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Bodywork: Self-harm, trauma, and embodied expressions of pain

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Abstract
Self-harm, or self-mutilation, is generally viewed in academic literature as a pathological act, usually born out of trauma and/or a psychological and personality defect. Individuals who engage in self-harm are usually seen as damaged, destructive, and pathological. While self-harm is not a desirable act, this paper argues through the narratives of those who engage in such acts that self-harm may be better construed as a meaningful, embodied emotional practice, bound up in social (mis)understandings of psychological pain and how best to attend to such pain. In particular, this paper suggests that those who engage in self-harm practices are performing embodied, socially situated acts of healing, survival, and self-creation in a physical attempt to retell complex, fragmented stories of abuse, existential angst, trauma, and loss of self. While these individuals may be more or less successful in such attempts, this paper suggests that understandings of self-harm would benefit from more nuanced approaches to individuals' embodied expressions of pain that take into account the difficult nature of psychological suffering and the effects of trauma.

Keywords
Self-harm, emotions, trauma, embodied practices, pain narratives

Introduction

Self-harm (also referred to as self-mutilation, self-injury, 'delicate self-cutting' (Brickman, 2004), 'cutting', parasuicide, non-suicidal self-injury, and deliberate self-harm (Chandler et al., 2011: 99)) is generally presented in academic literature and in popular culture as a pathological[1] act of 'intentional injury to the outside of the body, mainly through cutting, but including scratching, burning, biting, or hitting' (Chandler et al., 2011: 99).[2] These acts are referred to in the academic

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literature[3] as 'superficial' acts of self-harm and, while pathologised, are not considered in and of themselves 'serious' within the medical hierarchy of self-mutilation ('major' self-harm refers to 'infrequent acts such as eye enucleation, castration, and limb amputation' (Gilman, 2013: 151) and are considered indicative of a psychotic breakdown). Despite the often extreme physical damage that such 'superficial' acts of self-harm result in (tendon, nerve, and muscle damage; the need for skin grafts; keloid scarring, etc.), the medical community views 'superficial' self-harm as a nuisance at best, and at worst, refuses not only medical but also psychiatric treatment for self-inflicted wounds (Gibb et al., 2010; McHale and Felton, 2010; Pembroke, 2004, 2006a, 2006b). More than this, however, self-harm is seen as a destructive act, an act that must at all costs be stopped, and is in some way – possibly morally – 'bad'. This 'badness' is often a general sense that self-harm is unhealthy, but there is also a sense in much of the literature[4] that there is something fundamentally 'wrong' with self-harm. It is variously described as 'disturbing' (Feldman, 1988: 252; LeCloux, 2013: 324), 'maladaptive' (Lewis et al., 2011: 553), 'disfiguring and can be repulsive to counsellors' (Whisenhunt et al., 2014: 392), 'frightening' (Whisenhunt et al., 2014: 392), a 'problem behaviour' (Bakken and Gunter, 2012: 342), and a 'truly gruesome behaviour' (Levenkron, 1998: 22). In the wider culture, self-harm is also regarded as disgusting, disturbing, and socially inappropriate; many individuals who engage in self-harm practices, including myself, can testify to that.

The academic literature around self-harm does acknowledge that there are 'reasons why' individuals engage in self-harm. These include psychoanalytic concepts of ego, castration, penis envy, and the like (for example Failler, 2008; Suyemoto, 1998), and feminist ideas about gender and protest, and rebellion against bodily norms (see, for example Brickman, 2004). But the main, most commonly cited medical and psychological 'reasons for' self-harm behaviour are response to trauma, affect or emotion regulation, and/or control. Mental illness is also given as a 'reason for' why individuals may engage in self-harm, but in such cases self-harm is seen as a symptom, particularly in cases of borderline personality disorder and psychosis; I am interested here in reasons given in the literature that focus on self-harm *itself* as a problem or pathology.

This last point is particularly important. The literature generally classifies self-harm as a *symptom*; that is, self-harm, while disturbing for clinicians, is not the primary reason an individual 'needs', seeks, or is given 'treatment' such as therapy. In fact, the literature presents a consistent array of 'reasons for' or 'functions of' self-harm that clearly position it as a symptom of a broader pathology. These include self-harm as a symptom of mental illness, but self-harm is also reported to serve several functions that are widely accepted within the literature as adequate 'explanations' for why self-harm may occur; these functions can be categorised as 'pathological' responses to certain events and experiences, such as trauma, stress, or familial or interpersonal strife. Self-harm, within this functional model, is seen as a pathological act in response to a greater pathology – a mental illness, or a traumatic event (it is a 'secondary symptom', as Levenkron (1998) terms it). Yet despite

this understanding that self-harm serves some sort of purpose (it is not random; it is not inexplicable) and is usually a *symptom* of a greater problem, the literature and clinicians seem to fixate on self-harm as being the *ultimate* pathology, not a secondary one.

Most of the literature acknowledges that a person engaging in self-harm may have experienced physical, psychological, and/or sexual/incest abuse.[5] Various statistics are cited, but in general, the literature agrees that the majority of individuals who engage in self-harm practices have experienced some form (or multiple forms) of trauma[6] in their lives (Favazza, the most cited authority on the subject, estimates 50–60%). Self-harm in these cases is seen as a response to such experiences, but it is still framed as an 'abnormal' or 'pathological' response, as are any other responses to trauma that are seen as psychological or psychoanalytically problematic. This is the case *even though* such responses are seen as *understandable* responses to extreme events. In other words, instead of framing the result of abuse – results such as self-harm, distrust, self-hatred, fear, and unbearable psychic wounds – as the understandable if not almost *expected* outcome of such trauma, people who engage in self-harm or continue to exhibit 'abnormal' psychological responses are cast as 'failures'. The person who engages in self-harm has 'failed' to 'develop healthy coping mechanisms' to 'meet her [*sic*] own needs' (Spaulding, 2012: 81), 'failed' to have a 'normal' or 'healthy maturation process' (Spaulding, 2012: 81). Levenkron observes that 'the self-mutilator [. . .] is someone who has not found a workable medium [of attachment and trust], and usually does not have *any* attachments to others' (1998: 94, my emphasis). The results of abuse and/or trauma are framed as 'symptoms' that become problematic *the more they affect others*, rather than being framed as outcomes of abuse/trauma that may be disruptive or disabling *for the individual*, but are not necessarily pathological or abnormal. In this case, self-harm, due to its pathological status as 'damaging', is seen as an individual's personal inability to cope in ways that are deemed appropriate or non-pathological. There are acceptable and unacceptable responses to trauma; self-harm is not one of them. Nock (2009: 81) compares self-harm to 'non-injurious ways to regulate emotion (e.g., exercise, alcohol)', creating a hierarchy between acceptable and unacceptable (pathological and non-pathological) ways to cope with whatever it is the individual needs to cope with – emotion, trauma, abuse.

Self-harm is obviously 'about' certain things; specifically, it is 'about coping' with 'things' that the individual finds overwhelming and feels self-harm is the best or only coping mechanism available. I have no quarrel with this statement; individuals who engage in self-harm testify to this themselves (for example, in Strong, 2005). I also have no issues with the understanding that self-harm is 'about' trauma, in some cases; about mental illness, about personality disorders, about an attempt to reconcile dualism, about self-hate, low self-esteem, manipulation, hysteria, bodily rebellion, family screw-ups, stress (cf. Hornbacher, 1999: 4). All these reasons 'for' self-harm, or what self-harm is 'about', are given in the literature and spoken about by persons who engage in self-harm practices. I can testify to a few, if not most, of those listed. But my issue is that the 'reasons for' self-harm are

often obscured by the insistence on seeing self-harm as a pathological act. This narrowed focus leads to responses such as a demand by clinicians that individuals 'contract' to cease self-harm before any kind of treatment will occur – even if the individual did not seek treatment for the self-harm but something that the self-harm is merely a symptom of – and will threaten to terminate such 'treatment' if said contract is 'broken' (see Favazza, 2011: 267; Strong, 2005: 171–172; Whisenhunt et al., 2014). Alternatively, it leads to responses such as the refusal to provide medical treatment for self-harm wounds, or treatment that would be unacceptable for any other injury – being stapled or stitched up without anaesthesia, for example, as I have been (see also Pembroke, 2004: 30) – or being refused psychiatric help when requested or even required (Pembroke, 2004: 30). The response to self-harm becomes a focus on stopping self-harm behaviour and on pathologising the individual for engaging in such behaviour.

This paper seeks to challenge these views by suggesting that self-harm, rather than being *purely* a destructive act (although I do not deny that self-harm is damaging in many ways – to the psyche no less than to the body), may perhaps be reframed or reconsidered as an act that *does* specific, *meaningful* things for those who practice it – a form of *bodywork*, or 'embodied emotion work' (Chandler, 2012). I want to challenge the claim that self-harm is a destructive, disgusting, or harmful act. This is *not* to say that I advocate self-harm as a practice, but that self-harm is not *simply* about destroying or harming the body; nor is the person who engages in self-harm someone who is destructive or damaged. Granted, self-harm is not necessarily something that an individual is comfortable doing; often it is perceived as a terrible, albeit seemingly necessary act even by the individual themselves. It is also true that the damage that is done to the body during self-harm is often awful in its consequences – I am not talking about scars here, but the possibility of serious tendon, nerve, and muscle damage, infection, or even amputation – and may be regretted by the individual who engages in such practices. But I argue here that self-harm is not *in and of itself* a destructive act, though its *visible* effects are perceived as destructive. I argue that self-harm is a *productive* act – it does something, or some things, for the individual, that feel necessary and are therefore *generative* (not *merely* destructive) in its effects. This does not mean that self-harm is a 'good' act (as opposed to the 'bad' act it is framed as being in the literature and in everyday understandings). But it means that self-harm is more complex than it is portrayed. Self-harm is an act that is *meaningful for the individual* – in this sense it may be beyond value judgements as to whether it is a good or bad or wrong act, regardless of how it is perceived socially or culturally. I argue that a focus on self-harm as both a pathological act and a sign of pathology in the individual fails to take into account that self-harm is more often than not a tool for individuals to work out psychological and physical trauma, and I argue that those who engage in self-harm practices are performing embodied, socially situated acts of healing, survival, and self-creation in a physical attempt to retell complex, fragmented stories of abuse, existential angst, trauma, and loss of self. While these individuals may be more or less successful in such attempts, this paper suggests that understandings of

self-harm would benefit from more nuanced approaches to individuals' embodied expressions of pain that take into account the difficult nature of psychological suffering and the effects of trauma.

Self-harm as an embodied act

Self-harm is an act of physical wounding that is a response to the self and the self's place in the world. I believe that this is the most accurate general statement one can make about what self-harm is. To move from the general to the particular is to explore what self-harm *means* for the individual; that is, what it *does* for the individual. Because self-harm is a response, what that response signifies is bound up in what the individual is doing with the act of self-harm. Arthur W. Frank writes that the ill and the suffering need to be able to tell their stories of pain in order to be able to make sense of that suffering, 'to avoid living a life that is diminished, whether by disease itself or by others' responses to it' (2013: xvi–xvii). Suffering turns one's life to chaos, and being able to create a coherent narrative out of that suffering can make that chaos less painful, if not bearable. Narrative, as Frank writes, can help people make sense of their suffering, make it something one is able to live out, even live with. A story of suffering, to paraphrase Frank, is not just *about* suffering. 'The story [is] told *through* a wounded body,' he says (2013: 2). Although his book *The Wounded Storyteller* (2013) is about the telling of *physical* illness stories, I take my cue from David Morris (1991), who argues that the splitting of physical and so-called mental (emotional, affective, psychological, psychic) pain is a mythic structure of 'Western'[7] culture. Frank's words apply equally to pain that is supposedly 'mental': the way depression is felt in the utter exhaustion of a body that is also an exhaustion of the mind; the way the stress of a working week is expelled through the body in weekend flu-like symptoms (cf. Brennan, 2004). Trauma, too, is bodily in its experience and its residue.

'The ill body is certainly not mute – it speaks eloquently in pains and symptoms – but it is inarticulate' (Frank, 2013: 2). The traumatised body is not mute either, and although we classify trauma[8] as 'psychological' damage, emotion is also a bodily feeling – fear involves sweat and bile, disgust turns the stomach and threatens to lurch up the throat, sheer panic causes the eyes to blur and fail. Thus, trauma is also eloquent in its physical signs and symptoms. Barry Lopez, in his wrenching essay 'Sliver of Sky', writes how the trauma of sexual abuse manifested not only through his deep sense of humiliation and inability to respond to confrontation, but also through his body:

> If I sensed, for example, that I was being manipulated by someone, or disrespected, I quickly became furious out of all proportion. And I'd freeze sometimes when faced with a serious threat instead of calmly moving toward some sort of resolution. I suspected that these habits – no great insight – were rooted in my childhood experience [of sexual abuse]. Also, a persistent, anxiety-induced muscular tension across my shoulders had by now become so severe that I'd ruptured a cervical disc. When a

> regimen of steroids brought only limited relief, my doctor recommended surgery. After a second doctor said I had no option but surgery, I reluctantly agreed – until the surgical procedure was drawn up for me on a piece of paper: I'd be placed face-down and unconscious on an operating table, and a one-inch vertical slit would be opened in the nape of my neck. I said no, absolutely not. I'd live with the pain. (in Sullivan, 2014: 136–137)

Trauma so fundamentally alters one's sense of self that, as Lopez writes, it causes him to alter how he inhabits his body, rupturing his cervical disc, and then holding him hostage to the pain because the operation too closely echoes the trauma itself. This is not – devastatingly – an uncommon event after trauma: the way an individual experiences their body is ruptured, distorted, painful, humiliating. In many individuals, eating disorders and self-harm are not only ways of expressing such ruptures of the self and body, but are also a result of it: self-harm is an individual's physical demonstration of their relationship with their body, their self. Self-harm may be a way of controlling the body's boundaries through altering it or symbolically demarcating the outside from the inside (Strong, 2005: 66).

Taking these observations into account, how can we come to a more nuanced understanding of self-harm practices? Self-harm does not fit into wider ('Western') social constructions of how to interpret, manage, and express pain.[9] However, one could argue that self-harm is part of a subcultural discourse about pain, albeit a non-verbal discourse (see for example Brown and Kimball, 2013; Glenn and Klonsky, 2010; Klineberg et al., 2013; Scourfield et al., 2011; Strong, 2005). In this subculture, individuals tell narratives that demonstrate that self-harm – physical wounding – is a way for working through emotional or psychological pain: an embodied interpretation of suffering. Chandler's (2012) sympathetic research into self-harm describes these physical ways of working through trauma as 'embodied emotion work'. I find this a useful term to borrow. 'Embodied emotion work' describes how individuals negotiate the physical and psychological effects of trauma by acting them out on the body. 'Self-injury may be desperate, but it is something I can *do*', an individual called Andrew tells Marilee Strong (2005: 3, emphasis in original) about cutting himself to cope with 'aggressive impulses', 'guilt', and a problematic family life. A woman Strong interviews says of self-harm, 'It allows me to keep going – because I certainly wouldn't want to become like my mother and stop functioning, or go completely crazy on the manic angry side like my grandmother' (Strong, 2005: 14). A young woman named Chloe suffered from dissociative episodes and heard voices constantly; she tells Strong, 'I was absolutely convinced I was insane and it was never getting better' (2005: 111). Strong continues, 'She [Chloe] was cutting every day all over her body, methodically tracing her skeleton, bone by bone, with X-Acto knives – "trying to find *me* underneath what was going on, to see if I was really in there"' (2005: 111). Rosalind Caplin, in Louise Pembroke's compilation of individuals' perspectives of their self-harm experiences, writes about being involuntarily committed for treatment of her eating disorder, saying,

> I was forced into the position of withdrawal, of silence . . . just as they forced food and medication down my throat, so they also forced down my anger. So I began cutting my wrists and arms because that way the only way to get that rage out of my body. [. . .] My rage was like that of a tiger being stalked in the jungle – it was alive, moving, both frightened and frightening – an all-consuming fire that grew and grew inside me until I could no longer live with it – it had to come out or my body would not survive its ferocity. (Caplin in Pembroke, 2004: 26)

Louise herself writes

> I could not find the words to describe [my suffering]; cutting had become the language to describe my pain, communicating everything I felt. It was viewed [by psychiatric staff] as silly and attention-seeking. For me it was the only way I could survive. (in Pembroke, 2004: 31)

Understanding self-harm as embodied emotion work moves the clinical discourse around self-harm from one that is pathologising to one that views self-harm as productive and meaningful for the individual. More than that, it moves away from assuming that the individual who self-harms is somehow fundamentally 'bad' or 'wrong'. This can be explored further through examining how the literature around self-harm and trauma has difficulties attributing agency to individuals who have trauma experiences and who engage in self-harm as a response to those experiences. The literature vacillates between complex denials and attributions of agency to those who self-harm. On the one hand, those individuals who have experienced trauma are seen as acted upon by outside forces, victims broken by their experiences. On the other hand, these individuals have chosen to engage in a behaviour which is seen as pathological and indicative of something fundamentally wrong with them, a wrongness which is in the individual's control – hence the 'contracts' forbidding self-harm that are drawn up by clinicians for their patients to sign and comply with. Then again, the language of self-harm, described variously as a 'self-mutilative disorder' (Levenkron, 1998) and a 'repetitive non-suicidal self-injury syndrome' (Favazza, 2011) suggests a lack of agency, an illness; however, much of the research appears uncertain as to how much of the disorder or the syndrome is within the individual's control. Favazza, for example, calls it a 'habit' but also suggests that individuals '*cannot resist* the impulse, drive, or temptation to self-injure' (2011: 212, my emphasis). This may have something to do with the fact that self-harm is often linked to traumatic experiences, and 'trauma' itself is complicated by questions of agency (Leys, 2000), particularly trauma that involves incest and sexual abuse. This is because it is unclear to clinicians whether trauma is something that 'happens' to a passive subject, or whether the individual's psychological structure and coping style influences or causes the effects of trauma (Leys, 2000).[10] In the case of sexual abuse and/or incest, there appears to be both a cultural and clinical aversion to narratives that include the abuse survivor's pleasure in the abuse, which complicates the simplistic narrative of abuse as

traumatic *because* it is completely unwanted, instead of traumatic because it is complicated by an individual's bodily response to the abuse and the individual's emotional relationship with the abuser (especially in cases of incest) (Strong, 2005: 71–72).

Thus, questions of agency and victimisation, addiction, brokenness, and damage hover around the clinical discourse. The traumatised individual who self-harms is a damaged self, a self that has gone or become 'bad' or 'wrong'. In narratives by individuals who self-harm, while some do use the word 'addiction' to describe their relationship to self-harm, the question of agency is directly addressed and complicated by their stories. Self-harm is often described as a reclamation of the individual's body from the hands of an abuser, 'marking the body's boundaries, [. . .] proving what's inside and what's outside' (Strong, 2005: 66). Diane Harrison, sexually abused by her grandfather, writes of cutting herself with razors as 'control over the pain, over something in my life which strangely felt good' (in Pembroke, 2004: 9). Other individuals speak of self-harm as a form of control, a way of exerting agency over emotional distress, self-hatred, or feelings of unreality (see Pembroke, 2004; Strong, 2005). A woman named Fiona tells Strong (2005: 133), 'One sense of power is that you have enough control over yourself and your life to do this. It gives you a weird feeling of strength'. Another individual says, 'For a few moments it seemed as if the poison in my blood was then leaving – calmly, submissively. I was in control of it. It felt like rain' (2005: 55).

There are also narratives that describe self-harm as a way of 'speaking' about emotions or embodied states that were felt to be incommunicable (see Pembroke, 2004; Strong, 2005). A 15-year-old told Strong that 'she cuts when she is so angry she literally cannot speak' (2005: 45). Strong also reports that

> one cutter believed that simply describing her childhood trauma out loud would cause physical harm to her therapist. Eventually she threw a packet of razor blades at the psychologist, telling him that the blades could express what she could not. (44–45)

While the literature often sees this 'function' of self-harm (Nock (2009), for example, calls it 'social signalling') as manipulative or attention-seeking, individuals who engage in self-harm see this as an attempt to communicate distress, which they believe should evoke responses of compassion. This may be wrong-headed, as most responses to self-harm are negative, but there remains a very strong association with the idea that physical pain = sympathetic response (culturally and individually) that seems to guide at least initial self-harming behaviour:

> [. . .] one evening the inner pain, the deep aching became so strong that I felt it was burning a hole right through my body. It became so unbearable – so, so agonising that for the first time I really wanted to die. I locked myself in the bathroom and slowly started to scrape [my skin] – feeling my inner pain surfacing as the blood began to ooze through my skin. But it all felt too much. In tears I went and showed the [psychiatric] staff my distress [;] *all I longed for was to be heard, acknowledged, cared for*

> *and loved*. Instead I received medication and a course of 15 [rounds of electroconvulsive therapy]. (Caplin in Pembroke, 2004: 25, my emphasis).

Other individuals express the belief that without self-harm, their emotional distress would not be taken seriously; self-harm thus becomes an active way of seeking help, rather than a damaging act on an apparently damaged self (see Strong, 2005).

Although some individuals also express feelings of being overwhelmed by the need to self-harm and report that they are 'addicted' to it (see Pembroke, 2004; Strong, 2005), their accounts of self-harm very clearly point to acts of agency, control, and attempts to have power over their bodies and emotion states. This differs markedly from clinical portrayals of individuals who are pathologically damaged and unable to behave in ways that are rational and socially acceptable. Rather, narratives of self-harm show that many individuals engage in self-harm practices not to be manipulative or 'sick' but in order to manipulate their world, in the sense of 'manipulate' as to 'treat, work, or operate with the hands'.[11] Self-harm is used to alter the individual's relationship to themselves and to their environment, allowing the individual to physically change what may be intangible and otherwise unalterable (e.g. their emotional state, their body in space, their relationship to the effects of abuse, their ability to tolerate a painful situation).

Narratives of self-harm often revolve around the symbolic nature of wounds, blood, and scars. In this way, self-harm practices are highly social and cultural, not merely personal and individual. Cultural ideas about 'bad blood' often surface in narratives of self-harm (see Favazza, 2011: 277; Strong, 2005: 34, 72). Favazza also points to the 'Western'[12] legacy of blood as healing and transformative (2011). Strong writes,

> Blood, pumped through the body by a beating heart, is the essence of the life force. The spilling of blood both gives life, during birth, and takes it away, at death. Throughout time, blood has been used in religious ritual to demonstrate suffering and salvation, piety and enlightenment: from blood sacrifice to crucifixion, mortification of the flesh to the martyrdom of saints, from ecstatic stigmata representing the wounds of Jesus to the drinking of wine representing Christ's blood at Holy Communion. Bleeding has always signified healing, from the bloodletting of early medicine to the psychological release of ill will known metaphorically as ''getting rid of bad blood''. (Strong, 2005: 34)

Self-harm satisfies needs that are culturally grounded (and possibly humanly necessary): the need for healing and the transformation of pain. I would argue that watching the physical process of healing provides a symbolic way of healing non-physical, psychic wounds. The ability to tend to or not tend to self-harm wounds, to watch the healing process or interfere with it, provides a sense of security and control that an individual may not be able to perform in their psychic life. While Strong reports that the literature sees this self-soothing function of self-harm as 'a manifestation of a breakdown' in a mature individual's ability to gain

comfort from verbal communication alone (2005: 45), I suggest that self-harm is not so much a breakdown as a return to more embodied forms of self-comfort. Verbalising one's distress and receiving verbal affirmations in response may be what is socially acceptable, but I wonder if it is an adequate way for everyone of expressing and responding to pain.

The symbolic resonances of self-harm are also reflected in Favazza's comments on the nature of scars:

> They signify an ongoing battle and that all is not lost. As befits one of nature's greatest triumphs, scar tissue is a magical substance, a physiological and psychological mortar that holds flesh and spirit together when a difficult world threatens to tear them apart. (2011: 277)

He continues,

> Self-injurers seek what we all seek: an ordered life, spiritual peace – and maybe even salvation – and a healthy mind in a healthy body. Their desperate methods are upsetting to those of us who try to achieve these goals in a more tranquil manner, but the methods rest firmly on the dimly perceived bedrock of the human experience. (Favazza, 2011: 277)

While I disagree with the framing of self-harm as 'desperate', though certainly many who self-harm may *feel* desperate, the spirit of those sentences is true enough. Rather than viewing self-harm as a purely pathological act, self-harm can be symbolic and meaningful for the individual, as Favazza himself admits, and is often a deliberate act of transformation through the use of physical wounds.

Challenges and contradictions

Self-harm as I have described it above is a highly subversive use of pain and the body, but while it is subversive of dominant 'Western' cultural narratives of pain, self-harm may still be viewed as a problematic strategy, even if it is not a pathological one. This is because self-harm narratives still incorporate messages of shame and disgust that reflect broader social responses to the behaviour. Individuals, while recognising that self-harm is a behaviour that *does* things for them, generally feel that self-harm is an unhealthy or pathological behaviour that leads to 'addiction' (see Strong, 2005: 57–59). Again, while I do not deny that hurting oneself may be a distressing behaviour for the individual, and not an act that anyone should cling to, I do wonder if the belief that self-harm is 'addictive' (i.e. disordered) arises out of social and cultural pressures that stigmatise self-harm, leading the individual to feel that it is taboo, thus creating a sense of shame and guilt that makes self-harm behaviour *feel* unhealthy. An individual who feels that they should not be hurting themselves because it is 'bad' to do so may feel unable to stop such behaviour because of the complex relationship between their feelings of

relief from self-harm and the feelings of shame/guilt they experience when confronted by cultural messages and social pressures. They may not be able to create a meaningful relationship – a narrative – around their self-harm behaviours that is positive, and therefore not be able to perform the 'embodied emotion work' (Chandler, 2012) self-harm can be useful for. Such embodied emotion work is what may allow self-harm to be a technique that an individual uses at a particular time in their life, rather than a behaviour that feels like an addiction that cannot be controlled or stopped. I suggest that cultural and social responses towards self-harm have complex ramifications, ones that cannot be fully understood unless the cultural/social norms and values surrounding pain and its expression can be explored, understood, and perhaps exorcised.

A further, and possibly more important, problematic aspect to self-harm is that although self-harm is used to disrupt or transform distressing emotional or body states in ways that challenge 'Western' norms around pain, self-harm narratives also follow 'Western' cultural experiences of pain quite closely, in that the *avoidance* of painful states is the goal of self-harm practices. I suggest that although self-harm may be used by some individuals in a *transformative* way, many narratives indicate self-harm is used to *avoid* confronting painful experiences. In this sense, self-harm is not subversive of cultural pain norms but very much in line with them. Culturally speaking, 'Western' societies have few adequate channels for transforming non-physical (to speak about the body in binary) pain; hence, uncomfortable states of being are avoided or ignored (cf. Ahmed, 2010). For those who engage in self-harm practices, painful emotional states often feel threateningly permanent, so to avoid it they turn to physical pain, with its visual confirmation of temporariness and concrete healing process that can be controlled by the individual. Self-harm is then a problematic practice, as it is less a form of 'embodied emotion work', as Chandler (2012) sees it, and more of a technique of avoidance.

Conclusion

These problems regarding the nature of self-harm cannot be easily dismissed, and I do not wish to do so. Rather, I want to encourage the reader to see these issues as part of a broader view of self-harm as a meaningful, engaged, active practice in which individuals struggle with pain and its transformation. Instead of seeing self-harm as pathological, self-harm may be viewed as a culturally laden act that has symbolic weight. Regarding self-harm as pathological has often led to the treatment of individuals who self-harm in ways that are problematic and disturbing. In viewing self-harm as a meaningful behaviour, I want to open up our ability to respond to it with a deeper sense of how our responses impact upon those who suffer. Although I do not think self-harm is an ideal or necessarily desirable behaviour, in a culture that provides very few options for confronting and transforming pain in embodied ways, I believe that seeing self-harm as meaningful rather than pathological benefits both those who self-harm and those who treat it, as well as

perhaps providing us with insight into our own understandings of pain and how to live with it.

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Notes

1. 'Pathological' here refers to 'abnormal or malfunctional' and is either implicitly or explicitly used throughout the literature to describe self-harm; its explicit usage is also used to refer to self-harm as a disease category, which implies that self-harm is a sickness or illness that needs to be cured. I use the term to denote the fact that the clinical literature sees self-harm in purely negative, diseased, and/or damaged terms.
2. What constitutes self-harm is fairly ambiguous, although for the purposes of this paper I will follow Chandler, as self-cutting is generally understood to be a form of self-harm that is unambiguous both in the literature and in popular culture. However, the ambiguity of the term depends on the different social and cultural contexts in which such acts are carried out. Favazza (2011) includes tattooing and body piercing in his list of self-harm practices; some feminists include cosmetic surgery and even certain 'beauty' practices such as waxing, bleaching, and tanning. Deliberately provoking strangers to engage in physical fights by young males is seen as self-harming by some or as harmless masculine behaviour. Similarly, binge drinking and drug taking (both illegal and prescription for recreational purposes) are described in some contexts as self-harming behaviour and in others as normative and socially acceptable.
3. The academic literature I sourced are from psychiatry, psychology, sociology/social theory, and what I have grouped together as 'clinical literature', which includes nursing, counselling, and medicine.
4. This is not to say that the literature around self-harm is not dedicated towards helping those who struggle with self-harm practices. However, my point is that the literature *begins* from the assumption that self-harm is a form of pathology, proceeds to ignore the quite serious experiences of the individual who self-harms by focussing solely on self-harm practices, and ends by characterising individuals who self-harm as damaged beings, ignoring that self-harm actually *does* things for that individual. This is even the case in Armando Favazza's canonical work on self-harm, in which he recognises that self-harm *can* be constituted as a meaningful practice, but still sees self-harm as generally pathological and destructive. See Gurung (2016), unpublished thesis.

5. However, it is not the *only* or even the *main* reason why individuals may engage in self-harm behaviour. There are many individuals who self-harm who have not had such experiences, and there are many individuals who have had such experiences and who do not self-harm. There are also individuals who have had trauma experiences who engage in excessive drinking, drug taking, or other risk-taking behaviours which may or may not be seen as self-harm, but who do not cut or burn themselves; similarly there are individuals who have experienced trauma who cut or burn themselves but do not necessarily do so because of those experiences, or who manage those experiences through excessive drinking, etc. and cut or burn themselves in response to other events in their lives, including mental illness. Although I focus on trauma narratives here to frame the problematic aspects of self-harm literature, I want to make it clear that even when speaking about trauma narratives and self-harm, the issue is highly complex.
6. 'Trauma' is a complex concept to parse. Although beyond the scope of this paper, I think it is worth pointing out the cultural and social constructions, as well as the historical context, of trauma as a concept and illness. See Ruth Leys' *Trauma: A Genealogy* (2000) for a brilliant critical investigation into the history of the concept. Trauma is a highly politicised term due to the identities that are stake in its definition; the concept of 'post-traumatic stress disorder' as it is currently used in psychiatric practice is applied diversely to war veterans; Holocaust survivors and their descendants; domestic violence and sexual abuse survivors; people diagnosed with dissociative identity disorder; victims of crime; and more broadly to the experiences of women and people of colour, to name only a few. Exactly what constitutes 'trauma' and who can and does suffer from it is part of the politics of identity as well as the politics of psychiatry and medicine. For the purposes of this paper, I take it as a given that there are certain experiences which have disturbing or damaging consequences, although those consequences differ for the individual in both degree and kind. Those experiences are incest, sexual abuse, domestic violence, and physical and psychological abuse, and these are what I explicitly refer to as 'trauma' throughout this paper. I do also take as given that experiences such as family disruption, parental divorce or separation, death, physical and mental illness, or relationship problems can also be disruptive, painful, and damaging in prolonged and unpredictable ways, but I do not explicitly refer to these as 'trauma' within this paper. As a general rule, however, I believe an individual has the right to describe their own experiences however they wish; as the term 'trauma' is uncertain and contested, I don't presume to have a strict definition, but assume that some experiences can be, for a given individual, traumatic in the sense of profoundly damaging, disturbing, and painful, even though I do not refer to those experiences here.
7. I use quotation marks to indicate that I call the generalisable values, norms, ideologies, and undercurrents that structure North American (US and Canada), British, and Australian cultures 'Western', but that I do not see what is colloquially known as 'Western culture' as a monolith. See also Acheson (2008: 552, endnote 3).
8. But see note 6.
9. These ways are, generally speaking, the avoidance and intolerance of pain and of narratives that foreground pain as an important human experience. Pain, in contemporary 'Western' culture, under the influence of the medicalization of pain as 'pathological', is a 'scandal', as David Morris (1991: 71) puts it. Pain is to be confronted with 'silence and denial' (71). See Gurung (2016), unpublished thesis.

10. Leys actually frames this problem differently, in terms of whether trauma effects are simulated by the individual and are caused by the relationship between the patient and the clinician (as in the case of the satanic ritual abuse accusations in the 1980s); or whether trauma is something that happens to a passive subject. (This is of course a simplistic rendition of her much more sophisticated genealogy of trauma.) As remarked on above, the concept of trauma is a highly contested one.
11. There *are* individuals who report using self-harm as a form of attention-seeking, although it appears that they used self-harm this way only once; there are also individuals who report that attention-seeking was one of the reasons they began hurting themselves, or that attention-seeking was at least one of the reasons they hurt themselves in at least one incident (see Pembroke, 2004; Strong, 2005). Many individuals who used self-harm as a way to gain attention from others often came from environments in which attention from others was hard to gain or the kind of attention wanted/needed was hard to come by. In this sense, self-harm is manipulative in the sense of attempting to manage, change, or control one's environment, without any malicious intent. Most individuals hide their self-harm from others, especially if their self-harm behaviour is chronic or long term; despite this, it is still a cultural and clinical trope that self-harm is a perniciously manipulative act.
12. Of course 'Eastern' traditions also have strong symbolic relationships to blood, but Favazza is in this context referring specifically to 'Western' ideas, as is Strong in the quotation.

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