

**A FEMINIST QUALITATIVE STUDY OF FEMALE SELF-MUTILATION**

**Rosemary L. Ellis**

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**Dr. Toni Calasanti, Co-Chair**

**Dr. Martha McCaughey, Co-Chair**

**Dr. Carol Bailey**

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**(ABSTRACT)**

This study is an exploration of the ways that female self-mutilation has been medicalized in Western society and the consequences of this medicalization. The goal of this study is to provide an alternative approach to the way female self-mutilation is understood one that views self-mutilation not as a symptom of individual psychopathology, but as an extreme response to a set of deeply embedded social expectations. Using the feminist constructionist model, semi-structured interviews were conducted with five women who have participated in various forms of self-injurious behavior.

Findings indicate that this behavior does indeed occur within a social context one rooted in patriarchal ideologies. These ideologies also seemed to influence whether the women in this study, who had been medically treated for this behavior, perceived this form of intervention as a positive or negative experience.

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The topic I chose to explore in this study, female self-mutilation, is for me a deeply personal one. Consequently, writing this thesis has been one of the most frustrating, as well as, rewarding experiences of my academic career. I am grateful, therefore, to have the opportunity to acknowledge and thank those individuals who provided a seemingly endless supply of support and encouragement throughout this research project.

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## CHAPTER 1

### DIANA AND ME

*"How will you know I am hurting,  
If you cannot see my pain,  
To wear it on my body,  
Tells what words cannot explain."*

-C. Blount

#### **Introduction**

In 1995, Princess Diana shocked the world when she publicly admitted to participating in self-mutilation (Kalb 1998; Time 1998). In an interview with the BBC, Princess Diana confessed to cutting herself with "razors, pen knives and lemon slicers," (Time 1998:93) in what she held was a desperate attempt to cope with the strain of her failing marriage. Although the practice of self-mutilation has been evidenced in Western medical literature since the early nineteenth hundreds (Favazza 1987), it was not until Princess Diana's self-disclosure that it became known to the general public (Time 1998). Subsequently, the issue of self-mutilation has become as prevalent in today's postmodern society as anorexia nervosa has been since the seventies (Pipher 1994). Indeed, the media have dubbed self-mutilation the anorexia of the 90's (Finlay 2000). Although some individuals may be shocked when first hearing about this phenomenon, I myself was not surprised. Like Diana, I too have participated in self-mutilating behavior.

My defining moment came during my freshman year of high school when my parents informed me we were moving to Taos, New Mexico. I can still remember how angry and powerless I felt at that moment. Once in Taos, it did not take me long to enter a self-destructive mode. At 14 years of age, I was running the gamut of self-injurious behaviors such as clawing and punching my face, starving myself, binge drinking, using illegal drugs, and attempting to commit suicide. Consequently, I was thrust into a world full of psychiatrists, therapists, and medication one where I was deemed mentally defective and in need of medical intervention. So began my long struggle with mental illness, a struggle that would take me from a person who embraced the *objective truths* of medical science to a person who came to realize these *truths* were steeped in and shaped by the socio-historical context in which they were born.

After more than sixteen years of medical treatment including psychiatric hospitalization, psychotropic medications, and a variety of cognitive and behavioral therapies, I still suffer from feelings of low self-esteem, depression, anxiety, powerlessness, and anger. I asked myself, why? Why, after all these years of therapy and medication am I still plagued by feelings of inferiority? Might there be something that my therapists have overlooked? Could there be social factors contributing to my self-perception as well as the way others perceive me?

With these questions in mind, I began to search for sociological evidence that would help to explain the persistence of these self-depreciating feelings. After much searching, however, I was left disappointed and frustrated. Although I did find a variety journal articles and books on the topic of self-mutilation, the authors primarily addressed this phenomenon in relation to culturally sanctioned practices (Atkinson & Young 2001; Favazza 1987; Favazza 1998; Kiragu 1999; Myers 1992) or as a symptom of a more serious psychological disorder such as anorexia (Brumberg: 1988; Favaro & Santonastaso 1998; Favazza 1987; Favazza, DeRosear & Conterio 1989; Favazza 1998) or borderline personality disorder (Brodsky, Cloitre, and Dulit 1995; Dulit, Fyer, Leon, Brodsky & Frances 1994; Favazza 1987; Morey & Zanarini 2000). Consequently, I decided to conduct my own investigation in the hope that I would uncover the underlying social factors that contribute to self-mutilation that, to date, have been largely ignored.

### **Research Interest and Questions**

In the current study, I explore the ways that self-mutilation has been medicalized in Western society and the consequences of this medicalization. The goal of my research is to provide an alternative approach to the way we understand this female body project. This alternative views self-mutilation not as a symptom of individual psychopathology, but as an extreme response to a set of deeply embedded social expectations. Although self-mutilation has been viewed through the lens of medical authority, who is more qualified to talk about self-mutilation than those women who have participated in this behavior.

This research contributes to feminist studies of the medicalization of the female body and, more broadly, to sociological and feminist discourses pertaining to the social construction of health and illness. Female body projects modification of the female

body through diet, exercise, self-mutilation, and/or plastic surgery symptomize life in late modernity and women's struggles with a sexist culture. As such, female body projects can be important sites for the sociological examination of the self-reflexivity of the body and identity. Beyond this, those female body projects that render the female deviant and that consequently become medicalized as pathological tell us much about the boundaries of proper femininity, as well as how women negotiate those boundaries.

In the tradition of feminist methodologies used to critically analyze other deviant bodily practices, such as anorexia nervosa and bulimia, I wish to situate myself in the context of my exploratory analysis of self-mutilation. My research interest in this topic is twofold (1) my personal experience with self-mutilating behaviors, and (2) my position as a feminist scholar. First, I believe my experience as a woman who has participated in cutting lends itself to a deeper understanding of this behavior. I also contend that my status as a cutter may create a rapport with other females who mutilate themselves that might not be possible for a researcher who has never personally experienced self-mutilation. I wish to note, however, that although my experience with this behavior may give me some special insights, it may also constitute blinders of which I need to be aware. I also realize that self-mutilating behavior is physically damaging to the individual, and in extreme cases, may be life threatening. My intention here is simply to provide an alternative discourse in which to talk about this behavior, one that begins with women's agency and women's experiences negotiating medical discourses about their behavior.

Secondly, feminist scholars of the body research the ways in which gender ideology affects the social construction and medicalization of female body processes and behaviors, thus, I will attempt to explore the larger social context in which self-mutilation occurs, including social factors that mental health professionals have minimized or ignored. Applying the feminist model to my study, I shall ask the following questions: 1) How do females who practice self-mutilation account for their behavior?, a) More specifically, what social factors do they say preceded their behavior?; 2) What are some of the social consequences of their behavior?, a) Have they suffered informal or formal social sanctions as a result of this behavior?; 3) Have they been treated medically as a result of their behavior, and if so, how?; 4) How have others such as family, friends, and

professionals responded to their behavior?; and, 5) Is there evidence of a biomedical model in the ways in which they talk about their behavior or subsequent experiences?

Psychiatric practitioners rate self-mutilating acts in terms of the severity of the injury the most severe being the actual amputation of a body part and least severe being superficial injury to the body (Favazza 1987; Maris, Berman, & Silverman 2000). For the purpose of this paper, I define self-mutilation as an act of deliberate superficial self-injury to the body (e.g., hitting, cutting, scratching, or burning the skin and wound interference). Acts of self-mutilation performed specifically for decoration, sexual gratification, or with suicidal intent are excluded.

Conterio and Favazza (1989) estimate that at least 1 percent of Americans participate in self-mutilating practices. Additionally, researchers have found that the majority of individuals participating in this behavior are women (McLane 1996; Nichols 2000; Suyemoto 1998). Indeed, Conterio and Favazza (1989) noted that women comprised at least 97 percent of the self-mutilating population. Since these statistics indicate that individuals who mutilate themselves are predominately women, as well as the gender difference in the way medical practitioners perceive causal factors of this behavior,<sup>1</sup> men who self-mutilate were not considered in this analysis.

Using my definition of self-mutilation and examining only women, I address my research questions through in-depth interviews with five women who have participated in self-mutilation. Given the purpose of this study, interviews were one of the best ways to examine this behavior. The data collected from the accounts of these women provide an alternative way of looking at and understanding female self-mutilation one that uses their voice and their experience.

To illuminate the problem of medicalization, Chapter 2 provides an overview of the literature relevant to the body. I begin my overview by giving a brief history of anorexia nervosa and self-mutilation to demonstrate how and why these female body projects shifted from socially sanctioned, female empowering practices to practices considered socially deviant. In Chapter 3, I outline the feminist qualitative methodology

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<sup>1</sup>For example, oftentimes medical practitioners deem that men self-mutilate in an effort to prove their masculinity (Time 1998), whereas women self-mutilate to relieve feelings of anxiety and stress (Favazza 1987).

used in this study along with the rationale for why I chose this particular research design. Additionally, I introduce the five women who participated in this study of female self-mutilation documenting their general demographic characteristics (e.g., age, current occupation, marital status, etc.).

Using a substantial amount of the original interview transcripts, Chapters 4 and 5 provide an in-depth look into the lives of these five women. Chapter 4 is an examination of the social contexts embedded within the stories told by these women. Offering my own onset story as a beginning framework, I encourage the reader to view this behavior, not simply as a manifestation of individual pathology, but rather as an extreme, and in some cases learned, reaction to a set of difficult social situations. Additionally, I tease out the underlying themes located within the narratives of these women.

The medicalization of self-mutilation is the focus of discussion in Chapter 5, specifically as it relates to the women in this study whose behavior elicited medical intervention. Here I explore the positive and negative consequences of medical intervention as told by the women in this study, along with the strategies of resistance they employ.

The final chapter of my thesis is a discussion of the relevant findings in relation to the psychiatric literature and my research questions. Implications of these findings will also be discussed along with suggestions for future research.

specific to the diagnosed psychopathy. The client is, therefore in danger of receiving the wrong type of psychiatric treatment (Loring & Powell 1988).

Medicalization also helps to maintain the status quo by placing socially deviant behaviors into disease categories (Bartkey 1997; Irvine 1995). For example, oftentimes medical experts diagnose women who deviate from conventional gender relations with medical disorders such as Premenstrual Syndrome (PMS) or Borderline Personality Disorder (BPD), thus allowing for medical intervention and treatment usually in the form of pharmaceutical therapy (Swann 1997). Although medical experts may champion medicalization as an appropriate method of confronting socially problematic behaviors (e.g., anorexia nervosa, self-mutilation, and alcoholism), this method can also depoliticize, and thus privatize problems that might be better addressed in the public sphere.

Such medicalization is apparent in relation to self-mutilating behaviors. The discourses in the substantial medical literature that addresses the topic of self-mutilation tend to emphasize individual pathologies, paying only minimal attention to the social factors that may contribute to this behavior (Martinson 1998). Consequently, only the individual's behavior is acknowledged and treated, leaving larger scale contributory social factors, such as patriarchy, left unexplored (Shilling 1993; Turner 1992).

Feminists and postmodernists have challenged the medicalization of other body practices, such as anorexia nervosa, agoraphobia, and hysteria, in an attempt to illuminate the underlying social factors that contribute to these practices (Bordo 1997; Brumberg 1988; Irvine, 1995; McCaughey 1999).

The contributory social factors feminists most often cite are those closely related to a culture steeped in patriarchal values that prescribe how women need look, act, and feel. For example, some feminists believe that anorexia nervosa in women is due, at least in part, to the barrage of media images that promote highly sexualized and extremely thin women as the Western ideal (Brumberg 1988; Pipher 1994). Conversely, McCaughey (1999:134-135) argues that anorexia nervosa can also be interpreted as a resistance to men's sexual objectification by women who grew up expecting more, yet find no other means of protesting the meager rewards of heterosexual womanhood. Although

feminists may diverge when discussing the political implications of anorexia nervosa, they concur that it is the result of more than just individual pathology.

Medical discourses also fail to recognize the socio-political consequences that individuals who mutilate themselves may experience as a result of medicalizing this behavior. For example, individuals who mutilate themselves are often subject to psychiatric evaluation and treatment that may include involuntary commitment and/or pharmacological therapy (Favazza 1998; Martinson 1998). Social stigma may also occur once an individual is labeled with a psychiatric diagnosis that, in turn, may exacerbate the individual's condition (Scheff 1984). Therefore, a more inclusive discourse concerning self-mutilation is in order, one that considers the social context in which women manifest this behavior along with the social consequences suffered as a result.

### **The Body in Historical Context**

Historically, religious leaders and scientific authorities have interpreted the body in ways that define the individual's value within society (Shilling 1999; Urla & Terry 1995). During the Middle Ages, religious leaders assessed an individual's social value according to their cultural morality and spiritual enlightenment as measured by the actions of the individual's body. For example, thought to be divinely inspired anorexia nervosa, then termed anorexia mirabilis (miraculously inspired loss of appetite) and self-mutilation (specifically self-flagellation) were considered by religious authorities to be evidence of an individual's religiosity (Brumberg 1988; Favazza 1998). Since anorexia mirabilis was primarily a female phenomenon, some feminist theorists believe it was a means for medieval women to empower themselves within a patriarchal society (Brumberg 1988). Indeed, this practice often elevated women to a social status usually achievable only by men, since positions of religious authority were exclusively a man's domain. Therefore, it is not surprising that some medieval women chose this form of body modification. Whatever social status experienced by those medieval women who practiced anorexia mirabilis was not to last.

The advent of the Age of Enlightenment brought a shift from religious to scientific authority (Bordo 1997; Brumberg 1988; Favazza 1998). Consequently, determination of an individual's social and moral value became the task of scientists and medical experts. Thought to be the ultimate in objectivity and truth, scientific empiricism

became the instrument that scientists and medical authorities used to justify social inequality and patriarchal hierarchy (Schiebinger 2000). For instance, these authorities now redefine anorexia nervosa and self-mutilation as manifestations of physical and/or mental pathologies within the individual (Bordo 1997; Brumberg 1988; Favazza 1998).

Currently, scientific and biomedical discourses are under attack by sociological, feminist, and post-modern scholars (Gould 1981; Guillaumin 1988; Larson 1995; Proctor 1995; Somerville 1996; Martin 1992; Seidman 1997; Terry 1995; Ussher 1992; Wijngaard 1997). These scholars argue that medical discourses serve to produce and reproduce social inequality. This challenge to scientific and medical discourse reveals that knowledge and power work together to create a hierarchy of dominance a kind of political unconscious (Foucault 1995; Seidman 1997). Support for this argument is substantiated through numerous sociological, post-modern, and feminist critiques of medicalization. For the purpose of this thesis, however, I will focus only on those critiques that are relevant to the medicalization of social deviance behaviors that violate social norms (Thompson & Hickey 1994).

Since the early eighteenth century, scientists have endeavored to locate sex, race, sexual orientation, and class differences within the body (Gould 1981; Seidman 1997; Proctor 1985, Somerville 1996; and Terry 1995). These differences, if found, would lend credence to theories of biological determinism, thus rationalizing the racist and sexist practices of the social elite (e.g., middle- to upper-class white males). Gould (1981) found that, during the late 1800s, scientists used measures of the body to qualify racial and sexual inequalities. In one instance, cranial capacity was employed as a measure of an individual's intelligence. Although initially vast differences in cranial capacity were noted among the various races, as well as between sexes, Gould (1981) discovered that these differences were due to errors in measurement technique and statistical analysis, rather than some inherent inferiority. Nevertheless, these differences helped to establish a social hierarchy that is still in place today (e.g., African Americans and women are still considered to be inferior by some individuals as is evidenced by their continuing struggle for social equality). This social hierarchy also helped to legitimate such practices as sexism and racism. Indeed, the inferior status given to the African American once helped white men to rationalize their enslavement in the South (Larson 1995).

Other diverse groups of individuals have also been subjected to this type of scientific scrutiny. Jews, for example, once defined as a separate *race*, were labeled inherently defective by medical experts because of the higher rates of suicide and tuberculosis they experienced (Proctor 1995). The skulls of black people were measured by racist white scientists who, not surprisingly, found *evidence* of black inferiority (Gould 1981). Homosexuality was yet another *abnormality* scientists thought could be evidenced in the body. Through measuring the size and shape of female genitalia, medical researchers thought they could locate in the body the source of sexual deviance (Terry 1995). Consequently, medicalization has historically been used to individualize social problems and deviant behaviors. In this regard, medical regulation of deviant behaviors can be viewed as a relatively effective means of social control. Additionally, medicalization can be seen as a way to depolitize women's resistance to the system of patriarchy.

Feminist critiques highlight the ways that scientific empiricism and medicalization are combined to reify the subjugation of women and other minorities (Gould 1981; Seidman 1997; Proctor 1995, Somerville 1996; and Terry 1995). These scholars have attempted to deconstruct scientifically constructed categories of sex, race, sexual orientation, and class by highlighting biases in the scientific methodologies that were used to construct them, as well as illuminating the political implications of such construction. Although there is currently a plethora of feminist and other scholarly literature, that address these scientifically constructed categories, once again due to the spatial constraints of this thesis, I discuss only those writings pertinent to this topic.

While we see far fewer wildly biased studies of natural differences between racial groups today, still many scientific and medical researchers concern themselves with sex differences (Longino 1990). Additionally, medical researchers still focus their attention at the level of the individual and label those behaviors considered deviant as *madness* (e.g., self-mutilation) and the individuals who participate in such behaviors as *mad* (e.g. women who self-mutilate). Ussher (1992: 11) contends that "[m]adness' acts as a signifier which positions women as ill, as outside, as pathological, as somehow second-rate the second sex ." In this sense, madness becomes something that occurs as a result of women's inherent inferiority, instead of a symptom of the patriarchal oppression that

women have historically been forced to endure. Consequently, the social and political implications of women's madness remain immutable and unchallenged (Bordo 1997; Brumberg 1988; Conrad 1992; Thompson & Hickey 1994; Turner 1992; Ussher 1992).

Currently, deviant behaviors that have sociological causes are increasingly medicalized. Sociologists and feminists note that in Western society medical authorities have increasingly medicalized deviant behaviors such as alcoholism, eating disorders, stress, and sexual desire (Bordo 1997; Brumberg 1988; Brumberg 1997; Conrad 1992; Thompson & Hickey 1994; Turner 1992; Ussher 1992). They further argue that by medicalizing these behaviors, medical experts define individual pathology as the primary source of problem behaviors giving only minimal attention to potential contributory social factors. Consequently, the individual's pathology is treated leaving possible contributory social factors left unchallenged (Bordo 1997; Brumberg 1988; Conrad 1992; Thompson & Hickey 1994; Turner 1992). Bordo (1997), for example, challenged the medical model of anorexia arguing that we must stop viewing the anorexic as an individual with a pathological fear of eating and instead understand her as a member of a gendered, and oppressed, group in society. Highlighting the ways that gender inequality leads women to eating disorders. Bordo (1997) contests medical discourse for its failure to attend to the social problems that form the context of women's eating disorders.

Researchers have found that individuals who participate in self-mutilating behavior are primarily white, middle-class women of above average intelligence who initially began mutilating themselves in middle to late adolescence (Favazza 1987; Favazza, DeRosear & Conterio 1989; Favazza 1998; Suyemoto 1998). Additionally, researchers maintain that this behavior provides the females who participate in it with an internal sense of self-control, one that compensates for those external circumstances they perceive are beyond their control (Brumberg 1988; Favazza 1987; Kaplan 1994; McLane 1996; Martinson 1998; Nichols 2000; Suyemoto 1998). Indeed, many females report that they mutilate themselves after arguing with a boyfriend or a parent. They state that the act of mutilating themselves serves to create a renewed sense of external agency through control over their body (Brumberg 1988; Favazza 1987; Kaplan 1994; McLane 1996; Martinson 1998; Nichols 2000; Pipher 1994; Suyemoto 1998). Although this may be true

for some females who participate in this behavior, I believe that anger and rebellion at a culture permeated with patriarchal values are also contributory factors.

Pipher (1994:158) contends that self-mutilation can be seen as a concrete interpretation of our culture's injunction to young women to carve themselves into culturally acceptable pieces. What Piper (1994) is alluding to here is not that women are literally carving themselves up in to pieces, rather she presents this metaphor as a way of illustrating how women in Western society are lured into believing in and striving for an ideological perfection one that does not in reality even exist. Although I agree with Pipher (1994) in her assertion that women who participate in this behavior can be viewed as submitting to a cultural injunction, I also believe that this behavior can also be seen as a way of protesting this injunction using extreme forms of body alteration (McCaughey 1999; Pipher 1994; Shilling 1993). Other possible explanations researchers have posited for women's participation in self-mutilating behaviors are: (1) a lack of appropriate coping skills; (2) an inability to verbally express feelings (e.g., anger, sadness, disappointment, etc.); (3) to elicit the attention of others; (4) to relieve emotional pain; and/or, (5) to end a dissociative episode (Favazza 1987; Kaplan 1994; Kashgarian, 1999; McLane 1996; Nichols 2000; Pipher 1994; Suyemoto 1998).

Many of the researchers in this area contend that self-mutilation is both a psychological and biological phenomenon (Favazza 1998; Kaplan 1994; Kashgarian, 1999; McLane 1996; Nichols 2000; Suyemoto 1998). Levenkron (1998:23) asserts that self-mutilation is an, "...individual psychopathology; [or] mental illness. " Additionally he states that self-mutilators are not acting within the norms of any cultural microcosm; they do not plan their activity but rather are overtaken by a compulsion to commit these acts which is not about conscious intent for self-mutilation is the *experience* of physical pain [but] for it's calming effect on her more painful psychological states that is being sought (Levenkron 1998: 24). Although I agree with Levenkron (1998) as well as other researchers that self-mutilation can be seen as an individual psychopathology, and that the body's physiological response to this behavior can elicit a calming effect, that in turn may lead to the repetition of this behavior (Favazza 1998; Kaplan 1994; Kashgarian, 1999; McLane 1996; Nichols 2000; Suyemoto 1998); I wish to challenge the assumption that these are the only contributory factors related to this behavior. Indeed, as a

researcher, as well as a woman who has participated in this behavior, I believe that it is important to acknowledge that women who participate in self-mutilating behaviors do not exist in a social vacuum but, are located within a specific social context.

Even when conducting cross-cultural studies of self-mutilation, researchers fail to look at the social context of this behavior as it exists in Western society, whereas they acknowledge this context in other cultures. For instance, Austin (1999:49) in comparing African tribal rituals and self-mutilation in Western societies states that, for some patients, self-mutilation is a symptom of an underlying psychological problem: patients with Borderline Personality Disorder, for example, often cut or burn themselves in an effort to relieve their overwhelming psychic pain. Consequently, Austin (1999) also ignores the larger social context in which this behavior occurs in Western society, while simultaneously acknowledging the role that culture plays in relation to self-mutilating behaviors in African societies. The reality that self-mutilation occurs within a social context, that the act of self-mutilation is a cultural response to women's inferior status in Western society, and that this behavior elicits social consequences that are gendered still are ignored.

As I have attempted to illustrate in this chapter, self-mutilation in and of itself is not what constitutes a deviant behavior, but only becomes such when certain groups in society construct it as such (Loring & Powell 1988; Mirowsky & Ross 1989). Support for this argument is evidenced when examining this behavior in an historical context. Once considered a religious undertaking, women who self-mutilated were thought to be spiritually enlightened and were frequently assigned a significant degree of social status. As western society grew increasingly complex, however, scientific reasoning replaced religious reasoning and self-mutilation was now considered an aberration a socially deviant behavior. Additionally, when we combine the sociological literature of medicalization with feminist and postmodern discourses that highlight the ways in which scientific empiricism and medicalization reify the subjugation of women and other minorities, we begin to see the political undertones of medicalizing self-mutilation. Indeed, sociological and feminist scholars posit that medicalization helps to maintain a system of patriarchal social control, one that keeps "woman" her place as it robs her of her agency. This is most notable when exploring the current biomedical discourses that

present this behavior as an individual disorder ignoring the possibility of contributory social factors, hence the rationale for this particular study.

In chapter three, I present the research questions that guide this study along with an outline of the feminist methodology I employed to examine these questions. Furthermore, a brief description of each participant's demographic characteristics is rendered.

## CHAPTER 3

### METHODOLOGY AND PARTICIPANTS

#### **Methodology**

The main research question underlying this analysis is how do females who mutilate themselves understand their behavior, particularly in juxtaposition to the medicalization of this behavior? Sub questions derived from the main question include:

- 1) How do these females account for their behavior?
- 2) What social factors precede their behavior?
- 3) What are some of the social consequences of this behavior?
- 4) Have they been treated medically for this behavior and, if so, how?
- 5) How have others responded to their behavior?

In the previous chapters, I have argued that female self-mutilation is not simply an individual pathology, but is instead deeply rooted in a patriarchal culture. I have further argued that the medical model that many mental health practitioners employ in their attempts to understand and treat those women who engage in this behavior is implicitly laden with negative as well as positive implications. Although these two assertions are the primary focus of this analysis, I purposely remain open to new interpretations ones that may lead me in a different direction.

#### **Qualitative Research**

What qualitative research is, how it is conducted, how it is presented, and how it is evaluated is largely dependent upon the researcher's disciplinary training, historical time period, as well as applied paradigm. As a feminist scholar and researcher, I was compelled to choose a paradigm that would allow the women I interviewed to share their stories using *their* words and *their* voices.

#### **Paradigm**

The paradigm I chose to use in this study is a constructionist feminist paradigm. The ontological assumptions behind this paradigm are that reality is socially constructed, subjective, and multiple embedded in gender ideology, race, class, age, and sexual orientation. Consequently, I not only expect women to have different understandings of their behavior; I also anticipate these understandings will be different for women living in

other cultures as well as other historical eras. The understanding that I get from this study is therefore historically and culturally bound.

From a feminist constructionist perspective, findings emerge through relationship formation that comes from the interaction and collaboration of researcher and participant. The interviews were therefore structured in a way that allowed me to hold a conversation with these women; one with give and take, instead of one with me asking questions and the participant answering them. Thus, I openly shared with these participants some of my own experiences with this behavior.

The value stance required of this perspective is that values are inherent in the design. Consequently, I did not hide, nor should I have hidden, my desire to improve the understanding and conditions of this behavior for these women. Additionally, I did not nor do I now pretend to be an *objective* researcher, but rather claim the stance that the focus of the biomedical model, without the larger social context within which this behavior is situated, does a disservice to those women who participate in self-mutilation.

The voice taken by a feminist constructionist paradigm is first person as an active participant in the research process. I therefore write this narrative in such a way that the women I interviewed as well as others who engage in this behavior can understand and learn from this study. I write in a way that permits a readership beyond just the academic community while also maintaining the academic standards of scholarship.

### **Reflexivity**

The essence of feminist qualitative research is that of reflexivity. This requires careful reflection of who I am as a woman and a researcher, why I am doing this research, how I am doing this research, the affect this research has on me, how I might affect the results of this research, and how my past history may color my interpretation of these women's accounts. Thus, I have embedded reflexivity throughout my narrative.

### **Recruitment**

I employed availability and snowball sampling techniques to recruit interview participants. In order to locate a totally volunteer sample, I advertised this research project by:

- 1) Posting flyers in a number of buildings located on the Virginia Tech campus including the Women's Center, Lane Hall, McBryde, Derring, and Wallace (see appendix A for an example of the recruitment flyer).
- 2) Posting an ad to the Internet website Yahoo Message Board.

For the snowball sample, I asked people I knew (e.g., psychotherapists, college professors, and friends) as well as the participants I interviewed to talk to people they knew that may have engaged in self-mutilation to see if they would be interested in participating in this research project.

### **Interviews**

The interviews took place in a safe and convenient location to accommodate the participants and to protect their identities; consequently, I encouraged the participants to choose the location of the interview.

The length of time the interviews took was dependent on the participants lasting anywhere from one and a half to two hours. The interviews were for the most part unstructured, but did include general categories related to the research question and sub questions (see appendix B for the semi-structured interview schedule). In the course of the interview, I also elicited some of the more general demographic characteristics of each participant. Additionally, topics important to participants that were unrelated to the general categories were considered and discussed.

Permission to record and jot notes during the interview was obtained from each of the participants via informed consent. Transcription in detail followed immediately afterward to avoid potential inaccuracies resulting from poor-quality of the audio tape recording or in the event that the tape recorder failed to function properly.

To ensure confidentiality, each participant was asked to provide a pseudo-name that would be substituted for her actual name during the interview and transcription processes, as well as in my written account.

### **Analysis**

In accordance with the feminist methodology employed in this study, I did a careful and thorough examination of the participants' interview transcripts identifying recurring themes.

### **Ethical Issues**

In keeping with Virginia Polytechnic Institute and State University policy, I obtained Internal Review Board (IRB) approval, before beginning the recruitment process (See Appendix C for IRB approval document).

Before each interview, I obtained two copies of informed consent from each participant (see Appendix D for a copy of the participant's informed consent form). The first copy was kept in my research files and the second copy was given to the participant to keep for her own records. The participant's copy also included the telephone numbers of a crisis intervention hotline, community mental health support center, and the numbers of the co-chairs of my committee Doctors Toni Calasanti and Martha McCaughey. Also included was a list of Internet sites dealing with the issue of self-mutilation (see Appendix E the Internet Resources handout).

Cognizant of the potentially emotional nature of the interview, I also diverted the topic when touching on particularly upsetting subject matter and inquired if the participant wished to continue. Additionally, I sought to end the interview in time to alleviate any anxiety or tension that the participant may have been feeling as the result of the discussion of this topic, through casual conversation.

## **Sample**

### **Participants**

The women I interviewed were not just research subjects but participants, co-workers, volunteers, and warm human beings that graciously shared their very personal stories to assist in this research project. Although at times some of these women were irritating, rambling, and did not always say what I had hoped they would say (so much for researcher objectivity), I am indebted to these women for providing me an invaluable look into the phenomenon of this often misunderstood practice. In this section, I provide a glimpse into the more ordinary aspects of these women's lives.

### **Cassie**

Cassie, an 18-year old, single, white female from the Midwest, is the first of five women interviewed for this study. Cassie was recruited for this study after answering an ad I had posted on the bulletin board of one of the buildings located on the Virginia Tech campus. At the time of her interview, Cassie was living with her middle-class parents

and attending a large university. As a first year college student Cassie was enrolled in second summer session classes, while also working as a secretary.

An intelligent, exuberant, and articulate young woman, Cassie spoke openly about her past experience with self-mutilating behavior. Rapport with Cassie was quick to develop, and our conversation seemed natural and effortless.

### **Jamie**

My second interview was with an intelligent, quiet, single, 22-year-old white woman, who asked me to call her Jamie. She is also a close personal friend of mine. I asked Jamie if I could interview her for my thesis, since I knew that she had a history of self-mutilating behavior and she agreed.

Like Cassie, Jamie also had a middle-class background. At the time of her interview, Jamie was a first year Ph.D. student attending classes at a large university, and living with a roommate a platonic male friend. Jamie's interview was considerably more difficult for me than my interview with Cassie a potential result of the close personal relationship we shared. This interview was also challenging because of Jamie's verbally expressed reluctance to believe that she was the *right sort* of person to participate in this particular study.

### **Virginia**

Virginia was the third participant I interviewed. At the time of her interview, Virginia, a 23-year-old, white, middle-class female, was living with her boyfriend of ten years. After graduating from high school, Virginia decided to work full-time rather than attend college. Virginia volunteered to participate in this project, after she heard me discussing it with a friend.

### **Eve**

The fourth interview I conducted was with Eve. Like Virginia, Eve volunteered to be interviewed, upon hearing me talk about my thesis to a friend. At the time of the interview, Eve was 22-years old, involved in an intimate heterosexual relationship, and living alone. Eve is a college graduate with a Bachelor's Degree.

Eve's interview was a highly emotional one. At one point during the interview, I asked if she needed to stop or take a break, after she burst into tears when discussing her

childhood. Although Eve insisted that the interview continue, I could not help but feel a little guilty.

**Sarah**

My fifth and final interview was with a woman that I call Sarah. Sarah is a 35-year-old married mother of one living with her husband. Although originally from the eastern half of the United States, she now resides in the Southwest region. At the time of her interview, Sarah was not working outside the home. Sarah has a Graduate Equivalency Degree and is a Navy veteran. Sarah was recruited after she answered an ad I had posted to Yahoo message board on the Internet. After a brief discussion about issues of informed consent and logistics, my committee and I, in conjunction with Sarah, decided that I would email her a consent form that she would then print out, sign, and return to me via the US mail.

Following the receipt of Sarah's signed consent form, it was decided that an online interview would be the most productive, however, due to a number of scheduling problems she opted to fill out an emailed questionnaire instead (See Appendix D).

## CHAPTER 4 IN THE BEGINNING

### The Onset Stories

In this chapter, I present the narratives of five women that have participated in self-mutilation. More specifically, I examine the social context embedded in the onset stories told by these women. Offering my own onset story as a beginning framework, I posit this behavior not simply as a manifestation of individual pathology, but rather as an extreme (and in some cases learned) response to a particular set of social circumstances. In so doing, I illuminate recurring themes evident in these narratives that tell us more about the broader social context of the individual involved.

As I have previously mentioned, I first began injuring myself at the age of 14. My earliest recollection of this behavior was sitting in my room and crying while I scratched and hit myself in the face. Although I am unable to recall the specific incident that preceded this behavior, I do remember feeling inadequate, powerless, and angry with myself for being unable to live up to what I now recognize as Western ideals of female beauty. Flat chested, knobby-kneed, and pimple-faced I was a far cry from the seemingly perfect young women of the mid-70's that graced billboards, magazine covers, and television screens. Even worse, my negative self-perception was repeatedly reinforced by the people around me both women and men. Throughout my adolescence, I endured an endless stream of criticisms in regard to the adequacy, or should I say inadequacy, of my female body. One such incident occurred when I verbally expressed an interest in one of my male high school classmates. When I asked him if he might like to go out with me sometime he told me that he never dated flat-chested girls.

Even as an adult, I found little relief from this sort of body critique. For example, my ex-husband's grandmother (who was, by the way, very well endowed) expressed her concern about my ability to breastfeed my son. She believed that my breasts were too small to provide him with an adequate supply of milk. Needless to say, I learned to hate my body.

What I am trying to illustrate here is that feelings and behaviors that in isolation may be viewed, by medical authorities and the general population, as the manifestations of individual pathology, may be perceived much differently when placed within a

particular social context. Therefore, as you read the onset stories below, notice how in each story the women clearly identify a social event that preceded their first episode of self-mutilation. For Cassie, it was a combination of an overwhelming workload as well as what, in her view, were her bad sexual choices. Jamie's first episode occurred following the breakup of her relationship with her boyfriend. As for Virginia, she mutilated herself after losing a chance to sing a solo in the school choir. For Eve, sibling rivalry was the precipitating factor of her first self-mutilating incident, and, for Sarah, it occurred on the thirteenth anniversary of the death of her infant son.

Cassie first started cutting literally days after her 17<sup>th</sup> birthday. She attributes her self-injuring to her stress level at the time. A senior in high school, Cassie was the vice president of two organizations, taking five college preparation courses, and working two jobs. She also stated that she had been sleeping with her best friend' boyfriend behavior that she perceived to be sexually promiscuous. Cassie went on to declare that her promiscuous behavior combined with the lies that followed it made her feel really really shitty about herself. The lying started, she said, as a way to cover her ass.

**Cassie:** So, one night I was sitting in my room writing in my journal thinking about oh my God how the hell am I going to get through this and stuff. Worrying things are so fucked up and it s all my fault, and I had my lighter and I knew one of my friends had burned a little smiley face with the lighter thing so, I tried it and I thought it was really really cute and it felt so good. I don t know, so for at least three or four days I just did myself with the lighter and then I had heard about self-mutilation like razors and stuff so I knew I had some straight razors and went in my medicine cabinet and I got them out and I started cutting with straight razors and the first time I did it it wa oh my God it felt so

Contrary to the popular psychoanalytic literature that speaks of women who self-mutilate as highly impulsive and driven to cut, Cassie's experience demonstrates the inaccuracy of this assertion. Cassie's behavior was slow and methodical something she had learned

from friends. Using this perspective, Cassie's behavior can be understood as act of agency a conscious choice.

Jamie's first experience occurred when she was in the eleventh grade shortly after breaking up with her boyfriend.

**Jamie:** And, he was telling me that we weren't going to get back together and he didn't have the same feelings. I think I went down to the place where his classroom was and I was waiting for him to come out and I was very emotionally upset and aggravated and just desperate I guess desperate to get the relationship back. This time I remember I was pacing at the same time. I don't remember which started first, but I was pacing and there was the brick wall or whatever some kind of block wall and I remember I started hitting the wall and I did that and paced back and forth while hitting the wall with my fist for a long time. And, I think I was kind of hoping that I really didn't want anyone to see exactly what I was doing but I think I kind of hoped that someone would find me, so that I could talk to someone.

During her freshman year of college, Jamie, age 17, began a new method of self-injury picking scabs. Jamie's scab picking occurred shortly after she broke up with a man she had dated for a couple of months. During her interview, she stated that at the time of this incident she was really really angry at herself. She went on to say, however, that maybe she was angry at him and not myself, but I wasn't able to take it out on him, so I took it out on myself. Jamie recalls sitting in the college parking lot in her car wearing shorts and describes the incident as follows:

**Jamie:** I remember sitting there and just feeling so upset and feeling like I just had to do something about it and that's when I started picking scabs. And, I think I sat there for half an hour and just picked at my scabs and it wasn't like I was picking scabs that were there. I made many sores. I would have you know just little white bumps on my leg that were normal and I would just pick at them until they were all bloody.

Feelings of rejection, after losing a chance to sing a solo in the school chorus, preceded Virginia's first incidence of self-injury. In her narrative, Virginia indicated that she felt like nothing she did was right, and that she was unhappy about being compared with her older brother, as well as about the extra attention her grandmother was getting. Like Jamie, Virginia stated that, at the time, she was extremely angry. She describes her first incident as follows:

**Virginia:** I don't know. I just got mad and went into the bathroom and just did it. I don't know, I was just mad. It was the best way for me to vent my frustration and stuff. Let's see. I walked into the bathroom, checked all the stalls, ran some water, and I had one of those little pocket knives from the fair a couple of years ago, and I used to carry it around with me. I used to run with a crazy crowd in high school, and I used to carry it around with me, and I just took it in the bathroom and just cut my arms. Just dug it into my arms as far as I could all the way down my arms. I don't even have scars left, but that's why I did it. And, then I washed it off with the water and then went back to the room. It just made me mad.

Although medical authorities also view women's anger as pathological, when placed within the larger social context, both Jamie's and Virginia's anger can be seen as understandable, even justified. They were emotional responses to the actions of others.

Eve began injuring herself at a much younger age than the other women. Her first recollection of self-injury is when she was around the age of 9 or 10 and taking piano lessons. During this time, Eve stated that she was angry because she had wanted to quit piano, but her parents told her that she could not. Eve's description of her first self-injurious behavior seemed to indicate that it was used as a form of self-punishment. Eve gives this account:

**Eve:** And, so then every evening I would practice, because on Thursday's that's when I had my piano lessons if I didn't do good I would be so embarrassed. So, if I messed up on a key, I would slap my face or my hands and just be like, I can't believe

that, or I would pull my hair. And, I did that when I played in the band all the way through high school or when I played the clarinet or twirled the flag. When I messed up, I would just grit my teeth and [think] you're so stupid, and I would just pull my hair until it hurt, because I would try to punish myself I guess for messing up. And, I remember doing that when I was really little, when I first took piano cause my parents wouldn't let me quit. And, I got so mad, because my brother, when he took guitar lessons when he was in high school, as soon as he wanted to quit you know but I was still in band because I loved it, but if I messed up I would get so mad. I would like scratch myself or pull my hair or grit my teeth or say you're so stupid and things like that.

Later in this chapter, you will see that Eve's self-punishment stems from cultural and family ideals of perfection, something that appears repeatedly throughout the narratives of these women.

Sarah's onset story differs from that of the other women in that her first episode of self-injury was much later in life at the age of 32, far removed from adolescence. Sarah provided little detail of her first time, perhaps because she was not interviewed, but was instead given a list of questions to answer. I did not attempt to email her to request more complete and in depth responses, since I feared jeopardizing her emotional health. In her interview questionnaire, she revealed that she had just recently been released from the hospital; her husband had committed her after an incident of self-mutilation and her expression of suicidal ideation. Sarah related this story of the first incident:

**Sarah:** I don't really remember it much, I just remember I was alone, and saw a box cutter on the table, began playing around with it, and for some reason cut my upper arm with it.

Sarah stated that the first time she cut herself was on the 13<sup>th</sup> anniversary of the death of her infant son. If there were other life events that contributed to the onset of her self-injurious behavior, she did not reveal them.

As their onset stories indicate, most of these women began self-mutilating as a way of dealing with relationship problems. On a larger scale, these women seemed to be

responding to their perceived inability to live up to Western ideals of femininity. For Cassie, it was a means of punishing herself for behaviors (such as female promiscuity and competition) that we generally deem inappropriate for women. Eve's behavior served to punish her for not living up to cultural ideals of the perfect woman. Jamie and Virginia used self-mutilation to deal with the overwhelming feelings they experienced following real or perceived rejection. Jamie's self-mutilating behavior began with feelings of frustration, pain, powerlessness, and anger after breaking up with her boyfriend. Self-mutilation for Virginia also helped her cope with feelings of rejection, invisibility, and anger. The reality within the accounts of these women demonstrate that self-mutilation does not occur in a social vacuum, but within a particular social context.

### **The Social Context of Self-Mutilation**

As I began to delve more deeply into the accounts these women had given, I discovered that many of the social contexts listed above were becoming recurring themes. The most dominant theme in these narratives was other-directedness. In addition, a number of sub-themes emerged, including perfectionism, idealization, external stress factors, mental illness, alcoholism, drug addiction, gender issues (e.g. male children treated differently than female children), as well as questions of identity.

### **Woman as Other-Directed**

The woman as other-directed theme was evident in their reluctance to relate negative feelings or self-mutilating behaviors to the difficulties they may have experienced within the family structure. When asked to discuss their relationship with their parents or siblings Eve, Jamie, and Virginia provided confusing and conflicting accounts.

Jamie, for example, asserted that she had a good family environment. Later when I asked her why she had begun seeing a therapist she stated, The main problem for me and the things that I talked about basically involved my family, and problems that I was having with my parents. When I asked her to expand on this Jamie reclaimed her original statement of the good family insisting that the problems she was having were due to her own teenage angst.

**Jamie:** I don't think it's really relevant. I think I was already starting to have a lot of control issues cause I wanted to be very

independent and I guess they felt like I was learning too much. It was just probably the typical problems that teenagers have maybe too a little stronger degree.

Like Jamie, Eve and Virginia were also disinclined to attribute their unhappiness or self-injurious behaviors to their tenuous relationships with their parents. Eve told me that she thought her self-injurious behaviors were a result of her tendency toward perfectionism, rather than a result of parental expectation.

**Interviewer:** Was it expected of you to do really well?

**Eve:** No, because my parents didn't really...they are schoolteachers, but if I got a bad grade it was more that I punished myself I always put a lot of pressure on myself. If I made a D or an F, my parents they didn't degrade me or make me feel stupid I degraded myself. I'd feel like, gosh, I can't believe you did that I 'm so stupid.

She added that "I always felt like I had to do this perfect. If I didn't, I'm totally stupid you know. While denying that her parents where a source of pressure and accepting full responsibility for her perfectionism, she later identifies her parent's perfect relationship and perfect lifestyle as a potential influence.

**Eve:** My parents never fought. They are always in agreement with each other. They always have the same opinions, same ideas, everything and I'm not trying to blame it on something, but I'm trying to figure out why I do the things I do. And, I think it's because my parents have projected such a perfect lifestyle that I've felt like I have to be perfect in everything that I have done and in my relationships with men, too, I feel like I've had to compare everything with their relationship. And, I have to realize I guess that and I probably never will be able to accept this that was a different time and this is a different time that I'm dating than when they were dating and things were a lot simpler [back then]. And that's why my relationships I swear have been doomed. A lot of it's been my fault because I've expected so much. I've had such high expectations for the way things should be, and if they're not, I

just go irate and I'm just bawling crying and you know I just that's the only thing I can do.

Virginia's accounts of growing up were filled with the most striking contradictions as her responses vacillated between ideal and reality based images her family. At first, she described her father as an alcoholic and her mother as depressed, however, when the subject of her family life came up again she asserted that

**Virginia:** Everybody was always in a good mood . My mom is just the greatest mom ever. My dad was a good dad, you know. My brother was really girl crazy so he wasn't around a whole, whole lot, but everybody seemed to you know everybody loved everybody.

When I asked her why she had continued to self-mutilate, her response was again quite different from the one before.

**Virginia:** I don't know, I think it kept me sane. Honestly, I think it like kept me sane at the time cause it was just so absolutely crazy around the house and my mom she was trying to be strong for him and he apparently didn't care about anybody but himself I know that it's [alcoholism] a disease and he couldn't help it and all that stuff, but it really pissed all of us off. Because you know why would he do that to everybody else in the family?

Worth noting here is that the contradictions in Virginia's, Eve's, and Jamie's narratives about their families reflect the larger social inconsistencies between what Western society defines as the ideal family and its social reality.

### **The Need to Please**

Another theme these women expressed relates to being other-directed, and the stress they frequently experienced in their need to help or please other individuals such as parents and boyfriends.

**Cassie:** And, I was taking like 5 A.P.s (college credit courses), I was vice president of two clubs two job I'm sure that stress factor had a big thing to do with it. Usually it's stress.

**Interviewer:** Usually it's stress?

**Cassie:** Stress whether it's like school or friends or lack of friends or...

**Interviewer:** Outside stressors?

**Cassie:** Yeah, outside stress and the stress that I cause myself...

While Cassie talked about the tremendous school stress she was under, she initially attributed it to her "type A personality." However, eventually she also acknowledged that she had felt pressured by her dad to succeed, and at a fairly high level.

**Cassie:** ...I think my relationship with my dad, which caused me to put a whole lot of stress on myself for schoolwork. I graduated with like a 3.93

**Interviewer:** So, that is a lot of pressure.

**Cassie:** Yeah well, I got punished when I got Bs. I got a C+ on a test and I got in trouble for that.

**Interviewer:** What'd they do?

**Cassie:** They're just like, "You can do better than this."

**Interviewer:** So, kind of a verbal [reprimand]?

**Cassie:** Yeah.

Much like the other interviewees, Cassie was reluctant to assign blame to her parents. Nevertheless, these narratives facilitate an understanding of the extent to which parents truly do influence their children, whether through their actions, as was the case with Eve, or through their words, as was the case with Cassie.

### **Familial Dysfunction**

The reality that women who self-mutilate may be living in environments in which other problems such as alcoholism, drug abuse, and mental illness among other family members exist is often ignored by psychiatric literature. Nevertheless, these factors were evident in both Virginia's and Cassie's narratives. As previously mentioned, Virginia

asserted that her father was an alcoholic and her mother had struggled with bouts of depression.

These problems were also apparent in Cassie's family. Not only did she assert that she believed her father to be a borderline personality, but that much of her father's family had been addicted to one substance or another.

**Cassie:** ...like my dad's family. His dad was an alcoholic, his birth mom was an alcoholic, his adopted mom was an alcoholic, his brother's a drug addict, and I know he's bipolar. I'm one hundred percent convinced he's bipolar, not bipolar, borderline.

When I inquired about Cassie's brothers, she asserted that her older brother was the serious mess, up the drug addict. She also admitted to having abused alcohol and drugs herself, however, she did not believe her abuse was a serious problem.

**Cassie:** . . . this is debatable. My therapist thinks I have problems, you know, like small bouts with alcoholism, since I was like twelve. But, I just think it's common teenage behavior. I've been addicted to like mild addictions, not like crack, like codeine, no-do-

Cassie also told me that "when I cut I don't drink or smoke up." When I prompted her to tell me whether her mutilating behavior was planned she said, "normally the razors are there. Like I said I usually have them as my security blanket. I do get bandages. I get the really thick kind." This sort of pre-meditation, along with the fact that alcohol and drugs are not used when she self-injures, seems to contradict expert medical opinion that women who participate in this behavior do so out of impulse and lack of control.

### **Gender Relations**

Another sub-theme underlying the stories of these women relates to gender relations and the relative power and importance of men. The accounts these women give of their boyfriends and brothers illustrate the heterosexist and patriarchal assumptions embedded within Western society deeming that (1) women should be in intimate relationships with men; (2) men are more valued than are women; (3) patriarchal norms define the type of female body that is desirable; and, (4) a woman's worth is dependent upon her reproductive capabilities. Although, men are also subject to heterosexism, their

final self-worth is not tied to these assumptions in the same way as is women's self-worth. Consequently, the social context portrayed in their stories is not gender-neutral, but is immersed in a context of female inferiority. Each of these four assumptions constrains women in Western society.

The first assumption, designating that women should be in intimate relationships with men, was demonstrated in Jamie's onset story recounted earlier in this chapter. Both incidents of self-mutilation that she described occurred shortly after the break up of an important intimate relationship with a man. This is especially evident in the way she describes her feelings at this time, "I was very emotionally upset and aggravated and just desperate I guess desperate to get the relationship back. " Her statement is laden with heterosexist and sexist undertones.

These undertones were especially evident in Eve's narrative. Notice her premature response to a question I was attempting to ask her one that seem to threaten her heterosexual identity.

**Interviewer:** These are the fun questions, and you can choose to answer or not answer this no problem okay?

**Eve:** I'm not gay.

**Interviewer:** No, I wasn't going to ask you that hat's your business.

**Eve:** That's personal.

It is significant that, although Eve openly discussed her history of self-mutilation, speaking quite candidly about her relationships with family and friends, she believed that asking about her sexual preference was much too personal. Eve's reluctance to talk about homosexuality highlights the homophobic attitudes of many individuals in Western society. That she had even anticipated such a question was also surprising, especially since she had made clear the fact that she was currently in a monogamous heterosexual relationship.

The second assumption, that men are more valued than are women, is illustrated in Virginia's response to a question I asked her in relation to her academic performance in high school.

**Virginia:** I had good grades up until when my fiance and I started dating sophomore year and my grades started to slip.

**Interviewer:** Yeah.

**Virginia:** They were As and Bs up until then and then they started to slip, because I was carrying his work 'cause he could not have passed high school without me...doing his homework, so I spent more time doing his homework than mine. I was getting Cs and Ds.

That Virginia valued her fiance's academic welfare over her own is blatantly apparent.

An excerpt from Eve's narrative best illustrates the third assumption that men define the type of female body that is desirable. Oftentimes, a woman's father, in his status as an important adult male, is an influential person in determining how she comes to perceive her body.

**Eve:** I know that when I was young my dad used to call us all kinds of little nicknames. And, it wasn't like he was trying to be mean at all; he was just trying to be funny. He called me, Grape Ape, which is from the Grape Ape cartoon.

She continues

**Eve:** Like in high school he'd call me Hogitha mostly, and Flash off the Dukes of Hazzard the dog (laughs) on the Dukes of Hazzard. I don't know where he got that one from.

Her brother's opinion of her body combined with her father's to make her self-conscious of her physique.

**Eve:** I remember in high school my brother would say, boy, you're looking fat today. And, I'd be like, "Shut up...you know that really hurts my feelings, " and he's like, " Hey I'm just joking, " but it would be a continual thing like he'd pick at me about it, and I'd got to the point where I was actually taking it seriously 'cause if somebody's joking, I can take the joke, if it's a one time thing, but when it's a recurring thing I start to think it's a trend. I start thinking, Am I really fat? Maybe I need to lose

some weight. So, that's what I would do. And, I told my mom maybe if dad didn't call me Grape Ape and Hogitha then I wouldn't and dad would be like, " Oh, you know I'm joking." And I'd be like, " No, I don't!"

Eve burst into tears while telling me this story, a significant occurrence that punctuates the emotionally damaging aftermath of patriarchal attitudes and behaviors concerning the female body.

Finally, Sarah's narrative helps demonstrate the assumption that a woman's worth is often realized through her biological ability to reproduce.

**Sarah:** I never really hurt myself until I lost my second son so I really believe that it has a lot, if not everything, to do with that in some way. Unresolved grief? Like someone said, I hate my body and am punishing myself. Any number of things.

Although it would have been beneficial to ask Sarah to elaborate on this particular issue, this was not possible. As I previously mentioned, due to her recent hospitalization, I was reluctant to push for a more in-depth discussion of this issue, as I feared jeopardizing her emotional health to do so would be unethical.

In this chapter, I have illustrated that self-mutilation occurs, not in a social vacuum, but within a particular social context. As the accounts of these women reveal, self-injury is symptomatic of a patriarchal culture that values men over women. Consequently, in order to have a more complete understanding of why women self-mutilate, we must first examine the social context in which this behavior occurs. Only then can we hope to posit an effective alternative to self-injuring behavior.

In the following chapter, I explore the medicalization of self-mutilating behavior in Western society. More specifically, I highlight both the positive and negative consequences of medicalization evident in the narratives of the women I interviewed along with the ways that they resisted medical intervention.

## CHAPTER 5

### MEDICALIZATION AND RESISTANCE

In this chapter, I identify the themes grounded within these women's accounts that illuminate both the positive and negative implications of medicalizing self-mutilation. The positive aspects of medicalizing this behavior included providing these women with an explanation for their behavior, giving them an opportunity to talk about their feelings, allowing them to work on family dysfunction, and teaching them alternative coping skills, while the negative implications were their loss of agency through social and medical stigma, involuntary hospitalization, and strained relationships with medical personnel. In this chapter, I also discuss some of the ways these women attempt to reclaim their agency by actively resisting medical intervention through behaviors such as refusing or discontinuing psychotropic medications that are not working, discontinuing therapy and/or seeking a new therapist, as well as, hiding self-mutilating behavior to avoid this type of intervention resistance that I viewed as quite positive.

#### **Medicalization**

As discussed in Chapter 2, medical social control begins with "the authority to define certain behaviors, persons, and things" (Conrad 1992:216). In Western society, medical authority is achieved through the process of medicalization. Medicalization occurs when non-medical processes such as sexuality and reproduction and deviant behaviors including anorexia nervosa, alcoholism, bulimia, and self-mutilation are defined as medical problems in need of medical intervention (Conrad 1992; Turner 1992).

Medicalization can have a number of negative gendered consequences. For example, Ussher (1992:13) argues that "because of the positioning of 'madness' as a deadly secret, a fear, a means of dismissing and controlling women, and a means of pathologizing distress," women often endure feelings of shame, guilt, anger, and pain along with a loss of credibility. Often it is difficult to extract what is social from what might be amenable to medical treatment, and there can be no doubt that medical interventions can be helpful in some instances. At the same time, medicalization becomes another means by which women are positioned in the place of the *Other*, justifying their continued subjugation (Ussher 1992).

Additionally, once a deviant practice is medicalized and medical intervention is implemented, the individual is labeled with, for example, a psychiatric diagnosis that frequently leads to medical and/or social stigma that, in turn, can contribute to a loss of agency (Conrad 1992; Nehls 2000; Scheff 1984). This seems to be especially true of those individuals diagnosed with Borderline Personality Disorder (BPD), a diagnosis commonly given to individuals that self-mutilate (Nehls 2000). In fact, some scholars contend that the BPD label is so medically stigmatizing to the labeled individual that some therapists have actually refused to treat these patients, opting instead to refer them to someone else (Martinson 1998). Some sociologists also argue that diagnostic labeling can exacerbate deviant behavior, since the individual is now medically exempt from taking personal responsibility (Conrad 1992; Nehls 2000; Scheff 1984).

### **Doctor/Patient Relationships**

Another factor important to explore when considering the implications of medicalizing deviant behavior is that of the doctor/patient relationship. The medical system as it currently exists in Western society is based on a hierarchy one in which the doctor (e.g., the psychiatrist) is the authority and the patient is the object upon which this authority is substantiated. In the mental health system, this hierarchical order lends itself to a kind of paternal relationship, with the psychiatrist playing the role of an authoritative parent and the patient playing the role of a child. Indeed, this was often the case in the narratives of the women I interviewed as well as in my own experience with therapists and psychiatrists I found this was especially true when the therapist or psychiatrist was a man and the problem that the client was attempting to address was the side-effects of psychotropic medications.

One incident I remember quite vividly occurred when I was taking an anti-anxiety drug Thoridazine. The male psychiatrist I was seeing thought it would help even out my moods and alleviate my need to cut. At the time, I was height and weight proportionate; however, after taking this drug for three months my weight had increased by thirty pounds. Thirty pounds in three months; there had to be something terribly wrong! Feeling quite devastated by this sudden and unexpected weight gain, I asked my psychiatrist if weight gain was a side-effect of this particular medication, to which he replied, " No you simply eat too much. " In that one insensitive statement, my

psychiatrist had successfully invalidated my own observations and reinforced the hierarchical authority of the patient/physician relationship. What I find even more incredible is that I accepted his explanation as *truth* struggling unsuccessfully for the next two years to lose the weight I had gained through diet and exercise. I am still amazed at the fact that once I stopped taking this medication my weight quite rapidly returned to normal. Shortly thereafter, I learned that weight gain was a common side effect of this particular medication. My point, then, is that once I was diagnosed with a mental illness, my psychiatrist viewed my observations and inquiries as suspect and quickly discounted them, leading me to believe my eating was simply out of control.

Had this been an isolated incident I may have walked away believing that it was just a personality conflict between that particular practitioner and me. Yet, I knew that I had experienced this type of hierarchical power relationship before one that placed the psychiatrist in the role of the parental/medical authority while placing me in the role of the naive and uncooperative child. For instance, when I informed another male psychiatrist that the medication he had prescribed for me was making me feel anxious and out of control, he told me that I was only saying this, because I did not want to take my medication not because I was actually experiencing side-effects. Like before, I later found out that this medication does indeed produce this type of physiological response in some individuals. Consequently, I came to realize that what authorities presented as *truth* was actually embedded within the context of their personal beliefs and perceptions about the individuals and/or situations that they were applying this *truth* to; thus, for me *truth* became suspect.

As a result of my own experience with this type of medical hierarchy, I was not surprised when I began to see the same type of underlying theme in the narratives of the three women who had received some form of medical intervention. Cassie, for example, seemed well aware of her inferior position within the medical hierarchy. As the following excerpt from Cassie's interview demonstrates, client's voices are often ignored in favor of the voice of medical authority.

**Cassie:** And, I know it's not a psychiatrist's job to listen to your problems. It's just their job to figure out what's wrong and what needs to be done with the medication, and he did

that for the first few months but then probably about the third time that I saw him he was just like, " How you feeling? " And I was like, " Not good". He was like, " You wanting to cut? " I was like, " Yeah". He was like, " Have you cut? " I was like " Yeah. " So, he was like, " Oh, we'll keep the medication the same. " And I was like, " It's not working!"

Unfortunately, these experiences were not unique to Cassie and me. Jamie too spoke of feeling ignored and invalidated by her male psychiatrist.

**Jamie:** The first one that I saw, the psychiatrist, was not too long after I started counseling. I think it was to go on Prozac. I think my counselor had recommended that cause that's what he [psychiatrist] prescribed for me. After that was when my parents became aware of ADD [attention deficit disorder] and they thought that I might have that and so they talked to the same one [psychiatrist] about that and he wasn't convinced by it. Then we saw another psychiatrist for the same [thing] and I think I was tested in between [changing psychiatrists] the test results came back negative and he didn't seem convinced that I had a problem with this either, but my parents talked to him for about half an hour and I was there and somehow toward the end of the meeting his tone kind of changed and he said, Well maybe you're right. Let's let her try the medicine and see what happens. So, that's how that happened and it worked for me very well, and so I went back and I kept seeing the first one [psychiatrist], and he said, "Well I see that you're taking this (Ritalin)," and so he prescribed it for me. So then, eventually I decided to go off of that medication until I came to [the University], and I saw Dr. X and he was not nice about it at all. He didn't seem to believe me and he wasn't really willing to work with me and I didn't have the money to have the test made that you usually have and at the time I really didn't have the time

either I was in the middle of the semester and I was feeling desperate.

**Interviewer:** So how does it make you feel that he didn't believe you?

**Jamie:** Terrible . It made me feel like I was doing something wrong. I knew I wasn't. I knew that it had worked for me before and I'd gone off of it, because I didn't like having to take medicine and I knew that I needed to be back on it. That was in the middle of the Fall semester. Then, I guess I finally went back to see Dr. X, just because I was thinking about whether or not I was going to stay for a Ph.D. program.

Hierarchical relationships with psychiatrists were not the only problem these women encountered. At times, these women also viewed their therapists as being apathetic and ineffective. Cassie's assessment of her first therapist highlights this point.

**Cassie:** The first counselor was just an idiot!

**Interviewer:** Male or female?

**Cassie:** Male, of course. I don't know. He didn't ask really good questions first of all. He didn't really seem to care. First of all, he blamed it all on my dad. Like the first day blamed everything on my dad. And, I was like, "That's not cool!" So, I didn't like him and I was with him until I went into the hospital, which was beginning of June.

Although these hierarchical relationships made it difficult for these women to negotiate their medical treatment, they were not without some agency. Cassie ended her therapeutic relationships with her first psychiatrist and her male therapist when they seemed indifferent to her concerns. She later began seeing a female therapist that she perceived was more responsive to her needs.

**Cassie** I started seeing the counselor that I m seeing now. She has saved my life numerous times. She's cool. She's really, really awesome. She knew the right questions to ask and she knew when to stop asking them. She knew when to take a different road.

She helped me out with a lot of my issues that I did not even know that I had some of them I knew I had and some I wasn't willing to admit to out loud. She helped me figure out how to deal with them [issues] without cutting.

Jamie also found a therapist that she believed really listened to her and validated her feelings.

**Interviewer:** And, how was she [psychiatrist]?

**Jamie:** She was wonderful. She listened to me and took what I said for the best truth that I could give her, and she seemed very concerned about the things that I was concerned about.

I find it significant that Cassie and Jamie experienced their most difficult interactions with mental health professionals who were men; whereas, their more positive interactions with these professionals were with women.

#### **MEDICAL INTERVENTIONS: CONFORMITY AND RESISTANCE**

While both talk therapy and pharmacological therapy may be beneficial to women who self-mutilate; the above cases illustrate the necessity of choosing a psychiatrist and/or therapist that will validate a woman's experience as well as a woman's voice. Only then can these women begin to validate and trust in their own feelings and observations, something that many of these women were struggling with already.

#### **Pharmacological Treatment and Hospitalization**

In addition to the role medicalization plays in the social control of deviance, feminists and sociologists have also examined the social consequences of medicalization (Conrad 1992; Turner 1992). Individuals who self-mutilate, for instance, are often subjected to psychiatric evaluation, and treatment that may include voluntary or involuntary commitment, pharmacological therapy, or a combination of both (Favazza 1998; Martinson 1998). Although intervention to control this behavior is largely dependent on the expert's theoretical framework; standard treatments of individuals who self-mutilate are behavior therapy, hospitalization, and pharmacotherapy.

In my interviews, the women who had been medically treated for their self-mutilating behavior had been subjected to one or more of the aforementioned therapeutic interventions. Cassie, Jamie, and Sarah all mentioned that their psychiatrists had

recommended and prescribed for them various pharmacological agents in an effort to control their emotional instability and impulsive behavior. Although psychotropics can be useful in treating the manifestations of mood disorders such as manic-depressive and generalized anxiety disorders, an individual's reaction to these medications is highly variable, often resulting in a trial-and-error type of treatment. Furthermore, as the following interview excerpts demonstrate, pharmacotherapy does not necessarily prevent women from participating in self-mutilating behavior, and can sometimes even exacerbate it.

**Cassie:** They put me in counseling and I went on some low Celexa dosages. It didn't help at all with the cutting.

**Jamie:** [I took] Ritalin and that does tend to make it (skin picking) worse much worse extremely hard to control.

When asked what psychotropic medications Cassie's psychiatrist had prescribed for her during the course of her treatment, she cited quite an impressive list of the different drugs she had taken to control her "serious mood swings" and "impulsive behavior," before finding the combination that worked best for her.

**Interviewer:** What meds have they put you on?

**Cassie:** Oh lord. I started off on Celexa, went to Prozac, went to Zoloft and Xanax and Ambien and Resperidol. That's one of the combinations.

**Interviewer:** What are you on right now?

**Cassie:** I'm on Neurontine.

**Interviewer:** Did they tell you why they gave you Neurontine?

**Cassie:** Yeah. I more or less have the cutting part of my self-mutilation under control. I think that, because of therapy...I can work it out better now. And, I know I have resources that I can go to, if I do feel the need to cut. They took me off the anti-psychotic, and so far, I'm under control. The mood stabilizer is just a . . . I didn't know it , but if you look in my journal I have serious mood swings from like extremely low to just like leave me the fuck alone.

Although psychotropic medications may relieve the individual's symptoms of anxiety and depression, they often produce a variety of negative side effects such as the one Jamie experienced while taking Ritalin. Other side effects that individuals treated with psychotropic medications often suffer from include: constipation; decreased sex drive; sexual dysfunction; weight gain or weight loss; nervousness; insomnia or hypersomnia; agitation; anorexia or increased appetite; nausea; vomiting; headaches; dry mouth; and high blood pressure to name just a few. There is also the possibility of much more serious side effects such as convulsions, drug-induced psychosis, suicidal ideation, and in rare cases, death.

In my own life, I have intermittently struggled with the idea of taking psychotropic medications to control my depression, mood swings, and self-mutilating behavior. For me, these medications were simply a tool used by medical authorities to silence my pain along with insuring my conformity to behavioral social norms. Since I viewed pharmacological therapy in this way, I must admit that at the beginning of this research project, I had anticipated that the women I interviewed would recount stories and feelings about taking medication similar to my own feelings of being silenced and controlled. Much to my surprise, however, this was not the case. Instead, these women viewed taking psychotropic medications as a necessary part of their treatment one that helped them cope with feelings that, before receiving this type of intervention, seemed too overwhelming for them to endure. Indeed, Jamie and Cassie although their experiences differed in that Jamie's medication seem to exacerbate her skin picking behavior thought that the psychotropic medications they were taking helped them to function more efficiently both in therapy as well as in their everyday interactions with other individuals as the excerpt below demonstrates.

**Interviewer:** Do you feel like you need it (Ritalin and Prozac) to function?

**Jamie:** Yeah.

**Interviewer:** Okay. It's important for you to have it to function?

**Jamie:** Yeah.

**Interviewer:** You don't feel forced into taking it?

**Jamie:** No.

When asked whether she thought psychotropic medication was beneficial, Cassie replied, " Well, actually I think the medications help with my control, because I'm taking them. " Neither Cassie nor Jamie expressed feeling like their psychiatrists had coerced them into taking medication. As I listened to these women talk about their experiences with medical authorities, I came to realize that it was their relationships with medical authorities that was the problem, and not the psychotropic medications they were taking. I also came to believe that this had been my difficulty as well.

### **Hospitalization**

Another consequence of the medicalization of self-mutilation was evident in the interviews of Cassie and Sarah that of voluntary and involuntary hospitalization. I find it significant that the feelings these women expressed regarding hospitalization differed according to whether their commitment was voluntary or involuntary. Cassie was involuntarily committed to the hospital upon seeking medical attention following an episode of self-injury in which she cut her arm. For Cassie, this hospitalization meant relinquishing physical control of her body and her mind to medical authority. As the following account demonstrates, hospitalization is one of the various strategies medical authorities use to coerce women who self-mutilate into receiving medical treatment that, in turn, undermines their sense of agency and control.

**Cassie:** And, they were like, " You need to go to the hospital. We think it'd be better, if you go to the hospital. " And, the way they worded it I was like, " Okay you know I'll do that". My mom was like, " Okay I'm going to take her home, get her some stuff."

**Interviewer:** So, it was voluntary?

**Cassie:** No . They made me think it was voluntary. They said, "We'd like for you to do this, " so, I guess it would be more cooperative. And, I was like, "That's fine, let me go home and get my stuff". And they were like, " No, you can't. " That's when it turned like, oh my god, they were like, " No, you have to go . There is a life flight ambulance coming right now which is hospital transport, and you're going to go. " So, I was like, " Okay, I have no clothes, I am covered in blood I have nothing." And, they're

like, " Well they'll give it to you at the hospital". My mom was like--I've never seen my mom get mad--she was like, " Well, what if I just walk out with her right now?" She does not stand up to people. They're like, " Well then we'll have to arrest you." And so, they were like, " Yeah we will arrest you, we will put you in handcuffs, we've already called the police to come you know just watch over everything make sure everything was okay."

**Interviewer:** How does that make you feel?

**Cassie:** . . . you know the whole control thing. I lost control. I had no control of the situation whatsoever. When I got to the hospital, my mom went home to get me some stuff. I got to the hospital--this is once again four o'clock in the morning--the doctor told me that I would be able to see my mom that she'd be able to give me my stuff. I was like, "Fine." So, I got to the hospital and they're like, " No you can't see your mom."

Sarah's experience was somewhat different from Cassie's in that the first time she was hospitalized she admitted herself. For Sarah, the hospital represented a safe and nurturing environment a place she could go when the pain of losing her child threatened to overwhelm her. Although nine days after her release from the hospital, Sarah's husband had her readmitted she did not seem to view this as a negative consequence.

**Sarah:** The last time I cut was October 28<sup>th</sup> . I was in a psychiatric hospital. It was the second time I'd been there in less than three weeks. I was there for 9 days prior, then was released, spent five days out, then was readmitted on October 25<sup>th</sup> the 13<sup>th</sup> birthday of my deceased infant son. I also had become suicidal and extremely depressed. I had myself admitted into the hospital the first time; the second time, my husband took me back, because he came home from work early to find me drunk, crying, and bleeding all over the place after cutting my arm in several places, some cuts quite deep.

Indeed, Sarah viewed her hospitalization, both voluntary and involuntary, as medically warranted due to suicidal ideation and self-mutilating behaviors as

well as a safe place to escape from the everyday pressures she experienced as a wife and mother.

Although hospitalization made sense in Sarah's case, because she was suicidal, the reason for Cassie's hospitalization was not as clear cut, especially when considering that her self-inflicted injuries were not life threatening. As Cassie implies later in her account of this experience, she believed that her gender might have played a role in her involuntary hospitalization.

**Cassie:** When I was in the hospital there was not a single male there who was there against his will or who was there forcibly not a single one. Most of them were alcoholic wife beaters. And, they were there voluntarily. You know, if you beat your wife your not thrown in the hospital, you're not put in the hospital you are recommended to go in the hospital. You don't have to.

**Interviewer:** Interesting

**Cassie:** You know there was one guy there; he tried to kill his wife. Hit and run. He's going straight from there [hospital] to jail.

**Interviewer:** Okay, so you were the only person there that was a cutter?

**Cassie:** Um huh. One girl attempted suicide, but she wasn't like a cutter. She just slit her wrists.

The assumption that self-mutilation is simply a pathological and irrational behavior preformed by women who lack any kind of self-control may help to legitimate the involuntary commitment of these women. Indeed, I find it disturbing that a man can attack a woman's body and then has a choice of whether to commit himself to a hospital, whereas, a woman who attacks her own body forfeits such a choice. This double standard tells us much about who has the authority to alter a woman's body.

### **Diagnoses and Stigma**

In the Diagnostic and Statistical Manual of Mental Disorders-IV, women who self-mutilate are frequently diagnosed with one of eight different disorders. These include borderline personality disorder (BPD), mood disorders (MD), eating disorders

(ED), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), dissociative disorder (DD), anxiety and/or panic disorder (AD), and impulse-control disorder not otherwise specified (ICDO). As stated in chapter 2, psychiatric evaluation is not necessarily an objective and reliable measure of an individual's mental functioning, particularly when the individual is a woman (Loring & Powell 1988; Mirowsky & Ross 1989). Largely dependent on a psychiatrist's particular orientation, diagnosis of women who self-mutilate tends to vary between those disorders thought to have a biological basis (OCD, ICDO, MD, ED, PTSD, DD), and those disorders thought to result from a defect of personality (BPD), the more frequently used diagnosis falling within the latter of these two categories (Brodsky, Cloitre, Dulit 1995; Dulit *et al.* 1994; Maris, Berman, & Silverman 2000; Marziali 2000; Favazza 1987; Martinson 1998).

Suyemoto (1998) contends that the primary diagnosis of women who practice self-mutilation is BPD. Women diagnosed with this particular disorder are frequently stigmatized by medical professionals who see them as uncooperative, manipulative, and confrontational (Martinson 1998; Nehls 2000). In fact, it is not unusual for therapists to refer women with BPD to someone else rather than treating them directly. Additionally, medical professionals frequently treat these women with little compassion or understanding, holding them responsible for their own pain (Nehls 2000; Martinson 1998).

The first time I was hospitalized for self-injuring I was diagnosed with BPD. I remember the relief I felt at finally having a legitimate explanation for my self-injurious behavior one with a scientific foundation. At the time, however, I was unaware of the medical stigma attached to this diagnostic label. In fact, it was not until I was majoring in psychology that I learned how truly stigmatizing this diagnosis could be. I can still hear the professor in my abnormal psychology class telling us to avoid borderline patients as they were particularly difficult to work with and the prognosis was poor. Looking back I realized that once I had an official psychiatric diagnosis, my therapist, family, and friends tended to characterize my behavior as being a manifestation of my illness, whether or not that was actually the case. My self-mutilating behavior was now viewed by mental health practitioners as a defect in my personality and not due to situational stressors.

Even more startling to me was learning that rather than being an exact science, psychiatry was subjective at best, largely dependent on the preferences of the evaluator (Loring & Powell 1988; Mirowsky and Ross 1989). I first came to this conclusion when assessing my own experience with medical intervention. Over the last ten years or so, I have been diagnosed with seven different disorders including manic-depressive disorder, anorexia nervosa, chemical dependency, major depression, borderline personality disorder, narcissistic personality disorder, histrionic personality disorder with my most recent diagnosis being cyclothymia, a milder version of manic-depressive disorder. This sort of *musical chairs* diagnostics was also present in both Jamie's and Cassie's psychiatric encounters. As the excerpts illustrate, psychiatric diagnoses are not a stable and reliable measure of an individual's mental functioning, but are fluid, changing from one psychiatric evaluation to the next.

**Jamie:** I know I've been diagnosed with major depression but I remember at one point asking my counselor, my first counselor, what she would diagnose me with at that point and she said she thought Post Traumatic Stress Syndrome.

**Cassie:** Yeah, I was diagnosed with Borderline Personality Disorder and, the second one [psychiatrist] diagnosed me with Borderline Personality Disorder and Bipolar Disorder.

A few years later, Jamie was diagnosed with Attention Deficit Disorder and prescribed Ritalin, which, as I mentioned earlier in this chapter, exacerbated her self-mutilating behavior. The assumption that medical intervention is the most valid and beneficial way to treat women who self-mutilate is thus somewhat questionable when considering the inexactness of this so-called objective science.

Importantly, psychiatric labeling can produce stigma not only in the medical community, but in the larger social community as well. Although many of these women denied feeling stigmatized by individuals outside the medical community, their narratives tell us a different story. Indeed, all of these women spoke of hiding their self-mutilating behavior, particularly when immersed in a particular social context, demonstrating their awareness of the stigma tied to this behavior. In the subsequent passages, notice how these women refer to hiding and/or lying about their self-inflicted injuries. Sarah told of

the distress she felt at lying to her seven-year-old, when her daughter asked her about cutting her arm.

**Sarah:** Of course, I have a lot of scars that are hard to explain, and my daughter asks where scabs or sores come from at times and I lie to her. I really think she knows that I do it [for] two reasons she's, seven by the way [and] once, a few months ago she asked me, " Does it hurt when you cut yourself? " I asked her what she meant and why she asked . She dropped it. Then, when I was in the hospital, she saw cuts on my arm [and asked] " Mom, what happened to your arm? And tell the truuuuuuuuuuth! " Of course, I lied and told her I did it loading the dishwasher. That's the worst, part lying about it, especially to my daughter.

Eve also admitted that she had lied about her self-inflicted injuries whenever someone inquired about them.

**Interviewer:** Did you hide your injury from others?

**Eve:** Yeah, my mom. One time when I was in high school and my wrist was I guess it was scabby or scarred up or something and I was eating dinner and I didn't always cover I'd always go like this [covers her arm with her hand], if I was eating and stuff and so we were talking at the dinner table. And, I guess I just went like this [shows her arm] and she was like, " What happened to your wrist? " and I was like, " What? " I was like "Oh well, " 'cause it was like during the winter, " Oh well, I went to Jane's and I fell on her sidewalk and I scraped my wrist on the ice."

**Interviewer:** Did your friends ever know?

**Eve:** I don't think so , because I never would tell them. I didn't do it to make people feel sorry for me or to like gain attention or something. It was just a private thing that I did that worked for me I guess, and was something that made me feel better, you know?

When asked if anyone had witnessed Jamie's first self-injurious act she responded, " I don't think anyone really knew. No one saw me, and I was there for at

least half an hour " When I inquired if she hid her scab picking injuries from other individuals she replied, " I was probably putting some effort into hiding it, like wearing pants, but not to a great extent. I mean all my close friends know that I have this problem and my parents know and my sister knows. " Elaborating on this she explained that, although she sometimes hid her injuries when in public, most of her friends and family were aware of her self-injurious behavior.

**Jamie:** My sister certainly understands, because she was on medication for almost a year, so she understands. You know, my mom and dad, they watch my sister go through things like this, and I think that they're very understanding. They understand that I'm not just trying to get attention or that I'm not really trying to hurt myself. I think they understand that it just happens sometimes when I get upset.

**Interviewer:** What about your friends?

**Jamie:** The same thing, pretty much. They're supportive. They're supportive. You know they try to encourage you not to do it.

Cassie's parents found out about her behavior when she cut a vein in her arm, during an episode of self-mutilation, requiring her to seek emergency medical attention.

**Cassie** . . . and this time it was just a little bit too close and it busted [vein in her arm].

**Interviewer:** So, what happened? You got scared?

**Cassie:** Yeah, it was like squirting blood like you know you see on the movies. I was covering it up trying to get the bleeding to stop 'cause I didn't want to go wake up my mom 'cause I knew she'd have a hissy fit and I was crying and stuff I put pressure on it I put on a tourniquet. I started to feel light headed so, I was like, " This is not good, I'm losing a lot of blood. I am light headed. I need to do something, " so I got up and I told my mom.

Later in her narrative, Cassie stated that even though she hid the scars that were the result of her cutting behavior, she did so in a discretionary manner choosing to hid her scars from some individuals and not others.

**Cassie:** Sometimes, if I'm going to work, I usually cover them up just cause I don't want nosey [people] telling me, " What happened to your arm? " I don't want weird people asking questions. [A] couple of times I've told people--I used to work at a camp for mentally retarded adults and they'd ask me what happened and I was like, " My cat scratched me, " ' cause they wouldn't be able to understand it I don't think. For a while, I did want to hide it, like especially when it was scabbed and when the scars were bright red I wanted to hide it. Now it really doesn't bother me that much. Not like at a church thing, I'd definitely cover them up at church.

**Interviewer:** Why?

**Cassie:** 'Cause it's my mom's friends, you know? I don't want her to feel weird, and around my mom's family I do too 'cause my grandmother would literally have a heart attack if she found out.

As can be seen from this narrative, Cassie's choice to hide her scars was oftentimes a result of her wish to protect family members from stigma, rather than a wish to protect herself.

Sarah indicated that she self-injures only when she is alone, although there have been people nearby when she has done it. When asked about hiding her injuries she said:

**Sarah:** Yes, for the most part I hide them. This last time I didn't bother to hide them. I don't know why. Maybe ' cause I didn't care. I thought I would kill myself anyway, I guess.

**Interviewer:** Are other people aware that you self-injure? If so, how did they react to you as a result of your self-injury.

**Sarah:** My husband and doctors know. My doctors are very understanding and try to help. My husband tries to understand, but for the most part. If he sees anything, he doesn't say much. If he does, he may ask why or if I'm okay, but usually won't say anything. It's an uncomfortable subject to talk about for all concerned I guess.

Virginia alludes to privacy on two occasions.

**Virginia:** . . . it's usually done in bathrooms . I only did it in my parents house once and it made me feel so bad that I didn't ever do it there again. But, I normally did it at school you know just made sure all the stalls were empty and stuff like that, but other than that I really didn't care about it 'cause it didn't matter to me at all just like whatever if someone walks in they walk in, you know? I was just so angry at the time. I was just I don't know I was just so angry at the time. I remember you know wanting to hit people and hurt them and just do all kinds of just mean stuff.

Later in the interview, we had this discussion:

**Virginia:** They still don't know about the cutting.

**Interviewer:** Okay, they [family members] still don't know?

**Virginia:** No, they still have no idea.

Contrary to the psychological literature that views self-mutilation as a cry for attention, the narratives of these women illustrates that this is not the case. These interviews reveal that those who self-mutilate are aware of the negative social stigma that these behaviors could and often do generate. Indeed, as their accounts tell us, these women hid their injuries from those with the power to medicalize and pathologize this behavior, and at times, they hid their behavior from friends and family.

Medical intervention, at least for these three women, seemed to have more positive than negative consequences. The accounts of these women illustrate that this type of intervention gave them a legitimate explanation for their behavior as well as an opportunity to learn alternative ways to cope with overwhelming emotions. Contrary to losing their sense of agency, these women found empowerment in viewing medical treatment for this behavior as a choice. They decided when and if to continue treatment with a particular therapist and/or take prescribed medications feeling validated being the deciding factor.

## CHAPTER 6

### DISCUSSION AND CONCLUSIONS

In a quest to explore my research questions, I interviewed five women that had participated in self-mutilation. These questions were born from my personal struggle to understand why women, such as myself, choose to participate in this extreme form of body alteration. Although I initially viewed self-mutilation as a social protest aimed against Western ideologies of the female body, the narratives of these women illustrate that this protest was at best unconscious. Though the social context that preceded self-mutilation was different between and within the narratives of these women; the feelings they reported having during this act were strikingly similar. Ostensibly, these women injured their bodies in reaction to particular social situations that elicited feelings of powerlessness, frustration, anger, shame, and invisibility. As the accounts of these women reveal, with self-injury comes release and a temporary reprieve from emotions that they describe as intolerable and unacceptable.

#### **Why Women Self-Mutilate: Is There an Answer?**

Upon closer analysis, however, a much more complex picture of this behavior is revealed one that might be viewed as a form of social protest. I argue here that what these women perceive as retribution, and medical authorities understand as attention seeking, can alternately be viewed as a form of subversion to the gendered expectations of women's bodies and behavior. While none of these women specifically referred to their actions as forms of social protest, the possibility of protest is illuminated when examining the social context in which their self-injuring behavior occurred. More specifically, these women expressed feelings of failure in response to social conditions the inability to achieve gendered standards concerning Western ideologies of the female body, the myth of the *good girl*, or the myth of the *good woman* in relationships with men and as mothers. For instance, Eve's self-injurious behavior could be understood as a form of protest against the body norms set forward by her father, along with the myth of the *good girl* (e.g., Eve's perfectionism). Cassie's initial self-injury could also be considered a protest as she cut herself in response to the inequitable gender norms of sexual behavior. In other words, the complexity of this human behavior is such that it is not possible to adequately account for it using only one theoretical framework.

In the remainder of this chapter, I discuss how the women I interviewed spoke of and understood their self-mutilating behavior, as well as the ways they viewed medical intervention.

Piper (1994) found evidence of a gendered social context when working with adolescent girls suffering from a variety of eating disorders. She asserts that "[c]ertain themes, such as concern with weight, fear of rejections and the need for perfection, seemed rooted in cultural expectations for women rather than in the pathology of each individual girl" (Piper 1994:35). This was certainly evident in the accounts of the women I interviewed. Indeed, these women spoke of their self-injury as retribution for perceived transgressions such as inappropriate sexual behavior (e.g., Cassie's promiscuity); failing to achieve perfection (Eve's hair pulling after making a mistake); and/or, for perceived inadequacies as women (e.g., Sarah's miscarriage). The significance here is that all of these perceived transgressions are positioned within a context of gendered norms that these women believed they had violated. This suggests that these women have internalized the gendered norms of Western society and that therefore, their self-mutilating behaviors are a method of (perhaps unconscious) self-regulation. In other words, these women turn feelings of anger and frustration inward, punishing themselves instead of lashing out at others or the gendered social norms. Ironically, even though these women may be acting as their own form of social control, because women in Western society lack the authority to alter their bodies in socially unsanctioned ways, medicalization of this behavior shifts control away from these women and places it into the hands of medical authority.

As I listened to these women's accounts, I was struck by their reluctance to relate negative feelings or self-mutilating behaviors to the difficulties they were experiencing within their family structure. As I demonstrated in Chapter 5, three of the women I interviewed seemed particularly ambivalent when asked to discuss their relationships with parents or siblings, providing contradictory accounts of their familial histories. This sort of disinclination to lay blame at parental feet might well be a product of gender socialization, in which girls are encouraged to be other-directed. These women appeared to be struggling with two opposing needs (1) the need to validate their actual experience within the family structure; and, (2) the need to remain loyal to and protect the

family image. As mentioned in Chapter 4, these contradictions seem to reflect the larger social inconsistencies between the ideal family in Western society and the reality of the family as it currently exists. As their accounts illustrate, women who self-mutilate are frequently living in environments embedded in other problems such as alcoholism, drug abuse, and mental illness that psychiatric literature all too often ignores.

The reality of male hegemony in Western society was another underlying theme prevalent throughout the narratives of these women. Indeed, nearly all of the interviewees began self-mutilating in response to social situations involving their boyfriends, fathers, or brothers. This theme appears to be common in other female dominated mental disorders as well. Piper (1994:35), for instance, found that many of the adolescent girls she treated for eating disorders and self-mutilating behavior seemed "...obsessed with complicated and intense relationships. " This finding is not surprising when considering the culture in which these girls live. As previously mentioned, heterosexism and patriarchy undergird Western society, and as a result of these ideologies and structures (1) women are expected to be in intimate relationships with men; (2) men are more valued within the family and larger social structure than are women; (3) men define the type of female body that is desirable; and, (4) a woman's worth is dependent upon her reproductive capabilities. These assumptions not only outline the norms of gendered behavior in Western society, but also tell us much about the value and location of women in relation to men. Indeed, the women I interviewed spoke of how their relationships with men often elicited feelings of anger, rejection, desperation, powerlessness, worthlessness, anxiety, and failure. To ignore that self-mutilation occurs within a context of gender inequity further invalidates the experiences of these women while continuing to justify and maintain their inequitable treatment.

Although self-mutilation may initially be practiced in an attempt to circumvent and/or control the emotional pain triggered by a particular social event, in time it may become a behavior practiced in and of itself (Levenkron 1998; Maris, Berman, & Silverman 2000; Moskovitz 2001; Piper 1994; and, Yasgur 2001). Consequently, self-mutilation can be viewed as an addictive behavior in that the relief produced by the endorphins released in the body upon injury often act to anesthetize the individual's emotional pain, increasing the probability that this behavior will be repeated (Time 1998;

Winchel & Stanley 1991). Self-injurious behaviors that some psychiatrists believe are a result of poor impulse control might therefore be better understood as behaviors occurring in response to particular social situations that, in time, may progress into addiction. As their accounts demonstrate, self-injury for the women I interviewed began as a premeditated and deliberate act; not one attributable to poor impulse control. To indicate otherwise denies these women agency, reifying Western stereotypes of women as irrational and internally driven, and ignores the social context in which this behavior occurs.

Another misassumption among many mental health professionals as well as the general public is that women who self-mutilate do so out of a need for attention. Although this might be true for some women, the narratives of the women I interviewed did not lend support to this claim. First, these women took great pains to hide the physical evidence of their self-injurious behavior such as inflicting harm to parts of the body that were not normally seen (e.g., stomach, thighs, & breasts), as well as dressing in clothes that would cover their injuries. The fact that these women hid their self-inflicted injuries seems to confirm that they were aware of the social stigma attached to self-mutilation along with the possibility of medical intervention if this behavior were discovered.

Secondly, these women viewed their self-injurious behaviors as a means of coping with those feelings they perceived were too overwhelming to verbally express. Self-mutilation gave them a sense of agency and control over their emotional pain. Cassie expressed it best when she said that self-mutilation "...made my mental pain physical and it gave me something that I could see and it was pain that I had control over." Nowhere in any of these women's accounts did I find evidence to support the assertion that self-mutilation was performed in an effort to seek attention. On the contrary, their efforts to hide this behavior demonstrate the improbability that self-mutilation was performed as a way of attention seeking an assertion that only acts to infantilize this behavior.

Other explanations researchers have posited for women's participation in self-mutilating behaviors are more consistent with the accounts of the women in my study. These explanations focus on self-mutilation as an act individuals employ to compensate

for the lack of appropriate coping skills; the inability to verbally express certain emotions (e.g., anger, sadness, disappointment, etc.); and/or, as a means to relieve overwhelming emotional pain (Favazza 1987; Kaplan 1994; Kashgarian, 1999; McLane 1996; Nichols 2000; Pipher 1994; Suyemoto 1998). Some medical professionals, along with many of the women who self-mutilate, have described this behavior as a survival tool one they engaged in to avoid suicide (Favazza 1998; Leverkron 1998; Maris, Berman & Silverman 2000; Yasgur 2001). Thus it has been argued that self-injurious behavior be addressed only after teaching women who participate in this behavior more appropriate coping skills (Ussher 1992).

### **Medicalization and its Consequences**

The women that I interviewed who had received medical treatment because of their self-mutilating behavior spoke of both the positive and negative implications of this form of intervention. Contrary to what I had expected to find, these women considered most of the medical interventions they received as being quite beneficial in that it provided them with (1) a legitimate explanation for their self-mutilating behaviors; (2) a safe and supportive environment to discuss their innermost feelings; (3) an opportunity to understand and begin mending dysfunctional family relationships; and, (4) alternative coping skills. Even pharmacological therapies were viewed by these women as highly effective and beneficial in relieving feelings that they believed contributed to their self-mutilating behavior such as anger, anxiety, and depression.

Medical intervention, though seemingly quite benign in one sense, also has a much darker side one in which an individual loses agency and control of the body, which becomes the domain of medical authority. Evidence of this dark side of medicalizing self-injurious behavior was apparent in several of these women's accounts. Social and medical stigma, involuntary hospitalization, and strained relationships with medical personnel were all ways that the medicalization of this behavior negatively effected the lives of these women. Although none of these women specifically mentioned experiencing social or medical stigma as a result of being labeled mentally ill, indicators of stigma were littered throughout their stories. The most glaring was manifested in their relationships with male psychiatrists. As the accounts of Cassie and Jamie demonstrated in Chapter 5, women frequently feel invalidated and ignored by the

medical authorities entrusted with their care. Once labeled as mentally ill, the observations and behaviors of these women become suspect in the eyes of some medical authorities, producing in them feelings of powerlessness and loss of control.

Moreover, as was previously discussed, psychiatric diagnosis is highly subjective and thus frequently changes from one physician to the next. Based largely upon the combined personal and professional philosophies of a psychiatrist, women who self-injure are subject to a number of different psychiatric diagnoses some that even mental health practitioners argue are highly stigmatizing such as Borderline Personality Disorder (Martinson 1998; Nehls 2000). Additionally, psychiatric misdiagnosis of women who self-mutilate sometimes leads to ineffectual and inaccurate treatment, especially when the treatment involves psychotropic medications. Medications that may be quite effective in treating the manifestations of one disorder, for example, may actually exacerbate symptoms of another disorder, as was the case with Jamie. Furthermore, medications commonly produce a number of adverse side effects in the women who take them some that may even prove life threatening. Although I cannot deny that the women in my study thought this form of medical treatment quite effective in alleviating symptoms of anxiety and depression, I also think it important to remember the dangers attributed to psychotropic medications as well.

Hospitalization is another consequence of the medicalization of self-injurious behavior that women participating in these acts sometimes experience. The power to control a woman's physical body by confining her to a highly restrictive environment demonstrates the extent to which medicalization can and is employed as a social control. Women who dare to step beyond the gendered norms of feminine behavior may and often do find themselves at the mercy of medical authorities. Ussher (1992:170) contends that "[w]hat is mad within patriarchy is that which is at odds with the dictates of the patriarchs. Women who reject their designated role can be positioned as mad, and therapy helps us to conform."

Although Cassie and Sarah were both hospitalized for their self-mutilating behaviors, their perceptions of this experience countered each other depending on whether they were voluntarily or involuntarily committed. Whereas Sarah, whose initial hospitalization had been voluntary, perceived the hospital to be a safe and supportive

environment, Cassie, who was committed involuntarily, viewed it as coercive and controlling. In her narrative, Cassie alludes to an awareness of the gendered nature of her commitment. As discussed in Chapter 4, men in the hospital where Cassie was a patient were there of their own volition even though many of them had exhibited quite volatile behavior. This should come as no surprise, since men's violent behavior, whether directed toward the self or others, is often considered a normal response to the dictates of masculinity. Indeed, one need only look at the under-representation of men in the biomedical literature on self-mutilation to find support for this claim.

### **Resistance to Medical Intervention**

Although one might think that once medical intervention has occurred, these women become passive victims, this was not the case. The accounts of these women illustrate how, at times, they sought to reclaim their agency through acts of resistance acts such as discontinuing or refusing ineffective medications; discontinuing therapy and/or seeking a new therapist when their needs go unmet; and, as previously discussed, hiding their behavior from family and friends in order to avoid intervention altogether. These women asserted that simply knowing they had a choice in whether to continue their treatment was in itself empowering.

### **Where Do We Go From Here?**

In Chapter 2, I argued that the medicalization of self-mutilation did a disservice to women participating in this behavior, since only the behavior is acknowledged and treated leaving the larger contributory social factors, such as patriarchy, left unexplored (Shilling 1993; Turner 1992). Furthermore, I maintained that the medicalization of this behavior acts to depoliticize, and thus privatize an issue that might better be addressed in the public sphere. I also posited that medicalizing self-mutilation acted as an effective means of controlling the women who participate in this behavior, while diminishing their sense of agency and control. Although the accounts of the women I interviewed support some of these assumptions, they also illuminate a much more complex picture of this behavior than I had first realized. Whereas the biomedical model falls short in providing an adequate explanation of this behavior, so too does feminist analysis. As Ussher (1992), so eloquently expresses in her book *Women's Madness: Misogyny or Mental Illness*

There can be no simple answer to the question of whether women's madness is a misogynistic construct, or a mental illness. It is both. It is neither. It cannot be encapsulated within one explanation, one interpretation. As women, we are regulated through the discourse of madness. But the woman herself is real, as is her pain we must not deny that. So we must listen to women (306).

This thesis has been an attempt to do just that ; to validate women's pain by giving them a voice. Allowing women to tell their stories is the first step toward a more inclusive understanding of this behavior an understanding that embodies the everyday experiences of women living in a society that devalues and positions women as deviant.

## REFERENCES

- American Psychiatric Association. (1995). *Diagnostic and Statistical Manual of Mental Disorders, 4ed.* Washington, D.C.: American Psychiatric Association.
- Atkinson, Michael and Kevin Young. Flesh Journeys: Neo Primitives and the Contemporary Rediscovery of Radical Body Modification. *Deviant Behavior: An Interdisciplinary Journal* 22 (2001): 117-146
- Austin, Elizabeth. Marks of Mystery. *Psychology Today* 32, 4 (July 1999): 46-52.
- Bartkey, Sandra Lee. Foucault, Femininity, and the Modernization of Patriarchal Power. In Katie Conboy, Nadia Medina, and Sarah Stanbury, eds., *Writing on the Body: Female Embodiment and Feminist Theory*, pp. 90-110. New York: Columbia University Press, 1997.
- Bordo, Susan. The Body and the Reproduction of Femininity. In Katie Conboy, Nadia Medina, and Sarah Stanbury, eds., *Writing on the Body: Female Embodiment and Feminist Theory*, pp. 90-110. New York: Columbia University Press, 1997.
- Brodsky, Beth S., Ph.D.; Kevin M. Malone, M.D.; Steven P. Ellis, Ph.D.; Rebecca A. Dulit, M.D.; and J. Jon Mann, M.D. Characteristics of Borderline Personality Disorder Associated With Suicidal Behavior. *American Journal of Psychiatry* 154 (1997): 1715-1719.
- Brodsky, Beth S., Ph.D.; Marylene Cloitre, Ph.D.; and Rebecca A. Dulit, M.D. Relationship of Dissociation to Self-Mutilation and Childhood Abuse in Borderline Personality Disorder. *American Journal of Psychiatry* 152 (1995): 1788-1792.
- Brumberg, Joan J. *Fasting Girls: The Emergence of Anorexia Nervosa as a Modern Disease.* Cambridge, MA: Harvard University Press, 1988.
- Brumberg, Joan J. *The Body Project: An Intimate History of American Girls.* New York: Vintage Books, 1997.
- \_\_\_\_\_. 1999-2001. Citizens Commission on Human Rights [on-line].  
<http://www.cchr.org/children/eng/page09a.htm>
- Conrad, Peter. Medicalization and Social Control. *Annual Review of Sociology* 18 (1992), 209-232.
- Dulit, Rebecca A., M.D.; Minna R. Fyer, M.D.; Andrew C. Leon, Ph.D.; Beth S.

- Brodsky, Ph.D.; and Allen J. Frances, M.D. Clinical Correlates of Self-Mutilation in Borderline Personality Disorder. *American Journal of Psychiatry* 151, 9 (September 1994): 1305-1311.
- Favaro, Angela, M.D. and Paolo Santonastaso, M.D. Impulsive and Compulsive Self-Injurious Behavior in Bulimia Nervosa: Prevalence and Psychological Correlates. *The Journal of Nervous and Mental Diseases* 186, 3 (March 1998): 157-165.
- \_\_\_\_\_. Self-Injurious Behavior in Anorexia Nervosa. *The Journal of Nervous and Mental Diseases* 188, 8 (August 2000): 537-542.
- Favazza, Armando. R. *Bodies Under Siege: Self-Mutilation and Body Modification in Culture and Psychiatry, 2<sup>nd</sup> ed.* Baltimore: The Johns Hopkins University Press, 1987.
- \_\_\_\_\_. The Coming of Age of Self-Mutilation. *The Journal of Nervous and Mental Diseases* 186, 5 (May 1998) 259-268.
- Favazza, Armando and Karen Conterio. Female Habitual Self-Mutilators. *Acta Psychiatrica Scandinavica* 79, 3 (March 1989): 283-289.
- Favazza, Armando R.; Lori DeRosear; and Karen Conterio. Self-Mutilation and Eating Disorders. *Suicide and Life-Threatening Behavior* 19, 4 (Winter 1989): 352-362.
- Finlay, Liza. Aching for Affection. *Chatelaine* 73 (October 2000): 135-139.
- Foucault, Michel. *Discipline and Punish: The Birth of the Prison.* New York: Vintage Books, 1995.
- Gould, Stephen J. *The Mismeasure of Man.* New York: W.W. Norton & Company, 1981.
- Guillaumin, Colette. Race and Nature: The System of Marks. *Feminist Issues* 8 (1988), 25-43.
- Henslin, James M. *Essentials of Sociology: A Down-To-Earth Approach.* Boston, MA: Allyn and Bacon, 2000.
- Irvine, Janice M. Regulated Passions: The Invention of Inhibited Sexual Desire and Sexual Addiction. In Jacqueline Urla and Jennifer Terry, eds., *Deviant Bodies*, pp. 314-337. Bloomington, IL: Indiana University Press, 1995.
- Kalb, Claudia. An Armful of Agony: Treatment options for self-mutilators. *Newsweek*,

- Nov. 9, 1998 v132 i19 p82(1).*
- Kaplan, Lisa Faye. Hurting to be in Control: When Pain Makes it Feel Better. *Gannett News Service* Sept. 21, 1994.
- Kashgarian, Debora M. Self-mutilation: A hermeneutical phenomenological study. *Dissertation Abstracts International: Section B: the Sciences & Engineering* 60, 4-B (October 1999): 2857.
- Kiragu, Karungari. Female Genital Mutilation: A Reproductive Health Concern. In Robert Heiner s, *Social Problems and Social Solutions: A Cross-Cultural Perspective*, pp. 83-93. Boston, MA: Allyn and Bacon, 1999.
- Kreisman, Jerold J. and Hal Straus. *I Hate You — Don't Leave Me: Understanding the Borderline Personality*. New York: Avon Books, 1989.
- Larson, Edward J. *Sex, Race, and Science: Eugenics in the Deep South*. Baltimore: The John Hopkins University Press, 1995.
- Levenkron, Steven. *Cutting: Understanding and Overcoming Self-Mutilation*. New York: W. W. Norton and Company, 1998.
- Longino, Helen E. *Science as Social Knowledge: Values and Objectivity in Scientific Inquiry*. Princeton: Princeton University Press, 1990.
- Loring, Marti and Brain Powell. Gender, Race, and DSM-III: A Study of the Objectivity of Psychiatric Diagnostic Behavior. *Journal of Health and Social Behavior* 29 (March 1988): 1-22.
- Mann, Judy. *The Difference: Discovering the Hidden Ways We Silence Girls; Finding Alternatives That Can Give Them a Voice*. New York: Warner Books, 1994.
- Maris, Ronald W., Berman, Alan L., and Silverman, Morton M. *Comprehensive Textbook of Suicidology*. New York: The Guilford Press, 2000.
- Martin, Emily. *The Woman in the Body: A Cultural Analysis of Reproduction*. Boston, MA: Beacon Press, 1992.
- Martinson, Deb (1998) *Self-Injury*. [on-line] <http://www.palace.net/~llama/selfinjury>
- Marziali, Elsa, Ph.D. Role of Sexual Abuse Etiology of Borderline Personality Disorder. *Archives of Sexual Behavior* 29, 4 (August 2000): 407.
- McCaughey, Martha. Fleshing Out the Discomforts of Femininity: The Parallel Cases of Female Anorexia and Male Compulsive Bodybuilding. In Jeffery Sobal and

- Donna Maurer, eds., *Weighty Issues: Fatness and Thinness as Social Problems*, pp. 133-155. New York: Aldine De Gruyter, 1999.
- McLane, Janice. The voice on the skin: self-mutilation and Merleau-Ponty's theory of language. *Hypatia* 11, 4 (Fall 1996): 107-122.
- Mirowsky, John and Catherine E. Ross. Psychiatric Diagnosis as Reified Measurement. *Journal of Health and Social Behavior* 30, 1 (March 1989): 11-25.
- Morey, Leslie C. and Mary C. Zanarini. Borderline Personality: Traits and Disorder. *Journal of Abnormal Psychology* 109, 4 (2000): 733-737.
- Moskovitz, Richard, M.D. *Lost in the Mirror: An Inside Look at Borderline Personality Disorder*. Dallas, Texas: Taylor Publishing Company, 2001.
- Myers, James. Nonmainstream body modification: genital piercing, branding, burning, and cutting. *Journal of Contemporary Ethnography* 21, 3 (October 1992): 276-307.
- Nehls, Nadine. Recovering: A Process of Empowerment. *Advances in Nursing Science* 22, 4 (June 2000): 62-70.
- Nichols, Polly. Bad Body Fever and Deliberate Self-Injury. *Reclaiming Children and Youth* 9, 3 (Fall 2000): 151-159.
- Pipher, Mary. *Reviving Ophelia: Saving the Selves of Adolescent Girls*. New York: G. P. Putnam's and Sons, 1994.
- Proctor, Robert N. The Destruction of Lives Not Worth Living. In Jacqueline Urla and Jennifer Terry, eds., *Deviant Bodies*, pp. 170-196. Bloomington, IL: Indiana University Press, 1995.
- Scheff, Thomas J. *Being Mentally Ill: A Sociological Theory*, 2<sup>nd</sup> ed. New York, NY: Aldine De Gruyter, 1984.
- Schiebinger, Rhonda. Skeletons in the Closet: The First Illusions. In Rhonda Schiebinger, ed., *Feminism and the Body*, pp. ?. New York: Oxford University Press, 2000.
- Seidman, Steven. *Difference Troubles: Queering Social Theory and Sexual Politics*. New York: Cambridge University Press, 1997.
- Shilling, Chris. *The Body and Social Theory*. Tall Oaks, CA: Sage Publications Inc.,

- 1993.
- Somerville, Siobhan. Scientific Racism and the Invention of the Homosexual Body. In Brett Beemyn and Mickey Eliason, eds., *Queer Studies: A Lesbian, Gay, Bisexual, and Transgender Anthology*, 241-261. New York: New York Press, 1996.
- Suyemoto, Karen L. The Functions of Self-Mutilation. *Clinical Psychology Review* 18, 5 (1998): 531-554
- Swann, Catherine. Reading the Bleeding Body: Discourses of Premenstrual Syndrome. In Jane M. Ussher, ed., *Body Talk: The Material and Discursive Regulation of Sexuality, Madness and Reproduction* pp. 176-198. New York: Routledge, 1997.
- Terry, Jennifer. Anxious Slippages between Us and Them : A Brief History of the Scientific Search for Homosexual Bodies. In Jacqueline Urla and Jennifer Terry, eds., *Deviant Bodies* pp. 129-169. Bloomington, IL: Indiana University Press, 1995.
- Thompson, William E. and Hickey, Joseph V. *Society in Focus: An Introduction to Sociology*. New York: Harper Collins College Publisher, 1994.
- \_\_\_\_\_. What the Cutters Feel. *Time*, November 9, 1998, p93 (1)
- Turner, Brain S. *Regulating Bodies: Essays in Medical Sociology*. London: Routledge, 1992.
- Urla, Jacqueline and Terry, Jennifer. Mapping Embodied Deviance. In Jennifer Terry and Jacqueline Urla, eds., *Deviant Bodies* pp.1-18. . Bloomington, IL: Indiana University Press, 1995.
- Ussher, Jane M. *Women s Madness: Misogyny or Mental Illness?* Amherst: The University of Massachusetts Press, 1992.
- Wijngaad, Marianne Van Den. *Reinventing the Sexes: The Biomedical Construction of Femininity and Masculinity*. Bloomington, IL: Indiana University Press, 1997.
- Winchel, Ronald M., M.D. and Michael Stanley, Ph.D. Self-Injurious Behavior: A Review of the Behavior and Biology of Self-Mutilation. *American Journal of Psychiatry* 148 (1991): 306-317.1991
- Yasgur, Batya Swift. Antisuicidal Effect of Self-Injury Calls for Tolerance. *Clinical Psychiatry News* 29, 7 (July 2001): 50-53.

**APPENDIX A**  
**RECRUITMENT FLYER**

VIRGINIA TECH GRADUATE STUDENT  
SEEKS INDIVIDUALS TO PARTICIPATE IN  
A SOCIOLOGICAL RESEARCH PROJECT

Participants in this project will be interviewed to obtain information on the practice of female self-mutilation. In order to participate in this research project, individuals must meet the following criteria:

- **MUST BE FEMALE**
- **MUST BE 18 YEARS OF AGE OR OLDER**
- **PRACTICE SELF-MUTILATION (I.E., SELF-INJURY TO ONE'S BODY SUCH AS CUTTING, BURNING, HITTING, SCARRING, ETC.) EITHER CURRENTLY OR IN THE PAST**

For more information or if you are interested in participating in this research project, please contact Rosemary Ellis at [roellis2@vt.edu](mailto:roellis2@vt.edu)

**NOTE: All inquiries and interviews will be strictly confidential**

**APPENDIX B**  
**SEMI-STRUCTURED INTERVIEW SCHEDULE**

**SEMI-STRUCTURED INTERVIEW QUESTION FOR WOMEN WHO  
SELF-INJURE**

Demographics

- 1) How old were you on your last birthday?
- 2) Where were you born?
- 3) How many years of school have you completed?
- 4) Are you in school now? If so, what year are you in?
- 5) What is your major area of study? (if relevant)
- 6) Are you currently employed? If so, what is your occupation?
- 7) What is your current marital status?
- 8) Are you currently living alone or with others?
- 9) If you are living with others, what is their relationship to you?
- 10) Do you have any brothers or sisters? If so, what was your position in the family (e.g., where you the first born, middle, baby)?

Main Questions

- 11) How old were you when you first began injuring yourself?
- 12) If you can, explain the first time you self-injured in as much detail as possible.
- 13) When was the last time you self-injured? Starting about one week before you injured yourself, explain in as much detail as possible what led up to your self-injury (what circumstances were going on in your life) and what happened during self-injury and after.
- 14) What method of self-injury do/did you practice?
- 15) Why do you believe you self-injure?
- 16) What events usually occur prior to an act of self-injury?
- 17) What emotions do you feel just before self-injuring?
- 18) Do you have a certain ritual you practice before, during, or after self-injury?
- 19) What do you usually use to self-injure?
- 20) How do you feel during self-injuring?
- 21) How do you feel after self-injuring?
- 22) How long does an episode of self-injury usually last?

- 23) Do you injure yourself more than once during an episode? If so, about how many times would you say you injure yourself during an episode of self-injury?
- 24) When do you know that it is time to quit?
- 25) Do you usually experience pain while in the act of self-injuring?
- 26) Do you use drugs or alcohol before an episode of self-injury? If so, what do you use?
- 27) Are others around you when you self-injure or are you usually alone?
- 28) Where on your body do you self-injure?
- 29) Do you hide your injuries from others? Why or why not?
- 30) Are other people aware that you self-injure? If so, how do they react to you as a result of your self-injury?
- 31) Have you ever been medically treated for self-injury? If so, where and how?
- 32) How do you feel you were treated by the medical practitioners who attended to you?
- 33) Do you currently see a therapist?
- 34) If so, how long have you been in therapy?
- 35) Has therapy been successful in helping you end this behavior? Why or why not?
- 36) Do you currently suffer from other self-injurious behaviors such as anorexia, substance abuse, bulimia, etc.?
- 37) Where you ever abused or traumatized? If yes, please explain.
- 38) Are you currently taking medication that was prescribed by a psychiatrist? If so, what medications are you taking?
- 39) Have you ever been prescribed medication for self-injurious behavior in the past?
- 40) If so, can you explain the situation?
- 41) What circumstances in your life, if any, do you believe may have contributed to your self-injurious behavior?
- 42) Have you suffered any negative consequences because of this behavior (e.g., hospitalization, family backlash, social stigma, etc.)? If so, what were they?

**APPENDIX C**  
**IRB APPROVAL MEMORANDUM**

16 May 2001

**MEMORANDUM**

TO: Rosemary Ellis  
Sociology (0137)

FROM: David M. Moore

SUBJECT: IRB Review — *The Medicalization of Female Self-Mutilation: A Feminist Analysis* — IRB #01-235

The above referenced protocol was submitted for full review by the IRB at its May 14, 2001 meeting. The board members voted approval of this proposal contingent upon receipt of responses to questions and issues raised during its deliberation. The items requiring clarification or action are as follows:

1. The Informed Consent document uses the first, second, and third person in referring to the subject, and thus lacks consistency throughout. Please edit the IC to ensure that the subject is referred to as the subject and eliminate the use of you and your .
2. Please reword the Anticipated Benefits to Subjects section of the Informed Consent to clearly state that the study does not promise any particular benefit to individual subjects. Subjects involved in studies of their psychological/social problems likely enroll because they seek answers to or resolution of their problems, and the IC for this study must be clear in stating that participation in this study will not in and of itself provide resolution of those problems.
3. It was recommended that a handout be made available providing information about counseling services at the Cook Counseling Center, including telephone contact information. Please provide the IRB with a copy of the handout materials which will be given to the subjects.
4. Please communicate with the Cook Counseling Center and confirm that they will be able to provide assistance to your subjects on an as-needed basis.
5. It was recommended that the flier provide clearer examples of the range of self-mutilation behaviors practiced by potential subjects.
6. The e-mail address at the bottom of the flier was incomplete and needs to be corrected ( edu was not listed).

7. Please state clearly in the IC that the PI (Ellis) will be the sole individual conducting the interviews, and the sole individual transcribing the audiotapes. If the graduate committee members will be listening to the audiotapes, then the IC must clearly state that they, too, will have access to the raw tapes.

8. The Confidentiality section of the IC states "If notes or audiotape recordings of subjects will be used for 'educational purposes' ". What will those educational purposes would be? Will the raw tapes be played to students in classes or to professionals at scientific meetings or seminars? The use of the raw tapes in such settings would in effect breach the confidentiality promised to the subject in the IC. If indeed the tapes will be played for individuals other than the PI, there is a critical need for informing the subject of what the possible uses of those audio recordings will be and the likely audiences. Please clarify this statement and the intended educational uses of the audiotapes. If you will be playing the tapes in a public setting, then either an additional signature line must be included on the IC or a completely separate consent form be used to clearly state to the subjects that the tapes will not be held in strict confidence.

Following receipt and review of your responses, I, as Chair of the Virginia Tech Institutional Review Board, have, at the direction of the IRB, been authorized to grant approval for this study for a period of (12) months, effective the date of the final approval letter.

**APPENDIX D**  
**INFORMED CONSENT FORM**

*Virginia Polytechnic Institute and State University*

*Consent Form - 2001*

**CONSENT TO PARTICIPATE IN RESEARCH**

Female Self-Mutilation: A Feminist Analysis

The respondent is asked to participate in a research study conducted at the \_\_\_\_\_ (respondent s choice of location) by Rosemary L. Ellis. The respondent s participation in this study is voluntary. The respondent should read the information below and ask questions about anything she does not understand, before deciding whether to participate in this study.

**• PURPOSE OF THE STUDY**

The purpose of this study is to examine the ways in which the respondent understands and talks about her experience as a woman who mutilates herself. It will allow the respondent to talk openly about her behavior without the fear of medical and social repercussion. What I mean by this is that the respondent will be able to share her story in a safe environment without the fear of medical intervention or social stigma. The respondent is asked to participate in this study because she is a female over the age of 18 who has self-identified as a person who is currently or has previously participated in this behavior.

**• DURATION AND LOCATION**

The respondent s participation in this study will last for approximately 1-2 hours and will be conducted at \_\_\_\_\_ (respondent s choice of location).

**• PROCEDURES**

If the respondent volunteers to participate in this study, I will ask her to do the following things: I will first ask if the respondent will allow me to either audiotape or take notes while the interview is in progress. Before the interview, I will ask the respondent to choose a pseudo-name (false identity) that I will use within my thesis analysis. This will enable me to discuss research findings without revealing the respondent s true identity.

The interview itself will consist of carrying on a conversation about the respondent's experiences as a woman who mutilates herself. I will also share with the respondent some of my own experiences with this behavior. During the interview, I will encourage the respondent to talk openly and honestly about her understanding of why she chooses/chose to participate in this behavior. To help the respondent begin talking about her behavior, I will ask her questions like:

How old are you?

When did you first begin to mutilate yourself?

What form of mutilating behavior have or do you participate in (i.e., cutting, burning, picking at scabs, hitting, etc.)?

How long have or did you participate in mutilating yourself?

What do you think prompts you to mutilate yourself (i.e., a fight with someone, feeling lonely, sad, anger, etc.)?

#### • **POTENTIAL RISKS AND DISCOMFORTS**

Although this study does not involve any physical pain, the respondent may experience some emotional pain and discomfort due to the highly personal nature of this study. If the respondent feels herself becoming too uncomfortable while talking about a particular topic, the respondent can tell me and we can change the topic and discuss something else. In the unlikely event that the respondent is unable to regain emotional control, I will personally escort the respondent to the medical or mental health facility of her choosing. Remember the respondent is not under any obligation to discuss topics that she does not wish to discuss.

Another potential risk involved in this study is the possibility of a breach of the respondent's confidentiality. This could lead to embarrassment and further cutting behavior. To prevent this, the interview will take place in a safe and convenient location of the respondent's choosing. In addition, I alone will conduct all of the interviews and transcribe all of the audiotapes. Although audiotapes and research notes may be reviewed by thesis committee members, the respondent's pseudo-name will insure her confidentiality (audiotapes and research notes will not contain the respondent's true identity). All research material will also be kept in a locked file cabinet located within

my home. The respondent's true identity will be written only on the consent form. Furthermore, only I will have access to this consent form.

- **ANTICIPATED BENEFITS TO SUBJECTS**

This research project may be beneficial to the respondent by allowing the respondent to talk openly to an interested outsider without fear of medical intervention or social repercussions. This research may also be emotionally beneficial to the respondent by allowing her the opportunity to freely express what she believes perpetuates this behavior.

It is important to note that this study is not intended to provide diagnoses, treatment options, or resolution to the respondent's behavior.

- **ALTERNATIVES TO PARTICIPATION**

The respondent may choose not to participate in this study.

- **MEDICAL CARE FOR RESEARCH RELATED INJURY**

In the event of an injury resulting from the research procedures, no form of compensation (i.e., payment) is available from Virginia Polytechnic Institute and State University (unless you are a full-time student attending Virginia Tech in which case the respondent may be treated at the Thomas E. Cook Counseling Center). Medical treatment may be provided at the respondent's own expense; or at the expense of her health care insurer (e.g., Medicare, Medicaid, BC/BS), which may or may not provide coverage. If the respondent has questions, she should contact her insurer.

- **CONFIDENTIALITY**

When the results of this research are published or discussed at professional sociological conferences, no information will be included that would reveal the respondent's true identity (i.e., audiotapes or research notes).

- **PARTICIPATION AND WITHDRAWAL**

The respondent's participation in this research is voluntary. If the respondent chooses not to participate, her relationship with Virginia Polytechnic Institute and State University or the Sociology Department will not be affected. If the respondent decides to participate, she is free to withdraw her consent and discontinue participation at any time without prejudice.

- **WITHDRAWAL OF PARTICIPATION BY THE INVESTIGATOR**

The investigator may withdraw the respondent from participating in this research if circumstances arise that warrant doing so. The investigator will make the decision and let the respondent know if it is not possible for her to continue. The decision may be made either to protect the respondent's health and safety, or because it is part of the research plan that people who develop certain conditions may not continue to participate.

- **NEW FINDINGS**

During the course of the study, the respondent will be informed of any significant new findings (either good or bad), such as changes in the risks or benefits resulting from participation in the research or new alternatives to participation, that might cause the respondent to change her mind about continuing in the study. If new information is provided to the respondent, her consent to continue participating in this study will be re-obtained.

- **IDENTIFICATION OF INVESTIGATOR**

If the respondent has any questions about the research, she may contact Toni Calasanti, Ph.D., at 231-8961 or [toni@vt.edu](mailto:toni@vt.edu).

- **RIGHTS OF RESEARCH SUBJECTS**

The respondent may withdraw her consent at any time and discontinue participation without penalty. The respondent is not waiving any legal claims, rights, or remedies because of her participation in this research study. If the respondent has questions regarding her rights as a research respondent, she may contact David Moore, Chairperson of the Virginia Tech Institutional Review Board for Studies involving Human Subjects, at (540)-231-4991 or [moored@vt.edu](mailto:moored@vt.edu) or Rosemary L. Ellis, Primary Investigator, at (540) 231-6455 or [roellis2@vt.edu](mailto:roellis2@vt.edu)

- **OFFER TO ANSWER QUESTIONS**

If you have any questions about this study, you may call me at 231-6455 or email me at [roellis2@vt.edu](mailto:roellis2@vt.edu).

- **PSYCHOLOGICAL COUNSELING AND CRISIS INFORMATION**

If the respondent is currently enrolled at Virginia Polytechnic Institute and State University, she may contact the Thomas E. Cook Counseling Center at 231-6557.

If the respondent is not currently or has never been enrolled at Virginia Polytechnic Institute and State University, she may contact Family and Psychological Services at 961-2380 or the Psychological Service Center at 231-6914.

If the respondent is in need of emergency psychological assistance, she may contact the Access Emergency & Assessment SVCS-RAFT Hotline at 961-8400.

**SIGNATURE OF RESEARCH RESPONDENT**

I have read the information provided above. I have been given an opportunity to ask questions and all of my questions have been answered to my satisfaction. I have been given a copy of this form.

---

Printed Name of Respondent

---

Signature of Respondent Date

---

Address

**SIGNATURE OF INVESTIGATOR**

---

Signature of Investigator Date (same as respondent's )

**APPENDIX E**  
**INTERNET RESOURCE HANDOUT**

**FEMALE SELF-MUTILATION  
RESOURCE PAGE FOR RESEARCH RESPONDENTS**

• **PURPOSE OF THE STUDY**

The purpose of this study is to examine the ways in which the respondent understands and talks about her experience as a woman who mutilates herself.

• **RESEARCH CONTACT INFORMATION**

The respondent is welcome to inquire about the details of this study by contacting Toni Calasanti, Ph.D., at 231-8961 or [toni@vt.edu](mailto:toni@vt.edu) or Rosemary Ellis, graduate student, 231-6455 or [roellis2@vt.edu](mailto:roellis2@vt.edu).

• **INTERNET RESOURCES**

SECRET SHAME:

<http://www.palace.net/~llama/psych>

S.A.F.E. IN CANADA:

<http://users.imag.net/~lon.safe/>

SELF-INJURY:

<http://www.mirror-mirror.org/selfinj.htm>

SELF-INJURY SUPPORT GROUP:

[http://www.support-group.com/cgi-bin/sg/get\\_links?self\\_injury](http://www.support-group.com/cgi-bin/sg/get_links?self_injury)

• **PSYCHOLOGICAL COUNSELING AND CRISIS INFORMATION**

If the respondent is currently enrolled at Virginia Polytechnic Institute and State University, she may contact the Thomas E. Cook Counseling Center at 231-6557.

If the respondent is not currently or has never been enrolled at Virginia Polytechnic Institute and State University, she may contact Family and Psychological Services at 961-2380 or the Psychological Service Center at 231-6914.

If the respondent is in need of emergency psychological assistance, she may contact the Access Emergency & Assessment SVCS-RAFT Hotline at 961-8400.

**VITA**  
**ROSEMARY L. ELLIS**

**Home:**

**1100 Houndschase Lane  
Apartment F  
Blacksburg, VA 24060  
(540) 953-3247**

**Office:**

**Department of Sociology  
Virginia Tech  
Blacksburg, VA 24060  
(540) 231-6455  
E-mail: [roellis2@vt.edu](mailto:roellis2@vt.edu)**

**EDUCATION:**

M.S., Sociology, u u t 2002  
Virginia Polytechnic Institute and State University  
Blacksburg, VA 24060  
Thesis Title: A Qualitative Study of Female Self-mutilation

B.A., Psychology and Sociology, May 1998-99  
Concord College  
1000 Vermillion Street  
Athens, WV 24712

Medical Assistant National Certification, April 1989  
The Bryman School  
Salt Lake City, UT

**RESEARCH INTERESTS:**

Social Inequality  
Medicine  
Mental Health  
Gender Issues  
Sexual Orientation  
Science and Technologies of the Body

**COMPUTER SKILLS:**

Microsoft Word  
Microsoft Excel  
Microsoft Power Point  
WordPerfect  
SPSS

**COURSES TAUGHT/QUALIFIED TO TEACH:**

Sociology of Mental Health  
Medical Sociology  
Social Problems  
Social Psychology  
Marriage and the Family

COMMUNITY SERVICE:

Human Rights Committee, 1998-99  
Timberline Mental Health  
Lewisburg, WV

PROFESSIONAL ASSOCIATIONS:

Member, American Sociological Association

ORGANIZATIONAL MEMBERSHIPS:

Member, AKD  
Member, Psi Chi Honor Society  
Member, Cardinal Key Honor Society  
Member, Gamma Beta Phi Honor Society  
Member, Triangle Association

AWARDS:

Outstanding Undergraduate Award in Sociology, 1999  
Who's Who in American Colleges and Universities, 1996-99  
Academic Honor Award, 1989

SCHOLARSHIPS/GRANTS:

Damaris Wilson Scholarship, Concord College  
Adult Scholarship, Concord College  
Quest Scholarship, Concord College  
West Virginia Higher Education Grant, Concord College