflect ideas about bodies and health, equating the healthy body with the stable and regulated mind/body. Emily

Martin's book *The Woman in the Body* examines how scientific/medical discourses shape how women view and experience their bodies but also how such discourses are embedded within ideas about women's bodies and lives. I agree with Martin that such language and metaphors will inevitably result in affecting how women are viewed in general but also how women view themselves. Historically and socially, negative ideas are embedded within the discourses surrounding women's lives in general from menstruation to mental "illness" to mothering to sexuality. Such ideas are created and re-created by reducing people's lives and experiences to medical/scientific/ biological explanations and then using biology to promote inequality. She argues that these metaphors are reflective of particular ideologies and also affect the ways in which women conceptualize themselves—including how women internalize discourse.

Medicalization shapes women's lives, and the field of psychiatry is no exception. Psychiatric admission and use of psychotropic drug rates are higher among women than men even when both women and men present the same symptoms (Woodlock, 2005). According to Stoppard (in Woodlock, 2005), women make up 70 percent of the recipients of psychiatric drugs. A crucial question here is: Why do women receive psychiatric diagnoses and prescriptions more often? The answer, of course, is not a simple one because many factors need to be taken in account. Blum and Stracuzzi (2004) found that most psychiatric illnesses are implicitly gendered; they are constructed and understood in terms that convey femininity and/or masculinity. For example, they argue, addictive disorders and violent behaviors can be considered masculine while depression can be viewed as passive and feminine. Blum and Stracuzzi completed a study on Prozac,

focusing on its usage and influence in the popular media. They found that discussions surrounding Prozac were filled with covert messages about body disciplining for women, stating that the drug induces a masculine type of detachment. Women using the drug described themselves with vocabulary such as: “efficient”, “hard,” and “muscular”. Cooperstock and Lennard (1987), in Clarke (2004), described women’s usage of tranquillizers in terms of aids to help them cope with their socially assigned roles in the context of family and childrearing responsibilities.

Women labeled mentally ill or prescribed psychotropic drugs may experience negative reactions from other people. Goffman (1963) uses the term “stigma” to describe the negative associations given to a particular group or individual status. Goffman stated “Stigmatized attributes are those which are deeply discrediting in particular contexts, which tend to become the dominant identities by which the person is perceived” (1963: 3). He stressed that because of its devaluing, discriminative nature, stigma should be understood in the context of relationships. The majority of stigmatized views that surround mental illness are disseminated and maintained through the mass media where people are portrayed as violent and less competent. Low self-esteem is assumed to arise as a result of these processes because people apply these harsh beliefs to their own identities. People who self-mutilate are often portrayed as extremely unstable, unpredictable people and because of this may be treated with hesitation and harsh attitudes (Liebling et al, 1997).

A study by Camp et al. (2002) concluded that women with chronic mental health problems made negative comments about themselves and avoided disclosure of their

diagnosis out of fear of others' reactions (i.e., rejection). Although stigma can affect one's self esteem, other factors have to be considered. The loss of valued roles in the family or community and/or loss of relationships can also lead to a lowered self-esteem. It is also possible that people who expect to be rejected may isolate themselves out of fear of further rejection. Isolation is both a so-called symptom of being "mentally ill" and a result of being labeled "mentally ill". This is often where the boundary between what is or is not an illness begins to blur (Camp et al., 2002). Symptoms of mental illness are also the same sort of problems that arise when a person has been isolated and stigmatized; it is difficult to tell which came first. In relation to self-mutilation, the body is marked both overtly (scars) and subtly (norms, values) and voluntarily marking a permanent message on the skin offends Euro-American sensibility. Stigma associated with self-mutilation related scarring could lead to further isolation; negative reactions from others might also shape how those with scars view themselves.

7.2.2 Knowledge and the DSM

Knowledge affects people's lives and the DSM is a diagnostic tool that is a way of ordering knowledge (Malhi, 2013). The DSM and its constantly changing criteria and definitions provide a great example of how knowledge affects practice and is translated into reality. Changes to text affect people's day-to-day realities (Martin, 2009). In fact, the recent overhaul of the DSM is leading to considerable adjustments by both mental health professionals and some patients.

The DSM is an impressive and influential document in that updates and changes in wording and classification translate into real life effects for millions of people. These

changes can be positive or negative. The Axis II diagnosis in previous editions of the DSM (prior to the DSM-5) meant that some people with personality disorders did not receive coverage for treatment because Axis II disorders were not covered. The recent DSM, the fifth edition, no longer has the multi-axial system, and personality disorders have been moved from Axis II to the main disorders section. This may have positive effects for those who previously may not have been covered for expenses. Sometimes, psychiatrists question the DSM based on their what they see in practice. In my interview with Dr. G, she reported that she was seeing things in her practice that did not coincide with diagnoses in the DSM and became aware that most of those she had seen who self-mutilated did not have clinical depression and did not respond to medications. This meant that they did not fit any pathology in the DSM which maybe, she thought, may have led to the creation of the new proposed NSSI diagnosis or pointed to something larger going on (for example, self-mutilation acts as part of a social phenomenon). Perhaps this is why there is a proposal to include NSSI as a disorder in DSM-5 and why an alternate model of personality disorders is also being considered. Psychiatrists are seeing things in their practices that the DSM does not explain. Knowledge production is a two way street; knowledge is produced in the DSM but is also produced from clinical experience.

The proposal to include NSSI as a diagnosis, and the alternative models for personality disorders in the next DSM-5 revisions, at the very least expresses a more complicated and nuanced way of looking at these behaviors and characteristics; it also illustrates the effect psychiatric practice has on the development of and revisions to the DSM.

Knowledge is created and re-created and re-created by the many actors involved. The DSM is a critically influential actor that seems to take on a life of its own; it evolves and plays a huge role in psychiatric diagnostics and practice. It also finds its way into popular culture. Pop phrases and mainstream discourses use DSM terminology to describe everyday things: the weather is described as “bipolar” and conscientious people are described as “OCD”, Obsessive Compulsive Disorder (Martin, 2009).

It is not hard to see the ways the DSM influences psychiatric practice, first, by legitimizing certain disorders which have effects on people’s treatment and ultimately their quality of life and second, by medicalizing normal reactions to life experiences. The DSM of course plays a role within a system, and psychiatrists also have their own backgrounds and experiences in practice. My research suggests that psychiatrists use and resist ¹⁴ (are critical of) the DSM simultaneously. They are aware of the ways in which it is misused and the problems that occur because of its misuse. For example, Dr. A was aware of the ways in which the DSM could be misused and mishandled by those either blindly following criteria without looking and listening to the patient in front of them, or diagnosing someone based on DSM discourse without actually following the criteria. Dr. B agreed that a problem with the DSM was that it often meant psychiatrists followed checklists as opposed to talking and listening to patients. He also added that because the DSM was available to the public, patients often knew which criteria to verbalize in order to obtain a diagnosis.

¹⁴ That is, psychiatrists are often skeptical of the DSM. For example, they may see it as a political tool, pharmaceutically driven, or overly pathologizing, and yet still use it.

Classification systems in modern society and modern medicine play a crucial role in data collection and analysis. Classification gives voice to some perspectives while silencing others. Once classification is established, it reproduces itself in an instinctive way that silences debate (Jutel, 2011). Nosologies psychiatric or otherwise are rarely permanent and grow out of specific historical contexts (Grob, 1991). Davis (2006) argues that criteria have been included in the DSM are often based on clinical judgment rather than empirical research, a process of course that is more political than scientific. Over time, DSM construction in part is based on various political factors and is influenced by the historical time in which it is produced. Taking this into consideration, criteria then are not and cannot ever be objective as they are embedded in socio-cultural-political contexts in which they are produced and will inevitably change. This has been the case with references to self-mutilation over the past 60 years.

7.3 Reflections

When I started this research, I wasn't sure I knew what to expect, particularly when talking to psychiatrists. In retrospect, this research was both challenging and surprising. Psychiatrists provided invaluable insight into psychiatric thinking and practice. I appreciated their time and their honesty as they reflected on their training and experiences in practice. The interviews provided rich data that were useful and particularly so when complimented by an analysis of the DSM. The psychiatrists I interviewed are well intentioned and very much want to help reduce suffering for their patients. This sometimes means that they provide consistent appointments, or take on a psychotherapist role, or discuss alternative ways to deal with the overwhelming emotional

pain. Usually by the time a patient presents to the psychiatrist, it has gotten to a point where the person or, in some cases, the parent of a child, is seeking help because the behavior is distressing or impacting daily life. Psychiatrists have the knowledge that they received in their training, and iteratively they continue to build their knowledge via texts and through experiences in practice.

The DSM is particularly important in that it contains the procedures and language that is needed to communicate between mental health professionals, and is the main texts psychiatrists use to diagnose disorders. Adult psychiatrists often viewed self-mutilation as an indication of BPD and although they noted exceptions, the DSM still prompted psychiatrists to look for BPD. Other psychiatrists, particularly those specializing in child and adolescent psychiatry, saw variations of self-mutilation that fell outside of BPD and were not listed in the DSM. They did admit that they did not like to diagnose those under 18 with BPD. They understood the behaviors as a trend or a phase that would extinguish over time. Others acknowledged that both BPD and self-injury were still poorly understood, but they did their best to help with what they had. Psychiatrists, like everyone, are shaped by various knowledge bases, their personal histories, their training and the political dynamics within they work.

It was interesting to see and note the similarities and differences in approaches -- similarities in gendered, heterosexual approaches and differences in thinking about BPD. Some of the similarities may have been due to shared educational background and training, as most of the psychiatrists had completed undergraduate degrees in the same disciplines or had attended medical school at the same university. Differences in

perspectives could be the result of a combination of many factors such as: educational training, training post medical school or psychiatric residency, sub-specialization, psychiatrists' own subjective life experiences and personalities, type of practice, practice population, exposure and experience with practice, length of time practicing, age, sex, and the sources of textual knowledge they draw on in their day to day practices and in their own time.

Opinions about the function of self-mutilation were relatively consistent among all ten psychiatrists. They thought it was a coping mechanism, a way to manage intense emotions when patients felt numb and needed to feel, or when patients felt too much and needed to numb. However, perspectives on the reasons that lead to intense emotions varied. Some psychiatrists saw the underlying stressors as the result of trauma (physical, sexual, or emotional) or BPD; others had a multifaceted, complex understanding of reasons for self-mutilation. These tended to be the psychiatrists whose knowledge not only came from an intellectual and experiential place but also from a patient centered understanding of self-mutilation. They also were more likely to refer to patient's narratives of self-mutilation and numerous sources of literature on self-mutilation, and tended to refer to the DSM less. For example, Dr. G had a perspective on self-mutilation that was a complex interplay between different factors such as genetics, temperament, neurology (pathways being interrupted by trauma), environment, socio-economic status, and sensory profiles.

Dr. H on the other hand had a very linear perspective on self-mutilation and focused less on the various nuances that may lead someone to self-mutilate. He felt

strongly that genetics played a central role in determining those who have personality disorders. He felt that self-mutilation was an epidemic among teenage girls, was most often because of BPD, and was often used as a method of manipulation or to experience an endorphin release. Drs. A, E, and F, all whom have expressed a special interest in self-mutilation and BPD, told me they have done a lot of reading on the topic and actively continue to do so. They revealed a deeper understanding of those with BPD and those who self-mutilate and appeared to be highly compassionate to patients' pain and struggles with living in their own skin. All three had done extensive reading on the locations of cuts and what the location might have symbolically meant for patients. They had learned to look past the physical markings and try to understand the deeper meanings; they read scars differently (for example, cuts on the wrists were considered an outward expression of anger and cuts on thighs were considered self-hatred directed inwards—which they regarded as important clinical information).

Even though their backgrounds were different, for example, Dr. A practiced adult psychiatry and Dr. E practiced child and adolescent psychiatry, it was clear that they had some similar understandings and/ or they were influenced by similar schools of thought. For example, all used “self-soothing” (a much less judgmental or harsh term) to refer to the use and function of self-mutilation; they were the only psychiatrists to reference that term in the interviews.

There were differences between child and adolescent psychiatrists and adult psychiatrists in terms of how they understood self-mutilation and how they spoke in the interviews. Child and adolescent psychiatrists often spoke collectively, speaking in the

“we,” referring to the other child and adolescent psychiatrists they worked with. Adult psychiatrists almost always spoke exclusively of themselves and their own thoughts and experiences. I believe I obtained a somewhat more consistent perspective of self-mutilation from child and adolescent psychiatrists. It seemed that they worked as a team, or had similar training backgrounds. Their gentle, team-oriented approach may have also been reflective of the population they worked with: parents are often involved in the picture and children are often seen as vulnerable and still developing, thus perhaps eliciting more sympathy or patience from psychiatrists; they are still viewed as immature and their immature behaviors are understood and tolerated differently. Psychiatrists who see adults as patients seem to have less tolerance for what they viewed as immature behaviors (such as cutting or other impulsive acts).

Psychiatrists also seemed to read self-mutilation differently in different populations. In the adolescent population, self-mutilation was often seen as a phase, something transient that would pass. It was either understood as a part of a social phenomenon in schools or as a result of turbulence associated with the adolescent life phase. In contrast, self-mutilation in adulthood was often seen as pathological because it was thought that the personality was developed and fixed, therefore ruling out the possibility of a phase. Although this explanation subscribes to the view that the personality stops developing at some point, it must be noted that this is contradicted by other psychiatrists (and sometimes the same psychiatrist) who hold the view that the brain is malleable (the concept of neuroplasticity) and is changeable through therapy or medications. Self-mutilation in adulthood is almost always associated with BPD by

psychiatrists who practiced Adult psychiatry. Child and Adolescent psychiatrists, while they may have seen patients who they viewed as having traits of BPD, were hesitant to give a diagnosis of BPD because they also felt it was difficult to tease out BPD behaviors from “normal” adolescent behaviors (such as unstable sense of self, impulsivity and risk-taking).

Younger¹⁵ psychiatrists seemed to have a more nuanced and empathetic approach to self-mutilation and to BPD. They tended to talk about BPD in terms of invalidation, referred to the complexities surrounding self-mutilating behaviors and were fully aware of the negative connotation of BPD and what that meant for people who were diagnosed with the disorder. This did not mean, however, that they did not cite BPD patients as difficult or time intensive; some of them did. Older psychiatrists were also aware of the negative association attached to BPD diagnosis but spoke less about the nuances surrounding some of the behaviors; they spoke about both self-mutilation and BPD in rigid and very definite ways, leaving little room for alternative understandings or interpretations. These differences may have been reflective of different knowledge bases (i.e., curriculum they learned in their training) or length of time in practice.

In terms of sex differences, I cannot say that men or women seemed drastically different; some psychiatrists were gentler than others but this was purely based on individual personalities, although women tended to be more inquisitive and make more

¹⁵ This was a subjective judgment. I determined psychiatrists to be younger or older by either our informal conversations about the number of years they have been practicing (not everyone divulged that information to me) or based on their physical appearance (skin, posture, hair color). I determined older to mean over what I thought was 50 years of age and younger, less than 50 years of age.

eye contact. All of the psychiatrists were very cooperative and helpful. It was a pleasure interviewing them.

All references to long-term consequences of scarring were gendered, referring to women, and reflected heteronormative ideals such as marriage and family.

When asked if there was an increase in self-mutilation, most psychiatrists felt that there had been an increase in self-mutilation in the past 10-15 years, however some suggested that this may be because it had become more talked about and therefore more visible.

7.4 Implications for those who Self-mutilate

My research findings illuminate how psychiatrists need to re-understand and re-read the complexities of people's lives, in particular those who experience severe trauma. If part of the difficulty lies with how self-mutilation is read, then a new reading of the skin, trauma and pain is crucial. First, how distress and trauma manifest in the physical body and are mediated by gendered experience needs to be examined in more depth. Second, while some psychiatrists have very nuanced and critical understandings of self-mutilation, others do not and hold rigidly to a particular perspective, reading the DSM rather than reading the skin; the implications of this for patient care requires further research. Medical/ mental health professionals who are ultimately concerned with helping patients who self-harm need to have well rounded understanding(s) of what self-harm means for people's lives. This is less about a medical model of treatment but more about a human validation of one's pain and an acknowledgement of one's voice. Understanding the behaviors outside of diagnostic criteria may help to have different, alternative

readings of self-mutilation, moving the diagnosis from being considered a pathological behavior instead to being a sign of strength or self-preservation. Labeling distress as an “illness”, even with the best of intentions and as something in need of treatment, can be problematic.

7.5 Limitations

As with any research project, there are things I would have done differently if I were to do it again. While transcribing the interviews, I noticed that I could have asked some different questions or probed others a little more. While I did re-arrange and change a few questions after my first few interviews, it was not until I was transcribing and deeply involved in my data that it was clear that, while my findings were rich and very detailed, I would have liked to have a clearer picture of how psychiatrists defined self-mutilation and probed their ideas on normal, gendered bodies a little more.

If time had permitted, I would have liked to include the voices of lived experience, as I think that would have accessed incredibly important information that would help to provide a fuller picture of how self-mutilation knowledge is constructed by both experts and lay people (although one could argue that those who have lived experience are the experts). If nothing else, this research provided important information about how psychiatrists understand and deal with self-mutilation in their practices. Of course, without the point of view from a lived experience perspective, which is an important piece of the puzzle, I cannot speak to the ways in which patients feel they have been treated by psychiatrists when it came to sharing information about purposefully hurting

themselves. This perspective is critical. These considerations were realized through reflection once the data had been collected and analyzed.

7.6 Implications for Practice

The aim of my research was not to provide generalizable findings but to provide rich, detailed data. My research will be useful as a reflective account for psychiatrists to see how they themselves describe self-mutilation. It provides a solid starting point for future research on how self-mutilation is understood. In particular, it provides a snapshot of how self-mutilation is described by psychiatrists in the context of Newfoundland. Finally, highlighting the relationship between the DSM and self-mutilation reveals how expert knowledge is constructed, reproduced, adapted, and resisted by psychiatrists. I have illustrated how the DSM is gendered when it comes to the diagnosis of BPD and its relation to self-mutilation with the hope that health care professionals might exercise caution when interpreting behaviors and applying diagnoses.

7.7 Future Directions for Research

Future research might examine the lived experience of those who self-mutilate or have a diagnosis of BPD or have been hospitalized for either of these, to explore their experiences of staff attitudes, treatment by psychiatrists, other patients, and being an inpatient. Such a perspective would be extremely helpful in uncovering unhelpful interventions, gaps and inconsistencies in treatment. It would also be worthwhile to further examine ideas and discourses contained within self-mutilation knowledge or BPD. It would also be worthwhile to interview psychiatrists about the adjustment and changes

to the DSM-5 and whether or not the new text has changed how psychiatrists understand self-mutilation and in what ways this has changed how they practice.

Beyond psycho-medical approaches, it would be useful to have a multifaceted understanding of the commonalities in the subtle nuances in self-mutilation: for those with trauma, those who are trying it transiently and those who continue to do it and find it an effective coping skill over the course of many years. In addition, for those who try it transiently, we also need to understand the effect of celebrity culture and other cultural factors that influence behaviors that are considered pathological. A phenomenological approach would likely be most useful for these types of questions.

An important note that can be taken away from this research and interviews with psychiatrists is the need for validation when it comes to seeking help for self-mutilation or medical professionals' reactions to scars. Beyond the main concerns of infection rate (which remains low) and scarring which does have long term stigmatizing effects, one of the main reasons people chose to engage in self-harm behaviors is due to distressing feelings that come from some sort of invalidation. Invalidating environment is the new catchword in BPD literature. Older BPD literature suggested that sexual abuse was present in most patients with BPD and was thought to be a major contributing factor to the development of BPD. Recent studies suggest, however, that invalidation in some form or another is common in most people with BPD. Invalidation can take on a number of forms: toxic familial environments, verbal abuse, the child's emotional needs not being met by caregivers, or some would argue the ultimate kind of invalidation, physical or sexual abuse. People who self-mutilate do not need to be further invalidated by negative

reactions, misunderstanding or being told to stop the behavior. This is perhaps why doctors cite hospitalization for BPD patients as being unhelpful and making patients worse. While some psychiatrists see self-mutilating behaviors in hospital as a fight for control, they continue to help their patients as best they can with the resources available.

7.8 Final Thoughts

This thesis has outlined the intersections between gender, power, and psychiatric knowledge. The connection between and mutual transformation of these three was evident in the ways that psychiatrists talk about gender power, the skin and the typical patient. This thesis has demonstrated the discursive link between self-mutilation and BPD that reinforces particular gendered ideas about both BPD and self-mutilation. This is evident in the ways that psychiatrists talk about gender, the skin and the typical patient in the interviews. In addition there were also discourses of risk and healthy bodies, both of which are also gendered.

I outlined the shifts in DSM in terms of how self-mutilation and its association with BPD have shifted over time. I also provided insight into psychiatrists' perspectives on self-mutilation, the various discourses they used to describe their experiences and the ways in which they resist and reproduce DSM language. BPD and self-mutilation are discursively linked in both the DSM and in psychiatric practice, although this may be less so now over the past few years with the rise of alternative ways of reading self-mutilation and consideration that self-mutilation that falls outside of BPD criteria may speak to something more pervasive and perhaps, cultural shifts. My research was an original contribution to the literature on self-mutilation and its knowledge production. It is my

hope that in the future self-mutilation and scarred skin are both read in more nuanced and complex ways that fall outside of the dominant psycho-medical perspectives.

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Appendix A – Letter of approval from ethics review committee



Ethics Office
Suite 200, Eastern Trust Building
95 Bonaventure Avenue
St. John's, NL
A1B 2X5

December 8, 211

Ms. Ashley Patten
25 Rankin Street
St. John's, NL A1C 4W7

Dear Ms. Patten

Reference # 11.402

RE: How is Self-mutilation Constructed? An Examination of Knowledge Production Surrounding the Body, Gender, and Risk.

Please accept our apologies for the misunderstanding regarding your submission to HREB. After receiving further clarification from you regarding the use of blogs, as well as revisiting the use of the consent form, we are pleased to offer full approval of your study.

Your application was originally reviewed on **December 1, 2011** by the Health Research Ethics Board.

Full board approval of this research study is granted for one year effective **December 1, 2011**.

This approval will lapse on **November 30, 2012**. It is your responsibility to ensure that the Ethics Renewal form is forwarded to the HREB office prior to the renewal date. *The information provided in this form must be current to the time of submission and submitted to the HREB not less than 30 nor more than 45 days of the anniversary of your approval date.* The Ethics Renewal form can be downloaded from the HIC website <http://www.hrea.ca>

The health Research Ethics Board advises THAT IF YOU DO NOT return the completed Ethics Renewal form prior to date of renewal:

- *Your ethics approval will lapse*
- *You will be required to stop research activity immediately*
- *You may not be permitted to restart the study until you reapply for and receive approval to undertake the study again*

Lapse in ethics approval may result in interruption or termination of funding

email: info@hrea.ca

Phone: 777-8949

FAX: 777-8776

It is your responsibility to seek the necessary approval from the Regional Health Authority or other organization as appropriate.

Modifications of the protocol/consent are not permitted without prior approval from the Health Research Ethics Boards. Implementing changes in the protocol/consent without HREB approval may result in the approval of your research study being revoked, necessitating cessation of all related research activity. Request for modification to the protocol/consent must be outlined on an amendment form (available on the HREA website) and submitted to the HREB for review.

This research ethics board (the HREB) has reviewed and approved the research protocol and documentation as noted above for the study which is to be conducted by you as the qualified investigator named above at the specified site. This approval and the views of this Research Ethics Board have been documented in writing. In addition, please be advised that the Health Research Ethics Board currently operates according to *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans; ICH Guidance E6: Good Clinical Practice* and applicable laws and regulations. The membership of this research ethics board is constituted in compliance with the membership requirements for research ethics boards as defined by *Health Canada Food and Drug Regulations Division 5; Part C.*

Notwithstanding the approval of the HREB, the primary responsibility for the ethical conduct of the investigation remains with you.

We wish you every success with your study.

Sincerely,



Dr. Elizabeth Dicks, Vice Chair
Health Research Ethics Board - NCT

C C VP Research c/o Office of Research, MUN
 VP Research c/o Patient Research Centre, Eastern Health

Appendix B – Recruitment e-mail to the head of psychiatry



Faculty of Medicine
Division of Community Health and Humanities
The Health Sciences Centre
St. John's, NL, Canada A1B 3V6
Tel: 709-777-6213/6652 Fax: 709-777-7382
www.med.mun.ca

Dear Dr. X,

My name is Ashley Patten, I am a master's student in the division of Community Health and Humanities at MUN working with Drs. Natalie Beausoleil, Olga Heath and Fern Brunger. My research interest is in the area of non-suicidal self-injury (NSSI), often referred to as self-mutilation or self-harm. As part of my thesis research, I am interested in interviewing psychiatrists about their views on self-injury.

Research on the incidence and prevalence of purposeful self-injury in Newfoundland and Labrador is very limited. However, one recent quantitative study conducted at Memorial University examining the overlap between NSSI (non-suicidal self injury) and disordered eating behaviors suggests that NSSI is indeed a serious concern in this province and one warranting further investigation. The study surveyed 1639 undergraduate students (response rate 80%) and found that 6.52% of participants engaged in NSSI at least once in their lifetime and both females (6.5 %) and males (6.5%) engaged in self-mutilation as a coping mechanism (Duggan, Button, Heath and Heath, 2010). Furthermore, these numbers reflect higher prevalence rates than many other mental health issues including eating disorders (1.7%, Statistics Canada, 2002), schizophrenia (0.5-1.5%, DSM IV-TR, 2000) and bipolar I (0.4-1.6%; DSM-IV-TR, 2000) which have been the subject of closer examination.

My research examines how self-mutilation is described and understood in the DSM, by psychiatrists and from the perspective of lived experience. Thus, I am examining the construction of expert and lay knowledge. I believe a better understanding of how self-mutilation is described and understood sheds light on the complex phenomenon of purposeful self-injury and has implications for psychiatric practice.

I am wondering if I could set up a meeting with you to discuss how I might best recruit psychiatrists for these important interviews?

I would also be happy to meet with the Division of Psychiatry to present to discuss my findings.

If you would like any more information, I would be happy to answer any questions or concerns. You can contact me by email at apatten@mun.ca or by phone at 709-763-2445.

Thank you for your time. I look forward to hearing from you.

Sincerely,

A handwritten signature in black ink that reads "Ashley Patten". The signature is written in a cursive, flowing style.

Ashley Patten

B.A., Master's Student (MSc. Med)
Community Health and Humanities
Faculty of Medicine
Memorial University
apatten@mun.ca

Appendix C – Follow-up e-mail to psychiatrists interested in participating



Faculty of Medicine
Division of Community Health and Humanities
The Health Sciences Centre
St. John's, NL, Canada A1B 3V6
Tel: 709-777-6213/6652 Fax: 709-777-7382
www.med.mun.ca

Dear Dr. X,

Thank you for your interest in participating in my research. Your name and e-mail address has been forwarded to me by Dr. XX, the head of psychiatry.

I will be conducting interviews over the next month. Please let me know a date and time that is most convenient for you during this period. Each interview will last approximately one hour.

If you require any additional information regarding my research, please let me know; I would be pleased to send additional information along.

You can contact me at 709-763-2445 or apatten@mun.ca. I look forward to hearing from you.

Sincerely,

Ashley L. Patten

A handwritten signature in black ink that reads "Ashley Patten".

B.A., Master's Student (MSc. Med)
Community Health and Humanities
Faculty of Medicine
Memorial University
apatten@mun.ca

Appendix D – Information sheet



Faculty of Medicine
Division of Community Health and Humanities
The Health Sciences Centre
St. John's, NL, Canada A1B 3V6
Tel: 709-777-6213/6652 Fax: 709-777-7382
www.med.mun.ca

To whom it may concern,

My name is Ashley Patten, I am a master's student in the division of Community Health and Humanities at MUN working with Drs. Natalie Beausoleil, Olga Heath and Fern Brunger. My research interest is in the area of non-suicidal self-injury (NSSI), often referred to as self-mutilation or self-harm. As part of my thesis research, I am interested in interviewing psychiatrists about their views on self-injury. At this point, you have most likely received an e-mail from Dr. Callanan explaining my study and notice that I would be contacting you about possible participation.

Research on the incidence and prevalence of purposeful self-injury in Newfoundland and Labrador is very limited. However, one recent quantitative study conducted at Memorial University examining the overlap between NSSI (non-suicidal self injury) and disordered eating behaviors suggests that NSSI is indeed a serious concern in this province and one warranting further investigation. The study surveyed 1639 undergraduate students (response rate 80%) and found that 6.52% of participants engaged in NSSI at least once in their lifetime and both females (6.5 %) and males (6.5%) engaged in self-mutilation as a coping mechanism (Duggan, Button, Heath and Heath, 2010). Furthermore, these numbers reflect higher prevalence rates than many other mental health issues including eating disorders (1.7%, Statistics Canada, 2002), schizophrenia (0.5-1.5%, DSM IV-TR, 2000) and bipolar I (0.4-1.6%; DSM-IV-TR, 2000) which have been the subject of closer examination.

My research examines how self-mutilation is described and understood in the DSM, by psychiatrists and from the perspective of lived experience. Thus, I am examining the construction of expert and lay knowledge. I believe a better understanding of how self-mutilation is described and understood sheds light on the complex phenomenon of purposeful self-injury and has implications for psychiatric practice.

Each face-to-face interview will take approximately one hour or less and will involve a few guiding questions to get conversation started. Accessing psychiatrist's perspectives is important not only for my research project but also in better understanding the complexities of self-mutilation.

Over the period of January to April, would you be able to participate in a face-to-face interview?

If you would like any more information, I would be happy to answer any questions or concerns. If you would like to participate in this research project, please contact me either by e-mail or phone.

You can contact me by email at apatten@mun.ca or by phone at 709-763-2445.

Thank you for your time. I look forward to hearing from you.

Sincerely,

A handwritten signature in black ink that reads "Ashley Patten". The signature is written in a cursive, flowing style.

Ashley Patten

B.A., Master's Student (MSc. Med)
Community Health and Humanities
Faculty of Medicine
Memorial University
apatten@mun.ca

Appendix E – Consent form



Faculty of Medicine
Division of Community Health and Humanities
The Health Sciences Centre
St. John's, NL, Canada A1B 3V6
Tel: 709-777-6213/6652 Fax: 709-777-7382
www.med.mun.ca

Consent to Take Part in Research

TITLE: How is Self-mutilation Constructed? An Examination of Knowledge Production Surrounding the Body, Gender, and Risk.

INVESTIGATOR: Ashley L. Patten, Community Health and Humanities Master's Student

You have been invited to take part in a research study. Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. You can decide not to take part in the study. If you decide to take part, you are free to leave at any time. Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

Please read this carefully. Take as much time as you like. If you like, take it home to think about for a while. Mark anything you do not understand, or want explained better. After you have read it, please ask questions about anything that is not clear.

The researchers will:

- discuss the study with you
- answer your questions
- keep confidential any information which could identify you personally
- be available during the study to deal with problems and answer questions

1. Introduction/Background:

Self-mutilation is often misunderstood and gaining a better understanding from multiple perspectives is important. As mental health professionals, psychiatrists' experience in dealing with patients who self-mutilate provide important perspectives.

2. Purpose of study:

The purpose of this study is to gain insight into how self-mutilation is described and understood. I am examining both expert and lay knowledge production by examining psychiatric texts, interviewing psychiatrists and by examining blogs where people talk about/ write about their own experiences with self-mutilation.

3. Description of the study procedures:

Each participant will take part in a digitally recorded, face-to-face interview. Each participant will be asked a few demographic questions as well as open-ended questions including: age, sex, educational background, experiences in dealing with patients who have self-mutilated, and what they think self-mutilation is about. The purpose of open-ended questions is to encourage a less structured, conversational style of interviewing.

4. Length of time:

This interview will last approximately 1-2 hours.

5. Possible risks and discomforts:

Potential risks and discomforts of participating in this study are minimal.

6. Benefits:

It is not known whether this study will benefit you.

7. Liability statement:

Signing this form gives us your consent to be in this study. It tells us that you understand the information about the research study. When you sign this form, you do not give up your legal rights. Researchers or agencies involved in this research study still have their legal and professional responsibilities.

8. What about my privacy and confidentiality?

Protecting your privacy is an important part of this study. Every effort to protect your privacy will be made. However it cannot be guaranteed. For example we may be required by law to allow access to research records.

When you sign this consent form you give us permission to

- Collect information from you
- Share information with the people conducting the study
- Share information with the people responsible for protecting your safety

Access to records

The members of the research team will see study records that identify you by name. Other people may need to look at the study records that identify you by name. This might include the research ethics board. You may ask to see the list of these people. They can look at your records only when supervised by a member of the research team.

Use of your study information

The research team will collect and use only the information they need for this research study.

This information will include your:

- Sex
- Age
- Educational Background
- Information from study interviews and questionnaires

Your name and contact information will be kept secure by the research team in Newfoundland and Labrador. It will not be shared with others without your permission. Your name will not appear in any report or article published as a result of this study.

Information collected for this study will be kept for five years.

If you decide to withdraw from the study, the information collected up to that time will be destroyed. This information will only be used for the purposes of this study.

Information collected and used by the research team will be stored in the Division of Community Health and Humanities, faculty of medicine, Memorial University of Newfoundland. Both my supervisor, Dr. Natalie Beausoleil and I, Ashley Patten, as principle investigator, are responsible for keeping the collected data secure.

Your access to records

You may ask the researcher to see the information that has been collected about you.

9. Questions or problems:

If you have any questions about taking part in this study, you can meet with the investigator who is in charge of the study at this institution.

Principal Investigator- Ashley Patten - 709-763-2445 / apatten@mun.ca

Or you can talk to someone who is not involved with the study at all, but can advise you on your rights as a participant in a research study. This person can be reached through:

Ethics Office
Health Research Ethics Authority
709-777-6974 or by email at info@hrea.ca

After signing this consent form you will be given a copy.

Signature Page

Study title:

How is Self-mutilation Constructed? An Examination of Knowledge Production Surrounding the Body, Gender, and Risk.

Name of principal investigator: Ashley L. Patten

To be filled out and signed by the participant:

Please check as appropriate:

I have read the consent form.

Yes { } No { }

I have had the opportunity to ask questions/to discuss this study.

Yes { } No { }

I have received satisfactory answers to all of my questions.

Yes { } No { }

I have received enough information about the study.

Yes { } No { }

I have spoken to the principal investigator and she has answered my questions

Yes { } No { }

I understand that I am free to withdraw from the study

Yes { } No { }

- at any time
- without having to give a reason

I understand that it is my choice to be in the study and that I may not benefit.

Yes { } No { }

I understand how my privacy is protected and my records kept confidential.

Yes { } No { }

I agree to be digitally recorded.

Yes { } No { }

I agree to take part in this study.

Yes { } No { }

Signature of participant

Name printed

Year Month Day

To be signed by the investigator or person obtaining consent

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

Signature of investigator

Name printed

Year Month Day

Telephone number: _____

Appendix F – Interview script (Original)

Interview Script

1. Tell me about your educational background? What made you choose psychiatry?
2. Tell me about your experience as a psychiatrist in dealing with patients who self-mutilate?
3. How does it make you feel when you hear a patient describe the act of self-mutilation or see their scars?
4. In your training, do you remember learning about self-mutilation?
5. Tell me how would you describe self-mutilation?
6. Is there a typical self-mutilation patient?
7. Tell me, in your experience as a psychiatrist, what you think self-mutilation is about?

Appendix G – Interview script (Revised)

Interview Script

Pseudonym:

Sex:

1. Tell me about your educational background? What made you choose psychiatry as a specialty? (are you an adult or child/ adolescent psychiatrist)
2. In your training, do you remember learning about self-mutilation?
3. Is there a foundational or specific text that you often refer to or would cite as a useful psychiatric text?
4. Tell me about your experience as a psychiatrist in dealing with patients who self-mutilate?
5. Is there a typical self-mutilation patient? (who presents with self-mutilation behaviors more often?)
6. Would you say that self-mutilation often occurs along with a particular psychiatric diagnosis
7. Tell me, in your experience as a psychiatrist, what you think self-mutilation is about?
8. How does it make you feel when your hear a patient describe self-mutilating or see their scars?
9. In your practice, would you say self-mutilation a major concern in psychiatry today?
10. Are you seeing an increase in self-mutilation behaviors in the past 10-15 years? If so, why do you think that is?

Appendix H – DSM data

Given that there are multiple editions of the DSM, the search results concerning self-mutilation references were extensive. I organized the results in tables for each edition and outlined:

- The DSM edition / year published
- The search term used
- The search term results
- Page numbers
- Headings
- Associated diagnosis/ disorder

The search terms included the term “self-mutilation” but also included any related synonyms to ensure I was obtaining all references to self-injury or self-harm. I must also note that when search results were returned, sometimes terms were found on multiple pages but were associated with the same disorder. I began with a chart outlining the DSM editions spanning from 1952 to 2013. There were no references to self-mutilation or related terms in the DSM-I (1952) so I provided a breakdown of DSM editions II through IV in the tables. Brief observational notes are listed at the end of each table.

The search results are as follows:

Table H.1 DSM overview editions I through V

DSM Edition	Year Published	Number of Pages	Number of Disorders
DSM-I	1952	132 pages	106 disorders
DSM-II	1968	119 pages	182 disorders
DSM-III	1980	494 pages	265 disorders
DSM-III-R	1987	567 pages	292 disorders
DSM-IV	1994	886 pages	297 disorders
DSM-IV-TR	2000	943 pages	297 disorders
DSM-5	2013	947 pages	297 disorders**

** Complaints about the ever-increasing number of disorders led the chair of the DSM-5 task to announce that the number of disorders in the DSM-5 will not increase. However, as Rosenberg (2013) has pointed out that given the major re-structuring of the DSM-5 means that the addition of disorders can be hidden underneath or swallowed up by other disorders.

Table H.2 References to self-mutilation (and related terms) in DSM-II (1968)

Search Terms Results	Found on (# of pages)	Page #	Diagnostic category	Associated disorders
“Self-inflicted injur*”	1 page	p. 117	Section XVII (Accidents, poisonings and violence)	Suicide and Self-Inflicted Injury (E950-959)

* are included in search terms to obtain all possible variations of the word.

Notes: First reference to self-inflicted injury.

Table H.3 References to self-mutilation (and related terms) in DSM-III (1980)

Search Terms Results	Found on (# of pages)	Page #	Diagnostic category	Associated disorders
“Self-mutilati*”	4 pages	p. 91	Disorders Usually First Evident in Infancy, Childhood and Adolescence	299.9x Childhood Onset Pervasive Development Disorder (Listed under diagnostic criteria)
		p. 273	Under Psychosexual Disorders	302.83 Sexual Masochism (Listed under course)
		p. 41	Disorders Usually First Evident in Infancy, Childhood and Adolescence	319.0(x) Unspecified Mental Retardation (Listed under diagnostic criteria)
		p. 323	Personality Disorders	301.83 Borderline Personality Disorder (Listed under diagnostic criteria)
“self-inflicted injur*”	1 page	p. 191	Schizophrenic Disorders	295.2x Catatonic Type (Listed under description)

* are included in search terms to obtain all possible variations of the word.

Notes: Introduction of the classification-based system; First reference to self-mutilation.

Table H.4 References to self-mutilation (and related terms) in DSM-III-R (1987)

Search Terms Results	Found on (# of pages)	Page #	Diagnostic category	Associated disorders
“Self-mutilati*”	5 pages (excluding 2 pages where it was listed in the index)	p. 80	Disorders Usually Evident in Infancy, Childhood and Adolescence	307.23 Tourette’s Disorder (Listed under complications)
		p. 271	Dissociative Disorders	300.14 Multiple Personality Disorder (Listed under complications)
		p. 286	Sexual Disorders	302.83 Sexual Masochism (Listed under description)
		p. 346/347	Personality Disorders	301.83 Borderline Personality Disorder (Listed under description and diagnostic criteria)
“self-inflicted injur*”	2 pages	p. 94	Disorders Usually Evident in Infancy, Childhood and Adolescence	307.30 Stereotypy/Habit Disorder (Listed under complications)
		p. 196	Schizophrenia	295.2x Catatonic Type (Listed under description)
“self-injur*”	4 pages (excluding 1 reference found in index)	p. 94/95	Disorders Usually Evident in Infancy, Childhood and Adolescence	307.30 Stereotypy/Habit Disorder (Listed under prevalence)
		p. 29	Developmental Disorders (Axis II)	Associated Features
		p. 35	Disorders Usually Evident in Infancy, Childhood and Adolescence	Pervasive Developmental Disorder (Listed under features)

* are included in search terms to obtain all possible variations of the word.

Notes: First reference to self-injury.

Table H.5 References to self-mutilation (and related terms) in DSM-IV (1994)

Search Terms Results	Found on (# of pages)	Page #	Diagnostic category	Associated disorders
“Self-mutilati*”	7 pages	p. 120	Disorders Usually Evident in Infancy, Childhood and Adolescence	307.3 Stereotypic Movement Disorder (Listed under differential diagnosis)
		p. 478	Dissociative Disorders	300.12 Dissociative Amnesia (Listed under diagnostic features)
		p. 485	Dissociative Disorders	300.14 Dissociative Identity Disorder (formerly multiple personality disorder) Listed under Associated features
		p. 650/651	Personality Disorders	301.83 Borderline Personality Disorder (Listed Under diagnostic features)
		p. 654	Personality Disorders	301.83 Borderline Personality Disorder (Listed Under diagnostic criteria)
		p. 728	Criteria Sets and Axes Provided for Further Study	Dissociative Trance Disorder (Listed under associated features)
“ self-inflicted injur*”	6 pages	p. 118/119	Disorders Usually Evident in Infancy, Childhood and Adolescence	307.3 Stereotypic Movement Disorder (Listed under diagnostic features)
		p. 121	Disorders Usually Evident in Infancy, Childhood and Adolescence	307.3 Stereotypic Movement Disorder (Listed under diagnostic criteria)

		p. 382	Mood disorders	Catatonic Features Specifier (Listed under description)
		p. 288	Schizophrenia and Other Psychotic Disorders	295.20 Catatonic Type (Listed under description)
		p. 485	Dissociative Disorders	300.14 Dissociative Identity Disorder (Listed under Associated physical examination findings and general medical conditions)
“self-injur*”	7 pages (excluding 3 references in the index)	p. 119	Disorders Usually Evident in Infancy, Childhood and Adolescence	307.3 Stereotypic Movement Disorder (Listed under diagnostic features)
		p. 120	Same as above	Same as above (Listed under specific age and gender features)
		p. 121	Same as above	Same as above (Listed under diagnostic criteria and prevalence)
		p. 523	Sexual and Gender Identity Disorders	302.70 Sexual Dysfunction not Otherwise Specified (Listed under Paraphilias under diagnostic features)
		p. 42	Disorders Usually Evident in Infancy, Childhood and Adolescence	319 Mental Retardation, Severity Unspecified (Listed under associated features and disorders)
		p. 67/ 68	Disorders Usually Evident in Infancy, Childhood and Adolescence	299.00 Autistic Disorder (Listed under associated features and disorders)
“self-harm”	2 pages	p. 288	Schizophrenia and Other Psychotic Disorders	295.20 Catatonic Type (Listed under description)
		p. 382	Mood Disorders	Catatonic Features Specifier

* are included in search terms to obtain all possible variations of the word.

Notes: First reference to self-harm.

Table H.6 References to self-mutilation (and related terms) in DSM-IV-TR (2000)

Search Terms Results	Found on (# of pages)	Page #	Diagnostic category	Associated disorders
“Self-mutilati*”	9 pages	p. 133	Disorders Usually Evident in Infancy, Childhood and Adolescence	307.3 Stereotypic Movement Disorder (Listed under differential diagnosis)
		p. 520	Dissociative Disorders	300.12 Dissociative Amnesia (Listed under diagnostic features)
		p. 521	Same as above	Same as above (Listed under associated features and disorders)
		p. 527	Dissociative Disorders	300.14 Dissociative Identity Disorder (Listed under associated features and disorders)
		p. 572	Sexual and Gender Identity Disorders	302.83 Sexual Masochism (Listed under description)
		p.706/ 707	Personality Disorders	301.83 Borderline Personality Disorder (Listed under diagnostic features)
		p. 710	Same as Above	Same as above (Listed under diagnostic criteria)
		p. 784	Criteria Sets and Axes Provided for Further Study	Dissociative Trance Disorder (Listed under associated features)
“self-inflicted injur*”	6 pages	p. 131/132	Disorders Usually Evident in Infancy, Childhood and	307.3 Stereotypic Movement Disorder (Listed under

			Adolescence	diagnostic features)
		p. 134	Same as above	Same as above (Listed under diagnostic criteria)
		p. 315	Schizophrenia and Other Psychotic Disorders	295.20 Catatonic Type (Listed under description)
		p. 418	Mood Disorders	Catatonic features Specifier
		p. 527	Dissociative Disorders	300.14 Dissociative Identity Disorder (Listed under Associated physical examination findings and general medical conditions)
“self-injur*”	7 pages	p.44	Disorders Usually Evident in Infancy, Childhood and Adolescence	319 Mental Retardation, severity unspecified (Listed under associated features and disorders)
		p. 72	Disorders Usually Evident in Infancy, Childhood and Adolescence	299.00 Autistic Disorder (Listed under associated features and disorders)
		p. 131/ 132/133/134	Disorders Usually Evident in Infancy, Childhood and Adolescence	307.3 Stereotypic Movement Disorder (Listed under diagnostic features, specifiers, associated features and disorders, prevalence, and differential diagnosis, and diagnostic criteria)
		p. 466	Sexual and Gender Identity Disorders	302.70 Sexual Dysfunction Disorder Not Otherwise Specified (Listed under Paraphilias, diagnostic features)
“self-harm”	2 pages	p. 315	Schizophrenia and	295.20 Catatonic Type

			Other Psychotic Disorders	(Listed under description)
		p. 418	Mood Disorders	Catatonic Features Specifier

* are included in search terms to obtain all possible variations of the word.