4-21-2014

Beyond Cutting: Restorying Self-Injury

Brittany E. Presson

BEYOND CUTTING: RESTORYING SELF-INJURY

by

Brittany E. Presson

A Thesis

Submitted in Partial Fulfillment of the

Requirements for the Degree of

Master of Arts

Major: Sociology

The University of Memphis

May, 2014

ACKNOWLEDGEMENTS

I would like to thank Dr. Carol Rambo, my mentor, for her steadfast guidance, unwavering support, incredible patience, and for believing in me. I would also like to thank my other thesis committee members, Dr. Larry Petersen and Dr. Jeni Loftus, for their constructive feedback, gracious support, and valuable time. I am also thankful for Dr. Cliff Heegel and Dr. Jim Whelan who reviewed my materials, offered free services to participants, and answered several inquisitive emails from me. I am grateful to all of those who volunteered to participate in this project and made it more meaningful than I could have imagined. I want to also thank the University of Memphis, the IRB, and the Department of Sociology for providing me the opportunity to conduct this research.

Last but certainly not least, I want to thank Nicholas Tatum for motivating me, believing in me, and encouraging me to keep going.

ABSTRACT

Presson, Brittany E. M.A. The University of Memphis. May, 2014. Beyond Cutting: Restorying Self-Injury. Major Professor: Carol Rambo.

Using autoethnographic accounts from the author and the literature as a starting point, this researcher conducted in-depth life history interviews with former self-injurers. This research problematizes current perceptions of self-injury by looking beyond the typical pro/con debates and pathologizing discourses used to define and interpret self-injury. My specific research question is, "In what ways, if any, does self-injury serve as a narrative resource when self-injurers tell the story of their life?" Study participants engaged in biographical work that both affirmed and resisted the pathologizing discourses used by both researchers and mainstream society regarding their identity.

TABLE OF CONTENTS

CHAPTER ONE

AUTO-ETHNOGRAPHY AND INTRODUCING SELF-INJURY

"I love you. I hate you. I can't get around you. I breathe you. I taste you. I can't live without you. I just can't take anymore. This life of solitude, I guess that I'm out the door, And now I'm done with you" – *Always* by Saliva (Marlotte and Scott 2002)

***

The speakers drown out the don'ts. The don't do this. The don't think that. The be perfects. Smile. Breathe. What's the number one rule? Never cry. If you're bleeding, if you're broken, if you're afraid, if you're alone, never cry. Tears are a sign of weakness. Think of other people. You have it better than a lot of kids in this world. Smile.

I'm fourteen years old and I arrive home from school. My backpack hangs on the kitchen chair. There is no wall separating the kitchen from the living room. I live with my mother and step-father in a small rental house. The music is blaring from the family desktop computer. I hang up the phone.

I pace the floor. My teeth clench barring any vocal outrage. Forgotten. She forgot me. A friend was supposed to pick me up to go to the movies, but she ditched me. Left me behind. Stood me up. She would meet up with the group there and didn't bother to call.

I can feel my breathing quicken. I want to scream, but I cannot. I want to shout and punch things, but I won't. Young ladies don't do that. My heart stings with betrayal. She wasn't supposed to do this. She was supposed to be the one that cared. She was supposed to remember me. I put the song "Always" on repeat. I crank up the speakers even louder.

Abandoned. I am the unwanted child. The mistake. My dad regrets adopting me. My mother didn't mean to have me. She often joked that my name should have been, "Drunken Blackout". My paternal uncle threw a refrigerator at her three months before I was born. My biological father never met me. He signed the go-away papers quickly.

I open the silverware drawer and slam it shut. My fingers squeeze the lip of the counter. I turn on the hot water, washing my hands and forearms. I start to calm down. Supper dishes from the night before are in the sink. It's my job to wash them. My parents don't notice that I don't eat. My stomach feels like it is caving in.

The phone rings. It's my mother. She has a list of chores for me to do before she gets home or I'm grounded. She doesn't hear the strain in my voice. I look at the clock.

A fresh wave of anger hits. I grab a butcher knife from the strainer. The blade is gleaming. I rinse it with hot water and touch it to my skin. This isn't the first time that I have cut, but this is new for me. I've never used a knife before.

I typically cut with an aluminum shard peeled from a soda can. Sometimes, I feel emotionally numb and will saw away at my hips until the blood distracts me. The thought of the blood evens my breathing.

I go back into the living room and stand in front of the couch. I hold out my left arm and rotate it, first one way and then the other. I rarely cut on my arm. It's unwise. I don't care this time. I can excuse it away easily. It's still cool enough to wear a jacket anyways.

I decide on the inside of my arm. It's more concealable. I want to see it bleed. The tip of the blade reaches my skin.

My breath gets caught. I can't do this. I'm afraid. The knife is so big. What if I go too deep? What if someone sees?

This fear opens the emotional flood gates. I drop to my knees. The mental anguish hurts so much. My hands grab my ribcage, unsure of whether to rip my guts open or hold my torso together before I really crumble. What is so wrong with me?! Why am I unwanted? What did I ever do that was so bad? I try to be perfect but I can't.

Every muscle is tense. Tears blur my vision. My chest heaves with painful sobs. I feel like my sternum is tearing its way out of my chest.

I'm fat. I'm ugly. I shouldn't have been born. I'm not good enough. I'm in the way. My parents battled for custody over my younger brother. They never fought for me.

For some reason that last thought helps. All I have is myself. I need to be in control. My body involuntarily takes two very deep breaths. I twist my left arm over, exposing the back of it. The tip of the knife pricks the outside of my wrist. I let more of the blade touch. I stop thinking about the "what ifs", the pain, the abandonment. It is just the blade. I press down. I pull back, slicing my skin, guiding the metal across my arm, stopping when I reach the inner bend of my elbow.

The blood rises thickly. My cut was deep enough. I smear the blood with my fingers. I take the blade and retrace the incision. It's the longest cut so far. I stare at it, no longer feeling anger or pain. I'm in control. I watch myself bleed.

I rub the blood between my fingers. I stretch the sides of my skin back to observe the depth of the wound. It's perfect. It serves its purpose. I don't need stitches. I'm too smart for that. I push the skin back together. I let go. It won't scar.

I know that I don't need to cut on my arms again. I know that knives are too easy for me to be careless with. I know that this cut is risky. I don't care. I've reached my familiar level of emotional apathy. I decide not to apply pressure or a bandage, letting the wound finish bleeding on its own. I rinse away the evidence. I sanitize the knife. I sweep the floor, wash the dishes and start the laundry.

***

The above is a narrative account, or autoethnography (Ruiz-Junco and Vidal-Ortiz 2011), of my personal experience with self-injury. I do not pretend to speak on behalf of all self-injurers because each experience is unique based on the setting, the self-injury techniques, the events prior to the act, the actor's state at the moment, and the outcome. For my teenage self, cutting became a normal occurrence. It was a remedy to emotional pain and an outlet for expression. Self-injury validated my mortality and my existence. It was something that could not be taken away. I no longer cut. As I grew older, I learned that it was okay to cry, to make mistakes, to fail. With that said, I do not regret my status as someone who self-injured.

The purpose of this thesis is not to find ways to discourage self-injury or suggest ways to rehabilitate self-injurers. Numerous websites and agencies exist for that (S.A.F.E.; TWLOHA; Butterfly Project). In this thesis, I will not debate whether the intentional harming of oneself is good or bad. Previous researchers have examined these topics exhaustively; it is rare that they move beyond these issues. As someone who has self-injured and has known others that purposefully injured themselves, I find that self-injury is a subjective experience with multiple facets that seem to be ignored by the current literature.

In many ways it is similar to drinking alcohol. Some people are able to hold their liquor and others are not. Should everyone that has ever consumed a beer or glass of wine go to an Alcoholics Anonymous meeting? Likewise, it is my contention that not everyone who has self-injured needs to seek treatment or be forced into a rehabilitation facility for self-injury per se, however, the underlying factors leading towards and perpetuating the self-injury may be cause for psychological attention.

To be clear, self-injury should never be taken lightly. There are circumstances where treatment is needed, however it may be more beneficial to focus on the underlying issues leading to self-injury, particularly for those with traumatic backgrounds. For example, many self-injurers have a history with childhood sexual abuse (Adler and Adler 2011). In these instances, it might be more practical and beneficial to the self-injurer to address the psychological repercussions of the traumatic past (i.e. sex abuse) rather than solely focusing on cessation of the self-injurious behavior.

While it is important to address the psychological aspects of self-injury, it would be ill-advised not to note that self-injury can be dangerous. Pulling one's hair, cutting, picking, scratching, bone breaking, and numerous other methods of harming oneself, come with the risk of infections, scarring, improper healing, and unintended muscle or tissue damage (Adler and Adler 2011). Self-injury can lead to life threatening situations or death (Adler and Adler 2011; Whitlock, Powers, and Eckenrode 2006). During 2012, there were 8,420 cases, in England alone, of hospitalization due to intentional self-harm by use of a "sharp or blunt object". However, others argue self-injury can be a life saver. According to the United Kingdom's National Self-Harm Network (NSHN 2009) self-injury can serve as a preventive measure against suicide. Though self-injurers may go on

to attempt or commit suicide, the NSHN (2009) does not believe that self-injury encourages or increases the risk of suicide.

Studies show that up to 38 percent of young adults actively self-injure and 10 percent of University students have engaged in approximately 100 episodes of self-injury in their lifetime (Gratz, Conrad, and Roemer 2002). Thirty percent of young Americans between the ages of 18 to 35 have self-injured at least once in their lifetime (Adler and Adler 2011). While the statistics show that self-injury is on the rise, it is unclear as to whether the increase is a result of more people self-injuring or more people admitting to self-injuring. In *The Tender Cut* (Adler and Adler 2011), an exhaustive study of the phenomenon of self-injury, participants described being forced to adjust how they hid their injuries because of an increased social awareness of self-injury. Today, mainstream society and researchers alike continue to view the behavior as an attention-seeking strategy that is publicly encouraged by peers and media, or as a symptom of psychological distress among teenagers (Adler and Adler 2011).

For this project, I conducted in-depth life history interviews with former self-injurers. The interviews were analyzed for patterns regarding the discourses they drew upon to frame their life histories. Instead of focusing on self-injury as pathology or assuming it is intrinsically harmful, my primary focus was to discover how people create meaning around self-injury and specifically the ways in which the discourse surrounding self-injury impacts their identity construction processes. My specific research question was, "In what ways does self-injury serve as a narrative resource when self-injurers tell the story of their life?" It turned out that self-injurers both made use of the pathologizing

discourses around the activity and resisted the pathologizing discourses. They also talked about self-injury in alternative ways that neither resisted nor accepted pathology per se.

Generally self-injurers took on the identity of being someone who self-injured. They all, at one time or another in their interviews, engaged in a specific kind of biographical work called narrative resistance. This occurred when participants resisted or distanced themselves from the negative labels and constraints placed on them by others (Rambo-Ronai and Cross 1998). When telling their life story, self-injurers were painfully aware of the categories that both researchers and mainstream society applied to them. Similar to the exotic dancers in the Rambo-Ronai and Cross study (1998), instead of passively internalizing the stigmatizing discourses assigned to them, they resisted those discourses and talked about themselves and their status as self-injurers in other ways. By doing this, they resisted being grouped under a generalized pathology, and instead portrayed autonomy within their self-injury experiences.

A few participants indicated narrative acceptance. In these instances, participants accepted the pathology placed upon them. Even in cases where narrative acceptance occurred, participants indicated only accepting one aspect of pathology and often resisted others.

At times, participants rejected the identity of being someone who self-injured. They did this by using narrative resistance through the process of narratively marking (Brekhus 1996) an individual who they considered to be a "real" self-injurer and thereby narratively unmarking (Pruit 2012) themselves. Narrative unmarking acknowledged the pathology discourses attributed to the identity of one who self-injures, but served to shift and rearrange the salience of the pathology attributed to them specifically. Marking

separated a person or group from the greater pool of normalcy. Those in the normal pool were what Brekhus (1996, 1998) referred to as the "generic" (1996:501) or the "unmarked core" (1996:512). The unmarked were the normal and the socially accepted. Those marked were the marginalized and the deviant. An example of this would be straight men in a heteronormative environment versus gay men in the same environment (Brekhus 1998). Those who identify as straight are considered the normal, thus unmarked. People who identify as gay in this case would be marked as abnormal, and therefore distanced from the generic population. In addition, narrative unmarking occurs when a person unmarks themselves by distinguishing a difference between themselves and another. Therefore, they unmark themselves by marking others. Self-injurers used pathology exemplars to mark others as legitimate self-injurers, thus narratively unmarking themselves, rejecting the membership role of self-injury, and resisting the generalized pathology associated with self-injury.

Participants also engaged alternative frames to describe their self-injury experiences. This was done by making use of normative frames, positivity frames, and by specifying responsibility and guilt frames. These alternative frames served as a way for self-injurers to not only describe their experiences, but also to interpret and restory them.

The following chapters examine the previous literature on self-injury, the theoretical frameworks underpinning this project, the methods and procedures used to gather the data, an exploration of my findings, and some concluding thoughts regarding the implications of my research.

CHAPTER TWO

LITERATURE REVIEW – CONTESTING SELF-INJURY

What is self-injury? The obvious definition is that it is the intentional injuring of oneself. If that is the case, is anorexia self-injury? What about bulimia? It is well agreed upon that the practice of cutting is self-injury, but what about the culturally accepted practices of branding, burning and tattooing? What about smoking? How are these activities different from one another? Or are they? In this chapter, I examine some of the conventional ways that researchers have conceptualized self-injury including: mutilation, non-suicidal self-injury (NSSI) and parasuicide, and deliberate self-harm syndrome. I then address the problematic nature of defining self-injury by exploring the following activities: eating disorders, motorized vehicle crashing, smoking, tattooing and piercing, branding, cutting and scarification. By elaborating on the contested and problematic nature of the definition of self-injury, we can see how self-injury as a concept is both vague and contextual. If this is the case, then the assumption of pathology may not be the only way to frame self-injury.

Conventional Ways of Conceptualizing Self-Injury

According to the International Society for the Study of Self-Injury (ISSS 2007), self-injury is the intentional act of harming or inflicting bodily tissue damage on oneself *without* the intent to kill oneself. Examples of this are self-cutting, burning, branding, bone breaking, hitting, scratching, hair-pulling, and banging one's head (Adler and Adler 2011, 2008; Favazza 1998; ISSS 2007; Prinstein 2008). In this section, I address the conflicting terminology, techniques, and positions used by researchers to discuss self-injury.

Up until this point, I have been consistent with my use of the term self-injury instead of rotating between other common substitutions. This is in part due to a desire to be consistent, but more so as an effort to avoid engaging in the discourse of pathology which typifies the existing literature. Other common terms for self-injury are deliberate self-harm syndrome (Pattison and Kahan 1983), self-wounding, self-inflicted violence, (Adler and Adler 2011) self-mutilation, self-harm, NSSI, and parasuicide, (Adler and Adler 2011; Favazza, 1996; Hamlyn 2010; Whitlock, Powers, and Eckenrode 2006). In this section, I explore some issues with the following terms: mutilation, NSSI and parasuicide, and deliberate self-injury.

Mutilation. Many of the older psychological and medical texts used the term self-mutilation instead of self-injury. Back in 1987, Armando Favazza began what is still considered by researchers and Internet users alike to be the definitive work on self-mutilation within the psycho-medical community (Adler and Adler 2011). In his work, Favazza (1996) described three forms of self-mutilation. *Major self-mutilation* consisted of self-dismemberment. An example of this was castrating oneself. *Stereotypic self-mutilation* included acts such as head banging, scratching, and hitting that often were performed in rapid repetition. *Moderate and superficial self-mutilation* encompassed the actions of self-cutting and burning. It was the latter two categories that appeared most commonly and subsequently were the focus of most of the self-injury literature that exists today.

While Favazza's categories were helpful, the term mutilation is now seen as holding incorrect connotations among researchers and thought to be a triggering term for self-injurers (Adler and Adler 2011). Unlike mutilation, a self-injurer did not

intentionally set out to permanently mar and disfigure their body. Rather, the typical intention was to cope with stress or symbolize group solidarity (Adler and Adler 2008). The tissue damage was merely the means of achieving the goal.

NSSI and parasuicide. NSSI, along with parasuicide, were common terms used among American self-injury researchers. These labels were designed to distinguish self-injury from intentional suicide or suicide attempts. By including suicide within the term, the two concepts were immediately linked to pathological connotations. Researchers do not say "non-accidental self-injury" or "non-body modification self-injury" so why then specify the non-suicidal?

Deliberate self-harm syndrome. The term self-harm was more commonly seen in European and Australian literature (Adler and Adler 2011; Hamlyn 2010; Martiniuk et. al 2009). Alone, the phrase self-harm conveys a similar message as the term self-injury, however, self-harm was also linked to the longer phrase, "Deliberate Self-Harm Syndrome", commonly used in the psychology field. The word *syndrome,* defined as "a group of signs and symptoms that occur together and characterize a particular abnormality or condition" (Merriam-Webster 2013), pathologizes self-injury by immediately defining it as a medical oddity, defect, or problem.

Further Problematizing the Definition of Self-Injury: "What About…?"

At the beginning of this chapter, I cited the ISSS definition for self-injury and listed a few common examples: cutting, burning, branding, etc. Indeed, when I gave a guest lecture for an undergraduate Sociology of Deviance class on the topic of self-injury, the examples listed by the students matched the ones stated above. However, by the end of the lecture, the students began to question, "What about eating disorders? What about

motorized vehicle crashes? What about smoking?" The vagueness of the existing definition of self-injury opens the gates to asking "what about" other techniques of self-injuring. For the next section, I ask "what about" eating disorders, motorized vehicle crashes, cigarette smoking, as well as, tattooing and piercing. I also ask "what about" branding, cutting, and scarification.

What about eating disorders? The National Self-Harm Network (NSHN 2009) in the United Kingdom included eating disorders (anorexia nervosa, bulimia), along with substance abuse, on its list of types of self-injury. However, many researchers classified eating disorders as a separate psycho-medical problem that may intermingle with self-injury but was not itself self-injurious behavior (Adler and Adler 2011; Favazza and Conterio 1989). In social media and cyber cultures, such as Twitter and Reddit, self-injury and eating disorders were often linked together in posts but rarely referred to as the same thing. In 2012, cyber campaigns such as Pro-ana (pro anorexia) and Pro-cut (pro cutting) simultaneously began to make mainstream news (Castillo 2012). Pro-ana websites such as myproana.com (UBMM Holdings, LLC 2013) had self-injury forums where followers supported each other in the continuation of self-injury.

What about motorized vehicle crashes? There was a small body of research which had investigated vehicle crashes as a potential means of self-injury. Those who attempted to document intentional vehicle crashes did so by examining hospital records and police reports. These researchers found clues that might suggest intentional crashing, but nothing concrete (Grossman, Soderberg, and Rivara 1993; Martiniuk et. al. 2009). One study found what they believed to be a link between self-injury and crashing one's vehicle (Martiniuk et. al. 2009). The study followed a group of drivers for two years. The

results showed that self-injurers were 40 percent more likely to be involved in a motor vehicle crash than non-self-injurers. While Martiniuk et al. (2009) believed that some individuals purposefully crashed their vehicles as a means of self-injury, the results were inconclusive as to whether the crashes were actually an intentional self-injury attempt. Another study documenting intentional car crashes and suicide found similar results (Grossman, Soderberg, and Rivara 1993). The researchers were able to show that individuals who had been in a recent vehicle crash were 2.9 times more likely to attempt suicide. They concluded their study by suggesting that the number of "undetermined intent" (1993:118) could possibly be attempted suicides but could not definitively state that suicide was the intent of the car crash. Pointing to evidence of such a claim, The American National Standards Institute (ANSI 1996) created guidelines on how to classify every motor vehicle accident, and code E958.5 allowed for marking "deliberate intent" of self-injury (1996:18) as the cause of a crash. Because of legalities and reckless driving citations, people may have felt inhibited when discussing using a vehicle as a means of self-injury.

What about cigarette smoking? Cigarette packs are required by law to come with labels warning of the effects. Smokers are aware that what they are doing is harmful, yet they do so anyways. Is this self-injury? While the definition is not clear, some default to excluding behaviors that are "socially sanctioned" (ISSS 2007).

What about tattooing and piercing? Tattooing and piercing could also be thought of as forms of self-harm. There is pain involved in the process. In addition, diseases are transmitted through unclean needles, and if one is not careful, infections can develop at the tattoo or piercing site (Griffith 2012; Mayers, Judelson, Moriarty, and Rundall 2002).

Yet according to many researchers (Adler and Adler 2011; ISSS 2007; Whitlock, Powers, and Eckenrode 2006) self-tattooing and piercing do not count as self-injury because they are socially accepted as a means of body modification. This ignores the cultural practice of "flesh hook suspension" (Forsyth and Simpson 2008) where participants get together and suspend from hooks that have been pierced into their skin. At the end of the session, all hooks are removed. Though they injure themselves by piercing hooks through their flesh and then suspend from them, thus intensifying the injury, flesh hook suspensions are considered by mainstream society to be radical body modification rather than self-injury.

What about branding? While branding oneself is among the most common methods of self-injury, it is often accepted as a display of masculinity or a symbol of group cohesion, especially among athletic males (Adler and Adler 2011). For instance, Adler and Adler (2011) spoke with a study participant, Jason, about his experience with group branding. Jason described a time when his parents found out about the branding and became concerned until he explained that it was a bonding practice among the group and portrayed the branding as "boys will be boys" behavior. Depending on the context of the situation, branding is sometimes considered self-injury, and sometimes considered body modification.

What about cutting and scarification? Perhaps the most visible and discussed technique of self-injury is cutting. This technique has been documented in biblical passages (Conterio and Lader 1998) and in military records from 5th century Greece (Adler and Adler 2011). Today, cutting is so common that the term has become

colloquially representative of all self-injury. It is estimated that 72 percent of self-injurers cut themselves, either primarily or solely.

Scarification is also found throughout history (Adler and Adler 2011) and is still a cultural practice in Sub-Sahara Africa (Ayeni 2004). Unlike cutting, the basic process of scarification is to cut in a way that a scar, or scars, will form (Ayeni 2004). Both cutting and scarification involve external tissue damage and run the risk of infection. The main difference between the two is the intention of scarring, yet, scarification is typically seen as an ornamental procedure, making it socially sanctioned, whereas cutting is often considered self-injury. Scarification as body modification is specifically banned in some states (Obenschain 2013). Again, like branding, depending on the context of the situation, cutting and scarification are sometimes considered self-injury and sometimes considered body modification. There are an infinite number of activities that could be referred to as self-injury. The differences in classification are capricious and based on the context of the situation and social agreement. The veil between body modification and self-injury is thin; the boundaries between what is and is not considered self-injury are quite blurred.

Framing Self-Injury as Pathology

Much of the current literature describes self-injury as a psychological condition or a symptom of other conditions that requires intervention. These studies focus on understanding the behavior in order to stop it (Favazza 1998; Whitlock, Powers, and Eckenrode 2006). For example, when taking the psycho-medical approach, Adler and Adler (2011) found arguments for legitimizing self-injury as its own disorder, rather than it being a symptom of other disorders as evidenced within the Diagnostic and Statistical Manual of Mental Disorders IV (American Psychiatric Association 2000). However,

others claim the primary usefulness of documenting self-injury lies within predicting other disorders, such as borderline personality disorder (Selby et al. 2012). Currently in the DSM IV (American Psychiatric Association 2000), self-injury is proposed as a side effect of different impulse control disorders, borderline personality disorder, anti-social personality disorder, histrionic personality disorder, post-traumatic stress disorder, eating disorders (Adler and Adler 2011; Whitlock, Powers, and Eckenrode 2006), depression (Adler and Adler 2011; Ross and Heath 2002;), and substance abuse (Adler and Adler 2011; Joiner 2005).

Other research portrays self-injury as a rapidly spreading sickness, disease, or as having a contagion status (Matthews 1968; Ross and McKay 1979; Taiminen et al. 1998; Whitlock, Powers, and Eckenrode 2006). These researchers refer to media attention to self-injury to explain the phenomena. For example, prior to the 1990's, self-injury was commonly perceived to be a mental disorder that was accidentally learned (Adler and Adler 2008). In the 1990's, Marilyn Manson began self-injuring on stage during his live performances (Gabrielle 2011; Heath 1998). People following certain music subcultures, such as punk, began using self-injury as a symbol of group membership and proof of solidarity within the group (Adler and Adler 2008). Thus the first wave of modern mainstream self-injury had emerged (Adler and Adler 2011). This led to self-injury being viewed as "fad" behavior and subculture impression management. Actress Christina Ricci claims (Gabrielle 2011) that her initial reason for self-injuring was peer related. In an interview, she stated: "I was trying to impress Gaby. So I heated up a lighter and pressed it on my hand. I wanted to see if I could handle the pain. It's sort of an experiment to see if I could handle the pain" (Elsworth 2008; Gabrielle 2011).

Researchers pathologize self-injury with their terminology, definitions, and debates. Mainstream media sensationalizes self-injury, which has led to a broader framing of self-injury as "an epidemic" which in turn has perpetuated stigma and served to silence self-injurers regarding their status and behavior. Celebrities with histories of self-injury, such as Angelina Jolie, attribute their experiences to hormones, teenage mentalities, or experiments with strength (Gabrielle 2011). Many social media networks such as Facebook, allow cyber marketing companies to present themselves as movements to stop self-injury (Pudjou 2012; Silver 2014). Followers of these movements then post images, statuses, or promote awareness beyond the Internet realm. For example, the butterfly project requests people draw butterflies on their forearms in support of stopping self-injury. Users then post digital images on their social media outlet of choice. However, because they draw the butterfly on themselves, they are bringing the movement to physical life. They walk around in the physical "real" world supporting such movements. When supporters of these movements position themselves as empathetic heroes coming to the rescue of those who self-injure, self-injurers become positioned as defective victims in need of the support.

"Experts" claim that self-injury is a mental defect. Television specials spark "awareness" witch hunts. Celebrities distance themselves from their pasts and frowned upon behavior. Family or peers latch on to cyber help-the-victims movements. Are these the only ways in which self-injurers think about themselves? If pathology is removed as the primary frame for interpreting self-injury, what else could exist?

Conclusion: Beyond Claiming the Identities of Self-Injurers

Self-injury is being reported more frequently than in the past. Regardless of whether the increased social exposure to the behavior is causing more people to self-injure, or giving them the knowledge and opportunity to admit to self-injury, the language used by society and researchers is one of condemnation and problem solving. Self-injury is represented as an epidemic that must be treated.

Previous research debates what constitutes self-injury, what to call it, and whether it should continue to be a symptom or gain its own DSM inclusion. By keeping this ambiguity in mind and acknowledging the faulty boundaries or sheer fabric separating self-injury from socially sanctioned practices, it is my hope to move beyond these debates and examine other interpretive possibilities. As long as the focus is on the pros and cons of self-injury and the need of treatment, self-injury will continue to be viewed by outsiders and researchers as a mysterious behavior and unsightly epidemic in need of isolation and a cure.

In the next chapter, I discuss a more sociological approach to the topic of self-injury. Prior research has not focused on how self-injurers make use of self-injury as a narrative resource for thinking about who they are and where they are located in social space. By talking with self-injurers without assuming self-injury is intrinsically pathological in nature, it may be possible to gain insight into how the activity is a psychological and social component in identity construction.

CHAPTER THREE

THEORETICAL ORIENTATION – SELF-INJURY AS IDENTITY WORK

While the medical/psychological perspective has shed some light on the phenomena of self-injury, much can be gained from applying other, more sociological theoretical orientations to the topic of self-injury. In this section, I will discuss identity and narratives. Then, I will explore some aspects of biographical work, specifically: discursive constraint, alternative stocks of knowledge, and narrative resistance. Finally, I will propose the practice of narrative unmarking as a form of narrative resistance.

Identity and Narratives

My primary research goal is to discover how study participants will use the discourse of self-injury as a narrative resource to construct their identity. Identity is a fluid (Adler and Adler 2011) understanding of and presentation of self (Adler and Adler 2011; Tseëlon 1992). It is dependent on one's cultural background and highlighted by a shared system of values (Gergen 1991; Kroger 2007; Shotter and Gergen 1989). Erickson (1968) describes identity as stable patterns consistent with one's past and present. For example, the identity of being shy occurs not from one experience, but rather it is built up over time with a history of shyness that persists into the present. When one disrupts the continuity of that history, they may cease to maintain that particular identity. For example, once a self-injurer decides to stop the practice of self-injury, their identity begins to transform from someone who injurers themselves, self-injurer, to someone who used to injure themselves, former self-injurer. This calls for a new construction of self. As they restory their new, non-injuring selves, new narrative possibilities can emerge.

Erickson (1956) describes the concept of ego identity (Kroger 2007). Composed of three parts, ego identity addresses one's biological characteristics, psychological needs, and cultural environment as a recipe for identity construction. Therefore, identity is more dialectical (Ritzer 2010) in nature, rather than a uni-dimensional exchange where cause equals effect. For example, the identity of one self-injurer will differ from other self-injurers because of a variation of environmental, historical, psychological, and biological factors perceived by both the individual and onlookers. In turn, their environments, histories, psyche, and anatomy are affected by their self-perceptions and choices.

Life history interviews allow the participant the freedom to speak about their life experiences. This approach benefits the participants by serving as a means of comprehending and rationalizing their biographies (Kroger 2007). "Language is the text out of which identities are constructed, justified, and maintained." (Kroger 2007:22). It is through language that we are able to see ourselves and construct reality (Blumer 1969; Mead 1934). Narratives also serve as a way of applying social laws, mores, and roles within the actor's reality (Kroger 2007; McAdams 1988). It is my hope that conducting life history interviews with former self-injurers may illuminate the role that narrative strategies, such as negotiating and displacing stigmatic connotations, may play in the defining and construction of their identity.

Biographical Work

Biographical work is an orientation which examines how subjects use language and available categories to interpret and organize their life history (Gubrium, Holstein, and Buckholdt 1994; Rambo-Ronai and Cross 1998). The telling of one's story helps the

social actor to "make sense of his or her life experiences" (Rambo-Ronai and Cross 1998:105), which in turn helps the audience to better understand the stories being told. These biographies, like identity, are fluid and change with the variations of place, time, audience, and culture (Rambo-Ronai and Cross 1998). Depending on the conversation flow and the reactions of the audience, subjects may narratively edit their stories (Gubrium and Holstein 1998). This practice of managing their stories effects the interpretation and construction of their identities for both the narrator and the audience.

Discursive constraint. With self-injury, the available language and perspectives with which to view and define oneself are pathologized. This leaves self-injurers with negative categories available to them for their constructions of self, thus "discursively constraining" (Rambo-Ronai and Cross 1998) the discourses they are permitted to apply to themselves when taking on the identity of being one who self-injures. These discourses may constrain the individuals into silence. According to the data, if self-injurers speak of their behavior, they run the risk of being categorized as crazy, seeking attention, and out of control. With this definition of self comes the threat of medication, required counseling, forced institutionalization, and social isolation. Without alternative ways of interpreting their situations, self-injurers would be doomed to accept and reproduce the mindsets that constrain them.

Alternative stocks of knowledge and narrative resistance. Over time, self-injurers may become acquainted with "alternative stocks of knowledge" (Berger and Luckmann 1966; Rambo-Ronai and Cross 1998). One example could be a member of a music based subculture who self-injures as a way of expressing commitment within the group. In this case, the injurer could use the identity of group membership as a means of distancing him

or herself from the psycho-medical pathologies that surround self-injury. Through these stocks of knowledge, subjects can redefine and reinterpret their identities in ways that resist the discursive constraint from mainstream society. It could be argued that celebrity claims of self-injury and positive media expressions serve as sites where alternative stocks of knowledge regarding self-injury are being generated. Furthermore, it can be contended that by destigmatizing the status of self-injurers, these public conversations create safe spaces for discussion among self-injurers. While media can pathologize and constrain the public discourses regarding self-injury, they may also open up an internal dialogue among those who self-injure. The following passage is from autoethnographic materials about my own experience communicating with someone about self-injury.

***

I remember the first time I heard of self-burning. I was in my brightly colored bedroom; my walls were neon orange, my doors hot pink, their frames purple. Lime green baseboards sported multi-colored paw prints.

I lay on my bed with my head hanging off the edge. The cordless phone was pressed to my ear. A male friend was on the other end of the phone line. We had been discussing my cutting.

"I do something like that." He said.

"You do it too?" I asked, curious and intrigued.

"No, but I do something like it."

What could be "like" it I wondered, getting annoyed.

"I kinda turn the water on as hot as it will go… and let it burn me." He spoke slowly and quietly.

I was shocked. He burns himself. Why would you burn yourself? I thought back to when I would take baths rather than showers. Often I liked to see how hot I could stand the water, but that wasn't the same thing. I wasn't *trying* to burn myself. Who does that?

"You burn yourself?" I asked, "Where?"

He paused, "Um. I'm not sure I want to tell you."

This annoyed me. I had described my cuts to him. He could at least tell me where he burned himself.

"On your arms? Your legs? Where?" I needed to be patient or else he might shut me out.

"On umm… Down there."

I quickly sat up shocked. "You burn your penis?!" Ouch. What the hell?! I cut myself, sure. But at least I didn't do *that*! That's crazy!

***

Looking back on that exchange, I realize now that I defined my friend's behavior as more extreme than my own. As a teenager, and even today, I was constantly worried about other people's judgments in regards to my mental status. I would agree that I was overweight. I would believe that I was unlovable. But I would not and could not be "crazy". As a result, I sought to prove my sanity through the process of comparison. "At least I don't burn myself like him." "At least I don't cut on the bus, like her." "At least I sanitize it." To me, these arguments proved that I was a rational, thinking, and sane person.

I used comparisons with others, or exemplars (Rambo-Ronai and Cross 1998) to carve out my own cultural niche (Erickson 1968; Kroger 2007). By doing so, I

participated in a form of biographical work called "narrative resistance" (Rambo-Ronai and Cross 1998). "Narrative resistance is an active speech behavior which serves to decenter the authority of specific individuals or society to dictate identity" (Rambo-Ronai and Cross 1998:105-106). Narrative resistance pushes against discursive constraint by using alternative stocks of knowledge to reinterpret one's self and social place. Exotic dancers performed narrative resistance in their biographies by appealing to "deviance exemplars", claiming that they were not too far into the occupation (totally immersed) like some others because they were engaged in the occupation to support a child, as a vocation, or as a means to attend school. They resisted other forms of discursive constraint by claiming they were not as "sleazy" in their act as some dancers or that they were less artificial than other dancers (hair, breast implants, and liposuction). As we shall see later, for those who self-injure, they appeal to "pathology exemplars" which can be used to distance one's identity from pathology, or the pathology can be accepted.

When I conducted these interviews, I expected to see similar instances of resistance within the life histories of my participants because of my own personal experiences. I found another indicator that other former self-injurers may engage in narrative resistance in an interview conducted by Adler and Adler (2011) with a participant identified as Erica (2011:138).

> Q: At this point did you identify yourself, any part of your identity, as connected to that behavior?
> Erica: No. Actually I always just thought I wasn't actually a cutter. I was just utilizing it.
> Q: That's interesting. Tell me how you see the difference."
> Erica: I guess I thought cutters couldn't control themselves. And I thought I had major control, which I didn't. I just thought cutters are addicted; I'm not. Cutters always need to cut; I don't. I just do it for fun, which really wasn't true actually, at all." – (Adler and Adler 2011:138)

Though she later classified herself as a cutter, Erica used her perception of self-control as a way of separating herself from the stigmatized group of cutters. To her, being a cutter meant having no impulse-control. These criteria served as her alternative stock of knowledge. Since she was not addicted to cutting, she did not accept the negative label of "cutter." Erica also appears to change her stance on self-injury. When speaking from within the memory, Erica seems to accept self-injury as an okay behavior. When she speaks from the present, she appears to view self-injury as unacceptable behavior. While it is not the point of this study to determine whether self-injury is good or bad, it is important to note the shift in Erica's framing of self-injury. By editing her interpretation, Erica is adjusting her identity construction.

Narrative unmarking. My study participants employed narrative resistance through the a form of marking and unmarking, (Brekhus 1996, 1998) called narrative unmarking (Pruit 2012). Marking is the practice of separating the abnormal from the normal by highlighting or marking the abnormal. A visual example of this could be the literal marking of Hester Prynne in *The Scarlett Letter* (Hawthorne 1850; Brekhus 1998). In the book and film adaptations, Hester is forced to wear a red letter A, literally marked as an adulteress. She is thereby visibly distinguished from the other non-adulterers. Another example took place during World War II, when Jewish residents in Nazi Germany were marked by the Star of David as Jews. They were visibly marked as opposed to non-Jews. In this case, the markings held widespread and dire consequences for an entire population. Though not quite as extreme, current markers are exhibited in less physical means, primarily through the use of language. We mark through stereotypes. We mark through negative connotations.

In the article "A Sociology of the Unmarked: Redirecting Our Focus" (1998), Brekhus brings awareness to the lack of attention sociologists give to the unmarked. Brekhus argues that we are so focused on examining the marked that we completely neglect the practices of the unmarked. The practice of marking is effective in that way. Whether it is a bright red letter, a sewn on star, or stigma, marking draws attention away from the generic, normal, unmarked, and spotlights the abnormal, the marked, thus creating distance between the unmarked and the marked.

Brekhus (1996, 1998) describes two models of marking and unmarking, a binary and trinary model. The binary model is a continuum with the generic "unmarked" on one pole and the "marked" on the opposite pole. The trinary model features the generic unmarked in the middle of the continuum sandwiched between the "perverse" marked on one pole and the "exceptional" marked on the opposite pole. In the trinary model, the middle section of the continuum, those who are unmarked, consists of those who are average. For example, the middle group might consist of students falling within the average range of test scores. Those who are below average, those who failed miserably, would be on the perverse end of the pole. Those who made above average, for instance a perfect score, would be on the exceptional pole. For the purpose of this study, I rely predominately on the binary continuum when describing the discourses of those who self-injure.

Brekhus (1996) also distinguishes between the one-drop rule model and the entire-ocean model. The one drop model says one either is or is not generic (see Figure 1). Any suspicion that one is abnormal would immediately mark the individual. The entire-ocean model works more on a spectrum of markedness (see Figure 2). People can

locate themselves further towards the marked spectrum or closer toward the unmarked spectrum. This paper largely works with participants who felt the constraints of a one-drop model and attempted to situate themselves on an entire-ocean model.

Figure 1. Brekhus's (1996:501) One-Drop Rule as Binary Model
Brekhus, Wayne. 1996. Social Marking and the Mental Coloring of Identity: Sexual Identity Construction and Maintenance in the United States. *Sociological Forum* 11(3):497–522.

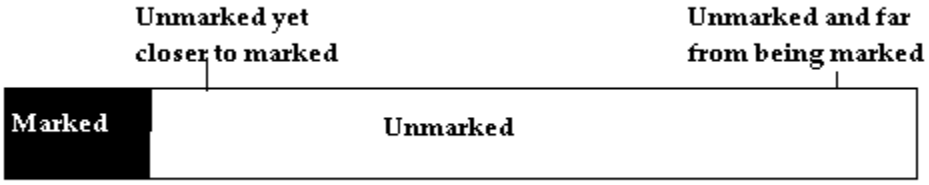

Figure 2. Brekhus's (1996:501) Entire-Ocean Rule as Binary Model
Brekhus, Wayne. 1996. Social Marking and the Mental Coloring of Identity: Sexual Identity Construction and Maintenance in the United States. *Sociological Forum* 11(3):497–522.

People who self-injure are often physically marked by their cuts, scars, bruises, broken bones, concussions, bald spots, and burns. Even when the physical markers are hidden, self-injurers are narratively marked by stereotypes, threats, and stigma. The inconspicuous self-injurer is still exposed to the negative connotations that surround self-

injury. These pathologies infiltrate the media, the school systems, retail stores, and various other pockets of mainstream society. They threaten to mark the private self-injurer. I argue that by internalizing these connotations, the self-injurer at every turn is invited to mark themselves. Marking becomes easy. Being marked becomes taken for granted. However, I found that some self-injurers, attempted to reject these markings and therefore engage in what Pruit (2011) calls "narrative unmarking."

In his article "Peak Oil and The Narrative Construction of Unmarked Identities", Pruit (2011) found that bloggers on Peak Oil websites managed to take Narrative Control (Gubrium and Holstein 2009) and unmark themselves. Narrative control allows the speaker to carve out the story in a way that defines, symbolizes, and adheres to the speaker's desired context, controlling the perspective through which the story is told (Gubrium and Holstein 2009; Pruit 2012). Through this narrative control, the bloggers were able to portray the story in a way that normalizes the speaker, in this case the blogger, and moves the marked identity from the speaker to those with different epistemologies. Pruit (2011) calls this process "Narrative Unmarking" (2011:441). "Narrative unmarking uses identity unmarkers to communicate normativity during storytelling" (2011:441). In other words, narrative unmarking is when the speaker, who is marked, uses unmarkers, which are accepted pieces of the unmarked generic culture, to normalize their own markedness during the telling of a story. An example of this could be a person that hits themselves, and then states, "Yeah, I hit myself but it's not really any different than if I participated in a contact sport. And it's not like I'm cutting myself. Now those people really need help." In this scenario, the speaker normalizes their self-injury by comparing it to a more generic, socially accepted form of self-injury, contact

sports. The speaker then marks people who cut themselves as the real abnormal. The speaker is practicing narrative unmarking. The speaker is also employing narrative resistance.

Conclusion

In this chapter I have briefly explored biographical work as a theoretical orientation and why I believed it was going to be a useful frame when considering the case of self-injury. I have also explored the practices of narrative unmarking. Later in the thesis I synthesize the concepts of discursive constraint, narrative resistance, and narrative unmarking to explore how self-injurers engage pathology exemplars when narrating their biography. This particular theoretical orientation towards narrative demands a particular methodological approach: life history interviews. The next chapter will explore the methods I use to see how, if at all, my research participants treated the idea of self-injury as a way to frame their life histories and the ways in which they talked about their identities.

CHAPTER FOUR

METHODS AND PROCEDURES

For this thesis, I conducted in-depth life history interviews with former self-injurers. By participating, former self-injurers narrated their own biographies, drawing from their own stocks of knowledge, with self-injury in mind. In this chapter, I describe the sample, discuss the interview and analysis processes, and elaborate on safety precautions used to minimize any potential risks.

The Sample

This section explores who was allowed to participate in the study, where demographically participants hailed from, and how I found them. I address the criteria necessary for inclusion within this study, discuss geographical considerations for participants, and explain the procedures used for recruitment.

All of my participants were former self-injurers ranging between ages 18 to 57. Of the 12 participants 10 self-identified as White, one as Black, and one as Hispanic. Of the participants, nine identified as female, two identified as male, and one identified as female to male transgender. Five participants were LGBT (Lesbian, Gay, Bisexual, and Transexual) community affiliated. Personal friends, students, and relatives were excluded from this study. Only those who self-identified as having a history of intentional non-suicidal self-injury were included. This did not mean that none of the participants had ever engaged in suicidal ideation or behavior. Many participants had previously considered (six participants) or attempted (four participants) suicide. For this study, suicide attempts were seen as separate from self-injury.

Several of the demographics, reasons, and back story of my participants closely resembled those found in previous research, namely Adler and Adler's *The Tender Cut* (2011). Female participants outnumbered male participants. Often, participants began self-injury during their school age years and stopped sometime during their 20s. Some participants admitted to self-injuring until as late as their 30s, 40s and 50s. The most frequent form of self-injury was cutting. Only three participants stated they had never cut themselves. Burning was the second most frequent. Tied for third were biting, hitting, bone breaking, hair pulling, and picking. Additional methods of self-injury included bruising, vaginal penetration with a clothes hanger, and self-asphyxiation. As found in the research of the Adler's (2008, 2011) and Whitlock Powers and Eckenrode (2006), many participants had a past history with sexual abuse. Five participants spoke about sexual abuse, three described physical abuse, and eight described neglect or isolation from caregivers. All reported feeling silenced and overlooked at some point leading up to their self-injury.

Former self-injurers, rather than current self-injurers, were chosen as research participants for three reasons. The first was that there was less of an emotional risk for the participant. People sometimes self-injure as a coping mechanism (Adler and Adler 2011). Looking at those who formerly self-injured suggested that they were no longer in an emotionally distressed state. The second reason was because Tennessee state law requires citizens to report any knowledge of someone planning to hurt themselves or others. While it was debatable as to whether self-injury was included in this, to avoid legalities and technical gray areas, only past experiences with self-injury were examined. The third reason was the notion that people were more apt to discuss their past than their

present. Because of the stigma regarding self-injury, it can be extremely difficult for current self-injurers to speak of it openly. In contrast, many former self-injurers have a desire to use their story to help others (Adler and Adler 2011).

Participation in this research was not restricted to University of Memphis students. Only four participants were current students. Members of the community made up five participants. The remaining three participants were referrals residing outside of the Memphis area. In an effort to provide accommodation for each of the participant's needs, participants chose their interview setting. An office on the University of Memphis campus was the setting for most of the interviews. Phone interviews were held with two of the participants – one lived too far away, the other was agoraphobic. I drove two hours to meet for one interview and three hours for another.

Recruitment for this study was done through fliers (Appendix D) posted in the lobbies of Dr. Cliff Heegel, a locally licensed psychologist, and Dr. Jim Whelan, a psychologist with the Psychological Services Center at the University of Memphis campus. My contact information was listed on the fliers and it was up to the respondents to initiate contact with me. Participants were encouraged to share information about the study with anyone they knew of who might be eligible. I did not accept any names or contact information from participants about potential respondents due to issues regarding confidentiality. Snowball sampling allowed those who would not have heard about the study through psychological services to participate. Participants recruited through snowball sampling made up slightly more than half (7 out of 12) of my overall sample.

Interview and Analysis Procedures

The interviews were semi-structured life-history interviews. Respondents contacted me via the contact information provided on the fliers. A time and place for the interview was negotiated between me and the individual participants. In this section, I discuss the participant's interview options, the interview structure, and my analysis process.

The interview. At the interview, the participant received a copy of the consent form. I verbally reviewed the consent form with the participant. Business cards for psychologists, Dr. Cliff Heegel and Dr. Jim Whelan, were given to the participants in case of any distress caused during or after the interview. I then asked if the participant had any questions about the form. I answered any questions and proceeded to outline the interview process.

Participants were told they would be asked a list of basic demographic questions. These questions were, in part, to break the ice for both interviewer and participant. The participants were then told that following the basic questions, I would ask them to describe as much as they could remember about the first time, or a memorable time they self-injured. From there, the interview would proceed in a more informal and organic manner. During this outline phase of the interview, I held up the interview guide for the participant to see. I explained that while it is expected that most of the questions will be answered naturally through the conversation, there was a chance I would have to glance over the guide and ask missed questions. The participants were reminded they could stop or pause the interview at any time and they were free to skip over any questions they did not feel comfortable answering. Again, I asked and answered any questions the

participant may have had. Typical interviews lasted between 1 hour and 30 minutes to three hours with the shortest interview timing in at 1 hour and 18 minutes and the longest being 2 hours and 38 minutes.

Safety precautions. Because of the sensitive nature of this research, several safety precautions were employed. Participants were able to create their own pseudonyms instead of using their real names. These pseudonyms served as the only distinguishable information on the transcriptions. Because of the perceived emotional risks involved with any in-depth interview, especially one on such an intimate topic, measures were taken to secure access to mental health services should the respondent have felt any emotional distress during or after the interview. A one-time session was set up with Jim Whelan, PhD. at the psychological services center (PSC) on the University of Memphis campus. Realizing that some participants might not feel comfortable attending a session on campus, arrangements were also made with Clifford Heegel, PhD., a locally licensed psychologist, as an alternative for the participant. Descriptions of the services were included in the consent form and verbally discussed by myself with the participants when the business cards and consent forms were presented. In addition, all interview questions were previously reviewed by Dr. Jim Whelan and Dr. Cliff Heegel to reduce the risk of potential emotional distress (Appendix C).

Also for confidentiality, the signature requirement for the consent form was waived (Appendix F). This allowed the respondent to participate without the increased risk of being identified. The IRB approved an alternative consent form that was given to each participant (Appendix A). Participants could keep the form. Arrangements were

made with the two participants who opted for phone interviews. Both received a copy of the consent form prior to their phone interviews.

Analysis. The interview was recorded with an Olympus DM-420 voice recorder. Recordings were transferred to a password protected file folder on my personal computer. I used headphones, windows media player, and Microsoft Word to transcribe approximately 21 hours and six minutes of audio recording. Recordings were then deleted off of the Olympus recording device. Backup copies of the audio recordings and transcripts were saved in a password protected file folder on my external hard drive.

Influenced by the coding processes described in Kathy Charmaz's book *Constructing Grounded Theory* (2006:43-71), I approached the data through multiple levels of coding. I began by employing initial coding, looking for emergent themes among the transcripts. Themes were then sorted under two categories, (1) Pathology exemplars and (2) alternative frameworks. In the following chapters, I discuss these categories and how they are used by self-injurers as biographical work.

CHAPTER FIVE

PATHOLOGY EXEMPLARS

At the beginning of this research, I asked, "In what ways, if any, does self-injury serve as a narrative resource when self-injurers tell the story of their life"? My goal was to see what else existed within self-injury without focusing on the conventional debates or pathological implications. What I have found, was that participants did indeed use self-injury as narrative resource when telling the story of their life.

Participants engaged in biographical work, to construct their identities and organize their life stories. While all of my participants made use of biographical work by drawing on some of the discourses of pathology mentioned in previous literature, they used pathology in a different way. Pathology was a narrative resource one could distance oneself from or outright claim or reject. They narratively unmarked identities along multiple pathology dimensions. Participants engaged in narrative resistance, a form of biographical work to narratively resist the discursive constraints placed upon them by others. This provided participants the means to accept their membership role as self-injurers while also resisting the pathology associated with self-injury stereotypes. On occasion, participants not only accepted their membership role as a self-injurer, but also embraced the pathology, and thus engaged in narrative acceptance. At moments during the interviews, several participants claimed to have rejected the membership role. They did this by appealing to specific dimensions of pathology. They marked self-injurers who matched a stated set of characteristics as legitimate self-injurers, and thus unmarked themselves in the process. Each participant used multiple exemplars to construct a more holistic identity and to negotiate their life-histories.

Unlike those in previous literature who used pathology discourses as a means of grouping all self-injurers into defined categories, my participants used pathology discourses as a means of demonstrating autonomy. They distinguished themselves from other self-injurers and self-injury stereotypes. They used the interview as a place to negotiate preconceived ideas about self-injury. Participant's then constructed their identity in relation to where they located themselves on multiple exemplar continua. The remainder of this chapter discusses a few of the pathology exemplars used by participants when accepting or rejecting the membership role. Following the discussion of the pathology exemplars I observed, in the next chapter, I will discuss how participants engaged alternative frames to describe and interpret their self-injury experiences. Both pathology exemplars and alternative frames were used by participants to construct their identities and help make sense of their experiences with self-injury.

Pathology Exemplars

Pathology exemplars directly reflected some of the pathology discourses that can be found in mainstream society, but they were reshaped and contextually applied and rejected across the telling of the life story. Self-injurers drew upon these particular discourses to talk about their identity and history with self-injury. Each pathology exemplar took the form of a continuum, which the participant would then verbally locate themselves on. When participants accepted the identity of self-injurer (all of them ultimately did), they often situated themselves between one extreme pole of the continuum or the other, either accepting the pathological characteristics implied by the continuum or appealing to the discourse to reject the pathology implied. In other cases and/or at other times in an interview, many participants used pathology exemplars to

reject the identity of being a self-injurer all together. My participants addressed pathology in two ways. One was from the perspective of someone accepting the membership role of self-injury and then situating themselves on a continuum. The second was from someone rejecting the membership role of self-injury and appealing to the exemplars to construct identity claims which excluded them entirely from membership.

Dimensions of Pathology: Accepting the Membership Role

In this section, I address some of the ways participants drew on pathology exemplars while accepting the membership role. Constructing the pathology exemplars as continua, participants often engaged in narrative resistance to distance themselves from the pathologies attached to self-injurers. Instead of resisting, a few participants embraced the pathologies as part of who they, at some point, were. At one point in an interview, a participant could claim to narratively accept pathology for him or herself; while at a later point he or she could resist the same pathology. Their identity construction was fluid, from moment to moment as they negotiated the various dimensions of who they thought themselves to be at any given moment. This section discusses how sanity, attention-seeking, mastery, the self-injury spectrum, and degree of harm function as exemplars. Though not an exhaustive list of the possible dimensions of pathology a participant could make use of when telling the story of who they are, these categories were the ones most frequently invoked in my interviews.

The sanity continuum. The sanity continuum is characterized by the participant's use of sanity as a pathology exemplar. Often participants used the terms "crazy" or "nuts". At one extreme of the continuum, participants typically identified as a self-injurer but not crazy. On the other end of the continuum the participant identified as a

self-injurer and crazy. Said in other words, not-crazy, or sane, indicated the absence of pathology, while crazy, or insane, indicated the presence of pathology. Self-injurers appealed to the sanity continuum when performing biographical work by drawing upon the discourse to locate themselves relative to other self-injurers they have known, or relative to the existing discourses regarding self-injury as they understood it.

Often, participants narratively resisted being characterized as crazy. For instance Aria, a 27-year-old female self-injurer who began cutting herself at age 17, specified the sanity continuum in the following way: "I think those people [bone breakers] are kind of crazy and extreme for the most part. Uh, to physically maim yourself in a way that impedes your livelihood is a little crazy." In this example, when Aria indicated that people who break their bones were crazy, unlike her. She resisted the pathology of crazy by positioning bone breakers at the extreme end of the continuum, while she herself was not crazy, and thus not pathological, like bone breakers.

CJ, a 23-year-old female self-injurer who began cutting in the sixth grade, also specified the sanity continuum as a form of narrative resistance. At this point in the interview, CJ had just described how her self-injury arose out of a desire to feel in control. She claimed to have observed the control her friends with eating disorders had. CJ, who claimed to like cookies too much, began cutting herself instead. The following quote is said in regards to her decision to cut rather than not eat: "And I also kept telling myself, 'I'm not crazy like that.' Like my friend who was anorexic… I was, you know, a soulless little sixth grader. I was like 'she's nuts. She has problems.'" In this example, CJ contrasted herself with an anorexic friend. The friend, because of her anorexia, was placed on the pathologized end of the continuum, while CJ, who was not anorexic and

therefore not crazy, placed herself on the non-pathologized end. Therefore, CJ was able to narratively resist the pathology of "crazy" that is commonly associated with self-injurers, by highlighting someone else as such.

Though it was less frequent in my study, participants, at times, claimed to take on the pathological identity of crazy. They were specifying the continuum of sanity as a form of narrative acceptance of pathology. In this regard Lucy, a 30-year-old female cutter and hair-puller, who began cutting at age 17, stood out. "I mean, I think I'm crazy, but I don't think that everyone that does it is." Later in the interview: "I don't know. Maybe it's just me feeling like more self-conscious and crazier than other people. That I feel like no one can be as nuts as me." In this example, Lucy did not resist crazy as a definition of self. But she did use the terms as a way to define herself relative to others she had known who had engaged in cutting.

In the sanity continuum, some participants resisted being talked about in pathological terms, and some accepted it, but most of my participants engaged in the discourse, locating themselves along the entire spectrum of the continuum. More resisted this particular pathology exemplar than not, but a few felt that at one time or another in their lives, the pathological end of the continuum matched who they would claim to be.

The attention-seeking continuum. It is commonly understood amongst self-injurers that self-injuring to seek attention is not okay. The attention-seeking continuum was characterized by the participant's use of seeking attention (or not) with self-injury as a pathology exemplar. At one extreme of the continuum, participants typically identified as a self-injurer but claimed they did not self-injure for attention. On the other end of the continuum the participant identified as a self-injurer who self-injured for attention. Said

in other words, not attention-seeking indicated the absence of pathology, while attention-seeking, indicated the presence of pathology. Self-injurers appealed to the attention-seeking continuum when performing biographical work by drawing upon the discourse to locate themselves relative to other self-injurers they have known, or relative to the existing discourses regarding self-injury as they understood it.

Some participants narratively resisted being characterized as an attention seeker. For instance Kari Ann, a 23-year-old male biter and picker who chose to use the name of a deceased relative, specified the attention-seeking continuum in the following way. He described a friend of his from high school as someone who sought attention, namely sympathy, by means of cutting. Kari Ann stated, "I couldn't imagine if people thought of myself as the martyr and the sympathy craver. I know just how frustrating and annoying that could be, when that's all that someone does." Kari Ann indicated that his friend self-injured to seek attention, unlike him. Kari Ann resisted the pathology of self-injurers as attention seekers by positioning his friend at the extreme end of the continuum, while he himself was not an attention seeker, and thus not pathological, like his friend.

Similar to Kari Ann, Shelia, a 45-year-old female cutter and head-banger, who at one point paid someone 300 dollars to break both of her legs, also specified the attention-seeking continuum as a form of narrative resistance:

> I remember I got busted when I was 11 or 12 in the bathroom. That's when all these hospitals they tried to send me to and them doctors were just like 'she's just wanting attention' and I wasn't wanting attention. I just wanted to get out of them foster homes. They didn't help.

In this example, Shelia did not specify an individual, but rather she appealed to the attention-seeking continuum as she perceived it for those who cut, in general.

Though it was less frequent in my study participants responses, there were individuals who, at times, claimed to take on the pathological identity of self-injuring for attention-seeking. Collin, an 18-year-old female to male transgendered person who began cutting at age 11, stated, "Well I suppose it wasn't scars at that time, it was just cuts. But I used those cuts sort of as attention and to assert myself as a person who was worth getting out of bed for." In this example, Collin did not resist attention-seeking as a pathology, but instead used attention seeking as a way to define himself.

Another plot on this continuum was indicated by Penelope, a 27-year-old female cutter and head-banger who at one point intentionally cracked a windshield with her head. "When I first did it I wanted to get caught. And then later on I didn't want anyone to know." In this example, Penelope at first claimed to be attention-seeking but later resisted the pathology. Penelope demonstrated how participant's not only located themselves on the continuum but also adjusted and readjusted their positions over time.

In the attention-seeking continuum, some participants resisted being talked about in pathological terms, some accepted it, and some shifted between accepting to not accepting it, but most of my participants engaged in the discourse, locating themselves along the entire spectrum of the continuum. More resisted this particular pathology exemplar than not, but a few felt that at one time or another in their lives, the pathological end of the continuum matched who they would claim to be.

The mastery continuum. The mastery continuum was characterized by the participant's mastery, or lack thereof, over self-injury. This was typically done by participants indicating aspects of being in control or out of control in regards to their self-injury. At one extreme of the continuum, participants typically identified as a self-injurer

and in control. On the other extreme of the continuum the participant identified as a self-injurer and not in control of their self-injury. On this end, the participants often claimed to be addicted to self-injury or described self-injury as a compulsion. Mastery, or being in control, indicated the absence of pathology, while lack of mastery, or not in control, indicated the presence of pathology. Self-injurers locate themselves relative to the mastery of other self-injurers they have known, or relative to the existing discourses regarding mastery and self-injury as they understood it.

In some cases study participants narratively resisted being characterized as not in control. For instance Penelope specified the mastery continuum in the following way:

> It's not compulsion. You aren't doing it unaware. I feel like with hair pulling you could just be doing it and not even realize you are doing it. But with other forms of self-injury you have to realize, you have to go you have to get an object to do that with and you have to consciously make an effort to make that happen.

Penelope indicated that people who pull their hair might not realize they were self-injuring and therefore would have less control over their self-injury. Unlike her when she would cut, she resisted the pathology of not mastering or having control of her self-injury by positioning hair-pullers at the extreme end of the continuum, while she herself had awareness and therefore control of her self-injury, and thus was not pathological, like hair-pullers.

Collin also specified the mastery continuum as a form of narrative resistance. In his interview he stated, "It's not as bad as people say it is. I know what I'm doing." In this example, Collin did not specify an individual, but rather he appealed to the mastery continuum as he perceived it for those who cut, in general.

Half of my participants, at some point, claimed to take on the pathological identity of not being in control. They specified the mastery continuum as a form of narrative acceptance of pathology. For instance, Abigail, a 24-year-old female self-injurer who was the only participant to begin self-injury after graduating highschool, discussed being out of control while intoxicated. She recalled, "Or there were days where I would drink and wake up and see bloody blades by me, and I don't remember cutting. That's when it got serious, because I was afraid that one night I would cut my throat and not know it." In this example, Abigail did not resist a lack of having control as pathology. But, she did use the terms as a way to define herself and the danger she perceived regarding her situation.

Similar to Abigail, Aria also narratively accepted her lack of mastery over self-injury on the mastery continuum to warn of the dangers of self-injury. Aria explained, "Like how when it first starts out it's a helpful tool. It's something that benefits you in the beginning but in the end it ends up being something dark and almost possessing for the most part. I mean it becomes part of who you are." In this example, Aria demonstrated a shift in location along the continuum. Aria moved from being in control of self-injury, by, as she claimed, using it as a tool. Aria then shifted towards the opposite end of the continuum when, as she claimed, seeing self-injury as being something that was, "almost possessing." In other words, Aria evolved from the "in control" position, and thus the "not pathologized" end of the continuum to "not in control" and therefore pathologized.

On the mastery continuum, some participants resisted talking about themselves in pathological terms, and some accepted it, but most of my participants engaged in the discourse, locating themselves along the entire spectrum of the continuum. Unlike with

the previous continua mentioned, an equal amount of participants fell on one extreme of the continuum as did on the other extreme end. A few located themselves between the ends, occasionally adjusting between locations. While some participants resisted the pathology of not having control over their self-injury, an equal number accepted the pathological self definition at one point or another in their life.

The self-injury spectrum. The self-injury spectrum is a continuum characterized by the participant's form, or chosen way of self-injuring. Participants who located themselves on this spectrum compared their form of self-injury to another. At one extreme of the continuum, participants typically identified one form of self-injury, their own, as the non-pathological form. On the other extreme of the continuum the participant identified another form of self-injury as not okay. Each participant who specified this continuum constructed their own unique version of the spectrum. There was not a great deal of agreement on what constituted a form of self-injury that was too dangerous.

Hot Wheels, a 47-year-old female hair-puller who began picking and scratching her skin at age 15, specified the self-injury spectrum as a form of narrative resistance in the following way: "Well, I mean hair pulling, you're obviously not going to be able to kill yourself with hair pulling." Later in the interview she stated:

> Cutting, it's funny because you would think scratching is a kind of cutting, but it's not like using a box cutter or scissors or a knife. I don't know if people use those kinds of things to cut but I would imagine so. I would be afraid of cutting too deep and it scares the shit out of me.

At this point, Hot Wheels indicated that people who pull their hair have a lesser risk than people who cut. People who cut have a higher risk and were therefore more dangerous. She resisted the pathology of risk by comparing forms of self-injury. She did this by positioning people who cut themselves at one end of the continuum, while she, being a

hair-puller, indicated less risk and was thus not pathological, like people who cut themselves. Hot Wheels marked those who cut themselves as partaking in more risk, and therefore pathological, while she took part in less risk and thereby unmarked herself as not pathological.

Like Hot Wheels, Aria also specified the self-injury spectrum as a means of negotiating her identity. In this segment of the interview, Aria was describing times where she had broken fingers, knuckles, and her wrist by punching objects. The following is her describing the difference between those experiences and her experiences with cutting. She said, "Punching a wall would be more of an anger I guess, where cutting was more of a emotional distress as far as like sadness or anxiety or depression." Later in the interview she stated:

> Like I said, self-injury is more of a secret uh injury versus punching a wall, people can see that but it's more of an aggression so it's more socially accepted. Everybody feels aggression or anger versus cutting something because you feel sad. Most people eat a chocolate chip cookie. Want to cut yourself? Here's a cookie.

Aria indicated how some forms of self-injury can be seen as more acceptable than others. For Aria, bone breaking was a sign of aggression, being more socially acceptable while cutting was a sign of sadness, anxiety, or depression and thus not acceptable. In this case, Aria placed bone breaking on the not pathological end while cutting was pathologized. Because Aria identified as both someone who had broken her bones and as someone who had cut herself, at different times she fit into different places on the continuum. Nevertheless, she engaged in this type of biographical work to negotiate her identity as a self-injurer.

In the self-injury spectrum, some participants resisted being talked about in pathological terms by distinguishing a difference in risk between one form of self-injury and another. Some participant's used the self-injury spectrum to indicate the difference in social acceptability between some forms of self-injury. Not as many participants made use of this continuum as previous continua. However, the self-injury spectrum was frequently talked about when appealing to the other pathology exemplars. For instance Aria characterized bone breaking as "crazy" when appealing to the sanity continuum. Penelope specified hair pulling versus other types of self-injury when she appealed to the mastery continuum. In these ways we can see the contours of how participants verbally map out identities for themselves, resisting one idea here, accepting another there, as they appeal to the various exemplars available to them to talk about who they are and are not.

The degree of harm continuum. The degree of harm continuum was characterized by the severity or degree of self-injury. This was typically done by participants comparing their degree of self-injury to one another, for example, pulling out all the hair in one's leg versus pulling out a few strands of hair from one's scalp. At one extreme of the continuum, participants typically identified as a self-injurer who injures to a lower degree. On the other extreme of the continuum the participant identified as a self-injurer who injures to a higher degree. Said in other words, lower degrees of injury indicated the absence of pathology while higher degrees indicate the presence of pathology. Self-injurers appealed to the degree of harm continuum when performing biographical work by drawing upon the discourse to locate themselves relative to other self-injurers they have known, or relative to the existing discourses regarding self injury as they understand it.

At times, participants narratively resisted being characterized as pathological by comparing their degree of harm to others. For instance River, a 24-year-old female who began cutting at age 14, specified the degree of harm continuum in the following way: "I'm not going to go deep. Like with cutting. Yeah, I would much rather have tons of shallow cuts than a deep one that is going to increase the risk of infection and hospitalization." In this example, River indicated that people who cut shallowly, such as herself, have a lesser risk than people who cut deeply. People who cut deeply have a higher risk and were therefore more dangerous. She did not resist the pathology completely; it seemed she attempted to lessen the pathology of her self-injury. While she accepted the pathology of cutting, she attempted to minimize the amount of pathology ascribed to her. She did this by placing herself as less risky on the degree model, thus positioning herself closer to the non-pathology end of the continuum.

Lucy engaged the degree of harm continuum as a way to not only accept the pathological identity, but to embrace it as something positive about who she was as a self-injurer. In this segment of the interview, Lucy discussed comparing her cuts to other self-injurers she knew, making sure she had the most and deepest cut marks. "Yeah, it definitely made me more like I don't know, be the best at it. Or the worst, you know, do it the worst." In this example, Lucy accepts the pathology of having a high degree of self-injury. If we take her claim as truth, it would seem that she not only accepted it, but she embraced the high degree as an intentional goal, placing herself at the pathological end of the degree of harm continuum. Her claim to a high degree of harm can be understood as a form of biographical work where she constructed for herself the identity as the "best" cutter.

In the degree of harm continuum, some participants attempted to minimize their degree of pathology, while others embraced or indeed amplified the pathology. Not as many participants used this continuum as often as some of the previous continua, however, the degree of harm continuum was implicitly and explicitly talked about when appealing to the other pathology exemplars. The entire self-injury spectrum can be seen in one way as a dialogue regarding degree of harm. The idea of mastery, or the lack of it, implies the ability to control the degree of harm. Each continuum is singled out here for clarity of discussion when in fact, pragmatically, many of the discourses overlap one another in usage as participants navigate their identity in conversation.

While the study participants discussed thus far have self-identified as self-injurers, some participants rejected the membership role of self-injury at times during their interviews. As we shall see in the next section, in order to reject the identity of "self-injurer" they made use of some of the same pathology exemplars as those who actively accepted the identity.

Dimensions of Pathology: Rejecting the Membership Role

Most of my participants, at some point during their interviews, rejected the membership role of being someone who is a "self-injurer". They typically did this by appealing to pathology exemplars. Participants used specific characteristics of these exemplars to distance themselves from the pathology associated with self-injury. In rejecting the identity, participants also engaged in narrative unmarking. They marked those on the pathology end as legitimate self-injurers, and thus unmarked themselves. By narratively unmarking themselves, they both resisted the pathology and rejected the

membership role. This section discusses a few of the pathology exemplars used to reject the membership role.

The self-injury spectrum. Many aspects of the self-injury spectrum, when the membership role is being rejected, are similar to when it is being accepted. In both cases a chosen self-injury methodology is pathologized and another one is deemed non-pathological in nature. In the case of rejecting the identity of self-injurer, by marking one method as self-injury, and another as "not" self-injury, they attempted to unmark themselves as self-injurers.

In some cases, study participants rejected being characterized as a self-injurer by comparing their form to another, a type of narrative unmarking. For instance Gerald, a 52-year-old male who self-injured for 15 years, specified the self-injury spectrum. At one point in the interview, Gerald was explaining why he hesitated to volunteer for this study. "I'm not a cutter so I don't really qualify for that." In this example, Gerald indicated that cutters would qualify for the study on self-injury, unlike him. Gerald, a bruiser and hitter, rejected the membership role of self-injurer by positioning cutters at the extreme end of the continuum, while he himself was not a cutter, and thus not a self-injurer, like cutters. In other words, Gerald marked cutters as "real" self-injurers and thus attempted to narratively unmark himself.

Similar to Gerald, Kari Ann also specified the self-injury spectrum as a method of rejecting membership. "I classify myself as someone who takes part in a habit that could be seen as being a self-injurer. But would I actually label myself as a self-injurer? Probably not." Later in the interview he stated: "I think of cutting when I think of self-injury." In this example, Kari Ann engaged the self-injury spectrum to explain why he

did not consider himself a self-injurer. Like Gerald, Kari Ann specified cutters to mark "real" self-injurers, thus unmarking himself.

By specifying the self-injury spectrum, participants resisted being talked about in pathological terms by distinguishing a difference in risk between one form of self-injury and another. In some cases, participants rejected membership all together. In both dimensions, accepting and rejecting membership, participants were able to use the self-injury spectrum as biographical resource to construct a sense of self.

The degree of harm continuum. Similar to the discussion of the self-injury spectrum, the degree of harm continuum can be invoked when the membership role is accepted or rejected. In the instance of rejecting the membership role, the study participant appealed to the idea that severity and degree matter in terms of defining what was and was not self-injury. In these cases, participants marked those behaviors with higher degrees of harm as being the "true" self-injurers, and thus pathological. By doing so, they attempted to narratively unmark themselves to locate themselves on the non-pathological end.

In some cases, participants rejected being characterized as a self-injurer by minimizing their degree of harm compared to another, a type of marking and unmarking. For instance, Penelope specified the degree of harm continuum in the following way: "Like, I wasn't doing more. I wasn't cutting deeper or accidentally injuring myself. So, I kind of viewed it like, 'Oh, I'm not really hurting myself.'" In this example, Penelope indicated that those who cut deeper or who were accidentally injuring themselves, unlike her, were the real self-injurers. Penelope, a self proclaimed "surface" cutter, rejected the membership role of self-injurer by positioning those who cut deeply at the extreme end of

the continuum, while she herself did not cut deeply, and thus was not a self-injurer, like those who cut deeply. In other words, Penelope marked deep cutters as self-injurers and thus attempted to narratively unmark herself.

Similar to Penelope, Abigail rejected membership and specified the degree of harm continuum in the following way: “Since I wasn’t going so deep that I thought I was gonna die, didn’t make me a cutter.” In this example, Abigail used the degree of harm continuum to reject the membership role. Abigail located those with a higher degree of harm and risk as self-injurers on the extreme end of the continuum, thus marking them as real self-injurers. Abigail claimed a lesser degree of severity and risk with her cutting, thus attempting to narratively unmark herself as a cutter.

The degree of harm continuum was specified in both the dimensions of accepting and rejecting membership. In the degree of harm continuum, some participants attempted to minimize their degree of pathology, while others embraced the pathology. Some participants used the degree of harm continuum to indicate the difference in social acceptability between some forms of self-injury. Some participants used the degree of harm continuum as a means of rejecting the membership role of self-injury. In both dimensions, accepting and rejecting membership, participants were able to use the degree of harm continuum as a biographical resource to construct a sense of self.

Making Further Sense of Self-Injury

Participants engaged pathology exemplars to negotiate their identity through the interview. They utilized pathology discourses to process and define their membership role. Participants, often drawing upon multiple exemplars, were able to use their different locations on the various continuums as map coordinates with which to construct a more

holistic sense of self. On all accounts, the pathology exemplars were used as biographical resources, wherein, participants located themselves in social space and constructed their identities.

Further processing the membership role. Earlier in the thesis, I discussed how participants who accepted the membership roles appealed to pathology exemplars. For a few participants, the process of getting to a point where they accepted the membership role occurred only recently. Until that point, they had rejected the membership role. For these participants, the interview served as a space where they could process their experience and redefine their membership role in relation to self-injury. This section discusses the transition from rejecting the membership role to accepting it.

One example of this was with Abigail, who initially used the degree of harm continuum to reject the membership role of self-injury. Through the process of participating in the interview, Abigail claimed the membership role of self-injurer. She made the following remark: "And until just now, I was never able to say 'us' when it comes to cutting. Cause' I never labeled myself as an actual cutter." For Abigail, the interview served, she claimed, as the first time she had taken on the membership role of cutting.

Gerald also went through a process of claiming the membership role of self-injury. Gerald did this by navigating around the self-injury spectrum. At the beginning of the interview, Gerald made it a point to inform me that he was not a cutter. Later in the interview, Gerald explained his hesitation in volunteering because he did not think his experience of bruising and hitting counted as self-injury. Encouraged by a friend, Gerald volunteered anyways. At one point in the interview, Gerald claimed he did not think his

experience counted as self-injury because it was not "sexy". Later in the interview, Gerald stated:

> I don't know if what I did is very common or not. Up until recently I never considered 'hey was I a self-injurer?' It didn't do me any good. You injured yourself. No it wasn't very profound. It wasn't, you know, you can't look at it but God some terrible shit must have been going on in my mind to want to do that.

By the end of the interview, Gerald had claimed his membership role as a self-injurer, stating that "injury is injury." In this way, Gerald negotiated and then renegotiated his identity along the self-injury spectrum. Thereby, he engaged in biographical work to construct a new sense of self.

Broadening definitions of self-injury. All participants had experiences of negotiating the self-injury identity during the interview. Penelope entered the interview as someone with a past of cutting and head banging. Through the interview she began to negotiate whether slapping herself counted as self-injury. Penelope had constructed a personal self-injury spectrum which rejected slapping as self-injury. Penelope claimed slapping did not count because it did not leave "visual" marks. Later in the interview, she claimed slapping did not count because the intention was different than cutting. By the end of the interview, Penelope stated: "Slapping myself across the face, like a week ago I would have never reported that as self-injury to you." In this example, Penelope negotiated and then renegotiated her self-injury identity by navigating around the self-injury spectrum. Penelope engaged in biographical work to construct and possibly even restory her identity.

Multiple exemplars. Participants frequently used multiple continua, often locating themselves in multiple places among more than one continuum. For example, Aria used the sanity continuum and the self-injury spectrum to negotiate her self-injury identity. At the beginning of the interview, Aria identified cutting as her form of self-injury. Aria indicated some views about other self-injurers, specifically placing bone breakers on the pathological end of the sanity continuum. Over the course of the interview, Aria stated that she had broken bones, multiple times, in her past. Until this point, Aria claimed the bone breaks as the consequences for acts of aggression, such as breaking a knuckle because she hit a wall out of anger. As the interview progressed, she began to indicate a change in her view on her experience with breaking her bones. "I guess I technically am a bone breaker." At this point, Aria began to expand her definition of self-injury to include bone breaking.

For participants, using multiple exemplars allowed a more holistic means of locating their position on the self-injury plane. I will continue to use Aria as an example for this. Through the course of her interview, Aria made use of the sanity continuum, the attention-seeking continuum, the mastery continuum, and the self-injury spectrum. Using the sanity continuum she positioned herself as sane. When engaging in the attention-seeking continuum, Aria located herself as one who shifted from seeking attention to not seeking attention. In the mastery continuum, Aria made claims of mastery or control over her self-injury. With the self-injury spectrum, Aria accepted one form of self-injury, cutting, and initially rejected another, bone breaking. By the end of the interview, Aria had further processed her membership role to include bone breaking in her self-injury experience. If we took her claims as true indicators of pathology plots, then it would

suffice to say that Aria resisted pathology on the sanity continuum, accepted and later resisted on the attention-seeking continuum, resisted on the mastery continuum, and negotiated membership roles through further processing. In other words, Aria was able to use pathology exemplars to construct her identity as a sane, private, in control, legitimate self-injurer rather than passively accepting the discourse of being an insane, attention-seeking, out of control, person who specifically cut herself; all pathologies associated with self-injurers.

Conclusion of Pathology Exemplars

In this chapter, I discussed a few of the pathology exemplars used by self-injurers engaged in biographical work. Due to the scope of this thesis, the exemplars discussed are by no means exhaustive. The continuums discussed in this thesis represent the most common ways participants utilized pathology exemplars, not the only ways. For example, participants also engaged in a tough/weak continuum to locate themselves on. By doing so, they often resisted or accepted the pathology of weakness associated with all self-injurers. Unlike the pathology approaches taken by previous researchers and others who have commented on self-injury, my participants did not use pathology to describe and categorize self-injurers as a whole, rather they used pathology to establish autonomy. This was done through narrative resistance, narrative accepting, rejecting, and narrative unmarking. By distinguishing themselves from other self-injurers, participants were able to locate themselves relative to other self-injurers and thus actively construct a sense of self.

These exemplars were engaged through the use of multiple continua. These continua allowed participants to narratively resist pathology, unmark themselves as

pathological, accept at times embrace the pathology, reject the membership role of self-injury and thus the pathology attached to it, and negotiate their identities. Most participants engaged multiple exemplars to negotiate their location on a type of n-dimensional self-injury plane, where each exemplar served as its own axis with which self-injurers map their location. In other words, each exemplar made up an additional piece of the participants overall identity, thus adjusting the location of the participant on a social map. In the next chapter, I discuss the alternative ways participants spoke about self-injury.

CHAPTER SIX

ALTERNATIVE FRAMES

This chapter discusses how participants used other frames to make sense of their self-injury and their lives. In the sections below, I discuss how participants used discourses of normalization, positivity, and responsibility and guilt to frame their histories.

Normative Frames

Participants often engaged discourses of normalcy to reframe their experiences with self-injury. In these cases, they were not setting up something or someone else as pathological and distancing themselves from that. Instead, sometimes they would position a socially acceptable form of self-injury as "normal" and then claim the same position for themselves or anyone else that self-injured. Generally, when they used this frame, they described self-injury in ways that indicated it was a normal part of their lives. In these moments, they appeared to speak of self-injury as an ordinary part of life or a coping strategy. It was framed as something generic and at times necessary. Self-injury just "was".

In some cases, normalcy discourses were used by comparing self-injury to other common injuries. In a discussion regarding the character of self-injury, Aria made use of the normative frame in the following way: "You know, everybody gets bruised. Every day, half the time, you get a bruise on you." In this example, Aria indicated the commonness of bruises. She engaged in normalizing discourse by claiming that injury, specifically bruising, was something that happens, intentionally or not, to everybody on a

regular basis. Thus, bruising was part of a normal everyday occurrence. By normalizing injury in general she attempted to normalize self-injury specifically.

Another participant, Abigail, engaged in the normalizing discourse in the following way: "In my brain, it was normal. You get mad, you drink a beer, I go cut. For me there was no difference to me." In the example, Abigail claimed cutting was a normal experience. By relating cutting to drinking a beer, a common and socially acceptable practice (which one *could* argue is a form self-injury), Abigail indicated that cutting was a common coping strategy, and thus normal.

For other participants, such as CJ, it was also necessary. "I mean then it was my way of surviving things. It was like a necessity like eating or sleeping or bathing or something. Then it was what I had to do to get through the day." In this example, CJ engaged in normalizing by indicating self-injury both as an everyday occurrence and as a common coping strategy. CJ did this by relating self-injury to very ordinary and necessary practices, such as eating and sleeping. In this way, CJ claimed self-injury was an essential part of her daily schedule, and thus normal.

Positivity Frames

Participants often discussed the positive aspects of their self-injury experience. This was done by indicating ways self-injury served as a benefit to their lives. By doing so, participants framed moments of their self-injury experience as positive. For example, Anne Lindsey, a 57-year-old female self-injurer who had self-injured for over 40 years, stated: "It [cutting] just made me feel better. It just took away whatever, I guess, I was feeling at that time." In this example, Anne Lindsey indicated that self-injury served as a way for her to cope and feel better. At several points in the interview, Anne Lindsey

referred to cutting as a “release”, a “relief”, and an “outlet”. For Anne Lindsey, these releases of negative feelings were benefits gained by self-injuring, thus positive aspects of self-injury.

Similar to Anne Lindsey, CJ discussed the positive aspects of self-injury in the following way: “Once I started doing it, and it made me feel a little better, I thought, ‘Everyone should be doing something like this. I feel good right now. And centered’”. Here, CJ indicated that self-injury provided her a needed release. For CJ, these releases were benefits gained by self-injuring, thus positive aspects of self-injury. If we take CJ’s claim to be true, the positive aspects of release were beneficial enough that CJ seemed to be willing to recommend self-injury to others.

Another way that participants, such as Hot Wheels, framed it in a positive way was through realizing a sense of collective identity with others who self-injure. By this point in the interview, Hot Wheels described opening up about her self-injury to other people and some of those people, in turn, opened up to her about their self-injury.

> And, you know, we’re all imperfect and just because somebody doesn’t say that they do something doesn’t mean that they don’t do it. And I am… I know I’m not alone and that there are a lot of people in the world who are doing things to themselves, and maybe, as a constructive way of dealing with things.

In this example, Hot Wheels indicated that knowing other people were going through things and self-injuring as a way of coping gave her a sense of group solidarity with others who self-injure.

A few participants, like Lucy, claimed self-injury provided benefits to their social status. Recall that earlier in the thesis Lucy was a study participant who took pride in the having the most and deepest cuts when she compared herself to others. She also

embraced the pathological identity of "crazy" even as she indicated that not all who self-injured were crazy in her view. In a discussion regarding her relationship to others who self-injured, Lucy stated:

> I felt better than them in a way. More powerful. Um, Kinda like, you know I said, like it made me feel like a bad person, but at the same time it made me feel like powerful, or like I had influence, I guess.
> Interviewer: On them?
> Lucy: Mm hmm. Yeah. Just kinda like they looked up to me. I, uh, I don't know. I was molding their young lives.

Though she claimed to have felt like a bad person to some degree, Lucy indicated self-importance and power as a benefit of her self-injury. If we accept Lucy's claims as truth, being a role model for other self-injurers gave Lucy a sense of self-importance. Lucy indicated power through claiming to mold the lives of fellow self-injurers to whom she was a role model for. For Lucy, self-importance and power seemed to be benefits to her social status provided by self-injury. These positive aspects, as biographical work, assist Lucy in shaping her identity.

Responsibility and Guilt Frames

Another way participants talked about self-injury was through responsibility and guilt frames. While responsibility frames occurred quite commonly on their own, guilt frames, more times than not, were accompanied by responsibility frames. In this section, I discuss responsibility frames, guilt frames, and how the two exist with one another.

Responsibility frames. The responsibility frame was characterized by participants claiming feelings of responsibility for other's self-injury or the other self-injurers' survival. In other words, participants appealing to the responsibility frame did so by indicating either responsibility for leading others to self-injury or by feeling responsible for the safety and well-being of their friends who self-injured. For example, River appealed to the responsibility frame in the following way:

> No one deserves my pain. No one needs to know. And while I would talk to her about being frustrated at home, it wasn't too deep. Um, because

> who am I to put that on someone else? I was nobody. So, she didn't need that. She didn't need that at all. So, in a lot of ways I felt like, I don't know if it's emotional protector or what, but it's not easy to talk about her. I feel like she would need to talk about her, I don't need to talk about her.

At this point of the interview, River had been discussing the relationship dynamics between herself and a friend who self-injured. River indicated responsibility by claiming to guard the emotional weight she placed on her self-injuring friend. River also indicated feelings of protection for her self-injuring friend. By claiming the need to protect her friend from extra emotional distress, River claimed responsibility for her words and for her friend's emotional well-being. By doing so, River shaped her biography in a way that made use of the responsibility frame.

Responsibility was also specified by Aria. "I'm not really sure with that whole relationship as far as if she would have been a cutter if I hadn't have started it." In this example, Aria indicates feeling somewhat responsible for her friend's cutting, claiming that she didn't know if her friend would have started cutting had the friend not been influenced by Aria's cutting. Though several of my participants engaged the responsibility frame alone, few appealed to the responsibility frame without simultaneously utilizing the guilt frame.

Guilt frames. Guilt frames were used when participants claimed guilt regarding their self-injury or guilt about other people self-injuring. Anne Lindsey used guilt framing, alone, in the following way:

> Because, I don't know, I was ashamed that I would do that to myself [cut], but I was ashamed of what had happened to me too. So, um I felt guilty for something that wasn't my fault, that I know now, but at that time I didn't realize it. So I felt guilty and ashamed. It made me feel shame to do that [cut] and you know. I didn't understand. I wasn't in my mind. You lose yourself.

Anne Lindsey specified guilt by claiming guilt for cutting herself, as well as for past traumatic experiences.

Similar to Anne Lindsey, CJ also engaged in the guilt frame. At this point in the interview, CJ describes the first time she saw her friend's cuts and scars.

> "I think seeing her legs like that, it kind of….like I just remember being very very worried for her. Like when we talked about it I never thought about her hurting herself. …And we didn't talk about things that night. I wish we would have.

For CJ, seeing her friend's injuries made her friend's cutting more real. CJ indicates feeling guilty for not talking about the self-injury with her friend that night. CJ states later in the interview that she still worries about her friend and tries to check in on the friend's well-being every so often. Though several of my participants engaged the guilt frame alone, few appealed to the guilt frame without simultaneously utilizing the responsibility frame, which will be illustrated in the next section.

Combining responsibility and guilt frames. When self-injurers believe that they have caused someone else to self-injure, they can express feelings of both responsibility and guilt. Collin, when discussing his relationship with someone who self-injured, combined both frames in the following way:

> "It was sort of… I have brought somebody else down to my gross level and let's just, let's throw this away.
> Interviewer: That's interesting that you said "gross level."
> Collin: yeah, um, there was always some level of guilt involved."

At this point in the interview, Collin was describing his reaction to watching a friend borrow his razor blade to cut herself for the first time since deciding to stop self-injuring. By saying, "I have brought" Collin indicated responsibility for his friend's latest cutting

experience. Collin then claimed to feel guilt for influencing his friend's self-injury. If we take Collin's statements to be true, then his sense of responsibility lead, in part, to his feelings of guilt and his viewing his self on a "gross level".

Like Collin, Lucy specifies responsibility and guilt in the following way:

> "Even though she was already like injuring herself when we met, she wasn't really cutting. And I, she got that idea from me , cause' she thought it was really cool and um. Actually, another one of my friends did that too and her parents handled it like it's a whole bad thing. I just feel really bad that all these people started, or tried to do it, like cause' they saw me doing it",

In this example, Lucy indicated feeling responsible for her friends cutting. This lead to Lucy feeling guilty, that her friends began cutting, as she claimed, because of her.

Frames of responsibility, guilt, or a combination of the two were appealed to by participants who had known other self-injurers. While participants did engage in responsibility discourses and guilt discourses separate from one another, several participants also combined the two. Responsibility frames and guilt frames served as alternatives utilized by participants to describe and make sense of their self-injury experience.

Conclusion of Alternative Frames

In this chapter, I have discussed a few of the alternative frames used by participants to describe and construct their sense of self. Participants indicated their self-injury as normal, at times claiming positive aspects from self-injury, and at other times describing feelings of responsibility and guilt for the impacts of their self-injury on themselves and others. Like the pathology exemplars from chapter five, participants were able to construct a more autonomous sense of self within self-injury rather than, as

previous literature describes, passively taking on and characterizing collective pathologies. In the next chapter, I discuss some concluding thoughts and themes for future research.

CHAPTER SEVEN

CONCLUSION

A Look Back

I began this thesis with an account of a self-injury experience, my self-injury experience. I did this in part to give a reader some context regarding self-injury, but also to paint a more in-depth portrait of self-injury that has been lacking in the previous literature. Until now, research on self-injury has primarily focused on numbers: the increasing rates of self-injury disclosure, the correlations between self-injury and suicidality, and delineating demographic differences between self-injurers. Other research has attempted to group self-injurers into a one-size fits all box, using pathology as a tool to describe self-injurers. Even as Adler and Adler (2011) attempted to investigate beyond the psycho-medical perspectives and conventional debates, they asserted the notion that self-injury is intrinsically pathological. Their focus on self-injurers as "loner deviants" (2008:34) and exploring how self-injurers navigated cyber communities to gain social connections while maintaining their real life secrecy regarding self-injury membership purports that self-injurers passively accept the pathologies associated with self-injury. In this sense, self-injurers accept, to some degree, a common and taken for granted identity.

Having been a self-injurer, I initially resisted the notion that my experience of self-injury could be generalized as pathology and nothing more. The approach was too reductionist. Because I knew of other self-injurers and their experiences, I recognized that my truth regarding self-injury was different than theirs – my reasons, my methods, my degrees, my benefits, my sense of responsibility, my lack of guilt. Sometimes these

differentiations were minute, yet, I knew I was not an anomaly – we all differed. In some ways, this research is resistance to the pathological generalizations for self-injurers as a collective. In many ways we are legion, we are many, yet we are also individuals with varying experiences that can construct unique identities and social places for ourselves.

Findings and Contributions

I was fortunate enough to interview 12 former self-injurers, each with story characteristics both in common and unique to them. I listened as Collin, the female to male transgendered person, described changing his form of self-injury to match his new masculine sense of self. Shelia recalled using self-injury as a way of both mentally and physically escaping her abusive home as a child. Abigail used self-injury, specifically cutting, to take on an addiction identity. For Gerald, self-injury served as an emotional timeline when reflecting on his life, noting traumatic events by an increase in self-injury. These stories could go on. Each account demonstrated the autonomy of the participants while also describing the ways in which the participants' individual experiences shaped their interpretations of their self-injury and thus their biographies. Participants engaged in biographical work by making use of both pathology exemplars and alternative frames.

Unlike with those in previous literature, participants who appealed to pathology exemplars did so as a way of locating themselves in social space rather than passively accepting the pathologies as true. Participants specified pathology exemplars through the use of continuums. These continuums were characterized by pathology on one end and non-pathology on the other. Participants who located themselves on the non-pathology end engaged in narrative resistance. Those who located themselves on the pathology end participated in narrative acceptance. A few participants utilized these continuums to

reject membership roles of self-injury. They marked others as legitimate self-injurers, and thus, narratively unmarked themselves. By narratively unmarking, they also narratively resisted the pathologies. Whether they narratively resisted, narratively accepted, or narratively unmarked, participants used pathology exemplars to engage in biographical work.

Participants also used other frames to talk about and make sense of their experience. These discourses served as a way of interpreting what the self-injury experience meant to them without having to accept or resist the pathologies placed upon them by mainstream society. Participants did this by using frames which described their self-injury experience as normal, having positive aspects, and at times inducing responsibility and guilt. These frames are largely neglected in much of the previous literature. Research that has discussed alternative frames such as these did so underneath a blanket of pathology. For example, Adler and Adler (2011) investigated the relationship dynamics of self-injurers, as loner deviants, among cyber communities. By doing so, they addressed non-pathology aspects of self-injury, specifically relationship dynamics, encapsulated within a pathological realm, as indicated by the classification of loner deviants. In this thesis, alternative frames were treated as just that –alternatives. They were not analyzed through the lens of pathologized self-injurers, rather they were viewed as frames which self-injurers used to describe their experiences of self-injury and construct a sense of self.

This study, by not assuming self-injury was intrinsically pathological, found that self-injury was a unique and autonomous experience interpreted through multiple frames and dimensions. In many cases, participants indicated a dissonance between what they

considered themselves to be, such as not pathological or normal, versus the pathologies imposed upon them by the research community and in the media. Their use of pathology exemplars served as an attempt to resolve some of that dissonance. Participants used pathology continuums to map a space for themselves. Alternative frames helped participants to re-interpret and convey the meaning of their experiences. Said in other words, pathology exemplars were used to define, while alternative frames were used to describe. All of the framing devices were vital to participants making sense of their stories and constructing a sense of self.

The synthesis of narrative resistance with narrative unmarking contributes to the existing theoretical literature, as the two have not previously been linked in this manner. It is my contention that narrative unmarking as a form of narrative resistance has applicability outside of the topic of self-injury. For instance, I would anticipate that narrative unmarking as narrative resistance would be evident when investigating the identity construction of people with eating disorders. Similar to self-injury, people with eating disorders are heavily pathologized and typified. However, what an eating disorder actually is varies. In a study on body image and attitudes, Haworth-Hoeppner (2000) indicated difficulty in finding "pure anorexics" for her study. This suggests that others may be able to narratively mark others as actual anorexics, while unmarking themselves and thus narratively resisting the pathologies associated with anorexia. Types of eating disorders are not set in concrete boundaries. Another study, (Harris 2006) stated a lack of consistent "cultural terms" used to define and measure eating disorders may indicate why eating disorders appear stereotypically non-existent among black women. I argue, these inconsistencies also provide a way of engaging in narrative unmarking. Due to the heavy

pathologies surrounding eating disorders, and the lack clear definitions, it seems reasonable that narrative unmarking as narrative resistance would be found in the accounts of some people with eating disorders. In the following section I address other suggestions for future research.

Limitations and Guide for Future Research

Future research should investigate whether other marginalized groups engage in similar kinds of biographical work to distance themselves from or accept pathology or not. If so, are they similar to those as identified in this paper? Future research should also examine whether narrative unmarking as narrative resistance is a common form of biographical work among groups other than self-injurers. For instance, drug users might engage in narrative unmarking by marking people who use other types of drugs or who use more as the real drug user, thus unmarking themselves and narratively resisting the stigma associated with drug users.

There were findings which emerged in my data that I was unable to investigate further. This was in part due to the time constraints of my project, but also due to the limited number of participants. Some of these findings included additional types of dissonance. One example of this was a process of negotiating self-injury and gender. This was specified by Collin in the following way:

> Well, I think the idea of being trans is sort of the impetus behind my cutting, or sort of the reason behind my unhappiness. Other than that I think it's mostly just, I think it's more stigmatized in boys because you are supposed to be more stoic. And the outward expression of your inner feelings is very much more frowned upon. You're not supposed to cry and you're not supposed to complain, and you're not supposed to self-injure.

For Collin, being a female to male transgendered person meant learning the norms of being a male. In his interview, Collin described learning that cutting was a "female" method of self-injury. Identifying as a male, Collin claimed to feel "embarrassment" for cutting because it symbolized femininity. In the quote above, Collin indicated that being a male means you do not self-injure. For Collin, there was a disjuncture between how he portrayed masculinity versus how he was supposed to. Future research should further investigate how gender negotiations play a role in the storying of self-injury. Future research should also look specifically at transgendered self-injurers and how their unique experiences shape their stories.

Race was another theme that emerged in my findings. Specifically, it was mentioned that the culture of the black community pressured its members not to discuss self-injury. Shelia specified this in the following way:

> You can't talk about it. See, self-injury is a mental illness and black people don't talk about mental illness. See I came up here, after all the stuff that went down in the North. One of the foster families that I did actually love, that didn't do nothing to me. They moved to the base in [nearby small town]. They told me I needed to share my story. But as I was researching before I moved down here… I was researching and it was saying people don't talk about cutting, they don't talk about being bipolar or PTSD in the black community, or being gay. Cause' it's a taboo. They will say that the demons need to be zoomed or taken out of you. I can't say the word. Exer something.
> Interviewer: Exorcised?
> Shelia: Yeah. So I was told never to talk about none of those from them.

It is a common understanding in African American culture that homosexuality is frowned upon more than in the white community (Lemelle and Battle 2004; Lewis 2003) and, as a result, that it is not as openly talked about as it is in the white community. Likewise, is also commonly understood that blacks don't talk

about mental illness in general and that they don't go for services as often, because of the stigma attributed to it (Ojeda and Bergstresser 2008) Due to my small sample size and limited racial diversity, I was unable to further explore the impact of race on the life story of self-injurers, but it is not a stretch to hypothesize that Shelia's assertions may have merit.

Similar to previous research, (Adler and Adler, 2011; Whitlock, Powers, and Eckenrode 2006) many of my participants spoke of trauma and abuse in their past. Two patterns emerged in the interviews where participants with histories of abuse linked self-injury to the trauma. One was to construct an emotional timeline where self-injury was used to mark or recall past events. In these cases, traumatic events were marked by an increase or shift in self-injury. One example of this was specified by Anne Lindsey in the following way:

> And then I cut a lot too after I had an abortion. My mother made me have an abortion. I was in a Catholic school, and that's when I was 16. I cut a lot after that too because I felt so horrible. I started cutting again. A lot. Um, because the pain of, it feels like a murder. It was so intense that um, I had to, it was a release.

In this example, Anne Lindsey claimed her cutting increased, in an attempt for a release, after being forced to have an abortion. Later, Anne Lindsey would claim an increase in cutting after the death of her mother and the death of her son. For Anne Lindsey, self-injury appeared to mark past moments of traumatic loss.

Another instance is indicated by Shelia. "Cutting got worse when I was about 15 or 16. Interviewer: And why did it get worse then? Shelia: I had my second child by my foster brother.Yeah." For Shelia, cutting increased with the birth of her second child. It is important to note that Shelia was repeatedly raped by her foster brothers. It was because

of rape that Shelia claimed to have self-injured in the first place. To her, self-injury was a way of escaping the trauma. “It was escape. It was my form of Prozac”. As the trauma increased, Shelia claimed self-injury increased. Therefore, for Shelia, self-injury served as an emotional marker of trauma from her past.

The second way participants linked self-injury to trauma was by using self-injury as a platform to speak about their trauma. In these cases, they claimed that talking about self-injury provided them with the place to speak about past sexual, physical, verbal, and emotional abuse. One example of this was specified by Abigail.

> And I still have these feelings sometimes. I want to get over it. And I have gotten over it. I’ve gotten over the big hump. Doesn’t mean there’s little humps. I still haven’t gotten over the fact that I was raped when I was seven. I still haven’t let that go.”

Abigail then began to tell a vivid account of the night she was raped. She recalled every detail, from what she was wearing, what was on the television, to what she ate for dinner. Towards the end of the account, Abigail described how the topic had been hushed throughout her life. Her mother, Abigail claimed, did not believe her. Abigail was never taken to a hospital to be treated. No police report was ever filed. She was not given counseling for it. The event was silenced. Yet, when Abigail’s mother saw Abigail cutting herself, Abigail claims she rushed her to the hospital and put her in counseling. For Abigail, self-injury was something she was encouraged to talk about. It was something her family asked her about. For her, speaking about self-injury opened up an opportunity to talk about her trauma. “With me, it [self-injury] might not have started there but something in my childhood is what progressed it to.” At the end of this account, Abigail stated: “Honestly, I feel relieved… I feel a whole lot better than I did. I don’t get to talk about that [the rape].”

Another example of the idea of the platform can be found with Shelia in the following way:

> It was horrible. Yeah. I cried a lot. Between that and them teaching me how to drink at a very young age. I started drinking when I was two years old out of a baby bottle to shut me up. Yeah. I was a, I have disabilities, you can't tell, but I have problems a lot. So, it was between the drinking and them having sex with me. I've been through hell and back.

Shelia, like Abigail, went for years without anyone believing her when she told them about ongoing abuse. Shelia began self-injuring, she claims, directly because of the sexual abuse. For Shelia, self-injury was always related to traumatic events or flashbacks to traumatic events. Accounts of trauma were necessary to illustrate her self-injury experience, however, at some points in the interview, self-injury served as a platform to discuss her trauma in more detail. Future research should further examine how self-injury is linked to trauma in the telling of their life stories.

Researchers may consider replicating this study with larger sample sizes to see what, if any, other ways participants use self-injury as a narrative resource to speak about their identity. In addition, because of my recruitment methods, about half of my participants had received psychological help for self-injury while the other half had not. Future research should limit their samples to only those who have received psychological help or only to those who have not to see if and how the process of psychological services, such as therapy, might additionally shape self-injury. Often times, therapy is a place to restory one's history. For a couple of my participants, therapy seemed to provide them with an analytically interpreted script full of psychology frames to describe their experiences, whereas others without therapy are actively and more intensely still creating their scripts.

Activist Stance

I have addressed a few of the ways in which my research has differed from and contributed to existing literature both on self-injury as a substantive topic and the theoretical frameworks of biographical work, narrative resistance, and narrative unmarking. However, I would be remiss to leave the thesis on that note. Therefore, this section serves as an activist section wherein I address emergent themes that indicate fundamental societal problems and major policy issues. This section is not supported by previous research and should not be taken as part of the academic merit of my thesis. It is rather my platform, if you will, and should be read as such. That being said, future research might benefit from investigating some of the themes I discuss here.

Listening to my participant's life-histories, I observed themes of silence leading to and surrounding self-injury. Participants indicated feeling as if they had nobody to talk to, nobody to care, and nobody to listen to them. Because of this, they often refrained from articulating their emotions and feelings. For these participants, self-injury served as their only source of emotional release.

Several participants used self-injury, at some point, to attempt to signify that they were going through something. Participants claimed these signs were, largely, overlooked by friends and family. When self-injury was addressed, it was in the context of stopping the self-injurer rather than finding out why the self-injury was taking place. For many participants, discovery of their self-injury was met by anger and hostility. "How do you think this makes me look?" "You're doing this on *my* watch?" Some participants were asked to keep their scars covered. Others were taken directly to hospitals and rehabs, as the participant described it, so professionals could take care of them, rather than the

significant other. These reactions, for participants, perpetuated the impact of pathology, and thus drove the participant further into silence.

In some cases, participants described a significant other who did take the time to question their self-injury without fixating on the cessation of the self-injury. For these participants, having someone who seemed to care about and listen to the them often provided them a new resource to release emotions, to talk about, and thus make sense of their life experiences. For the majority of my participants, self-injury stopped when a caring significant other entered the picture. The notion of having someone to "care", as I understand it described, seems to individualize and even humanize the individual. It indicates to the self-injurer that they are capable of being viewed not as an enigma but as an actual human being. This allows the self-injurer then to view themselves as an individual rather than a stereotype. From an interactionist perspective, one could argue that a caring other provided feedback which enabled the self-injurer to take on the role of the other and see themselves not as pathologized and problematic, but as someone worth being kind to. The caring other offered other resources for the self-injurer to restory their self. This autonomy, in my opinion, is essential for deep reflection on one's life and for interpreting the self.

The majority of my participants described somewhat traumatic experiences of ineffective mental health treatment. These were indicated by accounts of psychologists falling asleep during the patient's appointment, sexual assault by mental health professionals in hospitals, and being asked if they had "learned their lesson". All of those who reported negative professional help experiences indicated that the focus of their sessions was on stopping the self-injury and not on what led to or surrounded it. These

participants described never once being asked about their past. Instead, participants with negative mental health experiences described feeling treated like they were incompetent, inherently dangerous, not worth the attention, and not important. These experiences often lead toward a type of defiant self-injury rather than helping the self-injurer. Participants claimed to lie about their self-injury in order to terminate the "help."

As I type this, I realize I am painting an evil picture of the psychological community and their treatment of self-injurers. While traumatic experiences, like the ones listed above, were frequent among my participants, many eventually found high quality experiences with different therapists. These experiences were indicated by finding a therapist who seemed to care and who asked about past experiences. By exhibiting care and interest, these therapists individualized the participants, thus providing a space for the participant to exist without judgment and begin to restory their life histories. For these participants, professional help was a benefit that they recommended to other self-injurers, often with the advice of "keep trying until you find someone that will listen."

Every participant in my research had experience with either sexual, physical, emotional, or verbal abuse, or neglect. All the participants described feeling like they could not speak about these experiences. Many stated these experiences played a part in their self-injury. Talking about self-injury appeared to open the door to talking about their past trauma, while not being able to talk about self-injury acted as a further silencer of their traumatic pasts. It is my opinion that remaining silent about both self-injury and trauma increases isolation, hinders psychological growth, and traps people in the victim role. Thus, it is my contention that (1) opening up positive discourses to talk about trauma may reduce the risks of self-injury, and (2) Self-injury may not be the problem,

rather it may be a temporary solution to a deeper issue, therefore more focus within treatment should be placed on letting the self-injurer speak rather than fixating on stopping the act. By breaking the silence of self-injury, I argue, you provide room to break the silence about trauma.

I do not mean to suggest that all self-injurers have experiences of trauma or that all victims of trauma will self-injure. A few participants did not connect their trauma experience with self-injury. For these participants, talking about self-injury, it was hoped, would reduce stigma and increase understanding of self-injury in general, no trauma attached. The majority of my participants called for, sometimes quite passionately, a larger societal discussion of self-injury. The idea was that by talking about self-injury, you break some of the stigma and provide a safer space for other self-injurers to "come out". For them, self-injury needs to be talked about publicly, not by medical professionals or news anchors, but by individuals with actual experience as a self-injurer. The intention is to educate the general public and show them that self-injury is not a generalized pathology, rather a more complex topic that needs to be discussed. Self-injurers shouldn't be afraid to admit to it, silenced by pathological generalizations and fear. By "coming out", self-injurers are able to work through their life experiences to restory their histories.

Both the avoidance reactions by significant others and the poor treatment by mental health professionals, indicates a fundamental problem with the way we, as a society, talk about and treat self-injury. By avoiding deeper conversations of self-injury we neglect to see underlying issues. Fixating on self-injury as an inherently dangerous practice, alone, that needs to be stopped does not solve anything. Rather, it encourages

self-injury. Pathology and fears strip self-injurers of their autonomy by immediately placing them into a pathology box. These threats further silence self-injurers. Silencing self-injury solves nothing.

Concluding Thoughts

In this chapter, I have addressed the ways in which participants used narrative resources, specifically forms of biographical work, to construct their identity and restory their life histories. I found that participants did not speak of self-injury as inherently pathological, as previous research suggested, but rather self-injury was a highly subjective experience in which participants engaged continuums of pathology exemplars (sanity, attention-seeking, mastery, self-injury spectrum, degree of harm) and alternative frames (normative, positivity, and responsibility and guilt) by narratively resisting, narratively accepting, narratively rejecting, and using narrative unmarking as a form of narrative resistance. By doing so, participants created a social space for themselves where they could interpret their experiences, construct their identity, and restory their lives.

Participants, therefore, specify autonomy in self-injury rather than passively accepting a generalized pathology. Because of this, it is my contention that self-injurers should be treated as individuals, not stereotypes, that are complex human beings, who have rich and sometimes dark histories, and who should be allowed to speak for themselves about their reality with self-injury. If anything, my research shows that self-injury cannot and should not be considered one thing in particular. It is not always bad. It is not always good. It is not always a sign of being crazy. It is not always a way to seek attention. It is not always something we have control of. It is not always cutting. It is not always deep. It is not always abnormal. It is not always negative. It is not always

something to feel proud of. And sometimes, it is all of those things and more. Self-injury as a tool, a behavior, a mechanism, an identity, and sometimes, it just is.

REFERENCES

Adler, Patricia, and Adler, Peter. 2008. "The Cyber Worlds of Self-Injurers: Deviant Communities, Relationships, and Selves." *Symbolic Interaction* 31(1):33-56.

------ 2011. *The Tender Cut: Inside the Hidden World of Self-injury.* New York, NY: NYU Press.

American Psychiatric Association. 2000. "Appendix I: Outline for Cultural Formulation and Glossary of Culturebound Syndromes." *In Diagnostic and Statistical Manual of Mental Disorders* 4th ed.

ANSI, ed. 1996. "Manual on Classification of Motor Vehicle Traffic Accidents."*American National Standards Institute*. Itasca, IL: National Safety Council, s.v. Retrieved September 2, 2013 (http://wwwnrd.nhtsa.dot.gov/Pubs/ansid16.pdf).

Ayeni, Olubimpe. 2004. *Observations on the Medical and Social Aspects of Scarification in Sub-Saharan Africa*. Manuscript. University of Ottawa. Retrieved August, 2013 (http://www.medicine.uottawa.ca/historyofmedicine/hetenyi/ayeni.htm).

Berger, Peter L. and Thomas Luckmann. 1966. *The Social Construction of Reality: A Treatise in the Sociology of Knowledge.* New York: Anchor Books.

Blumer, Herbert. 1969. *Symbolic Interactionism: Perspective and Method*. Englewood Cliffs, NJ: Prentice-Hall.

Brekhus, Wayne. 1996. Social Marking and the Mental Coloring of Identity: Sexual Identity Construction and Maintenance in the United States. *Sociological Forum* 11(3):497–522.

------ 1998. The Sociology of the Unmarked: Redirecting Our Focus. *Sociological Theory* 16(1):34–51.

Castillo, Michelle. 2012. "Despite Social Media Bans of "Pro-Ana" Websites, Pages Persist." *CBS Interactive Inc.* Retrieved August, 2013. (http://www.cbsnews.com/8301-504763_16257405463-10391704/despite-social-media-bans-of-pro-ana-websites-pages-persist/).

Charmaz, Kathy. 2006. *Constructing Grounded Theory*. London: Sage.

Conterio, Karen, and Wendy Lader. 1998. *Bodily Harm: The Breakthrough Healing Program for Self-Injurers*. New York: Hyperion

Elsworth, Catherine. 2008. "Christina Ricci, the Remake.*"The Telegraph*. Retrieved March 23, 2014(http://www.telegraph.co.uk/culture/film/3672953/Christina-Ricci-the-remake.html).

Erickson, Erik H. 1956. "The Problem of Ego Identity." *Journal of the American Psychoanalytic Association* 4:56–121.

------ 1968. *Identity: Youth and Crisis.* New York: Norton.

Favazza, Armando R. 1996. *Bodies under Siege: Self-mutilation and Body Modification in Culture and Psychiatry.* 2nd ed. Baltimore, MD: Johns Hopkins University Press.

------ 1998. "The Coming Age of Self-mutilation." *Journal of Nervous and Mental Disease* 186(5):259–268.

Favazza , Armando R., and Karen Contiero. 1989. "Female Habitual Self-mutilators." *Acta Psychiatrica of Self-Injury Scandinavica* 79:283–289.

Forsyth, Craig J., and Jessica Simpson. 2008."Everything changes once you hang: Flesh hook suspension." *Deviant Behavior* 29(4):367–387.

Gabrielle. 2011. "Famous Self-injurers." *Selfinjury.net.* Retrieved April, 2013. (http://selfinjury.net/media/famous-self-injurers).

Gergen, Kenneth J. 1991. *The Saturated Self: Dilemmas of Identity in Contemporary Life.* New York: Basic Books.

Gratz, Kim L., Conrad, Sheree Dukes, and Lizabeth Roemer. 2002. "Risk Factors for Deliberate Self-harm among College Students." *American Journal of Orthopsychiatry* 72(1):1281–40.

Griffith, Richard. 2012. "Time to Repeal the Tattooing of Minors Act of 1969." *British Journal of Nursing* 21(18):1102–1103.

Grossman, David C., Robert Soderberg, Frederick P. Rivara. 1993. "Prior Injury and Motor Vehicle Crash as Risk Factors for Youth Suicide." *Epidemiology* 4(2):115–119.

Gubrium, Jaber F. and James A. Holstein. 1998. "Narrative Practice and the Coherence of Personal Stories." *The Sociological Quarterly* 1:163–187.

------ 2009. *Analyzing Narrative Reality*. London: Sage.

Gubrium, Jaber F., James A. Holstein, and David R. Buckholdt. 1994. *Constructing the Life Course*. Dix Hills, NY: General Hall.

Hamlyn, Mark. 2010. *The Silent Epidemic*. Retrieved April, 2013. (https://www.youtube.com/watch?v=IAcSeVCnJSA).

Harris, Shanette M. 2006. “Body Image Attitudes, Physical Attributes and Disturbed Eating among African American College Women.” *Race, Gender & Class.* 13 (1/2):46-58.

Haworth-Hoeppner, Susan. 2000. “The Critical Shapes of Body Image: The Role of Culture and Family in the Production of Eating Disorders.” *Journal of Marriage and Family.* 62(1):212–227.

Hawthorne, Nathaniel.1850. *The Scarlet Letter*. Ticknor, Reed and Fields.

Heath, Chris. 1998. “The Love Song of Marilyn Manson.” *Rolling Stone*. Retrieved 2013. (basetendencies.com/interview/RollingStone98.html).

ISSS. 2007. International Society for the Study of Self-injury. Retrieved April, 2013. (http://www.isssweb.org/Home.php).

Joiner, Thomas E. 2005. *Why People Die by Suicide*. Cambridge: Harvard University Press.

Kroger, Jane. 2007. *Identity Development: Adolescence through Adulthood*. Sage.

Lemelle, Anthony J. Jr., Juan Battle. 2004. “Black Masculinity Matters in Attitudes Toward Gay Males.” *Journal of Homosexuality* 47(1).

Lewis, Gregory B. 2003. “Black-White Differences in Attitudes toward Homosexuality and Gay Rights.” *The Public Opinion Quarterly* 67(1):59–78.

Marlette, Bob, and Josey Scott. 2002. "Always." *Back into Your System.* Island.

Martiniuk, Alexandra LC, Rebecca Q. Ivers, Nick Glozier, George C. Patton, Lawrence T. Lam, Soufiane Boufous, Teresa Senserrick, Ann Williamson, Mark Stevenson, and Robyn Norton. 2009. "Self-harm and Risk of Motor Vehicle Crashes among Young Drivers: Findings from the DRIVE Study." *Canadian Medical Association Journal* 181(11):807–812.

Matthews, P. C. 1968. Epidemic Self-injury in an Adolescent Unit. *International Journal of Social Psychiatry* 14:125–133.

Mayers, Lester B., Daniel A. Judelson, Barry W. Moriarty, and Kenneth W. Rundell. 2002."Prevalence of Body Art (Body Piercing and Tattooing) in University Undergraduates and Incidence of Medical Complications." *In Mayo Clinic Proceedings* 77(1):29–34.

Mead, George Herbert. 1934. *Mind, Self, and Society: From the Standpoint of a Social Behaviorist*. Chicago, IL: The University of Chicago Press.

McAdams, Dan P. 1988. *Power, Intimacy, and the Life Story: Personological Inquiries into Identity.* New York: Guilford Press.

Merriam-Webster 2013. “Definition of Syndrome.” Springfield, MA: Merriam-Webster. Retrieved August 26, 2013 (http://www.merriamwebster.com/dictionary/syndrome).

NSHN, "National Self Harm Network." 2009. Accessed August, 2013. (http://www.nshn.co.uk/index.html)

Obenschain, Philip. 2013. “Arkansas State Legislature Passes Bill to Ban Certain Body Modifications, Tattoo Procedures.” *Alternative Press.* Retrieved August, 2013. (http://www.altpress.com/news/entry/arkansas_senate_passes_bill_to_ban_certain_tattoo_procedures_nontraditional)

Ojeda, Victoria D., Sara M. Bergstresser. 2008. “Gender, Race-Ethnicity, and Psychosocial Barriers to Mental Health Care: An Examination of Perceptions and Attitudes among Adults Reporting Unmet Need.” *Journal of Health and Social Behavior* 49(3):317–334.

Pattison, E. Mansell, and Joel Kahan. 1983. “The Deliberate Self-Harm Syndrome.”*American Journal of Psychiatry* 140:867–72.

Prinstein , Mitchell J. 2008. “Introduction to the special section on suicide and non-suicidal self-injury: A review of unique challenges and important directions for self-injury science.” *Journal of Consulting and Clinical Psychology* 76(1):1-8.

Pruit, John C. 2012. Peak Oil and Narrative Construction of Unmarked Identities. *Symbolic Interaction* 35(4):438–455.

Pudouj. 2012. Butterfly Project. Retrieved March, 2013 (http://www.onemillionscars.com/the-butterfly-project-has-wings/).

Rambo-Ronai, Carol, and Rabecca Cross. 1998. "Dancing with Identity: Narrative Resistance Strategies of Male and Female Stripteasers." *Deviant Behavior: An Interdisciplinary Journal* 19(2):99–119.

Ritzer, George. 2010. *Sociological Theory*. 8 Ed. McGraw-Hill Publishing Company.

Ross, Shana, and Nancy Heath. 2002. “A Study of the Frequency of Self-mutilation in a Community Sample of Adolescents.” *Journal of Youth and Adolescence* 31(1):667–677.

Ross, R. R., and McKay, H. B. 1979. *Self Mutilation*. Lexington, MA: Lexington Books.

Ruiz-Junco, Natalia, and Salvador Vidal-Ortiz. Year. “Autoethnography: The Sociological Through the Personal.” Pp. 193-211. *New Directions in Sociology: Essays on Theory and Methodology in the 21st Century,* edited by I. Zake and M. DeCesare. Jefferson, NC: McFarland & Company, Inc. Publishers.

Selby, Edward A., Theodore W. Bender, Kathryn H. Gordon, Matthew K. Nock, Joiner Jr., and E. Thomas. 2012. “Non-suicidal self-injury (NSSI) disorder: A preliminary study.”*Personality Disorders: Theory, Research, and Treatment* 3(2):167–175.

Shotter, John, and Kenneth Gergen, eds., 1989. *Texts of Identity.* Newbury Park, CA: Sage.

Silver, Michael. 2014. Butterfly Project. Retrieved April 1, 2014 (http://www.cuttingdepression.net/butterfly-project/).

Taiminen, Tero, Kristina Kallio-Soukainen, K., Hannele Nokso-Kovisto, Anne Kaljonen, and Hans Helenius. 1998. “Contagion of Deliberate Self-harm among Adolescent Inpatients.” *Journal of the American Academy of Child and Adolescent Psychiatry* 37:211–217.

Tseëlon, Efrat. 1992. “Is the Postmodern Self Sincere? Goffman, Impression Management, and the Postmodern Self.” *Theory, Culture, and Society* 9:115–28.

UBMM Holdings, LLC. "Pro Ana." 2013. Retrieved August, 2013. (http://www.myproana.com/).

Whitlock, Janis, Jane Powers, and John Eckenrode. 2006. “The virtual cutting edge: The Internet and adolescent self-injury.” *Developmental Psychology* 42(3):407–417.

APPENDIX A

RESPONDENT CONSENT FORM

Self-Injuryand Identity

WHY ARE YOU BEING INVITED TO TAKE PART IN THIS RESEARCH?

You are being invited to take part in a research study about self-injury and identity. You are being invited to take part in this research study because you are a consenting adult who has volunteered to share your past experience of self-injury. If you volunteer to take part in this study, you will be one of about 15 people to do so.

WHO IS DOING THE STUDY?

The person in charge of this study is Brittany Presson of University of Memphis Department of Sociology. She is being guided in this research by her faculty advisor Dr. Carol Rambo. There may be other people on the research team assisting at different times during the study.

WHAT IS THE PURPOSE OF THIS STUDY?

This study seeks to examine how and if self-injury impacts the telling of one's life-history. The definition of self-injury as observed by the International Society for the Study of Self-Injury (2007) will be used for this study. Non-suicidal self-injury is the intentional act of harming or inflicting bodily tissue damage on oneself *without* the intent to kill oneself. Examples of this are self-cutting, burning, branding, bone breaking, hitting, scratching, hair pulling, and banging one's head. By doing this study, we hope to better understand the ways, if any, that self-injury serves as a narrative resource when self-injurers tell the story of their life.

ARE THERE REASONS WHY YOU SHOULD NOT TAKE PART IN THIS STUDY?

If you are younger than the age of 18, you should not take part in this study. If you have never self-injured, you should not take part in this study. If you are a relative of the researcher, you should not take part in this study. If you are a personal friend of the researcher, you should not take part in this study.

Due to the sensitive topic of this interview, it is possible that you may feel some emotional distress. If you feel the need to meet with a counselor due to any distress caused by the interview process, a onetime free counseling session is available through the University of Memphis Psychological Services Center. You may contact Dr. James P. Whelan at 901-678-3736. If for some reason you are in need of service but do not wish to use the PSC, you may contact Dr. Cliff Heegel at 901-763-0999.

WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?

You will have the choice to participate in either a face to face interview or a telephone interview. If you choose to participate in the telephone interview, it is not within the researcher's ability to control the privacy within your physical location during the phone interview. The researcher will take all possible measures to secure privacy on her end of the line, however if you are engaging in the telephone interview while grocery shopping, for example, the researcher will not be able to control who might overhear the conversation.

If you elect to participate in face to face interview, you will have a choice of setting. A private office on the University of Memphis campus will be available for interviews. If, however, you do not feel comfortable participating on campus, the researcher is willing to meet you at a mutually agreed upon safe, non-public, location. The one-time interview will take anywhere between 45 minutes to 2 hours.

WHAT WILL YOU BE ASKED TO DO?

You will be asked to take part in a private interview. No identifying information will be taken from you. You will work with the Investigator to create a pseudonym (false name). This will serve as the only identifier for you. With your permission, interviews will be recorded. No identifying questions, such as real name or phone numbers, will be asked. The recordings will be stored in a locked file until the end of the project, at which time they will be destroyed. Transcripts will be made for each recording. You will be asked to fill out a short survey. If you are being interviewed over the phone, this survey may be verbally completed. The survey and transcript will be kept in a separate locked file from the audio recordings. Any identifying information that might come up during the interview, such as a high school name or address will be replaced with a false name. An example is instead of East High School, something along the lines of Urban High School or Rural High School will be substituted.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?

You may find some questions we ask you to be upsetting or stressful. Due to the sensitive topic of this interview, it is possible that the participant may have some negative emotional responses. If the participant feels the need to meet with a counselor due to any distress caused by the interview process, a onetime free counseling session is available.

In addition to the risks listed above, you may experience a previously unknown risk or side effect.

WILL YOU BENEFIT FROM TAKING PART IN THIS STUDY?

There is no guarantee that you will get any benefit from taking part in this study. However, some people have experienced a sense of healing or enlightenment when

narrating events from their past. Your willingness to take part, may, in the future, help society as a whole better understand this self-injury.

DO YOU HAVE TO TAKE PART IN THE STUDY?

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering.

IF YOU DON'T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?

If you do not want to be in the study, there are no other choices except not to take part in the study.

WHAT WILL IT COST YOU TO PARTICIPATE?

There are no costs associated with taking part in the study.

WILL YOU RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?

You will not receive any rewards or payment for taking part in the study.

WHO WILL SEE THE INFORMATION THAT YOU GIVE?

We will make every effort to keep private all research records that identify you to the extent allowed by law.

Your information will be combined with information from other people taking part in the study. When we write about the study to share it with other researchers, we will write about the combined information we have gathered. You will not be personally identified in these written materials. We may publish the results of this study; however, we will keep your name and other identifying information private.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is.

No identifying information will be taken from you. You will work with the Investigator to create a pseudonym (false name), which will serve as the only identifier for you. With your permission, interviews will be recorded, but no identifying questions, such as name or phone numbers, will be asked. The recordings will be stored in a locked file until the end of the project, at which time they will be destroyed. Transcripts will be made for each recording, however, only a pseudonym (false name) will be used. Any identifying information that might come up during the interview, such as a high school name or address will be replaced with a broad description. An example is instead of East High School, something along the lines of Urban High School or Rural High School will be substituted. You will have an option of telephone or face to face interviews. The setting for face to face interviews will also be flexible within reason. For example, public spaces such as coffee shops or restaurants that pose a risk of breaching privacy and confidentiality will not be acceptable. These options allow you to choose a location that is

comfortable and secure both emotionally and confidentiality wise. If you opt for telephone interviews, the researcher cannot control who might overhear the conversation on your end of the line. All measures will be taken to secure privacy for you on the researcher's end of the conversation.

Because the consent form would be the only record linking identifying information to you, and because a breach of that information could result in potentially harmful risks to you, the researcher has asked that written documentation of consent be waived. This means you will not have to sign your real name to any document for this research.

We will keep private all research records that identify you to the extent allowed by law. However, there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information to a court: or to tell authorities if you report information about a child being abused or if you pose a danger to yourself or someone else. Also, we may be required to show information which identifies you to people who need to be sure we have done the research correctly; these would be people from such organizations as the University of Memphis.

CAN YOUR TAKING PART IN THE STUDY END EARLY?

If you decide to take part in the study you still have the right to decide at any time that you no longer want to continue. You will not be treated differently if you decide to stop taking part in the study.The individuals conducting the study may need to withdraw you from the study. This may occur if you are not able to follow the directions they give you, if they find that your being in the study is more risk than benefit to you, or if the researcher decides to stop the study early for a variety of scientific reasons.

ARE YOU PARTICIPATING OR CAN YOU PARTICIPATE IN ANOTHER RESEARCH STUDY AT THE SAME TIME AS PARTICIPATING IN THIS ONE?

You may take part in this study if you are currently involved in another research study. It is important to let the investigator/your doctor know if you are in another research study.

WHAT HAPPENS IF YOU GET HURT OR SICK DURING THE STUDY?

It is important for you to understand that the University of Memphis does not have funds set aside to pay for the cost of any care or treatment that might be necessary because you get hurt or sick while taking part in this study. Also, the University of Memphis will not pay for any wages you may lose if you are harmed by this study.

Medical costs that result from research related harm cannot be included as regular medical costs. Therefore, the medical costs related to your care and treatment because of research related harm will be your responsibility; **or** may be paid by your insurer if you are insured by a health insurance company (you should ask your insurer if you have any questions regarding your insurer's willingness to pay under these circumstances); **or** may

be paid by Medicare or Medicaid if you are covered by Medicare, or Medicaid (if you have any questions regarding Medicare/Medicaid coverage you should contact Medicare by calling 1-800-Medicare (1-800-633-4227) or Medicaid 1-800-635-2570.

A co-payment/deductible from you may be required by your insurer or Medicare/Medicaid even if your insurer or Medicare/Medicaid has agreed to pay the costs. The amount of this co-payment/deductible may be substantial.

You do not give up your legal rights by signing this form.

WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS, CONCERNS, OR COMPLAINTS?

Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have questions, suggestions, concerns, or complaints about the study, you can contact the investigator, Brittany Presson at bpresson@memphis.edu or 731-415-4720. If you have any questions about your rights as a volunteer in this research, you may contact Jacqueline Y. Reid, Administrator for the Institutional Review Board for the Protection of Human Subjects, via e-mail atirb@memphis.edu or by phone at 901-678-3074.

We will give you a copy of this consent form to take with you.

WHAT IF NEW INFORMATION IS LEARNED DURING THE STUDY THAT MIGHT AFFECT YOUR DECISION TO PARTICIPATE?

You may choose to stop the interview process at any time.

WHAT HAPPENS TO MY PRIVACY IF I AM INTERVIEWED?

The only identifying information attached to any document or recording will be the pseudonym (false name). Recordings and transcripts will be kept in a locked file until the study has been completed. Recordings will be kept in a locked file separate from your transcripts and demographic survey information. After completion of the study, all recordings and transcripts will be destroyed.

WHAT ELSE DO YOU NEED TO KNOW?

Your continuation with this study indicates that you agree to the following:

1) I have been informed of any and all possible risks or discomforts.
2) I have read the statements contained in this consent form and have had the opportunity to fully discuss my concerns and questions, and fully discuss the nature and character of my involvement in this research project as a human subject, and the attendant risks and consequences.

APPENDIX B

COVER SHEET

Pseudonym_____

What is your current age?_____

What sex is written on your birth certificate? _____

What gender do you classify as? _____

What race do you typically classify yourself as? _____

What is your highest level of education? _____

Before the age of 18, who did you live with? _____

Did you still live with them the first time you self-injured?_____

What did your mother do for a living?_____

What is her marital history?_____

What did your father do for a living? What is his marital history?_____-

What kinds of jobs have you held?_____

What is your marital history?_____

Do you have any experience viewing self-injury related media or participating in self-injury organizations? (May include but not limited to: vlogs, websites, To Write Love on Her Arms, One Million Scars, various music scenes)_____

APPENDIX C

INTERVIEW GUIDE

General:

Tell me about yourself?

What type of music do you listen to?

What type of hobbies and entertainment do you enjoy?

Do you belong to any organizations, groups, or sports?

Self-injury:

How old were you the first time you self-injured?

Would you be willing to tell me the story of what happened the first time you self-injured?

What area of the country were you in the first time you self-injured? (Home? School? In the city? In the south? In a rural area?)

Why do you think it happened?

What happened afterwards?

The research says that some people have a ritual and some don't. Do you ever follow a ritual?

(Y or N) Why do you think that is true for you?

(Y) Would you describe your ritual for me?

(Y)Why do you think some people don't have a ritual?

(N)Why do you think some people do have a ritual?

(If they answered sometimes) What was different about the times you followed a ritual and the times you did not?

What method of self-injury did you use the first time? Why?

What was your most memorable experience with self-injury?

Why did you first begin self-injury?

Did the reasons stay the same or have they changed?

Did you have a goal in mind when you self-injured?

Did you accomplish that goal?

Did you have other goals?

After the first time, about how often did you self-injure?

Why do you think that was?

How many times in total have you self-injured? (It's okay to guess if you can't remember exactly)

Do you think you injure more, less, or about the same amount as others you know of who self-injure?

Why do you think that is?

Did you use other forms of self-injury? If so, which ones?

(Y)Why?

(N) Why not?

(Y)Do you have methods you prefer over others? Why or why not?

(Y) Are there any that you would not use again?

(Y)Are there any methods that you refuse to try?

Identity:

What does it mean to you that you are someone who self-injures?

Does it mean some good things?

Does it mean some bad things?

Did anyone else know that you self injured?

(N) Why not?

(Y) What do you think others who knew thought about you?

(Y)Was that different from those who did not know? (Y) How So?

How did that affect you?

Have you ever known other self- injurers? I do not need the name(s).

What did you have in common with them?

How were they different from you?

Have you ever seen anyone else self injure?

If so, what was your reaction?

If so, how did they differ from you?

What did you think about others that self injure? Has that opinion changed any over time? How so?

Do you think you have changed much over time? How so?

Current Outlook:

What advice would you give someone that is thinking about or currently self injuring?

If you could travel back in time, is there any advice you would give your younger self?

Do you think much about past self-injury behavior?

Are those thoughts usually positive?

Are those thoughts usually negative?

What does the future look like for you?

Where do you see yourself in ten years?

Are there any questions that I didn't ask that might be helpful for future interviews?

Were there any questions that you expected me to ask that I didn't?

*Thank you very much for participating in this interview. I appreciate that you took the time to do this with me.

APPENDIX D

RECRUITMENT FLIER

Volunteers Wanted for a Research Study

Self-Injury and Life History Study

Purpose of study: This research seeks to examine how and if self-injury impacts the telling of one's life-history. For the purpose of this study, I will use the definition of self-injury as observed by the International Society for the Study of Self-Injury (2007). I will specifically be looking at non-suicidal self-injury, which is the intentional act of harming or inflicting bodily tissue damage on oneself *without* the intent to kill oneself. Examples of this are self-cutting, burning, branding, bone breaking, hitting, scratching, hair pulling, and banging ones head.

Procedure and duration: Seeking volunteers to participate in an interview regarding self-injury. The nature of this interview is to address life experiences with past self-injury. The interview is expected to take between forty-five minutes to two hours. Participants will also be asked to complete a short survey requesting demographic information. Participants will have the option of a face-face or a telephone interview.

Eligibility: All participants must be 18 years or older. Only participants that have self-injured in the past and are willing to talk about it confidentially will be accepted.

Contact: To volunteer, or to seek more information, please contact graduate student Brittany Presson of the Department of Sociology by phone at 1-731-415-4720 or by email at bpresson@memphis.edu

APPENDIX E

IRB APPROVAL

The University of Memphis Institutional Review Board, FWA00006815, has reviewed and approved your submission in accordance with all applicable statuses and regulations as well as ethical principles.
PI NAME: Brittany Presson
CO-PI:
PROJECT TITLE: Self-Injury and Identity
FACULTY ADVISOR NAME (if applicable): Carol Rambo
IRB ID: #2676
APPROVAL DATE: 5/17/2013
EXPIRATION DATE:
LEVEL OF REVIEW: Full Board
Please Note: Modifications do not extend the expiration of the original approval
Approval of this project is given with the following obligations:
1. If this IRB approval has an expiration date, an approved renewal must be in effect to continue the project prior to that date. If approval is not obtained, the human consent form(s) and recruiting material(s) are no longer valid and any research activities involving human subjects must stop.
2. When the project is finished or terminated, a completion form must be completed and sent to the board.
3. No change may be made in the approved protocol without prior board approval, whether the approved protocol was reviewed at the Exempt, Exedited or Full Board level.
4. Exempt approval are considered to have no expiration date and no further review is necessary unless the protocol needs modification.
Approval of this project is given with the following special obligations:

Note: Review outcomes will be communicated to the email address on file. This email should be considered an official communication from the UM IRB. Consent Forms are no longer being stamped as well. Please contact the IRB at IRB@memphis.edu if a letter on IRB letterhead is required.

APPENDIX F

WAIVER OF WRITTEN DOCUMENTATION OF CONSENT APPROVAL

The University of Memphis Institutional Review Board, FWA00006815, has reviewed your submission in accordance with all applicable statuses and regulations as well as ethical principles.
PI NAME: Brittany Presson
CO-PI:
PROJECT TITLE: Self-Injury and Identity
FACULTY ADVISOR NAME (if applicable): Carol Rambo
IRB ID: #2676
CONTINGENCY DATE: 5/23/2013
CONTINGENCY TYPE: Minor
Please Note: Major contingencies require a full board review of the revision, minor contingencies require an expedited review of the revisions, and administrative contigencies are issued when not enough information has been provided to complete a thorough review.
The contingencies are listed below:
1. Be sure to give the participants a copy of the informed consent form (ICF). 2. Page 9 of 19 on the ICF -To the best of our knowledge, the things you will be doing have no more risk of harm than you would experience in everyday life. Please delete this line 3. The Waiver of Written Documentation Consent is approved.
Your response to this letter is a chance for you, as the investigator, to ask questions about the contingency, supply the IRB with more information, and revise your protocol and IRB application. The IRB strives to make the contingencies as clear, concise, and compliant with the federal regulations as possible. Your feedback is invaluable in the collaborative effort to conduct compliant human subject's research.
Once you have addressed the contingencies listed above in your protocol, please e-mail a clean copy of your revised protocol in addition to a copy of your protocol with the changes either highlighted or tracked. These documents need to be e-mailed to irb@memphis.edu with the Subject line Revisions 2676. If you have a faculty advisor, your faculty advisor will need to be the one who e-mails the revised protocol to our office on your behalf or provide their signature in another fashion in order for the revisions to be processed.
If you have any questions regarding the Board's contingencies, you can contact me via e-mail (irb@memphis.edu). If you have questions regarding how to submit your revised protocol or questions about the IRB process, please contact the Institutional Review Board at irb@memphis.edu or 901-678-3074.
Please submit revisions within 30 days of this email. If you need more time, please reply to this email and request more time. If no revisions are received, your protocol may be administratively withdrawn with the understanding that you are no longer pursuing this research project.