Making Up Self Harmers: an investigation of the concept over time and from the perspective of two different self harm groups

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Contents

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Any errors in the following pages are mine only.

Abstract

This thesis aims to illustrate the processes involves in 'making up' the human kind of self harmers. Psychiatric attempts at defining, explaining, and controlling self harm behaviours are shaped by the people who they diagnose as much as they shape those who they are diagnosing. This relationship goes further, as the labelled respond to their category, the category changes, which alters the way in which they behave, which then again shifts the meaning of the category (Hacking, 2006). Medicine is a force that shapes and structures people's experiences of themselves, and through power relationships the array of available actions is limited to the individual (Foucault, 1982; Rose, 2007). In this thesis, Hacking, Foucault and Rose's theories will be illustrated and grounded by an extensive historiography using psychiatric journals, and applied to rich data gathered using internet forums. This thesis comprises both a history of the emergence and development of the concept of self harm, (i.e. the 'making up' of the category of self harmers) and an examination of the modern understandings of self harm (Hacking, 2006), using two clinical self harm discussion boards and two emo forums taken from a two week period in June. From this data, four themes were selected (use of medical discourse, identity presentation, integration with medical professionals and concealment) and will be discussed in detail. The 'looping effect' is illustrated using clinical self harmers, where their relationship with medical discourses is shown to influence both their understanding of self harm, and medicine's knowledge of self harm. A second group of emo self harmers will be compared and contrasted to the clinical self harmers, and their relationship to the medical sphere evaluated. These analyses shall demonstrate that the relationship between medicine and emo self harmers is predominantly unidirectional; medicine studies these teenagers closely, yet emo self harmers do not engage with the medical discourses. It will be shown that the two groups see themselves very differently in relation to medicine; clinical self harmers offered themselves to medicalisation readily, but emo self harmers are not medicalised to the same extent.

Key Terms:

Foucault, Kinds of People, Looping Effect, Medicalisation, Power, Self Harm

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Self harm is an emotive topic. 'Harm' in itself is a loaded term and part of its potency comes from being both noun and a verb; harm is both the result and the action. To turn a harmful force upon oneself contradicts many assumptions about life. . Potentially, some of the more disturbing connotations of self harm occur because of the abstracted language, the vagueness being filled in by our imagination. We do not know what someone means by 'harm'; there are too many possible meanings. Here we also come to one of the key problems: the definition of self harm that is used by individuals who self harm is not standardised, nor is it necessarily used in the same way by psychiatrists and medical practitioners (Laye-Gindhu & Schonert-Reichl, 2005).

The structure of this thesis is simple. This introduction will detail the problems encountered by psychiatry when attempting to define self harm, the aims and motivations for research, and the methods and ethical concerns which are salient. Following this, the necessary theoretical background will be discussed. Part one consists of a chronology of the development of the concept of self harm. This section is predominantly intended to show the negotiation of boundaries and the 'making up' of a new human kind. Part two and three rely on rich data to illustrate how two different populations relate to the category of self harm. Following on from these analyses, it will be concluded that these two populations interact with the psychiatric understanding in very different ways.

This thesis will argue that the behaviours which are understood as being self harming are not new behaviours. There are many available examples of behaviours that qualify as self harming, however they would not now be classified as such. To illustrate, mediaeval saints and holy women (such as Catherine of Siena) were harming themselves through *Anorexia mirabilis* (literally, miraculous lack of appetite). Despite literally falling under the heading of 'self harm' this behaviour does not fit in with our contemporary expectations of a typical self harming action. A more modern example to illustrate this problem could be smoking tobacco; literally, it is a self harming behaviour, but due to

what ever reason, it is ill-fitting within the category of self harm. Another, somewhat more graphic example involves the art movement of Viennese Actionism; artists such as Schwarzkogler, Nitsch, Brus and Müehl were routinely mutilating themselves as an aesthetic performance in the late 1960s intending to transgress and question societal norms (Tate Modern, 2009). These examples are very different to the common understanding of a self harmer, an emotionally charged, distressed and traumatised individual (Scoliers *et al.* 2008) So, it is clear that there is something that has emerged as the psychiatric category 'self harm', which involves more than the strict original denotation, which brings societal expectations and norms into the definition (Turp, 2002).

The definition of self harm is still unstable (Laye-Gindhu & Schonert-Reichl, 2005). Although self harm has been used in clinical psychiatric circles for a few decades, but it is not currently in the DSM-iv (the Diagnostic and Statistical Manual (APA 1994)) as a mental illness in its own right. Instead, self harm is described as symptom of mental illness, such as borderline personality disorder (APA, 1994, p. 654). Despite not being formally defined and explained in the DSM, self harm still is present in the medical, psychiatric and psychological literature and frequently investigated as a stand alone phenomenon. This causes complications: a non-standardised definition of self harm has been used for too long; two research articles claiming to investigate self harm can differ widely in their understanding of self harm (compare Turp, 2002, and Fortune, Sinclair & Hawton, 2008). It is worth noting that the incorporation of a deviant behaviour into the medical sphere is not necessarily progressive: "there are still compelling reasons for worrying about the tendency to portray social and psychological phenomena as medical problems" (Nye, 2003, p. 115), as this delineates our own behaviour as medical territory. The integration of the abnormal, the deviant and the immoral into the realm of medicine may have the effect of limiting the potential actions which are available.

This leads to another issue surrounding the concept of self harm: who is to it? Western biomedicine presents itself as a universal science, equally applicable and useful to everyone. As psychiatry sees itself as part of this medical science, how can it come to terms with the cultural specificity of self harm? If self harm is declared a Western culture

bound syndrome then medicine's claim to universality and materialism is compromised: psychiatric medicine would no longer have exclusive control over the knowledge surrounding self harm, due to culturally bound syndromes having a precarious place in Western medicine. Consequently, self harm would not be taken seriously. So, psychiatric medicine stresses the pervasiveness of self harm using statistics and terms of medical universality to imply a global problem as to maintain is dominance (e.g. Scoliers, *et al.* 2008).

Western biomedicine's perspective on mental illness is clothed with cultural beliefs and assumptions in the same way as ethnomedical models (Helman, 1978). This is best illustrated by scarification. In one setting, Western societies view scarification activities as deviant, problematic and a sign of mental illness (despite their increasing prevalence amongst body-modifiers[1]). In another setting, such as in societies in Papua New Guinea, Australia, Africa and others the same Westerners see scarification as exotic, traditional, symbolically and culturally rich (Cole & Haebich, unpublished). There are also examples from within a single culture. Not all that long ago, tattoos were considered a sign of degeneracy, criminality and deviancy (Cole & Haebich, unpublished). Today, tattoos are common among the middle classes. This demonstrates that western medicine is neither acultural nor ahistorical.

As stated above, the concept of self harm is still being negotiated by many stakeholders: psychiatry, those who fall under the classification of self harm, and the public. However, it is not only journals of psychology, psychiatry and medicine that are debating the meaning of self harm. Those who fall under the label (whether self-declared or institutionally diagnosed) also have an active part in classifying self harm. The relationship between an individual's agency, emotion and identity, with psychiatric knowledge is a point of tension between individual and society. It is in this space where compliance and resistance occurs, the influence of generated knowledge can be seen to be acting on individuals, as can the action of the categorised be seen to impact on the literature (Hacking, 2006).

[1] See www.bme.com

Throughout this thesis, the historical development of self harm will be outlined in relation to the historical development in the medical literature. This will be embedded into the wider discourse of the medicalisation of people's bodies and emotions, and the power relations involved in doing so. The relationship between self defined clinical self harmers[2] (including the subgroup of self labelled 'survivors') and the wider discourses of medicine will be investigated. Similarly, self defined emo[3] self harmers will be analysed and compared to the clinical and medical discourses.

Theoretical Background

Self harm will be shown as a point where many issues regarding agency, identity, emotion, society and psychology are performed using the human body. In this sensitive subject, it is especially clear to see the relationships of power play out between institutions of psychiatry and medicalised individuals. A broadly Foucauldian approach will be employed to analyse the issues involved. The process of medicalisation will be the main focus. More specifically, the impact of knowledge and power upon people's behaviour will be evaluated in terms of how the construction of 'kinds' of people develop (Hacking, 2006).

A suspicious attitude would see medicalisation as suggesting "something suspect when a problem is created or annexed, in whole or in part, by the apparatus of medicine", motivated by doctors "extending their empire" (Rose, 2007, p. 700). To have this malicious intention assumes that medicine is united and unanimously aiming for the same target, whatever that might be. Considering the fractured and disparate identity of medical sciences, this is unlikely. Instead, it will be argued, as does Rose that "medicine

[2] By this, I mean self harmers which are already medicalised in some way, through possessing a medical diagnosis such as depression or anxiety disorder. The clinical self harmers used in this study are self defined clinical self harmers, so see themselves as fitting what they see as a psychiatric classification.
[3] Emo self harmers will be defined in detail later. As this point, it is necessary to understand emo as a youth subculture which has particular styles of music and fashion, and is associated (rightly or wrongly) with self harm.

has had a profound effect on our forms of life: it has made us what we are" (2007, p. 700). This medical knowledge can alter how we experience ourselves and the world.

Foucault (1982) argues that the established scientific universals concerning human nature are constructed by society's upper strata (e.g. medicine, the state) and are consequences of society's ethical and political ideas. These ideas are codified, and then reflected and absorbed by the masses. This constructed medical knowledge, which is "presented as an objective, incontrovertible scientific discovery… [is] in fact the product of eminently questionable social and ethical commitments" (Gutting, 2008); medicine is not an ultimate truth, just the current, culturally-informed beliefs which are upheld by power relations. As self harm is an issue of moral contention, the imprint of these ethical commitments should be evident on the discourses surrounding the concept. It is this productive force that will be shown to subjectify self harmers into a system of relations. This understanding of power is taken from Foucault: power is a "productive network which runs through the whole social body, much more than as a negative instance whose function is repression" (Foucault, in Rabinow, 1986, p. 61). This understanding of power is much more than top-down, forcing certain behaviours and beliefs on to the masses, instead, this power regulates through self monitoring discipline. Furthermore, this power can transgress boundaries, it is productive and creates knowledge and discourses.

Reflecting Foucault's usual analysis on those at the periphery of society's relationship with the dominant bourgeoisie, self harming individuals[4] are an interesting and valid case which to apply these ideas; by studying self harming individuals we may more clearly see the expectations and beliefs of those who hold the power through their positions as generators of knowledge. Self harming individuals are at the periphery of society, marginalised and forced under the scrutiny of the medical gaze. However, there is evidence that the scientific, psychiatric and medical knowledge generated is not passively accepted by the classified 'self harmers'. Rather, this information is disputed, or appealed

[4] For our purposes, only those who identify themselves as someone who self harms will be discussed. There is a whole domain of body modifiers (see www.BMEzine.com for examples of this sub-culture) who are altering the skin they possess for aesthetic or hedonistic purposes. This groups relation to being categorised as 'self harmers' is worthy of further study, but is beyond the scope this thesis.

to, or used to structure their experiences, and impacts upon the way their experience themselves.

The body is a key place to witness the interaction of historical forces on a canvas that we assume to be natural and of which we assume to have an objective understanding. The body is seen to be objectifiable, and consistent through time, but historical analyses show that the perception and expectations of the body actually change. The body is the site where ideas and social reality cross; it is the point where objectivity and subjectivity cross:

> *We believe, in any event, that the body obeys the exclusive laws of physiology and that it escapes the influence of history, but this too is false. The body is molded by a great many distinct regimes; it is broken down by the rhythms of work, rest and holidays; it is poisoned by food or values, through eating habits or moral laws, it constructs resistances*. (Foucault, 1977, p. 87).

This is due to the objective and subjective capacities of the body that can reveal so much about society. It is for this reason that self harming behaviour – an act upon the body – is such an interesting study.

In the study of self harm as an evolving psychiatric category, we can see how the actions of the physical self are seen in terms of a mental or psychological problem. To translate an action on the body into a psychological issue is changing the description under which an act lies (see Anscombe, 1959; Hacking, 1995) and involves a leap across modalities. The way in which bodily acts are used to infer mental state is not new; indeed it is the subject of Foucault's genealogical analysis in *Madness and Civilisation* and *History of Sexuality* (1967, 1978) and in Hacking's *Rewriting the Soul* (1995).

Foucault's ideas are particularly important for this study. He explored ideas that medicine coerces individuals into becoming self regulating persons, disciplining themselves into complying with the categories applicable to them. Locating the normalising force within

the individuals removes the need for conspicuous force, and has an effect of homogenising deviances (there is a 'way' to be homosexual, there is a normal way to experience multiple personality, there are norms of being a self harmer) and confirming these categories. The process of medicalisation takes a social problem and defines it using medical rhetoric, enabling the powerful forces of scientific biomedicine to pathologize aspects of normal life, so as to describe, define and control beyond the legitimate biological boundary (Rose, 2007).

It is intended that this work will show the objectification of those classified as self harmers. According to Foucault, this objectification can occur in three ways: firstly, through "dividing practices", secondly through "scientific classification" and lastly through "subjectification" (Foucault, in Rabinow, (1986) pp. 7-11). Over the following pages, the dividing practices, scientific classification and subjectification will be made apparent in relation to self harming emos and clinical self harmers.

The second theoretical perspective that influences this thesis is Hacking. Hacking builds upon Foucault's work, arguing that knowledge has the power to shape the identity of individuals, creating 'kinds' of people, one of which is the psychiatric category of self harmers. As it will be proposed that self harming individuals are being forged into a kind of person -in the same way that multiple personality (Hacking, 1995) and the autistic child (Hacking, 2006) were made into types of people- it is necessary to explain the basis of Hacking's theory.

Hacking believes that 'kinds' of people can come into existence, in a type of "dynamic nominalism" (ibid, p. 3). By this, he means that through the creation, but more importantly the co-evolution of the name through its interaction with the labelled group (c.f. Wittgenstein's, nominalism). Hacking argues that the sciences can create a new type of person: a new way for someone to be understood, and a new way of experiencing oneself through this label (ibid, p. 6). Casting people into moulds enables them to be under the medical gaze, so knowledge can be generated to control, help, organise understand and emulate (ibid, p. 2). In a three-way co-dependent cycle, the classification

– in our case, self harm – affects the individual's understanding of self harm, which in turn alters their behaviour, and leads to a shift in the way the classification is understood, and the cycle continuing. It is from this framework that those classified as self harmers will be explored. Hacking's dynamic nominalism theory will be considered as a basic framework from which to understand the emergence and evolution of self identified self harmers.

Throughout this thesis, it is intended that the body as a symbolic site will be maintained as a theme; how we possess, and control and perform in our bodies is symbolic of our relationship with ourselves and society. Our bodies are the site of the performance of identity: the "body as a method of self-expression" (Crozier, unpublished, p. 12). As our experiences of our own bodies are affected by how our selves are socially constructed, (Rose, 2007) our behaviours and the performance of identity will be both a communication to others and a reflection of how we see society's perception of us.

This research will be conducted on online discussion boards. Over the last decade, digital media has become commonplace and prevalent, becoming increasingly accessible to a wide range of individuals and institutions, and consequently, the internet has become another location to observe social interaction (Ito *et al.*, 2008, p. *vii*). Not only is internet media present in everyday life, but it has also affected "how we engage in knowledge production, communication, and creative expression" (ibid). These new ways of connecting with others in a digital dimension can therefore be subjected to analysis as validly as any other social communication. As language is still the predominant communication online (bolstered with emoticons and profile pictures) is it suitable to analyse the discourses, which are shown in the linguistic choices. Forums have been used as data for many studies investigating identity (see Buckingham, 2008, for a collection of research based using internet sites). Much more similar to this thesis is Dias' work on the discourses present on pro ana sites (Dias, 2003), where this online community was investigated in relation to pro-anorexia sites, medical and psychiatric discourses.

Aims and Motivations for Research

In the course of this work, the historical development of this new type of person will be plotted from its beginning as a form of failed suicide to the modern medical understanding of self harm as being a symptom of mental disorders. In contrast to the official definition of self harm, the meaning of self harm as used by the self labelled self harm groups will be evaluated, with attention to how they use, understand, negotiate and use self harm as a category will be studied as an aspect of their identity(in relation to Hacking's looping effect (2006)). How self harmers relate to medical treatment (in terms of how they see themselves, how they uphold/resist a medical understanding of themselves and their experiences, how they perform a medicalised identity) and personnel, and the theme of concealment will also be discussed.

Psychiatric journal articles will be used to assess how current professionals locate self harm in psychiatric space and plot its development over time. The grassroots' understanding of self harm will be analysed from two contrasting perspectives. The first group consists of clinical patients (typically those who have been diagnosed as having mental illnesses, and are or have been receiving a form of treatment) who are participating on either the National Self Harm Network[5] (henceforth shortened to NSHN) or the self harm page of the Mental Health Forum[6] (NHF). It will be assumed that members posting on the boards of these sites identify themselves as someone who self harms. In contrast to self harm in a clinical sphere, the postings of 'emo-kids' will also be subject to analysis.

Emo is a well recognised youth sub-culture (see Frean, 2004; Frith, 2009; Skenker, 2009 for recent reports on emo culture), which is characterised by "overt demonstrations of emotions, feeling misunderstood and self harming behaviour" (Scott & Chur-Hansen, 2008, p. 360) and which have an identifiable style of clothes, music and behaviours (ibid, p. 361). Emo sub-culture is widely assumes to endorse self indulgent melancholy,

[5] http://www.nshn.co.uk
[6] http://www.mentalhealthforum.net/forum/forumdisplay.php?f=29

glamorises disturbed sleeping patterns, and promotes internal angst[7] (Greenwald, 2003; Simon & Kelley, 2007). The online discussion forums that will be used are taken from Emo Bucket website[8] and Virtual Teen forum[9] (shortened to EB and VT respectively).

A possible objection to my methods could be based upon the arguments concerning the relationship between the 'online' and the 'offline' self. Despite the opportunity to present a character, Robinson found that those who portray themselves online "do not seek to transcend the most fundamental aspects of their offline selves" (2007, p. 94), as for most users of the web, the internet "enhances, extends, and supplements what they do offline" (Rainie, 2004, *xiii*). So, it can generally be assumed that the opinions expressed online are in effect a representation of what these groups say outside of the internet forum, and as such, a satisfactory way to evaluate the power involved in the medicalisation of the subject. Furthermore, as the use of the internet to communicate socially has increased rapidly with the invention and popularity of Twitter, MySpace, blogs Facebook and discussion forums – it is assumed that this communication is equally valid for analysis as speech.

Furthermore, it is assumed that the clinical groups and the emo groups each have a collective identity, and that within these groups there are shared common ideas concerning self harm and mental health. It is also assumed that neither of these collectives are isolated, that they are aware of each other, the wider views of society and psychiatry on self harm.

Methods and Ethics

In this research, four online forums will be analysed for thematic content concerning power relations and conceptions of self harm. Two clinical discussion boards will be

[7] It is not unnoticed that the stereotypical behaviours are not dissimilar to the Diagnostic and Statistical Manual -iv (APA,1994) criteria for major depressive disorder.
[8] http://forum.emobucket.com
[9] http://www.virtualteen.org/forums/forumdisplay.php?s=&daysprune=&f=5

investigated (NSHN and MHF) as will two emo sites (VT and EB). Any new threads posted between the first and the 14th of June will be subject to analysis. Content, in terms of conceptual ideas, language, common themes and features, of the online text will be reduces to key themes, which will be written and evaluated in detail. Other aspects of the forums will be neglected, such as profile pictures, signoff slogan and screen names used by the users, as well as the use of emoticons and images, and the web layout of the site. All this data is potentially rich, but it is outside the scope of this research.

There is one methodological limitation to this investigation. Due to ethical guidelines imposed by the British Psychological Society policy, no direct quotes can be used. These ethical concerns stem from an expectation of privacy that may be present when writing to a forum audience. If an individual posts on a forum with the intention that only other forum readers have access to it, then to quote this use without his/her prior consent is unethical. Due to this, only public forums have been used: no passwords or logins were required to access the information; all quotes in this work are paraphrases resulting in the actual poster being anonymous.

Section I: Historical Development of the Concept of Self Harm

In this section, the development of the concept self harm will be explored. Concepts are not universal; they come into existence, change meanings and eventually become obsolete. Self harming behaviour may have always existed, in some form or another, but the 'kind' of people with which we now associate with self harm is a recent development. Self harm's birth and evolution will be followed historically from the 1950s until the present. The act of 'making up people' (Hacking, 2006) will be seen in the psychiatric literature, in the survivor and clinical self harm movement and the rival third perspective of emo self harmers. These three ways of looking at self harm has formed discourses that have produced a general image of what self harm, and a self harmer, is.

Self harm has emerged out of the discourses on suicide. It used to be the case that acts of self harm were seen as mini-suicides, and as suicides used to be an issue for criminal courts and religious burial rites, the chief authority used to be religious or legal. It is now firmly in the territory of psychiatric medicine, which has identified itself as the source of generated knowledge on self harm. Furthermore, the general public also link self harm with mental illness, relying on medical knowledge to provide explanations and treatments. Because medicine's power is due to its claim to universality, it was necessary for medical professional to associate self harm with psychiatric illness in order to be the dominant authority on self harm. Self harm gradually formed as a branch of suicide, and split off due to changing discourses. Suicide became a psychiatric issue before it was de-criminalised in the UK, (Neeleman, 2007). After psychiatry became the dominant discourse concerning suicide, psychiatry also held power over subsumed categories, in this case self harm. In the following pages, the process of making up the category of self harm is delineated from its origins in suicide. The negotiation of a new category will form the contemporary understanding on self harm.

Before the introduction of the Suicide Act 1961, suicide and attempted suicide were illegal in England and Wales. Despite this strong legal discourse, the medical sphere has been medicalising suicide for a long time, potentially as early as the 1830s (Hacking,

2006). Whether suicide was considered evil, wrong or the result of illness was the due to boundary work between these authorities, and, as time has shown, medicine gained dominance.

In the 1950s, current understanding of self harm was very different to the contemporary understanding, but the idea that there was a behaviour which looked like a failed suicide, but which was different to a failed suicide began to emerge (Stengel, 1952). It is in this space where the category of self harm will develop. This division was based on the grounds that a failed suicide necessarily had to have a genuine intention to kill oneself, and merely by accidental chance did the suicide remain uncompleted. A suicide attempt had to have the intention of self destruction (1952, p. 613); Stengel acknowledged that there was something which could be called an insincere suicide, and the difference between this and an unsuccessful suicide was the "level of mental commitment" (1952, p. 617). Not only is there a difference, but this difference creates two different groups of people, with different norms, intentions and thought patterns. Published medical knowledge at this time creates the typical self harmer as being: single (i.e. unattached, divorced or widowed), emotionally frail, more often than not having a prior mental condition, and likely to complete suicide in the future (Stengel, 1952, pp. 616-617). These are the first norms of the self harming person.

Despite creating a linguistic paradox[10], Stengel then proposes a continuum of suicide attempts, ranging from failed suicide to mild suicide attempts. There is an anomalous situation that does not fit into this spectrum: insincere suicide attempts which accidentally result in suicide (Stengel, 1952, p. 618). Obviously, it is impossible to know what the intention was in this case, but it is a case to be considered when reviewing statistics.

To distinguish failed suicide from ambivalent suicide attempt Stengel sets out these distinctions:

[10] If suicide is by definition an intention to self destruct, then to have a weaker form of self destruction is no longer destruction, destruction is reduced to damage.

> *It becomes obvious that self-destruction cannot be the main and only purpose of the suicidal attempt. The self injury in most attempted suicides, however genuine, is insufficient to bring about death, and the attempts are made in a setting that makes the intervention of others possible, probable, or even inevitable*. (1952, p. 22).

The division between suicide and this attempted suicide (with ambivalent intention) is decided through the purpose of the act. Therefore, instead of an intention to self destruct, the intention is a communication of distress, or to create a social intervention. This more functional interpretation of attempted suicide is a radical departure from the religious or legal understanding of the time (remembering that when this was published the Suicide Act of 1961 was still in place). This intention is estimated using the context surrounding the self harm.

In 1959, Lennard-Jones and Asher proposed another term to distinguish attempted suicide from failed suicide. Using the terms "doubtful pseudocide" and "spurious suicides" – where doubtful suicides are "gambling with death", while spurious suicides "never meant to kill themselves" – they created fragment within the continuum (1959, p. 1138). This further segmentation of pseudocide reveals the extend to which boundaries are arbitrary and negotiable: the demarcation of the continuum into categories and subcategories shows how psychiatric medicine is using persuasive rhetoric to define and medicalised a "suicidal performance" as a demonstration of distress (Lennard-Jones & Asher, 1959). Removing the suicidal intention is a further development to the self harm category.

Due to complications with pseudo-homicide, or its spoken similarity to suicide, pseudocide was only used in the literature for a short time. After this, there was a reversion to the original term of attempted suicide, and in the mid 1960s, the concept of attempted suicide really formed its own identity; more terms, definitions and statistical measurements were added to the attempted suicide knowledge base. At the same time as these new knowledges were being formed, the approach to self harming episodes takes a functional turn. Instead of the individual's psychiatric state being the focus, the attention

is turned to the social consequences. Self harming behaviours are still very much associated with mental illness, but theories of social manipulation start to be seen in the literature (e.g. Stengel & Cooke, 1958). As Batchelor and Napier wrote: "their suicidal attempts had compelled the attention of others to the seriousness of their sickness, and had this facilitated more effective treatment" (1954, p. 264). Lennard –Jones and Asher imply that it is a "hysterical gesture" an intense distress that cannot be communicated with words (1959, p. 1140).

As the manifestation of a suicidal performance, self harm is subject to fashions and norms, but in whatever form it takes, attempted suicide was seen as a social demonstration of a severe state of mind, and its potency comes from attempted suicide being so closely associated with failed suicide. So, regardless of it being poisoning, overdosing or the modern incarnation of cutting, at this point in the literature attempted suicide was seen as a method of facilitating a social response, as in the example above, such as treatment.

The behaviour of attempted suicide (still in Stengel's use of not failed suicide) was construed as being socially manipulative; there was a sense that if it was not a sincere attempt, then it therefore must be feigned (see *The Lancet*, 1965). Moreover, if it is feigned, then "these acts of self-damage tend to be regarded as purely demonstrative and manipulative" (*British Medical Journal,* 1965, p. 1322). It seems that the pendulum has swung back the other way; instead of being almost synonymous with failed suicide (indeed, as seen as part of the same continuum), it is seen as being almost theatrical, purely a way of "generating concern" (*Lancet*, 1974, p. 936). Not all research was this cynical, this understanding was seen by some to be a double edged sword, there is concern that attempted suicides will lack impact if seen as mere theatrics, which could result in more dramatic and risky acts (Aitken, Buglass & Krietman, 1969, p. 115). The professional psychiatric attitude to self harming behaviour was still very much in flux.

Other changes to the psychiatric understanding in the mid 1960s included Kessel's proposal to replace attempted suicide with "self poisoning" or "self injury" (1965). This

alternative term was recommended on the grounds that reference to suicide was a misleading term, and alluded to failed suicide rather than Stengel's attempted suicides. The issue of failed rather than attempted suicide is an issue that haunts the literature. This did not receive unanimous support, an anonymous article in the *British Medical Journal* responded:

> *The literature on suicidal acts has been bedevilled by semantic confusion. Until recently the term suicide was often used for both the fatal and the non-fatal act. The necessity to distinguish between the two has in recent years been accepted. Now Professor Kessel proposes to drop 'attempted suicide' and speak of 'self-poisoning' or 'self-injury' instead. But 'self-poisoning' is apt to lead to new confusion because most people when told that a person has poisoned himself will think that he is dead. Certainly, 'attempted suicide' is not a good term either, for it sounds too rational and suggests a planned effort, but it does refer to the self-destructive component of the act and the risk in the individual runs in taking a poison the effect of which he is unable to judge*. (1965, p. 1323).

In this extract, it can be seen that the contemporary issues that surround self harming behaviour are being discussed. It demonstrates how precision is needed to distinguish the range between failed suicide and mild self harm, but that the terms which psychiatry insists upon using are unsuitable. Kessel's proposed "self poisoning" also reflects the contemporary trend of overdosing on barbiturates – and does not classify the behaviour in abstract terms (unlike self harm, or self injury, it refers to a mode of self harm) creating a problem when other methods of self harm become more common. But the more abstracted attempted suicide was not satisfactory either: in Aiken *et al*. (1969), all references to attempted suicide are surrounded with quote marks, implying that it is not the usual denotation that is to be read and that there is no suitable alternative.

The development of self harm as a category has so far been convoluted. It appears that there is a group of people that are different to those who fail suicide, and this group (with

shifting names and identified characteristics) is still attached to the suicide label, but also seen as separate. Hill (1969) set a new precedent: he used "self harm" as coterminous with Stengel's use of suicide attempt. Hill acknowledged that it "is difficult to estimate the significance of an attempt at self harm, [so] an arbitrary decision was made to include only those attempts mentioned in the in-patient summary […this] must result in excluding minor suicidal attempts…" (1969, p. 301). In this extract, we can still see that there is a continuum of suicide attempts, one end of which is suicide and the other is what will become self harm as we now know it. The oxymoronic "minor suicide attempt" is the dominant psychiatric terminology in the 1960s. It is also here where we see this selecting bias; only using in-patient records will bias the sample used in psychiatric research.

Keeping with this chronology, the next major development was in 1970, when Birtchnell separates attempted suicide from threatened or contemplated suicide:

> *Suicidal attempt has been taken as a definite and determined attempt to harm oneself. The act must be been initiated, but life need not have been endangered. Suicidal contemplation or threat must have involved reference to the suicidal act, though it need not imply serious intent.* (1970, p.308).

This attempt at creating a new sub-category, that of "threatening suicide" never caught on as a psychiatric category, but did impact upon the way that self harm was later understood. Those that threatened suicide were counted and correlated with later completed suicides, and this self harming behaviour was used to predict later attempts. This relationship is still assumed in today's psychiatric journals (as in Hawton, Zahl & Weatherall, 2003).

A change to the nomenclature of attempted suicide was proposed and later defended by Kreitman, Philip, Greer and Bagley in two letters to the *British Journal of Psychiatry*

(1969; 1970). These two texts elaborate on the arguments put forward against Kessel's self poisoning diagnostic category and also against the continued use of attempted suicide as a term, presenting 'parasuicide' as a solution to these problems. He used parasuicide as a better term to indicate the concept of failed suicide. Despite initial oppositions (Merskey, 1969; Stengel, 1970), parasuicide had some impact, in the *British Journal of Psychiatry* alone there are close to 300 articles referencing parasuicide (compared to just two articles related to the earlier pseudocide). One of the perceived advantages of parasuicide was that it could incorporate both self poisoning and self injury cases. This shows that psychiatric medicine were willing to group these two behaviours together, as linked with a single disorder; drawing the boundary around these two groups. By labelling these two under the same term, allows the new category of self harmer to begin, it is no longer only understood in relation to suicide, nor to the behaviour, but to something else. Indeed, to confirm this new group, in 1974, White renames this same category "intentional self harm". Simultaneous to the re-naming, the causes and motivations changed: research articles focus on the 'escape' aspect, rather than the functional or psychotic explanations.

The first use of intentional self harm was defined as being "a hasty, ill considered escape activity" (White, 1974p. 33), and those who resorted to self harm were having an "acute emotional upheaval, a background of normal developments, precipitated by problems, usually temporary, of the sort that appear particularly intense to the adolescent" (ibid, p.27). White also tried to separate intentional self-harm from any connotations of suicide, the first sign of discrete type of person in the psychiatric literature. White was incredibly influential on the development of self harm, in this paper, he almost suggests that it is an extreme stage of normal development. Now, the understanding of the typical demographic details of the typical self harmers increases. The usual self harmer has "a great deal of social pathology" (Kennedy and Norman, 1973), has personality problems (*Lancet,* 1974), and is usually a teenager, from the lower classes, with poorer educational background, and a disturbed family unit, and statistically more likely to be from an ethnic minority (White, 1974). As this concept of self harm becomes more established, more

details concerning the characteristics of a self harmer are circulated, and form scientific knowledge (Hacking, 2006).

Following White's precedent Morgan, Pocock and Pottle (1974) tried to "avoid deficiencies inherent in current terminology such as attempted suicide, self-injury or self-poisoning" by using "deliberate self-harm as a useful alternative which is sufficiently general in meaning yet free from implied motive" (p. 606). They defined deliberate self harm as "deliberate non-fatal act, […] done in the knowledge that it was potentially harmful" (ibid, p. 320). This definition did not last long, a year later, the same authors (with some additions) altered their definition, to include a theme that self harm could be a recurrent disorder "an act of deliberate self harm is in many cases a symptom of continuing disorder rather than a turning point in a patient's life" (Morgan, Barton, Pottle, Pocock, Burns-Cox, 1976, p. 366). It was at this point in the literature when self harm became considered as a maladaptive behaviour, an attitude that is still upheld by the grassroots today.

In Morgan *et al.* (1976), the continuum between attempted suicide and demonstrative attempts was divided into three types: personal, interpersonal and social. Personal reasons include a genuine intention to commit suicide or alleviate suffering, interpersonal motives were attempts to influence others or to communicate distress, and social motives were those which try to "influence a particular aspect of his social situation" (p. 367). These three levels of motives recognise the subjective nature of self harming behaviours; it is only the psychiatric belief of the proponent's intention that distinguishes them from each other. This is a clear claim of territory, in this situation the only person with the authority to classify someone as a self harmer is a professional in psychiatric medicine.

The next big alternations in the evolution of self harm as a concept happened in 1986 and 1988, when the creation of two 'survivor' activists groups occurred (Cresswell, 2005). These two pressure groups (Survivors Speak Out, and Bristol Crisis Centre for Women) were formed to provide a support network and to improve the treatment given to self harm patient in accident and emergency units. The label 'survivor' was a crucial change,

according to Cresswell (2005), this was the first time survivor had been used rather than 'patient' or 'ex-patient'. Survivors are so labelled because they "have survived an ostensibly helping system which places major obstacles in our path to self-determination" (Campbell, 1992, p. 117). More than any other change, these survivor activists wanted to have an active role in their health, to be able to control, possess authority and to have self-advocacy over their 'constitutional' rights. What this is really asking –when it is remembered *who* is requesting this – is for those who are classed as mentally ill to be granted autonomy and authority over their bodies on the grounds of experience. The members of this movement clearly did not see themselves as mentally ill: independent self harmer survivor conferences were held, (*Asylum*, 1989, pp.16-17). This open challenge to the psychiatric literature attempted to claim initiative and control over self harm, and use a definition that the self harmers were satisfied with, without need for a psychiatric label. This resistance to the psychiatric label works through generating a new discourse originating from new institutions. This is exactly the counter actions to which Hacking refers (2006). Through conflicting classifications, experts, institutions and knowledges, the meaning of self harm is negotiated between psychiatric medicine and survivors (Hacking, 2006, p. 5).

One of the most lucid self presentations of survivor concepts of self harm was spoken at the 1989 conference, where Maggy Ross' speech (as reported in Cresswell, 2005) declares who she is, why she self harms and how medicine misunderstands her:

> *I'm Maggy and I started to cut my body 5 years ago. I go to casualty and get hauled onto the psychiatric bandwagon. I am then given a nice little 'label'. The current label is Schizophrenia. That's how the professionals see me. I'm a self destructive Schizophrenic. But how to I see myself? I am survivor of sexual abuse and a survivor of the system. I know why I self injure. When I feel I am losing control, I reach for a razor and prove to myself that I can have control over my body. When I am lost for words, my cuts speak for me. They say – look – this is how much I am hurting inside… I'll tell you what self injury isn't – and professionals take note. It's not attention seeking. It's not a suicide attempt. So*

> *what is it? It's a silent scream. It's a visual manifestation of extreme distress. Those of use who self injure carry our emotional scars on our bodies.* (Pembroke, 1994, pp.13-15).

Despite Maggie claiming she is misunderstood, she uses the same tropes as medical discourse to describe herself. The way in which these survivors understand self harm is not very different to the psychiatric theories: the communication of distress, and the initiation of help, are both given by Morgan *et al*. (1976). So the only real argument is over the medicalisation of (what both groups agree on being) extreme emotional distress. Psychiatric professionals see these emotions as being abnormal and needing regulation, while survivors do not see the emotional disturbances as needing medical control. The effects of self harm scars are the reason why the self harm community came under the medical gaze, but the real argument is not about cutting yourself; it is about the limits of pathological emotions, and the way you handle these emotions being classified as a psychiatric concern.

The survivor movement can be seen as a second wave anti-psychiatry movement, initiated from the grassroots and missing the academic force of Laing (e.g. 1960) or Szasz (1960). The original anti-psychiatry movement challenged the use of medications and the existence of mental illnesses, Laing famously argued that schizophrenia is a consequence of hyper-reality (Laing, 1960). Survivors created a community of sharing experiences, especially of misdiagnoses and maltreatment, which resulted in the intensification of the evangelical fury of the lobbying campaigns, resulting in changes in NHS policy and a written declaration of rights (Cohen, 1998).

So far, two different groups have been portrayed as contributing to the knowledge on self harm. The psychiatric discourse has been plotted from its beginning in the 1950s until its clash with the second force of survivors. These survivors generated knowledge from their experience, rather than the scientific method. Due to survivors campaigning, later research has worked with the self harmer to create new knowledge (e.g. Fortune, Sinclair & Hawton, 2008; Laye-Gindhu & Schonert-Reichl 2005; Scoliers *et al.* 2008). It is these

interactions which propel the looping effect, the labelled engage with the category, and by doing so, alter how the classification is understood.

The second phase of research (i.e. post survivor activism) has narrowed its focus: there are hardly any mentions of mental disorders, and instead the focus is on predictors of self harm, and on self harm as a predictor (Hawton and Fagg, 1998). As such, self harm is not necessarily seen as a mental disorder, but rather linked with identities and being a type of person. Through this development of the psychiatric literature, what it is to be a self harmer has become more complex, and associated with certain traits (the typical age, sex, class, etc) have become more known, and the next medical research focuses on this group, creating a more narrow definition, and generating knowledge about this group. This shows that there are characteristics that are granted as being essential in this group of people, so much so that Haw, Hawton, Houston and Townsend (2001) argued that the self harm population might have changed since the 1970s.

However, this further research does not mean that there is a common understanding of self harm. In 1997, the World Health Organisation defined self harm (or in their terms, deliberate self harm) as being an act which has a non fatal outcome, which was deliberately initiated, with the intention of "realising changes that the person desires via the actual or expected physical consequences", and which is not considered an habitual behaviour (Platt *et al.* 1992, p. 98). The additional clause of not being a habitual behaviour is interesting, not only does it rule out alcoholism, smoking, and rituals, it also omits routine self harm which self harmers may use. This excludes habitual self harming practices, implying that only sporadic cases of self harm are to be considered medically.

It is necessary to discuss Favazza's *Bodies Under Siege* (1996), in which he compares 'self mutilation' as a psychiatric category to social rituals in other cultures. He uses ethnographic sources to show that self harm (rather than a sign of a mental disorder) is a display of the mind dominating the body. This comparison between clinical patients and small scale societies is highly insulting to the cultures used, although it does highlight the social sanctioning of some self harm behaviours. Favazza (1996) used self mutilation and body modification to stress a qualitative gap between these acts and failed suicide. This

appears to be boundary work in action, by proposing that there is at least a type of self harming behaviour which is not indicative of any mental distress, it can be expounded that self harm does not necessarily have to have an underlying mental disorder: “the deliberate destruction or alteration of one’s body tissue without suicidal intent. There are no necessary negative connotations.” (p.*xiix,* 1996).

As he wrote it as a cultural studies text, Favazza’s work has had only a slight impact on psychiatric literature. He influenced Webb and Turp (both 2002), who are both on the margins of serious psychiatric medicine. Both Turp and Webb argue that (in Favazza’s terms) self mutilating behaviour can be adaptive, it “can be a coping strategy in anxiety and is a protective element against suicide” (Webb, 2002, p. 236). By arguing that self mutilation can be preventative of suicide, Webb reverses all of the assumptions of previous research where self harm was used an as precursor to suicide. She does maintain that self harm (as opposed to self mutilation) is part of the failed suicide continuum, but fails to point to a distinguishing feature between self harm and self mutilation. Webb’s addition to the knowledge concerning self harm has merely muddled and further fractured an already complicated concept.

This issue of unanimous understanding is not aided by Turp (2002), who has an alternative conception of self harm. She places self harm on a spectrum from failed suicide to good enough self care. Due to this extended scale, it is possible to cause self harm by omission, such as anorexia or neglecting medication. In addition to this, to be considered self harming behaviour, it must transgress a cultural expectation. Turp’s definition is the only one that can come over the problem of smoking and piercing as being literally self harming behaviours and ones that do not provoke clinical concern, allowing psychiatric medicine to create universal ‘laws’.

Glossing over these mavericks for the time being, the definition of self harm is still an issue. In some papers an operational definition was conspicuously absent (e.g. Owen, Horrocks & House, 2002). This could either indicate they believe that a satisfactory working definition has been unanimously agreed upon, or alternatively, that they are not

sure how to conceptualise self harm, especially in relation to their international review. There have been other attempts to avoid the issue of definition of self harm, for example:

> *Self harm includes non-fatal self poisoning and self injury. The former is defined as the intentional self-administration of more than the prescribed dose of any drug, whether or not there is evidence that the act was intended to cause self harm. It also includes poisoning by non-ingestible substances and gas, provided that the hospital staff consider these are cases of deliberate self harm. Self injury is defined as any injury recognised by hospital staff as being self inflicted.* (Zahl & Hawton, 2004, p. 70).

In Zahl and Hawton, it suggests that it is the subjective opinion of the medical staff whether a case is to be considered. This is a circular argument, the medical definition of self harm on what ever medical professionals consider self harm to be. In some ways this has brought the advocacy which the survivors demanded; if a case can persuade the medical professionals that they need no mental health treatment, then presumably they are not labelled with a mental health label (other than that of self harm).

The development of the classification does not end there. Further precedent has been set with more recent research. Studies focus on the teenage prevalence rates, on associated links with family break ups, disturbed friendship groups (Moses, 2009), on the mixed intentions and communications of self harm (Scoliers *et al.*, 2008), and on the media's influence in causing and preventing self harm. This all contributes to building a more detailed picture of what and who a self harmer is. Due to the impact of the survivor movement (and a more 'customer centred' heath system), research is asking teenagers and self harmers how they understand self harm, and how they recommend dealing with it (Fortune, Sinclair, and Hawton, 2008). In some respects, research is asking the self harmers and the public how they think self harm should be understood (Collins and Evans, 2002). It is in these ways which the classified can affect their classification; they have direct influence on how they are made up.

It is worth reviewing at this point how far the medical nomenclature has changed. Self harm evolved due to the fracturing of the concept of suicide, and was taken into the psychiatric realm. Not only has the terminology changed since the 1950s, the meaning, connotations and definition has changed: from seeing all acts which appear like suicide as being attempted suicide, there are now degrees of suicidal intent. From having only one interpretation –an intention to kill oneself – there are now multiple (including social manipulation and maladaptive escape strategies) purposes of self harm. The question of who has the ability to apply this label (professional psychiatrists or the self harmers) and generate knowledge is a conflict which is still ongoing. These themes will continues into the next two sections.

Part II: Investigating Clinical Self Harmers Relationship with the Concept of Self Harm

In this section, the relations between the contemporary psychiatric understanding and self defined clinical self harmers will be discussed. The evidence presented will illustrate Hacking's looping effect (2006). It is a limitation of Hacking work that few examples are used; it is intended that this research will bolster his theory. To conduct these analyses, NSHN and MHF discussion boards between the first and the 14th of June were analysed. As stated before, no direct quotes can be used for ethical reasons, but evidence to support Hacking's theory shall be provided in footnotes. All statements contained in quote marks are indicative of paraphrased posts. The content will be looked at terms of discourses, and four selected themes will be discussed: relationship to clinical concepts, self presentation, treatment regimes and concealment.

At this point it is necessary to say that people are not homogenous, nor do groups of people have 'essences', but what is important to realise is that we *treat* people as if they possess metaphysical essences, which unite a group under a common identity (Hacking, 2006, p.14). So, by no means are clinical self harm patients identical, but we think about them in terms of an archetypal model of the self harmer; any selected case could hold an position in radial relation to the typical, central model of self harm (Hacking, 1995, p. 32; Rosch, 1975). These categories are known by both those within and outside of the flexible defining border, and presumably self defined self harmers have an idea as to their relative position to the centre model. And, depending on their behaviour within certain contexts, their proximity to the epitome of self harm will alter: while using an online self harm forum the facet of their identity concerning self harm will become more prominent, when moving house, or commuting to work, or applying for a bank loan, their self harm identity is out of focus. So, clinical self harm identity is not necessarily pervasive over all of life. However, there is still much to be said about the common attitudes and understandings that this group of people possess, how this knowledge was generated and how the power relationships are constructed.

As it has been shown, a self harmer as a type of person has only been formed recently. Before the late twentieth century, self harming behaviour was seen as an indicator of suicide. It is only recently that the expectations and norms of self harmers have been created. These norms are created by the scientific investigation of this type of person, through medicine's application of statistics. Hacking (2006, p.10) suggests 'ten engines of discovery': counting, quantifying, creating norms, correlating, medicalising, biologising, geneticising, bureaucratising, and reclaiming identity[11].

The current medical discourses surrounding self harm (as described in the previous section) has been engaged with by clinical self harmers. The ideas used by medicine to define and explain self harm as a psychiatric category are reflected in the language used on the self harm websites[12]. In these online discussion forums, individuals refer to themselves using the medical classifications, define themselves as being clinically depressive or as having an anxiety disorder[13], they label themselves in term of psychiatric categories which can be used as heuristics for other readers to use. Some postings on the discussion boards use the same language not only to classify themselves, but also to describe their experiences. For one forum user, her self harming behaviour is a "symptom of stress" and "a frequent precursor to a dissociative phase"[14]. She shows evidence of being embedded in the medical sphere: the two categories she chooses to refer to -that is to say, dissociation and stress- are the two locations in which self harm is indexed in the DSM-iv (APA, 1994). This is an example of her expressing her own experiences through a medical lens: the language she uses is framed in terms of medical knowledge, and furthermore, she assumes that the readers of her post are familiar with this language.

[11] Hacking goes into some detail about what these engines are, and what the consequences of the engines are. However there is not enough space here to go into the depth which these engines deserve, so it is recommended that Hacking (2006) is read.
[12] The two forums which are being used to analyse clinical self harm attitudes are: the National Self Harm Network forum:
http://www.nshn.co.uk/forum/index.php?PHPSESSID=a3a4425997fb53c0611d09a8688e697b&board=5.0
and the self harm branch of the Mental Health forum:
http://www.mentalhealthforum.net/forum/forumdisplay.php?f=29
[13] See post #1, http://www.nshn.co.uk/forum/index.php?topic=50276.0
[14] See post #2, http://www.mentalhealthforum.net/forum/showthread.php?t=4998

It is not unusual for a new post to begin with a rough profile of who is posting, typically how long they have been self harming, the time elapsed since they last harmed, and frequently, what diagnosis they are under and what medication they are taking. Blunt confessions such as "I have diagnosed depression"[15] or I am on the "half max dose of Sertraline[16] for OCD"[17] display the medicalised way in which these individuals see themselves and the way in which they expect others to see them. As these users are presenting themselves as medical case studies, this highlights the extent to which medical science has shaped how clinical self harmers understand themselves. This demonstrates the full effect of making up people, these clinical self harmers relate to others through a medical label. As they express themselves in terms of medical categories, and experience themselves through this classification, it shows an internalisation of the medical discourse.

Not all clinical self harm forum users are so comfortable introducing themselves according to their diagnoses. Some individuals are somewhat ambivalent towards their category. In one post, a forum user stated how it would take time to accept his medical condition as an integral and internal part of himself[18]. This remark is indicative of two simultaneous ideas. Firstly, it assumes that medicine is irrefutable; that psychological measures taken reflect an irresistible internal condition that truly exists. Secondly, this poster assumes that it is necessary for him to come to terms with this diagnosis, and the ambivalence towards being medicalised is temporary. It is also worth observing that despite not being at ease with accepting his mental illness as part of himself, he expects that others would want this information. Only through a medical frame does he present himself to other people. This example illustrates the impact of medicine, this labelled individual feels the pull of his diagnosis, and adheres to medical knowledge knowing him more than he knows himself. As power is constituted of systems of relations, we can see that this individual is tied to a medical category, even if he tries to refute it.

[15] See post #8 , http://www.nshn.co.uk/forum/index.php?topic=49961.0
[16] Sertraline is a Selective Serotonin Reuptake Inhibitor type antidepressant that is also prescribed for obsessive compulsive disorder.
[17] See post #8, http://www.nshn.co.uk/forum/index.php?topic=49763.0
[18] See post #12, http://www.mentalhealthforum.net/forum/showthread.php?t=5044

This population's relates to medical knowledge in a way which demonstrates Foucault's model of power. Clinical self harmers' understanding of self harm as a psychiatric category has engaged with and is congruent with the medical understanding. However, this is not a one-way process, both the psychiatrists and the patients they work with affect each other's ideas. Due to dissemination of knowledge through conferences, publications, and discussion forums it is not surprising that these transferred concepts rapidly evolve. The self defined clinical patients tend to see self harming behaviours as indicative of internal, emotional distress, a pressure that cannot be communicated or released through normal means[19]: the same ideas that are frequent in psychiatric research. Interestingly, in the same way that issues of pain, the physical consequences of self harm and the corporeality of the subject are absent from psychiatric journals, so are these omitted from the online forums. The missing body is replaced with a hyper conspicuous discussion of embodied emotions, tapping into discourses about internal pain being expressed in the physical experience of self harming.

The comprehension of emotion that is used by clinical self harmers uses a hydraulic metaphor, stemming from Freudian themes (Freud, 1963). Freud was influenced by Helmholtz's theory of closed systems and conservation of energy, and saw the psychic energy within each person's mind as subject to the forces and tensions which can be understood (and thereby controlled) using the principles of catharsis, cathexis and sublimation (1963, pp.10, 32 & 80). Catharsis is the act of expressing internal tension with the aim of releasing tensions. Cathexis is the investment of emotional energy into another person or object, and as such is not as relevant to the purposes of this research. Sublimation and other defence mechanisms are an attempt by the unconscious to protect the fragile ego (1963, p73). It is apparent in the language through the way that users of the self harm forums discuss their understanding of self harm, that Freud's ideas are still prevalent: Freud's impact has lasted longer in the public understanding of psychiatric medicine than the scientific world would like to admit.

[19] See post #2, http://www.mentalhealthforum.net/forum/showthread.php?t=5055

Frequently, users of the NSHN and MHF talk about 'releasing pressures' and self harm being a 'coping mechanism' which can express internal conflict and thoughts[20]. Obviously, this Freudian understanding of emotions as the hydraulics within a closed system is outdated, yet despite this, as a metaphor it is still used, especially in defending self harm as a 'coping strategy', an idea with more than a passing similarity to a Freudian defence mechanism of sublimation (changing a negative outward force into –in this case- inward facing negative force).

Another feature which maintains the Freudian understanding of psychiatry are what the clinical self harmers call "urges"[21]. According to the popular psychology, these urges are wishes, desires or appealing thoughts to self harm which originate in an unconscious source. Urges are internal and tidal: they are not a constant force, but instead are seen as a destructive and unpredictable power that intends to overcome their will[22]. Urges are seen as something that you have to fight against. In addition, the methods that are circulated to combat this self-destructive streak are modern elaborations on defence mechanisms, such as 'sublimation' and 'displacement' or distraction. Advice posted on forum boards frequently recommends channelling the aggressive force into other activities, such as self indulgence or exercise[23], such as "taking a bath"[24], "reading a book"[25], "shopping", "going to the gym"[26]. This transfers a socially disapproved act (self harm) into a socially endorsed behaviour.

It is in the medical sphere where clinical self harmers distinguish themselves from emo teenagers who self harm; according to the clinical self harmers emos who self harm are not doing so as a sign of deep internal stress and need psychiatric help, but rather are motivated by seeking attention, and getting recognition from their peers. Many who post

[20] See posts #3, #4, #5, and #11 http://www.mentalhealthforum.net/forum/showthread.php?t=4998, and post #2 on http://www.mentalhealthforum.net/forum/showthread.php?t=5055 .
[21] See post #4, http://www.mentalhealthforum.net/forum/showthread.php?t=5125 for an example of how 'urges' is used as a concept.
[22] See post #4, http://www.mentalhealthforum.net/forum/showthread.php?t=5125 and post #1 in http://www.mentalhealthforum.net/forum/showthread.php?t=5164
[23] See post #3, http://www.nshn.co.uk/forum/index.php?topic=49847.0
[24] See post #3, http://www.nshn.co.uk/forum/index.php?topic=49847.0
[25] See post #3, http://www.nshn.co.uk/forum/index.php?topic=49847.0
[26] See post #3, http://www.nshn.co.uk/forum/index.php?topic=49864.0

on NSHN and MHF are keen to distinguish themselves and their group away from emo stereotypes; they see self harm being linked with emo, a group with which they go not want to be affiliated[27]. There is a close association between self harm and emo according to public knowledge (Sugden, 2008), but clinical self harmers are keen to be distinct from emos, clinical self harmers see themselves as more genuine, as having authenticity *because* of a medical diagnosis, and any accusation that all self harmers are emos is shown to indicate "a vast absence of understanding" on behalf of the speaker[28].

Clinical self harmers separate themselves from emo self harmers in the way in which they present their online profiles. It is typical to post a short biography when starting your first thread[29]. In these introductions, several points are usually covered: how long they have been self harming, what form (e.g. cutting) and frequently a psychiatric classification such as "I have emotionally unstable personality disorder", "I have unipolar depression" or "I have severe anxiety disorder" etc[30]. This medical identity is also portrayed by informing other forum users of the drugs which they are currently taking. These forum users also discuss what medications they have had experience, in terms of efficacy and side effects. Medications such as depixal, Mirtazapine, Citalopram, Diazepam, Propranolol, Quetiapine etc.[31] are referred to using non-trade names, mimicking medical knowledge through exposure[32]. By presenting themselves in terms of a medical classification, these individuals present their self harm identity clearly in terms of a psychiatric illness regulated with psychiatric drugs. This is a clear illustration of Rose's arguments (1996; 2070b).

Another key area in which clinical self harmers differentiate themselves from emo self harmers is their relationship to medical professionals. As it will be shown later, emos'

[27] See post #4, http://www.mentalhealthforum.net/forum/showthread.php?t=5136 , and #7 and #8 http://www.nshn.co.uk/forum/index.php?topic=49859.0
[28] See post #8, http://www.nshn.co.uk/forum/index.php?topic=49859.0
[29] For an example, see post #1, http://www.mentalhealthforum.net/forum/showthread.php?t=5136, post #1 http://www.mentalhealthforum.net/forum/showthread.php?t=5055 , and post #1 http://www.mentalhealthforum.net/forum/showthread.php?t=5041
[30] For example, post #1, http://www.nshn.co.uk/forum/index.php?topic=50276.0
[31] These are fairly common prescription drugs, which are used to treat depression, anxiety, and stress.
[32] See post #1, http://www.nshn.co.uk/forum/index.php?topic=50276.0

relationship to psychology professionals is largely restricted to school counsellors, while clinical self harmers have a closer relationship with higher ranking medical professionals. As such, most frequent response to any question posted is to go and seek professional medical advice[33]. The role of the doctor is wider than being a physician; doctors are expected to be able to treat mental illnesses. Medicalisation is not just medical professionals colonizing more and more of our selves, it is also the masses offering up their selves for examination and medical scrutiny (Foucault, 1982).

The closeness of the client-doctor relationship is demonstrated in the way forum users talk about 'their' psychiatrist or doctor[34]. This relationship can be very possessive, on one thread an individual talks about her distress at her therapist leaving her[35]. In a long post detailing how her therapist has given her notice to leave in a week, after working with her regularly over a six month period, the poster speaks in very emotionally attached terms about the end of this relationship; she says she would have preferred short term sessions and a less intense relationship if she knew that her therapist would be leaving so soon. She states that if she knew from the beginning that her therapist would be moving away, she would not have invested so much in the relationship[36]. For this patient, this medical relationship was extremely valuable and more than purely medical. Their therapist was the embodiment of knowledge; this figure knows what is wrong, and how to fix it. This client got more than medication from the therapist; she is the source of knowledge. The closeness between medical practitioners such as psychiatrists, therapists, counsellors and doctors to their patients or clients is a significant relationship for the individuals who post on the forum. This relationship between patient and therapist can be seen as a new form of Foucault's pastoral power; an individualising gaze which relies on confession. Foucault puts this situation as follows:

[33] See post #2, #10, http://www.nshn.co.uk/forum/index.php?topic=49851.0, post #2 http://www.mentalhealthforum.net/forum/showthread.php?t=5041 , and post #4 http://www.mentalhealthforum.net/forum/showthread.php?t=5125
[34] For examples, see post #1, http://www.nshn.co.uk/forum/index.php?topic=49689.0 and #1 http://www.nshn.co.uk/forum/index.php?topic=49818.0 and #1 http://www.nshn.co.uk/forum/index.php?topic=49864.0
[35] See post #1, http://www.nshn.co.uk/forum/index.php?topic=49629.0
[36] See post #7, http://www.nshn.co.uk/forum/index.php?topic=49629.0

> *The confession is a ritual of discourse in which the speaking subject is also the subject of the statement; it is also a ritual that unfolds within a power relationship […] a ritual in which the expression alone […] produces intrinsic modification in the person who articulates it.* (Foucault, 1990, p. 61-62).

The act of confession in this context is seen as redeeming and therapeutic, while at the same time it allows people to be transformed into case studies, in to statistics and monitored under the gaze of surveillance medicine. Therapists, counsellors and psychiatric professionals are the new figures of pastoral care, who can command and direct these self harmers, but are also in the position of being commanded by their clients therapists are in a position to be commanded by the patient (see Foucault, 1982 p. 783; Rose, 2007b, p. 6). The impact of this pastoral relationship is that it necessarily enmeshes clinical self harmers into the network of medical powers. Bringing these subjects closer to the source of the creation of a new kind of person strengthens the interactive evolution of making up people.

From reading NSHN and MHF, it is clear that most clinical self harmers have seen a form of medical authority concerning their self harming behaviours. It is hard to tell whether this is a regular appointment, or a one-off occasion, and whether this is accompanied by medication, but it is fair to say that clinical self harmers are highly medicalised beings. Furthermore, it is evident that clinical self harmers are very aware of the procedures and treatments available on the NHS[37], and also aware of their rights as self harmers[38]. It is this knowledge of the medical system that traps the psychotherapist, doctor, and psychiatrist in to the system as much as the clinical self harmers. The layers of surveillance are not just acting upon patients.

In relation to psychiatric medicine, clinical self harmers refer themselves to medical authority quickly, but do so on their own terms. They are aware of how the health system

[37] See post #5, http://www.nshn.co.uk/forum/index.php?topic=49629.0 for an example of intimate knowledge of NHS policy.
[38] Bodies under Siege (a self harm survivor lobby group) have created their user of rights http://buslist.org/pdf/billofrights.pdf

works, and what treatments/drugs are available to them[39]. In one of the most interesting discussion threads, an individual declined a psychiatric test (Clinical Outcomes in Routine Evaluation (CORE)). He was later sent the CORE questionnaire by post, where he filled in his answers and later marked himself. When his scores for 'well-being', 'functionality', and 'risk' classified him as needing corrective treatment, he asked the forum for advice – whether to post the form back answered, to alter the answers, or not to reply[40].

Consciously controlling the public face of your mental health to your own psychiatrist is problematic: the care of the psychiatrist is dependent on access to the client's mind and mental states, and consequent treatment is provided accordingly. By gate keeping information, he is not only altering the current treatment, but also keeping the medical documents clear of being labelled a 'risk', and as Foucault has argued, it is the classifying documents which define you politically and for posterity (1972, p. 6). This person's awareness of the risk of being classified in a detrimental category affects the way he presents his 'medical' identity, which has effects on his treatment, his medical label and implies that he wishes to manage his 'medical face'. This power struggle is a dispute over who has the authority to categorise.

So far, the clinical self harmers' attitude towards self harm as a category, as a part of their identity, and their relationship to treatment has been discussed. There is one final theme that will be subjected to analysis: concealment. Concealing is a highly symbolic act: to conceal is to hide, which necessarily entails someone from whom self harm behaviours are hidden. This brings us to the question, why should a person want to censor him or herself, and if they do so, does this indicate shame or privacy: what is the motivation? If we remember that clinical self harmers define themselves to each other using medical terms and as being 'self harmers', then does this projected identity change when talking to a different section of society? What motivations do clinical self harmers have to hide this important identifying aspect of themselves, and how do they do so?

[39] See post #6, http://www.nshn.co.uk/forum/index.php?topic=49866.0
[40] See post #1, http://www.nshn.co.uk/forum/index.php?topic=49757.0

Out of the sixty discussion boards on the NSHN, three were a direct request for advice on concealing scars[41]. In one post, a person who works with primary school children described wearing a sleeveless t-shirt with 'fresh' cuts covered but revealing self harm scars[42]. She describes how she answers children's curiosity by saying her scars were a tattoo, or due to a household cat, but still fears that she "could have given them ideas". This woman has made a deliberate decision to display old, healed scars, but has kept recent cuts hidden. This may suggest that it is the 'freshness' of the cuts which is a factor in concealment. One of the responses to this post says that the extremist reaction that the school could have was to ask her to keep her scars covered. The common understanding is that employers can request concealment. Depending on whether the individual conceals wholly for herself or due to explicit external pressure alters what can be taken from this practise. If concealing occurs to project an illusion of being a non self harmer, then clinical self harmers are buying in to the idea that they are deviant and abnormal. If covering up scars is due from overt pressure from employers then this compliance may indicate something else.

In another discussion board post, an individual asks whether anyone has come across specialist scar make up, or found a concealer which works well to disguise scars[43]. This demonstrates that these self inflicted scars should be not revealed in public, that scars symbolise a part of themselves that is meant to remain hidden. In some posts, covering up physical traces of self harm is a symbol of regret over their actions[44], or that scars are a reminder of a bad emotional time[45], or that they expect society to judge them if scars are visible[46]. This shows that the reason for concealment is multifaceted, not only are scars hidden from the public gaze, scars are also hidden from themselves.

[41] See http://www.nshn.co.uk/forum/index.php?topic=49724.0
http://www.nshn.co.uk/forum/index.php?topic=50054.0
http://www.nshn.co.uk/forum/index.php?topic=50095.0
[42] See post #1, http://www.nshn.co.uk/forum/index.php?topic=49724.0
[43] See post #1, http://www.mentalhealthforum.net/forum/showthread.php?t=5136
[44] See post #3, http://www.mentalhealthforum.net/forum/showthread.php?t=5164
[45] See post #2, http://www.mentalhealthforum.net/forum/showthread.php?t=5055
[46] See post #1, http://www.nshn.co.uk/forum/index.php?topic=49885.0

There is an evident conflict at work. Clinical self harmers are happy to concede that these scars are physical evidence for a psychological problem, that their emotions cross over a threshold and are physically manifested[47], but also believe that so long as the scars are covered, the evidence for having a mental disorder is also concealed. A superficial covering of their scars (which they see as a physicalized emotion, their distress written in razored incisions) restores clinical self harmers to full citizen status. So long as they conceal this evidence, employers, colleagues, and the public must treat them as normal people.

The Survivor Subgroup

The NHSN is an internet resource, calling itself a 'survivor-led' self harm support group[48]. So, it should be noted that one of the undercurrents throughout the discussion boards is propelled by this lobbying force. Self harm survivors are a potent minority, who see their experiences as having equal authority as medical expertise[49]. This is not unique to self harming individuals; this new 'survivor' movement has reached across psychiatry in a smaller and less revolutionary way than the 1960s anti-psychiatry movement (see works by Laing, (e.g. 1960) and Szasz (e.g. 1960) for examples of the full force of the anti-psychiatry movement). In this second, weaker wave, survivors are asserting their 'rights', and limiting the medical space which doctors and medical professionals have authority over. Furthermore, they see the site of their body as being in the realm of their own possession, and claim authority over any medical treatment on the grounds that their experience has as much authority as medical qualifications (Collins & Evans, 2002).

These self styled survivors are seen as a resource for other forum users, their experiences are written as long, detailed, biographic posts[50], which are seen as a vital source of

[47] See post #10, http://www.nshn.co.uk/forum/index.php?topic=49961.0
[48] http://www.nshn.co.uk/
[49] The experience based, survivor led alternative force to medicine is discussed in detail in Collins and Evans, 2002.
[50] See http://www.nshn.co.uk/forum/index.php?topic=49943.0 for a detailed biography.

inspiration by other forum users[51]. This movement to uphold their rights as survivors is interesting, they are reclaiming "control from the experts and the institutions", and to do so, they are "creating new experts, new institutions" (Hacking, 2006, p. 12) such as the national self harm network. Even more interesting, not only are they asserting the rights of themselves as experiencing beings, they are using the medical terms and knowledge in order to do so. This is not unique to self harm survivors, Nye discusses how wide-spread use of medical knowledge can be used as a form of resistance (2003, p. 124). The paradox of lay expertise is a double edged sword; it can defend the rights of these survivors, but does so by embedding them further into the medical discourses.

This section has discussed four aspects that were found in the rich data sample. It has been demonstrated that the usual understanding of clinical self harmers are closely related to the medical discourses, but the way in which they choose to engage with medical concepts of self harm have affected the medical understanding, which has altered the patterns of normal behaviour present in the grassroots. The clinical self harmers experience and understanding of self harm will now be contrasted with that of another group, self harming emos.

[51] See post #4, http://www.mentalhealthforum.net/forum/showthread.php?t=5125 , and especially http://www.nshn.co.uk/forum/index.php?topic=49885.0

Part III: Investigating Emo Self Harmers Relationship with the Concept of Self Harm

In the last section, clinical self harmers were used to illustrate Hacking's looping effect (2006); showing how those labelled interact with their categorisation and change it. In this section, an alternative interaction with the category will be presented. The data analysed is taken from EB[52] and VT[53] discussion forums between the first and 14th of June. Due to ethical constraints, no direct quotes can be used, so any speech marks are indicative of paraphrasing. The same four topics (as used in the previous section) of definition, identity, treatment and concealment will be discussed.

As stated in the previous section, the groups that are analysed are not homogeneous, nor are they static. However, the forces of power which alter the field of available actions impact differently to those acting on clinical self harmers compared to emo self harmers. These two groups are not distinct, their boundaries are permeable. However, the quintessential emo and the archetypal clinical self harmer are very different in terms of age, social position and responsibilities.

Emo subculture is linked in the public eye with self harm (Frith, 2009; Sudgen, 2008). This is commonly understood by the emo self harmers, but they do not monopolise the label of self harm as being purely theirs. Emos are aware that adults and other teenagers self harm, and see their self harm as being the same as emo self harm. So, both emo and non emo self harm is seen as equally valid, equally motivated and equally determined. One emo self harmer was preparing a presentation for school assembly, raising awareness by sharing his own experiences of self harm with his school[54]. This thread discussed what information should be disseminated: the lower secondary school audience should know "the emotions behind self harm"[55] as "people disregard self harm because they only are

[52] http://www.emobucket.com/
[53] http://www.virtualteen.org/forums/forumdisplay.php?f=16
[54] See threads http://www.virtualteen.org/forums/showthread.php?t=46533
[55] See post #5, http://www.virtualteen.org/forums/showthread.php?t=46533

aware of the statistics and the facts"[56]. This suggests that teenagers are already aware about the prevalence of self harming behaviour, through music (and their favourite self harm themed songs were recommended as music for the assembly[57]) media[58], and popular culture much more than the general population. Emos have a clear definition of self harm, but one that does not engage with official medical discourses, which will be discussed shortly.

In this same thread, it was acknowledged that self harm is associated with emos, but not to the exclusion of other groups of people[59]. It was stressed that "anyone could self harm" and it is not for attention, instead its purpose is to negate the internal pain by causing physical pain[60]. So, emos accept that others self harm, but interestingly, rather than seeing themselves as being as valid as the clinical patients who are highly medicalised, sees other non-emo self harmers as also having access to what they see as their category[61].

The medical discourses that run through the language and ideas expressed in Virtual Teen and Emo Bucket are touched upon, but without the knowledge or experience of the medical system to back up claims. For example, these teenagers argue that they have not seen the school counsellor because they "have a phobia of counsellors"[62], or that they cannot stop cutting themselves because they are "addicted"[63]. These terms are in common use outside of psychiatric discourse, but the impact they possess is inherently because of the medical tones of addiction and phobia. Neither 'addiction' nor 'phobia' is used in a way which psychiatrists would approve, but they have more weight than non-medical synonyms. Furthermore, these concepts cannot be refuted by other forum users, using a

[56] See post #7, http://www.virtualteen.org/forums/showthread.php?t=46533
[57] See posts #1, #2, #13, #14, http://www.virtualteen.org/forums/showthread.php?t=46533 for titles and artists who have a large emo following. The songs recommended all had self harm content (often implicit rather than explicit).
[58] The channel four television soap 'Hollyoaks' aimed at teenagers ran a storyline concerning self harm: http://www.reference.com/browse/wiki/Hollyoaks and the BBC 1 ran a prime time documentary: 'A World of Pain: Meera Syal on Self Harm' http://www.bbc.co.uk/programmes/b00l17tq
[59] See post #17, http://www.virtualteen.org/forums/showthread.php?t=46533
[60] See post #17, http://www.virtualteen.org/forums/showthread.php?t=46533
[61] See post #16, http://www.virtualteen.org/forums/showthread.php?t=46533
[62] See post #3, http://www.virtualteen.org/forums/showthread.php?t=45824
[63] See post #1, http://www.virtualteen.org/forums/showthread.php?t=46176

medical label is the ultimate trump card against contradiction as it claims authority from an acknowledged science.

The emo interpretations of medical constructs are not the same as the medical meaning. To illustrate, depression, self harm and even what constitutes a scar to emos are different to psychiatric and medical understanding. Depression is often cited as a reason for self harm, and often referred to possessively as "my depression"[64], without any evidence of medical diagnosis or treatment. Especially in the case of depression and anxiety, the terms are used for both the feeling and the medical disorder. So, there is usually ambiguity as to what sense these words are used.

What is defined as self harming behaviour is also wider than the medical definition. In one thread, a poster was concerned that his excessive nail biting was tantamount to self harm; he "bites the top few layers off until his fingers are raw"[65]. Suggestions to clarify this ambiguous behaviour asked "whether he did it intentionally for the pain"[66], whether it was intentional or "more an OCD tendency"[67]. The negotiation of what is meant by self harm is widened and inclusive, so that all who fall remotely near to the category of self harm can claim the label. The definition of self harm for emos is the literal meaning, an act that harms. This leads to behaviours such as "smoking and drinking being forms of self harm which your parents might do"[68]. In some ways, this definition is more sophisticated than clinical self harmers' definition, but really illustrates that emo self harmers do not engage with medical discourses.

The final example of how medical language has been appropriated and interpreted by emos is the term 'scar'. Common and medical understandings of a scar state that scars are newly formed tissue that forms after injury. It is usually assumed to be a permanent mark, which is incompatible with the way emos use the term scar. For emos, scars are marks

[64] See post #1, http://www.virtualteen.org/forums/showthread.php?t=45544 and post #3, http://www.virtualteen.org/forums/showthread.php?t=45737
[65] See post #1, http://www.virtualteen.org/forums/showthread.php?t=46273
[66] See post #2, http://www.virtualteen.org/forums/showthread.php?t=46273
[67] See post #7, #8, http://www.virtualteen.org/forums/showthread.php?t=46273
[68] See post #20, http://forum.emobucket.com/my-parents-arre-going-to-find-out-i-am-was-a-cutter-soon-t41903-15.html

that can fade, and disappear entirely[69]: for example, one forum user says that her scars "'will be gone in a couple of weeks"[70]. Again, this widening of the definition of scar shows a lack of interaction with the medical understanding. By allowing scars to refer also to fully-healable marks allows the category of self harmers to widen, incorporating more and more of emos into this new kind of person.

These emos are keen to diagnose each other with illnesses; it gives them access to an identity that is defendable of the grounds of medicine. The psychiatric classifications that emos readily offer to each other are seen as eternal and true labels, locating agency and responsibility outside of the self harmer. Furthermore, the mental illnesses that are readily suggested (such as borderline personality disorder, depression, obsessive compulsive disorder, etc.) fit into the stereotype for the dysfunctional teen: pathologizing the institution of teenage angst in terms of psychiatric categories. Despite these terms being used as explanations for other's behaviour, they are rarely used to define themselves. Nor are these suggestions maintained, a forum user who was suggested to have depression is not held to this label in subsequent posts. Again, it appears that another facet of emo self harm is based in transience, a removable element of their selves.

The medical categories that are used to present themselves to the other forum members are accompanied with additional information to create a profile. These emos, especially when starting their first thread, present information as to give other forum users a sense of who they are and where they are coming from. Most first posts state how long they have been self harming[71], the time elapsed since their last self harm[72], and their social situation (recent relationship break-up[73], family troubles[74], and precarious friendships[75]),

[69] See post #1, http://www.virtualteen.org/forums/showthread.php?t=45864
[70] See post #9, '#11, and #13, http://www.virtualteen.org/forums/showthread.php?t=45636
[71] See post #1, http://www.virtualteen.org/forums/showthread.php?t=46048 , post #1, http://www.virtualteen.org/forums/showthread.php?t=46314 , post #1, http://www.virtualteen.org/forums/showthread.php?t=46176 , post #1, http://www.virtualteen.org/forums/showthread.php?t=46279 .
[72] See post #1, http://www.virtualteen.org/forums/showthread.php?t=46601 post #1, http://www.virtualteen.org/forums/showthread.php?t=46824 , post #2, http://www.virtualteen.org/forums/showthread.php?t=46325 . and post #1, http://www.virtualteen.org/forums/showthread.php?t=46545
[73] See post #1, http://www.virtualteen.org/forums/showthread.php?t=45599

and frequently explicitly state "I am a cutter"[76]. Unlike clinical self harmers, no statements concerning mental illness arise. More interestingly, individuals define themselves as "ex-cutters"[77] and "retired cutters"[78]. This demonstrates that emos see the identity of a 'cutter' as a clear type of person, and as a category that these emo teenagers are confident using to define themselves. Not only that, but the self harm identity is so strong, that even when the self harm behaviours are absent, their relationship to self harm is still how they define themselves. Seen from the perspective of emo self harmers, these 'ex-cutters' are a source of strength, information and have experienced 'the other side' – life without self harm.

Contrasts can be seen between emo self harmers and clinical self harmers in the words they chose to define themselves. As discussed in the previous section, clinical self harmers use the medical categories (in which self harm is subsumed) to define themselves "I have depression'"[79], while emo self harmers find it more suitable to classify themselves as 'self harmers' or 'cutters'[80]. This shows that the official medical discourses have been adopted readily by the clinical self harmers, while the emo teenagers use an alternative understanding, one which does not have the prerequisite of a mental illness. In the infrequent cases where self harm is linked with mental illness, it is also coupled with another symptom: in one thread, someone woke up after cutting herself, but with no memory of doing so[81] and suggested explanations for this severe memory loss included borderline personality disorder[82]. More typical examples of self harming behaviour are seen as a sign of distress and depression (in an ambiguously semi-colloquial, semi-medical sense) rather than a direct symptom of a bio-chemical

[74] See post #1, http://www.virtualteen.org/forums/showthread.php?t=46279
[75] See post #1, http://www.virtualteen.org/forums/showthread.php?t=46218
[76] See post #3, http://www.virtualteen.org/forums/showthread.php?t=45737 , post 4, http://www.virtualteen.org/forums/showthread.php?t=45559 , and post #3, http://www.virtualteen.org/forums/showthread.php?t=45544
[77] See post #3, http://www.virtualteen.org/forums/showthread.php?t=45544
[78] See post #2, http://www.virtualteen.org/forums/showthread.php?t=45559
[79] See post #3, and #5, http://www.mentalhealthforum.net/forum/showthread.php?t=4998
[80] [80] See post #3, http://www.virtualteen.org/forums/showthread.php?t=45737 , post 4, http://www.virtualteen.org/forums/showthread.php?t=45559 , and post #3, http://www.virtualteen.org/forums/showthread.php?t=45544 .

[81] See post #1, http://www.virtualteen.org/forums/showthread.php?t=46197
[82] See post #27, http://www.virtualteen.org/forums/showthread.php?t=46197&page=2

imbalance. Due to the absence of any psychiatric explanation of self harm, any mention of mental illness are missing from the emo self harmer language.

This brings us to the question, how are emo self harmers presenting themselves? What are the characteristics that they use to communicate their identity to the forum readers? On the discussion boards, emo self harmers say that their lives are complicated[83], they feel isolated[84], and generally "messed up"[85]. This conforms to the emo identity of complicated teen: a misunderstood malcontent amongst other misfits. Part of the identity of this group that is evident in the sampled forums is that of being misunderstood, or not being granted the respect they deserve. This is demonstrated in statements like "no one listens to what I say"[86], "no one cares about me"[87], and "I feel like two different people sometimes"[88]. This teen-with-issues is one of the staple stereotypes of the emo[89], alongside fashion, melancholia and distinctive music (Greenwald, 2003; Simon and Kelley, 2007). However, this does not mean that these feelings are fake or less powerful; instead it shows how the teenage angst discourse has structures their experiences of themselves more profoundly than medical discourses.

Emo self harmers are not shy of talking about the physical body – an aspect which is conspicuously absent from the clinical self harmers' forums. As emo teenagers, they are conscious of their body and the way in which it is viewed by the world[90]; a fashionable way to conceal scars was a frequent topic on the emo forums (which were absent from the clinical self harmers discussions). The awareness of themselves as objects in the world, and as feeling subjects meets at this point: they discuss the corporeal self in relation to concealment, but are not reluctant to talk about the experience of pain[91]. In one

[83] See post #1, http://www.virtualteen.org/forums/showthread.php?t=45599
[84] See post #1, http://www.virtualteen.org/forums/showthread.php?t=46218
[85] See post #1, http://www.virtualteen.org/forums/showthread.php?t=45544
[86] See post #1, http://www.virtualteen.org/forums/showthread.php?t=46048
[87] See post #1, http://www.virtualteen.org/forums/showthread.php?t=46218
[88] See post #1, http://www.virtualteen.org/forums/showthread.php?t=46176
[89] For a pop-culture and media understanding of emo look at www.myspace.com .
[90] I mean this chiefly in the way that denotes awareness rather than an extreme reflexivity.
[91] See post #1, http://www.virtualteen.org/forums/showthread.php?t=45864

discussion topic, 22 posts over the feelings of numbness or pain during self harm were discussed[92].

This un-medicalised attitude to self harm does not mean that the self harming emos are not treating the issue with gravitas, on the contrary, they show a vast amount of concern for anything which falls under their broad umbrella of self harm[93]. However, the advice for treatment is somewhat less medical compared to clinical self harmers. The emo teenagers advise each other with 'alternatives' or 'distractions' to prevent self harm behaviour, but tell forum posters to "tell your parents"[94] or to "talk to a school counsellor"[95] about the underlying emotional conflicts. Suggestions to go straight to a doctor are rare; parents and school counsellors are the first port of call. It can be seen that parents and counsellors are the first layer of power to which the emo self harmers defer; in the hierarchy of observation, parents are the embodiment of wider discourses and attitudes. This is shown in the posts, forum users say that when they talked to their parents about self harm, their parents took them to a therapist or medical professional[96]. These teenagers are removed from direct medical contact, the mediation of parents enforcing and regulating medical interaction.

This relationship of power can be seen as another manifestation of Foucault's pastoral power: the act of confession to a person representing a layer of power. However, the emo self harmers both confirms and resist this structure: school counsellors are seen as the authority, but it is also clear from the forums that not many of the emo self harmers talk to school counsellors. Instead, this role of confidant and guru is adopted by the other forum users and school peers. The other forum users listen and advise on the grounds of common experience, those with the epithet of 'ex-cutter' being imbued with a higher status. As well as referring to yourself as an ex-self harmer, emo self harmers can gain

[92] See thread http://www.virtualteen.org/forums/showthread.php?t=45484
[93] See threads http://www.virtualteen.org/forums/showthread.php?t=45861 and http://www.virtualteen.org/forums/showthread.php?t=45737
[94] See post #2, http://www.virtualteen.org/forums/showthread.php?t=46176 , see post #2, #3, #6, and #7 http://www.virtualteen.org/forums/showthread.php?t=46279 , and post #2, #6, #10, and #11, http://forum.emobucket.com/my-parents-arre-going-to-find-out-i-am-was-a-cutter-soon-t41903.html
[95] See post #11, http://www.virtualteen.org/forums/showthread.php?t=46067
[96] See post #2, http://www.virtualteen.org/forums/showthread.php?t=46176

status through regular postings; the forum tracks how many times you have contributed to the website's discussion board, and after certain milestones (50, 100, 250, 500 etc) users' display profile is accompanied with an icon. In this way, status can be built up, creating an internal power system to the emo network.

Returning to the issue of treatment, recommended 'distractions' and 'alternatives' to self harm are frequently suggested on these boards. On both EB and VT, specialised threads have been created to list alternative options and distractions for self harm[97]. Frequent suggestions for alternatives included "cutting a pillow instead"[98], or "drawing with red pen"[99], "holding ice cubes"[100], while distractions are more typically "read a magazine, watch a film, go for a walk"[101]. As a rule, alternatives are seen as using the aggressive energy in a new, outward, (sometimes creative) direction while distractions are tasks that are intended to take your mind of self harming. Similarly to the clinical self harmers, the common understanding of a closed circuit, emotional hydraulic analogy is used, but emos are using these ideas in a more simplistic way. None of these usual suggestions has a medical tone, no mention of pharmaceuticals, nor therapy sessions discussed. This is a stark contrast to the posts of clinical self harmers, who discuss themselves in terms of the medical discourses.

The emo discourse surrounding self harm lacks the medical overtones of the clinical self harmers' forums. Because self harming emos are not engaged with medicine as clinical self harmers are, self harming emos do not often see themselves as medical objects. In most cases, they see having "someone to talk to" is enough[102]. Both PM and IM (private messaging and instant messaging) is seen as a way to reduce the self harming behaviours, and are frequently offered to members by each other[103]. This online social communication is considered a decent replacement for life outside of their computers; these teenagers want validation and support and to receive this they turn to online friends
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[97] See thread http://www.virtualteen.org/forums/showthread.php?t=46604
[98] See post #2, http://www.virtualteen.org/forums/showthread.php?t=46048
[99] See post #3, http://www.virtualteen.org/forums/showthread.php?t=46048
[100] See post #8, http://www.virtualteen.org/forums/showthread.php?t=45559
[101] See post #8, http://www.virtualteen.org/forums/showthread.php?t=45479
[102] See post #1, http://www.virtualteen.org/forums/showthread.php?t=46279
[103] See post #2, http://www.virtualteen.org/forums/showthread.php?t=46279

rather than their parents or school friends. Online friends are seen as more supportive[104] and less judgemental[105], and as they are insulated from school, it is unlikely that a rumour of self harm "could be spread all over the year group"[106].

The themes of the typical emo self harmers' profile, their definition of self harm, and the consequential treatment of self harming behaviour has been evaluated. The next theme to be considered is the motif of concealment on emo forums. Paradoxically, one of the most apparent thread topics is concealment: how to hide scars, how to stop parents from finding 'tools', how to prevent friends discovering your self harm secrets. From 45 threads, four were specifically requesting concealment advice. There is an established belief that self harm is a covert action, yet there are public discussions concerning anything from "how deep do you cut"[107] to stating "it has been four months since I last cut"[108]. This conspicuous concealment is perpetuated by emo fashion: bandanas and wrist bands are typical emo accessories, whether self harm scars are present or not. In one discussion thread, the fashionable alternative cover up to wrist bands was proffered: duct tape. Evidently, this is the latest fashion statement "duct tape conceals, but it is also kind of hot", "they do that where you are too? It does look cool, yeah"[109]. The great advantage of these casual, fashionable coverings is that non self harming emos also wear them. This has two implications, firstly that emo self harmers are not conspicuous to others (presumably parents, teachers, and friends) but it also normalises concealment of scars, potentially giving the illusion of the majority of emos self harming.

This ambiguity is yet another motif in emo identity. Typically the ambiguity is in relation to sexuality (Simon & Kelley, 2007), but it can be seen that this feign/genuine concealment grants emo access to an identity which their peers are exclusively aware. By engaging into discourse focused on teenage life and adolescent issues rather interaction with medical knowledge, the emo self harmers are not influenced by the psychiatric

[104] See post #9, http://www.virtualteen.org/forums/showthread.php?t=45864
[105] See post #2, http://www.virtualteen.org/forums/showthread.php?t=45544
[106] See post #1, http://www.virtualteen.org/forums/showthread.php?t=46279
[107] See post #1, http://www.virtualteen.org/forums/showthread.php?t=45636
[108] See post #1, http://www.virtualteen.org/forums/showthread.php?t=46408
[109] See post #25, and #26, http://forum.emobucket.com/my-parents-arre-going-to-find-out-i-am-was-a-cutter-soon-t41903.html

sphere to the same extent as clinical self harmers. The interesting point to observe is that emo self harmers ignore medical knowledge, but this medical knowledge has taken a specific interest in these teenagers (such as Fortune, Sinclair & Hawton, 2008; Laye-Gindhu & Schonert-Reichl, 2005; Scoliers, *et al.* 2008), which informs the definition of self harm, which impacts on clinical self harmer.

In this section, the self harming emos' understanding of medical categories, their presented identity, the expected treatment and the motif of concealment has been evaluated. It should be apparent that the differences between clinical self harmers and emo self harmers are great – even when considered on these four aspects. Emo self harmers have a very different relationship to medical authority, medical authority is very interested in emo self harmers but this group are too focused within their own group to be grossly affected by the medical discourses. This one way relationship shows that emo self harmers are subject to medicalisation, but do not see themselves in terms of it.

Conclusion

It can be seen from the evidence presented that emo self harmers and clinical self harmers understand and use the concept of self harm in different ways. Emo self harmers use their own definition of self harm (and other medical terms such as 'depression' and 'scar' are used in a way which is not identical to the medical usage) to include the widest possible meaning, emo self harmers present themselves in terms of emo themes rather than medical themes, are not integrated into medical treatment, and emos conspicuously conceal scar areas whether or not there is evidence of self harm to be hidden.

On the other hand, clinical self harmers show a detailed awareness of the medical system, the drugs and therapies available, and use medicalised language in a way which is similar to psychiatrists and medical professionals. Typically, a diagnosis is part of their presented self. Clinical self harmers tend to be enmeshed in the medical system, in the form of pharmaceuticals or a cognitive or behavioural therapy. Concealment was a much smaller issue for the clinical self harmers; it was a rare topic of discussion. In general, clinical self harmers saw themselves as medical beings; this is evidence of the embodiment of medical discourses. This group take an active role in their medicalisation; they actively seek and act out the construction of scientific truth, self-regulating themselves as limited by the medical knowledge. This is a real illustration of Foucault's theory of power and knowledge.

Foucault's understanding of power is complex, far more sophisticated than, for example, a Marxist top-down perspective. However, as these networks are in every relationship, suspending individuals and created by the individuals, there is no escape. There is never a point where every relationship of power is revealed. In this thesis, the relationships that have been discussed were those which were nearest the surface. It was not intended that every power link would be revealed; the connections that were between the key groups and over key issues were discussed.

Self harmers are not a universal group; it has been shown that clinical and emo self harmers are sufficiently distinct to be considered as two separate groups. Their have very different attitudes to medicine, but the medical world fails to distinguish between these groups. Furthermore, emo self harmers fail to engage in the medical discourses, while clinical self harmers' behaviours, experiences and knowledge is affected by the medical world. Taking a medical perspective, the current psychiatric research focuses predominantly on teenage self harmers (e.g. Fortune *et al.*2008; O'Connor, Rasmussen, Miles and Hawton, 2009), rather than the already present clinical population. The interesting effect which this could have on the existing clinical population in terms of the looping effect is that as the medical understanding is being informed by a specific teenage population, the clinical self harmers may be shaped by this, moving the target towards the emo norms of self harm. Also, it would be interesting to see how these changes in the medical perception of self harm will be reflected in the next edition of the DSM-v. These are things which will be played out over time, and which will continually evolve.

It is important to understand that the body is a symbolic and socially constructed site. It is the place of embodied emotions and the performance of identity. By experiencing their own self harm through either the lens of medical knowledge or emo discourse, the experiences of the self harmers are altered (Rose, 2007). This objectified understanding of themselves changes the content of their self; the discourse is internalised and becomes the self. In a sense, self harm infers internal characteristics of their selves, and renders them concrete, able to be measured, compared and explained (Rose, 1996). This is all another way of saying that the body has a political anatomy, is it "explored and rearranged" by a "mechanics of power", which transforms and controls through discipline regimes (Foucault, in Rabinow, 1984, p. 182). These self harmers are suspended in relations of knowledge and power.

In this thesis, Foucault and Hacking's theories have been applied to two different communities of self harmers. The historical development from failed suicide to self harm has been plotted, and related to the changes in the typical demographics of the

medicalised target population. Two different groups of self harmers have been used to demonstrate the medical categorisation in action, and located these groups in relation to the medical discourses. The ideas of Rose, Hacking, and Foucault were demonstrated using examples from genuine postings on popular forums. As this research was grounded on this data, it provides support to Foucault and Hacking's overly theoretical models. It is a demonstration that their methods have explanatory benefits, and that the use of these models result in new insights. Ideally, this research can be extended in two ways: firstly, across time, plotting how the understanding of self harm develops. Secondly, as a demonstration of how the self harm spectrum should be broadened to include body modificators or cross cultural groups in analysis.

Self harm is a concept which is accessible both to specialists, self harmers and to the public, as self harm has been the subject of publications aimed at practicing medical professionals, psychology academics, survivors and at a wider, more general audience. The boundary work and negotiation of the concepts involved in self harm is messy and complicated, and is a microcosm of a larger dispute: does medicine have the right to infer mental states from physical actions? Who has the last word in defining our own behaviour? Only through reflexivity and constant analysis are these power relations revealed, only through understanding how these discourses affect the field of our potential actions can be seen how power relationships influence the choices we can make.

References

Aitken, R. C. B., Buglass, D. & Kreitman, N. (1969). The changing pattern of attempted suicide in Edinburgh, 1962-1967. *British Journal of Preventative and Social Medicine,* 23, 111-115.

American Psychological Association, (1994). *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition). Washington DC: American Psychological Association.

Anscombe, G. E. M. (1959). *Intention*. Oxford: Blackwell.

Armstrong, D. (1995). The rise of surveillance medicine. *Sociology of Health and Illness,* 17(3), 393-404.

Batchelor, I. R. C., & Napier, M. B. (1954). The sequalae and short term prognosis of attempted suicide: the results of a one-year follow-up of 200 cases. *Journal of Neurological Neurosurgical Psychiatry*. 17, 261-266.

Birtchnell, J. (1970). The relationship between attempted suicide, depression and parent death. *Journal of Psychiatry.* 116, 307-313.

Buckingham, D. (2008). *Youth, Identity and Digital Culture.* Massachusetts: Massachusetts Institute of Technology.

Cohen, M. (1998). Users' movement and the challenge to psychiatrists. *Psychiatric Bulletin*, 22, 155-157.

Cole, A., & Haebich, A. (unpublished). 'Re-markable bodies: marked bodies of gender, race, class, age, disability. In I. Crozier (ed.), *A Cultural History of the Human Body in the Modern Age.*

Collins, H. M., & Evans, R. (2002). The third wave of science studies: Studies of expertise and experience. *Social Studies of Science.* 32 (2), 235-296.

Campbell, P. (1992). A survivor's view of community psychiatry. *Journal of Mental Health,* 1 (2), 117-122.

Cresswell, M. (2005). Psychiatric 'survivors' and testimonies of self harm. *Social Science and Medicine,* 61, 1668-1677.

Crozier, I. (unpublished). Introduction: bodies in history- the task of the historian. In I. Crozier, (ed.) *A Cultural History of the Human Body in the Modern Age.*

Dias, K. (2003). The Ana sanctuary: Women's pro-anorexia narratives in cyberspace. 17th August. Accessed Online: http://66.102.1.104/scholar?q=cache:R-0MI1oA5qsJ:scholar.google.com/+foucauldian+discourse+analysis+internet+discussion+boards+pro+ana&hl=en

Favazza, A. R. (1996). *Bodies Under Siege: Self mutilation and body modification in culture and psychiatry*, Baltimore: John Hopkins University Press.

Fischer, M. (unpublished) 'Body marks: social and biotechnological imaginaries'. In I. Crozier, (ed.), *A Cultural History of the Body in the Modern Age.*

Fortune, S., Sinclair, J., & Hawton, R. (2008). Adolescents' views on preventing self harm: a large community study. *Social Psychiatry Psychiatric Epidemiology*, 43, 96-104.

Foucault, M. (1972). *The Archaeology of Knowledge.* London: Tavistock Publications.

Foucault, M. (1982). The subject and the power. *Critical Inquiry*, 8, 777-795.

Foucault, M. (1986, [1977]). 'Nietzsche, Genealogy and History'. In P. Rabinow, (Ed.), *The Foucault Reader*. Harmondsworth: Penguin Books.

Foucault, M. (1990). *The History of Sexuality: an Introduction.* London: Penguin.

Frean, A. (2004). Britain worst in Europe as self-harm increases. *The Times*. 31st March Accessed online: http://www.timesonline.co.uk/tol/news/uk/health/article1054037.ece

Freidson, E. (1970). *Profession of medicine: A study of the sociology of applied knowledge*. New York: Dodd and Mead.

Freud, S. (1963). *Early Psychoanalytic Writings: Freud's first studies of obsessions, phobias, anxieties, hysterias, and other symptoms of neuroses.* New York: Collier.

Frith, H. (2009). Emo on the web: Exploring a subculture. *The Times*. 08th August. Accessed online: http://technology.timesonline.co.uk/tol/news/tech_and_web/the_web/article3895757.ece

Greenweld, A. (2003). *Nothing Feels Good: punk rock, teenagers and emo.* New York: St Martin's Griffin.

Gutting, G, "Michel Foucault", *The Stanford Encyclopedia of Philosophy (Winter 2008 Edition)*, E. N. Zalta (ed.). 14th July, Accessed Online: http://plato.stanford.edu/archives/win2008/entries/foucault/.

Hacking, I. (1995). *Rewriting the Soul: Multiple Personality and the Sciences of Memory.* New Jersey: Princeton University Press.

Hacking, I. (2006). Kinds of people: Moving targets. (Tenth British Academy Lecture). *The British Academy.* Accessed online 21st March: http://www.britac.ac.uk/pubs/src/britacad06/index.cfm

Haw, C., Hawton, K., Houston, K., & Townsend, E. (2001). Psychiatric and personality disorders in deliberate self harm patients. *British Journal of Psychiatry*. 178, 48-54.

Hawton, K., & Fagg, J. (1998). Suicide, and other causes of death, following attempted suicide. *British Journal of Psychiatry,* 152, 359-366.

Hawton, K., Zahl, C. & Weatherall, R. (2003). Suicide following deliberate self harm: long term follow up of patients who presented to a general hospital. *British Journal of Psychiatry*, 182: 537-542.

Healy, D. (2004). Shaping the intimate: Influences of the experience of everyday nerves. *Social Studies of Science,* 34, 219-259.

Helman, C. G. (1978). "Feed a cold, starve a fever" – Folk models of infection in an English suburban community, and their relations to medical treatment. *Culture, Medicine and Psychiatry*, 2 (2), 1077-1037.

Ito, M., *et al.* (2008). 'Foreword', In D. Buckingham, (ed.), *Youth, Identity and Digital Media*. Massachusetts: Massachusetts Institute of Technology.

Kennedy, P., & Norman, N. (1973). An epidemiological survey of parasuicide ('attempted suicide') in general practice. *British Journal of Psychiatry*, 123, 23-34.

Kreitman, N., Philip, A. E., Greer, S., & Bagley, C. R. (1969). Parasuicide. *British Journal of Psychiatry,* 115 (523), 746.

Laing, R. D. (1960). *The Divided Self: An existential study in sanity and madness*. Harmondsworth: Penguin.

Laye-Gindhu, A., & Schonert-Reichl, K. A. (2005). Nonsuicidal self harm among community adolescents: understanding the whats and whys of self harm. 43(5), 447-457.

Lennard-Jones, J. E., & Asher, R. (1959). Why do they do it? A study into pseudocide. *Lancet*. 1, 71.

Merskey, H. (1969). Attempted suicide, *British Journal of Psychiatry,* 115 (527), 1227.

Moncrief, J., & Crawford, M. J. (2001). British psychiatry in the twentieth century – observations from a psychiatric journal. *Social Science and Medicine*, 53, 349-356.

Morgan, H. G., Barton, J., Pottle, S., Pocock, H., & Burns-Cox, C. J. (1976). Deliberate self harm: a follow-up study of 279 patients. *British Journal of Psychiatry*. 128, 361-368.

Morgan, H. G., Pocock, H., & Pottle, S. (1974). Synopsis of 'The urban distribution of non fatal deliberate self-harm'. *British Journal of Psychiatry,* 606.

Morgan, H. G., Pocock, H., & Pottle, S. (1975). The urban distribution of non fatal deliberate self-harm. *British Journal of Psychiatry,* 126, 319-328.

Moses, T. (2009) Self Labelling and its effects among adolescents diagnosed with mental disorders. *Social Science and Medicine*, 68, 570-578.

Neeleman, J. (2007). Suicide as a crime in the UK: legal history, international comparisons and present implications. *Acta Psychiatrica Scandinavica*, 94 (4), 252-257.

No Author, (1965). Leading article: Self-poisoning. *British Medical Journal*, 2, 1323.

No Author, (1974). Annotation: self injury. *Lancet*, ii, 936.

No Author, (1989). Survivor news. *Asylum: the magazine for democratic psychiatry*. 4 (1), 16-17.

Nye, R. A. (2003). The evolution of the concept of medicalisation in the late twentieth century. *Journal of History of the Behavioural Sciences.* 39 (2), 115-129.

O'Connor, R., Rasmussen, S., Miles, J., & Hawton, K. (2009). Self harm in adolescents: self report survey in schools in Scotland. *British Journal of Psychiatry,* 194, 68-72.

Owen, D., Horrocks, J., & House, A. (2002). Fatal and non fatal repetition of self harm: Systematic review. *British Journal of Psychiatry*, 181, 193-199.

Pembroke, L. R. (1994). *Self harm: perspectives from personal experience.* London: Survivors Speak Out.

Platt, S., *et al.* (1992). Parasuicide in Europe: the WHO/EURO multicentre study on parasuicide. Introduction and preliminary analysis for 1989. *Acta Psychiartria Scandinavica,* 85, 97-104.

Rabinow, P. (1984). *The Foucault Reader: an introduction to Foucault's thought.* New York: Pantheon Books.

Rainie, H. L. (2004). 'Forward' in P. N. Howard and S. Jones (eds.) *Society Online: The Internet in Context,* pp. xi-xiv, Thousand Oakes, CA: Sage.

Robinson, L. (2007). The cyberself: the self-ing project goes online, symbolic interaction in the digital age. *New Media and Society*, 9 (1), 93-110.

Rosch, E. (1975). Cognitive representation of semantic categories, *Journal of Experimental Psychology 104 (3), 192-233.*

Rose, N. (1996). *Inventing Our Selves: Psychology, Power and Personhood.* Cambridge: Cambridge University Press.

Rose, N. (2007). Beyond Medicalisation. *The Lancet*. 369, 700.

Rose, N. (2007b). *The Politics of Life Itself: Biomedicine, power, and subjectivity in the twenty-first century*. Oxford: Princeton University Press.

Scoliers *et al*. (2008) Reasons for adolescent deliberate self harm: a cry of pain and / or a cry for help? Findings from the child and adolescent self harm in Europe (CASE) study. *Social Psychiatry Psychiatric Epidemiology*, 44 (8), 601-607.

Scott, L. & Chur-Hansen, A. (2008). The mental health literacy of rural adolescents: Emo subculture and SMS texting. *Australasian Psychiatry*, 16 (5), 395-362.

Shenker, J. (2009). Egypt's emos: the latest hate figures. *The Guardian*. Accessed online 7th August: http://www.guardian.co.uk/commentisfree/2009/may/06/egypt-emo-backlash

Simon, L. & Kelley, T. (2007). *Everybody Hurts: an essential guide to emo culture,* Harper Collins: New York

Stengel, E. (1952). Enquires into attempted suicide. *Proceedings of the Royal Society of Medicine*. 45 (613), 17-24.

Stengel, E. (1970). Attempted suicide. *British Journal of Psychiatry.* 116 (531), 237.

Stengel, E., & Cooke, N. G. (1958). *Attempted suicide: its social significance and effects.* London: Chapman and Hall.

Sugden, J. (2008). Young girls think that self harm is a normal way managing stress. *The Times.* Accessed online 9th August: http://www.timesonline.co.uk/tol/life_and_style/health/article4327233.ece

Szasz, T. S. (1960). The myth of mental illness. *The American Psychologist*, 15, 115-118.

Tate Modern, (2008). Viennese actionism exhibition. Southbank: London.

Turp, M. (2002) The many faces of self harm. *Psychodynamic Practice*, 8 (2), 197-217.

Webb, L. (2002). Deliberate self harm in adolescence: a systematic review of psychological and psychosocial factors. *Integrative Literature Review and Meta-Analyses,* 38 (3), 235-244.

White, H. C. (1974). Self-poisoning in adolescents. *British Journal of Psychiatry,* 124, 24-35.

Zahl, D. L. & Hawton, K. (2004). Repetition of Deliberate Self-Harm and Subsequent Suicide Risk: long term follow up study of 11583 patients, *British Journal of Psychiatry,* 185, 70-75.