The construction of self-injury in the clinical literature: a sociological exploration

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Abstract

This article presents a sociologically informed critique of a range of academic literatures relating to self-injury. The first half of the paper highlights how lack of consensus on definitional issues, together with the inaccurate portrayal of the ‘typical self-injurer’ in the clinical literature, has impeded the development of a sound understanding of the behaviour. The second half of the paper focuses on some of the more problematic – yet still widely accepted – explanations for self-injury, arguing that the individualistic focus of existing research is inadequate, since it fails to take account of the social context. We call for the incorporation within current debates of social science perspectives which critically examine psychiatric and psychological constructions of self-injury, explore wider social and cultural meanings of the behaviour, and examine its distribution across different social groups.

Introduction

This paper presents a sociological exploration of ‘self-injury’, a construct which is coming under increasing scrutiny in a range of literatures (academic, practitioner, popular and self-help). First, we discuss definitional issues, highlighting how a lack of consensus on the definition of self-injury has limited effective study in the area. We then examine the image of the ‘typical self-injurer’, which has been accepted and used unproblematically across a range of disciplines, despite these definitional inconsistencies. One of our key aims is to demonstrate how the invocation of the ‘typical self-injurer’, combined with definitional problems, weakens efforts to understand self-injury. The final section of the paper discusses future directions for research on self-injury. We argue that the individualistic focus of existing research is inadequate, since it fails to take into account the social context in which self-injury takes place. Referring to past studies that have produced hitherto important, but largely ignored, findings, we call for a more sociologically informed
understanding of self-injury, and a move away from clinically constructed and limited images and studies of the behaviour.

The paper draws on a previous literature review on self-cutting, commissioned by the UK National Inquiry into Self-harm among Young People (2006), together with material derived from an ongoing search of the literature undertaken by the first author in connection with her doctoral research on self-injury. Literature was identified through searches of major medical, psychological, and social science bibliographic databases (Medline, PsycInfo, IBSS online and Web of Science), using a variety of key word searches, including ‘self-injury’; ‘self-cutting’; ‘self-mutilation’; ‘self-harm’; and ‘self-laceration’. These searches were limited to English language material but no limits were put on the dates of publication. References cited in this literature were also checked and incorporated in the review, where appropriate. (See table 1 for an overview of primary studies on self-injury included in this review.)

Terminology and prevalence

Self-injury in this paper is defined as intentional injury to the outside of the body, mainly through cutting, but including scratching, burning, biting or hitting. However, this is an area of study beset by the inconsistent use of assorted terms to describe a variety of different, but related, behaviours, and even our own definition is imprecise. With regard to scratching, for instance, there is no accepted threshold of severity beyond which the behaviour changes from normal to pathological. Self-injury has many other names, including self-mutilation (Favazza, 1998), self-injurious behaviour, parasuicide, non-suicidal self-injury (Jacobson & Gould, 2007), self-harm (Harris, 2000) and deliberate self-harm (Hawton, Harris, Simkin, Bale & Bond, 2004). Many of these terms are problematic, for different reasons.

Self-mutilation usually appears to refer to the same types of behaviour as self-injury (as defined in this paper). However, the use of the term has been criticised for the assumption that the injuries caused are mutilations, which may not always be how the behaviour is perceived by those practising it (Adler & Adler, 2007). The
term non-suicidal self-injury attempts to differentiate self-injury from suicidal behaviour in an unambiguous manner. It is difficult, however, to ascribe motives retrospectively (i.e. after the act). While it is now widely accepted that much self-injury is not intended to end life, it is also acknowledged that the line between ‘suicidal’ and ‘non-suicidal’ can be blurred in individual cases (Solomon & Farand, 1996). Thus, sharp differentiation of self-injury from suicide may well inhibit attempts to understand the range of motives and feelings associated with the behaviour.

Parasuicide, self-harm and deliberate self-harm are terms used by researchers who typically seek to avoid ascribing motives to self-injurious behaviour. However, their usefulness is limited by variations in usage. Self-harm and deliberate self-harm refer to a range of behaviours, including self-injury, but also encompass self-poisoning/overdose and sometimes also eating disorders, substance abuse, reckless behaviour and other activities which either do or may result in harm to the self. However, self-harm and deliberate self-harm are also sometimes used to refer to self-injury alone. As Jacobson and Gould (2007) point out, in the US, deliberate self-harm usually refers to non-suicidal self-injury, whereas in the UK the term typically refers to any self-harm which does not result in death. Unfortunately, much research does not state which self-harming behaviours are being studied, often resulting in misleading conclusions (see discussion of Shaw, 2002 below).

These definitional inconsistencies are compounded by and confound attempts to assess prevalence of self-injury. In fact, very little is known about the incidence of self-injury in the general population. Most studies have focused on clinical or student populations. One exception, which used random sampling and a large sample in the US, found a prevalence rate for self-mutilation of 4% over the last six months (Briere & Gil, 1998). Studies on adolescent samples have found higher rates over longer time periods, such as a Canadian school study which found 14.5% life-time prevalence of self-mutilation (Ross & Heath, 2002).

Studies of self-harm in school-based populations have found similarly higher rates for life-time prevalence compared to behaviour in the preceding year. For example, Hawton, Rodham, Evans and Weatherall (2002) and De Leo and Heller (2004) reported rates of around 12% and 6%, respectively. Both studies also found
that, among those reporting self-harm, self-injury (about 60%) was reported more often than self-poisoning (about 30%). This is in stark contrast to the ratio found among those presenting to hospital accident and emergency departments and short-term admission wards where over 85% of cases of self-harm are overdoses (Hawton, et al., 2004). This difference is particularly relevant to the above argument regarding terminology. Many studies of self-harm are based on hospital samples; but these largely comprise patients who have taken overdoses. Additionally, the minority of people who self-injure and receive hospital treatment may well differ in significant respects from those who are not admitted to hospital. It is therefore unfortunate that findings from studies based on hospital samples are generalised to those who have self-injured and those who have self-poisoned, when in fact such groups may differ significantly, in respect, for example to demographic characteristics.

THE EMERGENCE OF THE ‘TYPICAL SELF-INJURER’

Brickman (2004) argues that an image of the ‘typical self-injurer’ emerged out of clinical psychiatric literature in the 1960s which sought to describe and interpret self-cutting as feminine – thus the genesis of the phrase “delicate self-cutting” (p. 91, emphasis added). However, despite more recent claims that self-cutting is not “simply a problem of suburban teenage girls,” this image has been widely accepted and reproduced by both the medical profession and in popular culture (Brickman 2004, p. 87). The ‘typical self-cutter’ is presented as female, white, young and middle-class in many different disciplinary literatures, and accepted as such by researchers and commentators alike (Froeschle & Moyer, 2004; Schopmann, Schrock, Schnepf & Buscher, 2007; Shaw, 2002, Zila & Kiselica 2001). Much research is therefore carried out on exclusively female samples, which only serves to reinforce the view that self-cutting and self-injury are overwhelmingly female activities (Abrams & Gordon, 2003; Alexander & Clare 2004; Simeon, Stanley, Frances, Mann, Winchel, & Stanley, 1992).

Assumptions about gender

Brickman (2004, p. 90) argues that the interpretation of self-injury as a female activity is consistent with “conservative cultural narratives about gender.” She demonstrates how literature in the 1960s focused on explaining the self-injury of female patients, ignoring male self-injury as largely irrelevant. She suggests that
it was more acceptable for clinicians to interpret self-injury as feminine than it would have been to understand the behaviour in both genders as aggressive and therefore masculine. Thus, males who self-injured were described as “effeminate” or simply omitted from analysis (p. 94). This type of attitude is evident in Shaw’s (2002) more recent analysis of female self-injury. She argues that male self-injury is mainly carried out in clinical, institutional settings, and may therefore be a result of institutionalisation, before going on to discuss research on female self-injury conducted in similar settings.

Shaw is not alone in her conclusions. That self-injury is a female behaviour is stated repeatedly in the clinical literature: samples of people who self-injure, mainly comprising females, are studied, on the basis of which it is concluded that the ‘typical self-injurer’ is female (Favazza & Conterio, 1989; Schoppmann, et al., 2007). This ‘finding’ is then reproduced in review papers (Froeschle & Moyer, 2004; Zila & Kiselica, 2001). The use, in a variety of papers (e.g. Schoppmann, et al., 2007; Zila & Kiselica, 2001), of the abstract from the article by Favazza and Conterio (1989), which describes the ‘typical subject’ as female and Caucasian, is a cautionary tale. Favazza and Conterio (1989) recruited their sample through a day-time television talk show, and acknowledged in the body of their paper that “[t]he high proportion of Caucasian females is a sampling artefact” (p. 287). Nevertheless, numerous subsequent papers have cited this study in support of the claim that “the vast majority of individuals who self-injure are female” (Shaw, 2002, p. 193).

Studies on self-injury have frequently used samples drawn from populations more likely to be female, e.g. psychiatric in-patients (Rosenthal, Rinzler, Walsh & Klausner, 1972), day-time TV viewers (Favazza & Conterio, 1989) and patients diagnosed as having a borderline personality disorder (Simeon, et al., 1992). These studies often acknowledge that the sample being studied is biased, and findings are therefore unlikely to be representative of self-injury in the general population. However, these studies are frequently used by other authors to support claims that self-injury is a female activity, which is then used to justify further research focusing on female-only populations (e.g. Schoppmann et al., 2007). Thus, self-injury in males is thought either not to exist or to exist only in certain populations/settings, such as prisons/prisoners. As a result, understanding and knowledge about male self-injury is limited (Gratz & Chapman, 2007).
Studies which have included male self-injury tend to paint a rather different picture. Briere and Gil (1998), for example, found no gender difference in rates of self-injury in their community study. Hospital studies have found rates of presentation at hospital for self-cutting were higher for men than for women (Hawton et al. 2004). School-based studies have found that about one third of those reporting self-injury are male (Ross & Heath, 2002). Young, Van Beinum, Sweeting, & West (2007) found that 32% of young people reporting self-cutting or scoring were male. Although these figures do suggest that the majority of people who self-injure may be female, they do not justify ignoring male cases as anomalous or ‘unusual’.

Assumptions About Youth

Self-injury does not cease at the age of 25, nor does the behaviour necessarily begin in early adolescence. Nevertheless, this is exactly what the majority of the literature suggests. Suyemoto and Macdonald (1995, p.168), for example, concluded that “most cutting appears to take place within adolescent years.” They also note, however, that the ‘age at first cut’ of patients in their study ranged from 13.5 to 23.9 years, and the ‘age at last cut’ from 13 to 37 years. Seventy per cent of patients had stopped cutting by the age of 18. However, their study was focused on “female adolescent patients, as the literature suggested this was the most relevant population” (p. 168) – indeed, their study was based on a survey of therapists which asked questions specifically about patients aged 13 to 25 years. The survey also found that just under half of the therapists involved in the study had seen a ‘self-cutter,’ but, of these patients, 64% did not fit the ‘traditional’ picture. They went on to suggest that future studies should “expand inclusion criteria in terms of both gender and age” (p. 168). This discussion is surprising given the number of authors who use Suyemoto and Macdonald unproblematically to argue that self-cutting is a largely adolescent, female activity (Hodgson, 2004; Tyler, Whitbeck, Hoyt, & Johnson, 2003; Zila & Kiselica, 2001).

While the evidence does suggest that many people start self-injuring in adolescence (Adler & Adler, 2007; Favazza, 1998; Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006), more attention should be given to the ‘natural history’ of self-injury in the general population and beyond adolescence. Indeed, it has been
suggested that self-injury in older populations may be particularly ‘hidden’ because older people may be especially affected by issues of stigma (Babiker & Arnold, 1997). Further, because self-injury is frequently characterised as a behaviour of the young, self-injury may be more readily misidentified in older age groups.

Assumptions About Social Class

That self-injury is more common among middle-class groups is occasionally suggested (Zila & Kiselica, 2001). Although this position appears to have been more common in earlier research, as Brickman (2004) noted, it is still present in popular culture, as evidenced by films such as *Girl, Interrupted* (1999) and media representations of self-injury. The research reviewed, however, largely overlooks the associations between socio-economic circumstances and patterns of self-injury. Where reference is made, conclusions vary. Self-injury is seen as more common in middle-class groups in literature which draws on a psychoanalytic or psychotherapeutic perspective (Zila & Kiselica, 2001). In contrast, where psychiatric literature mentions the social class of patients, it is usually to note that the majority have low incomes or are unemployed (Hawton et al., 2004; Suyemoto, 1998). It is possible that these conclusions are more suggestive of the differential impact of social class on access to psychiatric/ or psychotherapeutic interventions (Pilgrim & Rogers, 1999, p. 35). Indeed, Briere and Gil’s (1998) general population study found no difference in income between those who reported self-injury and those who did not.

The impact of socio-economic background on the experience of self-injury is rarely discussed. One exception is a paper by Abrams and Gordon (2003) which highlighted potentially important differences in the experiences of six self-injuring adolescent females, three from a deprived urban area and three from an affluent suburban area.

We were unable to identify other studies which investigated this issue in relation to self-injury. Although there are examples of recent relevant research where the self-harming behaviour is mostly by overdose (Platt, Pavis, Sharpe, & O'May, 2005; Redley, 2003).
Assumptions About Abuse

Much of the research which has found a statistical relationship between childhood abuse and self-injury has been based on clinical, often in-patient, samples (Brown, Houck, Hadley, & Lescano, 2005; Deiter, Nicholls, & Pearlman, 2000). Concluding, on the basis of such studies, that all people who self-injure “are usually survivors of some kind of childhood abuse”, as McLane (1996) does is problematic. However, a number of authors have done just that (see also Crowe, 1996; Kilby, 2001; Shaw, 2002).

There is evidence that some claims regarding the relationship between self-injury and sexual abuse are erroneous. Shaw (2002) and Deiter et al. (2000) cite a study by Romans, Martin, Anderson, Herbison, & Mullen (1995) to support their claims for a strong relationship between self-injury and sexual abuse. However, Romans et al. (1995, p. 1341) concluded that “chronic self-mutilation is a rare outcome of childhood sexual abuse”, while they found that overdosing was more strongly associated with past experience of abuse. Both Shaw (2002) and Deiter et al. (2000), however, were looking specifically at self-injury; thus, their use of the Romans et al. study in this instance is misleading and inaccurate. This demonstrates how the inconsistent use of definitions such as deliberate self-harm can compromise research and theorising.

There are a number of other studies which have found an association between self-harm and past experience of abuse (Boudewyn & Liem, 1995; Hawton et al., 2002; Van der Kolk, Perry, & Herman, 1991), but, unlike Romans et al.(1995), these studies give no indication of variation by method of self-harm. Briere and Gil’s (1998) community study did find an association between self-mutilation and childhood sexual abuse. However, self-mutilation was identified only in the six months prior to the study, and, as discussed below, their definition of sexual abuse was rather wide-ranging. More recent research has argued that the relationship between childhood sexual abuse and self-injury is actually “modest” (Klonsky & Muehlenkamp 2007).

Briere and Gil’s study highlights a further problem in looking at this aspect of self-injury – that of defining ‘childhood sexual abuse’. As Santa Mina and Gallop (1998) demonstrate, definitions vary greatly. For instance, Briere and Gil (1998) defined childhood sexual abuse as any sexual contact between someone under
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18 with someone at least five years older. In contrast, Boudewyn and Liem (1995) defined childhood sexual abuse as any *unwanted* sexual contact under the age of 14. Santa Mina and Gallop (1998) also note that definitions of sexual abuse can differ from the understanding of the person who may have been abused; as many of these studies are based on self-reporting of abuse, this too could be important.

Although there does seem to be some statistical association between childhood abuse and self-injury, in both clinical and community samples (Briere and Gil 1998; Whitlock, Eckenrode, & Silverman, 2006), this association may be exaggerated. Community studies demonstrate that significant proportions of those who report self-injury do not report childhood abuse (Briere & Gil, 1998). Nevertheless, commentaries frequently flag childhood abuse as an important risk factor and precursor to self-injury and some even assume a causal relationship.

**EXPLAINING SELF-INJURY**

In the second half of this paper we focus on some of the more problematic – yet still widely accepted – explanations for self-injury, before introducing some recent (and more successful) efforts.

**Sexuality**

As the ‘typical self-injurer’ is often thought to be female, many of the proposed explanations for self-injury have focused on female sexuality. Although increasingly other explanations are taken more seriously, the suggestion that women might cut or injure themselves *because they are women* is rarely critiqued, and still occasionally reproduced and endorsed.

One particularly stark example of this can be seen in a review by Zila and Kiselica (2001), in which they suggest that there is a relationship between self-injury and “sexual confusion”. They support this with reference to Favazza and Conterio (1989) and Rosenthal et al. (1972). Favazza and Conterio found that the women in their study “reported the presence of troublesome sexual feelings: 34% hated their breasts, 56% strongly hated having a pelvic exam, and 10% indicated they would be better off without a vagina” (Zila & Kiselica, 2001, p. 48). Zila and Kiselica take this to mean that women who self-injure have disturbed
relationships to their bodies and sexuality, to which their self-injury may be a response. This is a highly contentious conclusion. None of these papers offer any indication as to what women in the general population might feel about these issues. Had they done so, their conclusions would have been more difficult to sustain. For instance, a comparative study of US women found that a significant proportion of women in the general population appeared to have similarly negative attitudes towards their bodies and sexuality (Cash & Henry, 1995). The medical gynaecological literature is replete with references to women’s ‘dislike’ of having pelvic exams (e.g. Rifkin, Shapiro, Regensteiner, Stotler, & Schmidt, 2002). Further, analogous questions relating to men’s views of their bodies and sexuality have thus far not been asked in relation to men’s self-injury.

Zila and Kiselica (2001, p. 48) further argue that “[t]he onset of menstruation often correlates with adjustment problems for female adolescents and young adults. For the self-mutilator, this time is frightening and often even repugnant.” In support, they cite Rosenthal et al. (1972), who found that 65% of their sample of female psychiatric inpatients had “negative, unhappy or disgusted reactions to menarche.” Again, this argument fails to consider that menstruation may be experienced negatively by women who do not self-injure. Some research suggests that this may well be the case (Bailey, 1993). Conclusions should certainly not be drawn without appropriate comparisons to the general population or a non-injuring control group. Nevertheless, these assumptions about an association between menstruation and self-injury continue to be reproduced in recent literature (e.g. Froeschle & Moyer, 2004).

Criticisms of the assumed linkage between self-injury and female sexuality feed into wider feminist debates regarding the pathological female body (e.g. Bordo, 1993). As Brickman (2004) contends, many of these arguments beg the question of why, if menstruation and female body parts are so problematic, more adolescent and adult women are not self-injuring. These arguments also place the ‘problem’ securely with the female individual who is self-injuring; there is no discussion of how (if this is indeed the case) these problematic relationships to bodies and menstruation might be affected by wider negative societal attitudes towards women’s bodies. Finally, these explanations further underline how little is understood about male self-injury, or how male sexuality may impact upon self-injuring behaviour.
Many explanations of self-injury are clinically based, relying heavily on psychiatric and psychological classifications of behaviour. ‘Impulsivity’ is a particularly important construct and risk factor used in explanations of self-injury and self-harm. It is also one of the key defining characteristics of borderline personality disorder (BPD), a diagnosis which is commonly applied to individuals who self-injure (Strong, 1998).

As a result of the strong association between self-injury and BPD, many clinical studies of self-injury have been conducted on patients diagnosed with BPD (further reinforcing this association). This is problematic for research and understanding into self-injury, since it offers explanations based on what may be a certain manifestation of the behaviour. Self-injury as carried out by those diagnosed with BPD may differ from self-injury by those who are not so diagnosed.

‘Impulsivity’ is frequently employed in explanations of self-injurious behaviour, as well as being another of the nine diagnostic criteria for BPD. However, impulsivity is a contested term in psychiatry and psychology. It is accepted that scales purporting to measure impulsivity (of which there are many) probably measure a number of different behaviours, feelings, beliefs and understandings (Gerbing, Ahadi, & Patton, 1987).

Despite this complexity and lack of clarity, impulsivity is used unproblematically across a range of literature which attempts to establish its association with either self-injury or (more often) suicidality (e.g. Kashden, Fremouw, Callahan, & Franzen, 1993).

From a social scientific perspective, impulsivity raises a number of important issues. Firstly, it is probably gendered – for instance, one study found that girls exhibiting ‘impulsive’ behaviour also received high ratings for hyperactivity and aggression from parents and teachers, whereas boys exhibiting similar behaviour did not (Olson, Schilling, & Bates, 1999, p. 159). Impulsivity is generally characterised negatively – it represents an inability to control allegedly ‘natural’ urges, and a lack of ‘impulse control’ is expected in young children (ibid). However, impulsivity also indicates an ability to act quickly, without thinking, which may be a positive
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quality in many situations, such as driving or sporting activities. Thus, the context and content of the impulsive behaviour are likely to be important in determining how far an individual is seen as impulsive, and this may well be affected by assumptions about gender. The socio-cultural nature of impulsivity is rarely acknowledged in the clinical literature.

Attributing self-injury to impulsivity is problematic, then, because the term lacks clarity and as such is particularly open to socio-cultural influences in the way it is employed and constructed. It is possible, for instance, that self-injury is thought to be a result of impulsivity because it is assumed that the behaviour is carried out without thought – and indeed, some studies on adolescent self-harm have confirmed this assumption (Hawton et al. 2002). Nevertheless, this may not always be the case: some people who self-injure do so in a planned and methodical manner, and others self-injure in a regular, almost habitual way (Adler & Adler, 2007).

**Biological Factors**

Modern psychiatric discourse highlights the biological basis of psychiatric illnesses (Gaines, 1992; Palmer, 2001). However, biological psychiatry has recently come under extensive critique from social scientific perspectives. Our discussion is partly inspired by the work of theorists such as Lakoff (2005) and Martin (2006) who address the socio-cultural contexts in which psychiatry is practised, especially questioning the privileging of biology over social and cultural factors in explaining illnesses and challenging the construction of psychiatric knowledge.

Attempts to explain self-injury from the perspective of biological psychiatry include exploration of the biological or genetic bases for the impulsivity which is thought to underlie self-injury (Evans, Reeves, Platt, Leihebnau, Goldman, Jefferson, & Nutt, 2000), especially the role of the serotonergic system (Simeon et al., 1992). Another often cited, but little researched, biological explanation for self-injury is that it is caused by ‘deviations’ in the opioid system, which might account for the lack of pain some people report when they self-injure (Simeon et al., 1992).
Most research which has attempted to measure these possible biological correlates of self-injury has been conducted on samples of patients admitted to hospital. Further, the research often examines patients presenting with deliberate self-harm and rarely makes any distinction between methods. Results from these studies have varied, with some finding a relationship between patients presenting with deliberate self-harm and some biological marker (e.g. Audenaert, Peremans, Goethals, & Van Heeringen, 2006), whilst others find little or no difference between deliberate self-harm patients and controls (e.g. Lindström, Ryding, Bosson, Ahnlide, Rosén, & Träskman-Bendz, 2004). Simeon et al. (1992) looked explicitly at self-mutilation and impulsivity, but they focused on a small sample of females diagnosed with BPD, reporting mixed and inconclusive results.

These studies are similar in that they focus solely on biological factors, with no attempt to examine or account for any potentially influential social factors. Thus, differences between the serotonergic systems of patients with deliberate self-harm, compared to controls, are assumed to have causal significance. However, it is possible that some other factor (e.g. life events, socio-economic conditions) may account for the association between deliberate self-harm and the serotonergic system. Nevertheless, authors such as Audenaert et al. (2006) conclude that their research supports the use of Selective Serotonin Reuptake Inhibitors with patients at risk of deliberate self-harm – reinforcing biological intervention over and above social or psychological interventions.

TOWARDS A MORE SOCIOLOGICALLY INFORMED EXPLANATION OF SELF-INJURY

In recent years, several studies have been published which run counter to the trends discussed above. These seek to identify and understand self-injury in non-clinical contexts, and/or with gender-balanced, representative samples (e.g. Gratz, 2006; Gratz & Chapman, 2007). Although their sample was largely drawn from a specific socio-cultural group, mainly female students, Adler and Adler (2007) offer a sociologically informed understanding of self-injury, arguing that the behaviour has increasingly become a “deviant sub-cultural choice” for many adolescents. While this claim is questionable (there is no way of ascertaining the
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level of self-injury in the general population in the past, and not all of their participants appeared to accept the difficult label of ‘deviant’), their study marks an important departure in that it attempts to explore wider cultural influences (as well as individual factors). Abrams and Gordon (2003) highlighted important areas for future research, including the potentially different manifestations of self-injury in different socio-economic contexts, as well as the different experiences of psychiatric care. Research on self-harm by Platt et al. (2005) identified potentially important socio-economic factors which may also apply to self-injury. This research suggested that self-harm may be more likely to occur in contexts where there is a high level of social exclusion and socio-economic deprivation.

There is also a large amount of sociological research into suicide which has thus far been relatively untapped by those working on self-injury. A review by Stack (2000a, 2000b) highlighted a number of important sociological themes with respect to suicide rates and socio-economic and cultural factors. Studies on imitative (‘copy-cat’) suicidal behaviour might be particularly relevant, given the increase in media coverage that self-injury has received over the past decade, and the apparent corresponding increase in prevalence. Much of the existing sociological research on suicide has been quantitative, however, and as statistics regarding rates of self-injury are even more scarce and problematic than those for suicide, this does limit the applicability of existing sociological approaches to suicide. More recent qualitative work on suicide and self-harm may offer more promising routes in to a better understanding of self-injury (Scourfield 2005). Indeed, an important aspect of what sociology can add to existing understandings of suicide and suicidal behaviour is a through a more critical eye on accepted explanations, definitions and understandings, driven by rigorous qualitative research (e.g. Owens, Lambert, Donovan & Lloyd 2005).

**CONCLUSION**

This review has demonstrated that existing research on self-injury is beset by a lack of definitional clarity, based on biased, all too often female, samples, and focused on individualistic explanations of the behaviour. These explanations locate the ‘reason’ for self-injury securely with the person doing the injuring: they are struggling with puberty, they are ‘impulsive’, they are coming to terms with past abuse, or they have genetic
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or serotonergic defects. Despite a rich history of sociological research on suicide, very few studies look beyond these individual explanations to wider social contexts, such as differing socioeconomic circumstances, issues of power inequalities (on the basis of, for example, gender, socioeconomic inequality or sexuality), or wider social and cultural meanings of self-injury.

What this indirectly exposes is a narrowness of disciplinary fields of vision. On the one hand, there is a long tradition of sociologically informed explanations for suicidal behaviour (Durkheim 1952; Atkinson 1978, Stack 2000a, 2000b), which has not, until recently, been extended to the area of self-injury. Conversely (and relatedly), studies of self-injurious behaviour have largely drawn on a clinical paradigm and relied on individualistic explanations, dislocating the person from their socio-cultural context. What is needed is research that draws from within sociology and across the social and clinical sciences to develop a transdisciplinary understanding (Rosenfield 1992) of the ways in which both individual and social factors shape self-injurious behaviour. Without this, our grasp of what comes to be defined as 'self-injury' will be both partial and unbalanced.

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