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THE SOCIAL SIDE OF “BORDERLINE:” EDGEWORK IN THE NARRATIVE
ACCOUNTS OF SELF-INJURERS

by

Victoria Lynn Gaines

A Thesis

Submitted in Partial Fulfillment of the

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Master of Arts

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DEDICATION

For my friends and family.

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ABSTRACT

Eleven in-depth life history interviews with respondents who identified as former self-injurers and a thematic analysis of the existing qualitative literature on self-injury constitute the data for this research. Self-injury, a growing public health concern, has typically been framed by researchers as an individual level, psychological, phenomenon with largely negative connotations. Edgework, a theoretical orientation which has been used to explain voluntary risk-taking such as skydiving and mountain climbing, has been applied to the activity of self-injury. The interviews and qualitative research on self-injury were coded for the presence of edgework as a vocabulary of motive. Framed as edgework, this distinctly sociological approach casts self-injury as a socially produced phenomenon which can be viewed as a reaction to oversocialization/alienation, a way to regulate negative internal conversation, a bid for self-actualization, realization, and determination, and more. Through edgework theory, self-injury can be understood to “make sense” at times.

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CHAPTER ONE

INTRODUCTION

Self-injury is a growing public health concern according to the Centers for Disease Control and Prevention (CDC) (Centers for Disease Control and Prevention 2017; Claassen, Smith, and Kashner 2012). Demographic patterns of people who self-injure vary according to sociocultural context, though it appears that, in the West, adolescents and college students are most at risk for engaging in the practice (Walsh 2012). It is estimated that roughly 13%-15% of adolescents, 17%-38% of college students, and 4%-22% of adults self-injure (Inckle 2014; Kerr, Muelenkamp, and Turner 2010). Further, statistics hold that up to 20% of individuals who self-injure will continue the practice throughout the course of their lifetime (Klonsky, Victor, and Saffer 2014).

Self-injury has myriad definitions in the literature, both academic and mainstream, which is to say that what is defined as self-injury in one setting may not be in another. The CDC broadly defines the phenomenon as “anything a person does intentionally that can cause injury to self, including death” (Centers for Disease Control and Prevention 2017). As this definition makes clear, self-injury is quite often considered in the same vein as suicide (Andover and Gibb 2010; Brown, Comtois, and Linehan 2002; Hawton, Saunders, and O'Connor 2012; Nock 2012). While the relationship between self-injury and suicide is complex, as self-injury is believed to lead both into and away from suicide, studies find that a majority of those who receive medical attention for self-injuries attempt suicide (Chandler 2018; Klonsky 2007; Klonsky and Muehlenkamp 2007), and that self-injury is a predictor of future suicide attempt (Klonsky, Victor, and Saffer 2014).

Self-injury is also broadly considered to be mental illness (Klonsky 2007; Victor Glenn, and Klonsky 2012; McCloskey, Look, Chen, Pajoumand, and Berman 2012). Much of the psychological and medical literature on self-injury associate the practice with mental health problems such as depression, anxiety, drug and alcohol abuse, eating disorders and behavioral disorders (Centers for Disease Control and Prevention 2017). For years, self-injury was considered a defining characteristic of borderline personality disorder (Gratz, Dixon-Gordon, Chapman, and Tull 2015). The most recent edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-5), however, lists criteria for nonsuicidal self-injury disorder (NSSID), and an otherwise undiagnosed version of self-injury as a symptom of several other disorders (American Psychiatric Association 2013).

For the purposes of this thesis, I employed a sociological perspective through which to understand the practice of self-injury, that of edgework (Lyng 1990). Edgework is a theoretical approach to voluntary risk-taking as it pertains to negotiation of boundaries that are positioned liminally “betwixt and between” (Turner 1979) opposing extremes, such as life and death. Leisure activities such as skydiving and mountain climbing are typical examples of edgework. I employed a dual methodology in the collection and analysis of my data, which are drawn from a content analysis of existing qualitative sociological research on self-injury, and 11 in-depth interviews conducted with individuals who self-identified as having a history with self-injury. Specifically, this research answers the questions: Will edgework discourse be found within a) the qualitative sociological literature on self-injury and b) interviews with former self-injurers?

This thesis begins with an overview of the existing self-injury literature, including a section which focuses special attention on the qualitative sociological literature on the topic. Next, I discuss my theoretical frame, edgework, followed by a discussion of my methodology. Afterwards, I present my findings regarding edgework as a vocabulary of motive in the literature and in the narrative accounts of self-injurers. Lastly, I discuss the information I have presented in this thesis and conclude that understanding self-injury as a form of edgework yields insights for individuals who self-injure, therapists, and researchers.

CHAPTER TWO

LITERATURE REVIEW

Chapter Two provides an overview of the self-injury literature. The following questions are considered: 1) What is self-injury? 2) How is self-injury performed? 3) Who practices self-injury? and 4) Why practice self-injury? Afterwards I summarize the ambiguous nature of self-injury before reviewing the existing qualitative sociological research on self-injury. Familiarity with this literature will be important for understanding the relevance of this research question and my thematic analysis of the qualitative literature.

WHAT IS SELF-INJURY?

Self-injury has been defined in myriad ways in the literature and in Western culture generally (Adler and Adler 2011; Muehlenkamp 2005; Presson and Rambo 2016; Sandoval 2006). In fact, when considered altogether, these definitions become a conundrum. For example, a synthesis of just a few definitions of self-injury is any “incident” (Sandoval 2006:218) of “repeated self-aggressive activity” (Brossard 2014:558) meant to “cause direct and immediate pain and/or damage to oneself” (Inckle 2014:4). Or, self-injury can be anything “irrespective of the purpose of the act” (Chandler 2012:443) “that may or may not be construed as suicidal” (Chandler 2018:2). Or, another example is any “intentional injuring of oneself” (Presson and Rambo 2016:2) “where an individual has attempted to deliberately alter or destroy body tissue” (Sandoval 2006:218) “so that blood flows and scar tissue is left” (Gradin Franzén and Gottzén 2011:279). Some have said that this is typically “performed to relieve ‘emotional malaise,’ without the intention of committing suicide (suicidal attempts), getting sexual

pleasure (sadomasochism), or pursuing some aesthetic goals (body art)” (Brossard 2014:558). Finally, self-injury has been defined as any “specific behaviors that have been identified by the psychiatric and medical communities as falling into this specific syndrome” (Adler and Adler 2007:538), which include practices that draw blood, such as cutting and stabbing, and those that do not, such as bruising and burning.

Not only do the definitions of self-injury contradict one another and become confusing, there are seven terms that have been used interchangeably with the self-injury designation which heightens conceptual uncertainty. Those terms are deliberate self-harm syndrome, self-wounding, self-inflicted violence (Adler and Adler 2011), self-mutilation, non-suicidal self-injury (NSSI), self-harm, and parasuicide (Adler and Adler 2011; Presson and Rambo 2015; Whitlock, Powers, and Eckenrode 2006). To further problematize this idea, multiple taxonomies have been constructed around the practice. For example, Favazza created three types of self-injury, which he termed “self-mutilation.” They are superficial or moderate self-injury, stereotypic self-injury, and major self-injury. He characterized each type according to method and severity of injury, and associated each with varieties of psychomedical categorization. He specified that superficial or moderate self-injury “includes compulsive acts such as trichotillomania and skin picking and such episodic acts as skin-cutting and burning” (1998:77). Stereotypic self-injury “includes such acts as head banging and self-biting most often accompanying Tourette's syndrome and severe mental retardation” (1998:77). Finally, major self-injury “includes infrequent acts such as eye enucleation and castration, commonly associated with psychosis and intoxication” (Favazza 1998:77).

HOW IS SELF-INJURY PERFORMED?

The most prevalent documented form of self-injury is self-cutting (Kokaliari and Berzoff 2008), but individuals also report practicing other forms of self-injury that include scratching (Gradin Franzén and Gottzén 2011), burning (Sandoval 2006), biting, and pinching (Kokaliari and Berzoff 2008; Sandoval 2006). There are reports of individuals tying self-ligatures [...] scalding, [...] self-hitting or head-banging, [...] scraping at the body, inserting sharp objects [...] into body orifices, interfering with wounds [...] scrubbing away the surface of the skin, and swallowing sharp objects” (Inckle 2014:4) or chemical substances, which is called “overdosing” (Inckle 2014) or “self-poisoning” (Chandler 2018). People also report “branding, picking the skin [...] embedding objects, breaking [...] teeth, tearing or severely biting cuticles or nails, and chewing the inside of the mouth” (Adler and Adler 2011:1). Further, there are contradictions surrounding whether actions can be considered self-injury or not. For instance, eating disorders, substance abuse disorders, and hair pulling (or trichotillomania) are often characterized as separate disorders, but are noted as being self-injurious; and practices like tattooing, piercing, and engaging in certain spiritual ceremonies may be injurious, but when culturally sanctioned, they are not considered as such (Favazza 1998; Presson 2014; Presson and Rambo 2015). Thus, quite often behaviors can be characterized as both self-injury and not self-injury, depending upon sociocultural context.

WHO SELF-INJURES?

Self-injury is traditionally thought to affect mostly young, well-educated, middle to upper class white women with some history of trauma (Adler and Adler 2011; Presson and Rambo 2016) who are separated or single (Kokaliari and Berzoff 2008). Researchers have found that this information is overstated. Self-injury is “associated with younger age, being unmarried and a history of mental health treatment, but not with [...] ethnicity, educational history or household income” (Klonsky 2011; see also Nock 2009). Females may or may not be at a higher risk of self-injury, though typically, those whose history includes self-injury begin self-injuring at younger ages, they injure longer, and they use more severe methods (e.g., cutting over bruising). Males who self-injure, on the other hand, may show fewer external signs of mental strain than females who self-injure (Victor, Muehlenkamp, Hayes, Lengel, Styer, and Washburn 2018) and they may be more inclined to injure themselves in social settings and/or when intoxicated (Self-Injury and Recovery Research and Resources (SIRRR) 2018). Due to sociocultural norms surrounding masculinity and vulnerability, it has been particularly difficult to measure self-injury in men (Inckle 2014).

There is also limited data on transgender people who self-injure (Alexander and Clare 2004), though it appears that sexual minorities may be at a heightened risk for self-injury. More non-heterosexual men and boys report self-injuring over heterosexual men and boys, and bisexual women and girls appear to be especially vulnerable to engaging in the practice (Alexander and Clare 2004; DeAngelis 2015). Rejection from peers and bullying has also been found to increase the odds of self-injury (DeAngelis 2015). Further, individuals who self-injure typically begin in their early teenage years, between

ages 12 and 15, and rates are believed to spike around college age (Kerr et al. 2010; Klonsky et al. 2014; Kokaliari and Berzoff 2014). Roughly 6% of adults report a history with self-injury, while 4% of adults report maintaining a current practice of self-injury. It is also estimated that 15%—20% of individuals who begin self-injuring will continue the practice through the course of their lives (Klonsky et al. 2014). However the self-injury phenomenon is conceptualized, or operationalized, the rate of practice is recognized to be growing (Walsh 2012), which leads us to question why people may engage in the phenomenon.

WHY PRACTICE SELF-INJURY?

Self-injury has been characterized in many ways in the literature. It has been described as a claim to group solidarity, like within music (Adler and Adler 2011; Presson 2014; Presson and Rambo 2016) and cyber subcultures (Adler and Adler 2008; Gradin Franzén and Gottzén 2011; Steggals 2015); and a practice that can elevate social status for some (Inckle 2014; Jeffreys 2000; Presson and Rambo 2016). It can be a religious or military ritual, and is associated with other cultural customs, such as coming of age ceremonies and rites of passage (Adler and Adler 2011; Favazza 1996; Presson 2014; Presson and Rambo 2016). Self-injury has also been described as a form of embodied emotion work (Brossard 2014; Chandler 2012), and is often considered a coping mechanism (Turner, Chapman, and Layden 2012; VanDerhei, Rojahn, Stuewig, and McKnight 2014), “providing rapid but temporary relief from feelings of depersonalization, guilt, rejection, and boredom as well as hallucinations, sexual preoccupations, and chaotic thoughts” (Favazza 1998:77).

Irrespective of the numerous reasons people have claimed to engage in self-injury, the practice has broadly been characterized as mental illness (Adler and Adler 2007, 2011; Glen and Klonsky 2009; Klonsky 2007; Favazza 1996; Presson 2014; Presson and Rambo 2016). It has been connected to a range of disorders, including but not limited to borderline personality disorder (Adler and Adler 2011; Gratz et al. 2015; Presson 2014; Favazza 1998), antisocial personality disorder (Claes, Vandereycken, and Vertommen 2007; Favazza and Rosenthal 1990; Virkkunen 1976), bipolar disorder, dissociative identity disorder, and schizophrenia (Adler and Adler 2007, 2011; Favazza and Rosenthal 1990; Favazza 1998). It is, at times, classified as a symptom of other clinical diagnoses like post-traumatic stress disorder, anxiety disorders, and multiple depressive disorders (Klonsky, May, and Glenn 2013).

The practice has been connected to disorders concerning impulsivity, such as obsessive-compulsive disorder, and to those that are marked by obsession and compulsion, such as substance abuse and eating disorders. Self-injury is also considered potentially addictive in and of itself, with the injury producing a drug-like effect (Bareiss 2013; Klonsky 2011; Nock, Joiner, Gordon, Lloyd-Richardson, and Prinstein 2006; Nock 2010; Victor et al. 2012; Whitlock, Powers, and Eckenrode 2006). Glen and Klonsky (2010) distinguished four types of impulsivity that were characteristic of self-injurers.

Those were:

Urgency, the tendency to commit rash, regrettable actions in the face of negative affect; Perseverance (lack of), the ability (or inability) to stay with a task through completion; Premeditation (lack of), the ability (or inability) to delay action in order to deliberate and plan; and, Sensation Seeking, or the tendency to seek excitement and adventure (2010:68).

Notably, their study made use of the UPPS Impulsive Behavior Scale which had previously shown validity in measuring impulsivity in those with attention-deficit hyperactivity disorder, borderline personality disorder, and depression, which, again, connects self-injury practices back to diagnostic criteria for these disorders.

Self-injury, in and of itself, has traditionally been bound to countless mental disorders, but only recently was it formally recognized as such. In the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) self-injury was listed only as a symptom of diagnosable disorders (American Psychiatric Association 2000). In the fifth and latest edition of the DSM, however, nonsuicidal self-injury disorder (NSSID) received its own classification and diagnostic criteria (American Psychiatric Association 2013). Gratz and colleagues (2015) stated that inclusion of criteria for NSSID was meant to recognize the disorder as its own entity, separate from other disorders, such as borderline personality disorder for instance, which has cited self-injury as “the ‘behavioral specialty’ of patients with BPD” (2015:527). The inclusion of this criteria was also meant to encourage more research on the phenomenon. Results of field trials conducted prior to print yielded low reliability, thus NSSID is currently categorized in the manual as a disorder requiring more research (Gratz et al. 2015). Nonetheless, criteria for the diagnosis of NSSID was differentiated from an otherwise less severe, or undiagnosed, categorization of nonsuicidal self-injury that appears as a symptom of other disorder classifications in the manual (American Psychiatric Association 2013).

Socially, self-injury and suicidal behavior have been regarded synonymously. The CDC has said that “self-harm is a risk factor for suicide [...] [therefore] nonfatal self-

harm in and of itself is an important public health concern” (Claassen et al. 2012). In fact, some studies find a majority of those who self-injure have also attempted suicide (Klonsky 2007; Klonsky and Muehlenkamp 2007; Nock 2010), and that self-injury may be a *stronger* predictor of suicide than other associated risk factors, even past suicide attempts (Klonsky et al. 2013; Klonsky et al. 2014). According to Joiner’s interpersonal theory of suicide, one must possess not only the desire to kill oneself, but also the capacity for acting on that desire (Joiner 2007). The fear of pain may provide a barrier to suicide. Self-injury, though, can de-sensitize one to external pain through repetitive injuring of oneself, thus someone who experiences suicidality (i.e. thoughts and emotions) and also self-injures may be at a heightened risk for suicide (i.e. behavior) as this de-sensitizing aspect of the practice may encourage an attempt (Klonsky et al. 2014). Separate from pathological and medical explanations that connect the two behaviors are explanations of social foundations that influence both phenomena.

Some of the literature has characterized self-injury in the same manner as suicide; as spreading by way of social contagion (Adler and Adler 2007, 2011; Heath, Ross, Toste, Charlebois, and Nedecheva 2009; Jarvi, Jackson, Swenson, and Crawford 2013; Presson 2014; Presson and Rambo 2016). According to the sociology of suicide literature, contagion networks are often clustered temporally or spatially (Baller and Richardson 2002), the reasons for which are differentiated by media influence and other sociocultural elements, which regulate the roles, statuses, and identities of individuals within the context of their environments (e.g., the influence of role models, etc.) (Abrutyn and Mueller 2014a, 2014b; Gould, Jamieson, and Romer 2003; Mueller, Abrutyn, and Stockton 2015; Phillips 1974, 1979). To the extent that individuals are attached, or

“integrated” (Durkheim 1951 [1897]), to their social groups, and guided, or “regulated” (Durkheim 1951 [1897]), by those groups will they be swept away by social psychological and socioemotional forces (Abrutyn and Mueller 2014c) that can lead to self-destructive contagion by suggestion/imitation (Abrutyn and Mueller 2014b, 2018). There is a growing body of evidence supporting contagion within self-injury networks (Adler and Adler 2011; Jarvi et al. 2013; Muehlenkamp, Walsh, and McDade 2010; Presson 2014; Presson and Rambo 2016; Prinstein, Heilbron, Guerry, Franklin, Rancourt, Simon, and Spirito 2010).

Presson (2014) chronicled a history of self-injury contagion beginning with assumptions that self-injury was both unintentionally learned and maladaptive prior to the 1990s, which is when research exploring the topic surged. The practice was framed as a “craze” with pop-culture media portrayals of self-injury and claims of group solidarity between those who self-injured. Musicians injured themselves on stage; self-injury subcultures created movements involving the practice; and actresses openly admitted to using self-injury as a means of impressing peers, regulating emotions, and testing their limitations with pain and strength (Presson 2014). More recently self-injury networks have been noted among adolescent peer groups and within online communities (Adler and Adler 2008, 2011; Presson 2014; Presson and Rambo 2016). Adler and Adler (2008) described the cyber world as a liminal space that can facilitate disembodied relationships between loner deviants who live in the margins of their social worlds in everyday life.

SELF-INJURY: DEFINITIONALLY AMBIGUOUS AND “BORDERLINE” SUICIDAL

Self-injury has been defined equivocally in literature. There are many ways that individuals have reported engaging in self-injury, which may or may not be classified as such depending upon sociocultural context. As such, measurement of the phenomenon has proven challenging, though its current manifestation has been found to affect younger populations, unmarried individuals and those who have received mental health treatment. Sexual minority status is reported to increase the risk of self-injury, along with peer rejection and being bullied, and the prevalence of the practice appears to be growing (Walsh 2012).

People have claimed many reasons for practicing self-injury, however it has been predominantly typified as mental illness. Considered pathological by association, psychomedical literature has most often framed it as a symptom of a multitude of disorders that range in type and severity. In the past, self-injury was formally recognized within the diagnostic criteria for borderline personality disorder only. The DSM-5 listed nonsuicidal self-injury disorder (NSSID) as a disorder requiring more research. Studies find that while the relationship between self-injury and suicide is complex, self-injury may increase the risk of suicide attempt as it could ease fear around the physical pain of death. Self-injury and suicide are also associated with social contagion. Originally, it was thought to be an accidentally learned behavior, then it was associated with popular media in the 1990s, and most recently, self-injury contagion has been associated with adolescent peer groups and internet subcultures.

QUALITATIVE SOCIOLOGICAL RESEARCH ON SELF-INJURY

The qualitative research on self-injury serves several purposes in this thesis. First, I review it for the purposes of informing readers regarding the qualitative sociological work that has been done on the topic of self-injury. I will directly address this literature again in the discussion of my findings. Second, these research projects have served as sources of “data” for this thesis and have been coded for themes which support my contention that sometimes self-injury is framed by both the literature and respondents in edgework terms. Familiarity with these qualitative research projects will help readers understand both the existing literature on this topic and one of my sources of data.

To begin, Presson (2014) and later Presson and Rambo (2016) defined self-injury simply as the “intentional injuring of oneself” (2016:2). They defined the practice ambiguously in order “to show how self-injury as a concept is both vague and contextual” (2016:2). They conducted in-depth interviews with individuals between the ages of 18 and 57 who identified themselves as former self-injurers. Of those respondents:

10 self-identified as white, one as black, and one as Hispanic. Nine of the participants identified as female, two identified as male, and one identified as a female to male transgendered person. Five participants were lesbian, gay, bisexual, and transsexual community affiliated (2016:5-6).

Further, of those 12 respondents, six had experienced periods of suicidal ideation and four had previously attempted suicide. Specifically, Presson and Rambo’s research focused on whether “self-injurers make use of the discourse of pathology when talking about themselves in the same ways that researchers, caring professionals, and the media do” (2016:219-220).

Respondents used biographical work (Gubrium, Holstein, and Buckholdt 1994; Rambo Ronai and Cross 1998) to claim, resist, or exempt themselves from mainstream pathology exemplars of self-injury. The most frequent pathology exemplars that respondents drew from were situated along continuums of sanity, attention-seeking, mastery, a self-injury spectrum, and degree of harm. Biographical work examines the categories individuals use to define their biographies, which are fluid and able to be edited according to circumstance (i.e. conversation and audience). “Narrative resistance” (Rambo Ronai and Cross 1998), a type of biographical work, was employed to resist “discursive constraints” (Rambo Ronai and Cross 1998), or narrative devices that restrict the language a stigmatized person can employ, in order to grant respondents personal agency over their definitions of their identities. Specifically, the pathology discourse revolving around the identities of self-injurers constrained the way respondents were able to identify, or define, themselves, while “alternative stocks of knowledge” (Berger and Luckmann 1966; Rambo Ronai and Cross 1998) allowed respondents to distance themselves from pathology.

Gradin Franzén and Gottzén (2011) defined self-injury as “the deliberate practice of hurting oneself through cutting or scratching the skin so that blood flows and scar tissue is left” (2011:279). Data was drawn in two stages. First, observations were made within a Swedish internet community. The website used to make observations specifically catered to individuals with “suicidal thoughts and other problems” (2011:283), but self-injury was a common topic of conversation. The majority of members from the community indicated they were women between the ages of 15 and 28. The second stage of data collection drew from eight members of the community (six

women; one man; one unidentified; ages 15-27) who had contributed rich information through blogs, personal websites and on the community discussion board. Specifically, the authors addressed how “members of the studied Web community have to balance between a locally prevalent normalizing discourse on self-injury and a culturally dominant pathologizing discourse that depicts self-injury as repulsive” (2011:280).

The authors used positioning theory (Davies and Harré 1990; Harré and Langenhove 1999), which draws on post-structuralist thinking, to analyze “how individuals are positioned and position themselves in relation to different culturally available discourses” (Gradin Franzén and Gottzén 2011:284). As such, this study positioned self-injury as a social phenomenon that individuals navigate with their bodies and discourse surrounding behavior that places them somewhere between normal and pathological. Normalizing discourses surrounding self-injury made the practice legitimate for working with mental health issues, and the embodied components of the practice (e.g., blood and scars) were perceived as beautiful. On the other hand, pathologizing discourse held that self-injury was morally reprehensible, and the embodied components of the practice were repulsive. Respondents appealed to both discourses when framing their experience with self-injury, which positioned them as ambivalent along the normal/pathological continuum. Further, this alternation between discourse surrounding normalized behavior and pathological behavior made them “authentic” in their self-injury in the context of their culture.

Chandler (2012) provided a general definition of self-injury as “self-poisoning or self-injury irrespective of the purpose of the act” (2012:443), which included “cutting, burning or hitting the outside of the body” (2012:442). She conducted life history

interviews with 12 individuals who had self-injured. Respondents were interviewed on two separate occasions. Most of the first interviews made use of life-grids, or tables that respondents could fill in to organize their narratives. The second interviews were more directly focused on self-injury. Respondents were located through purposive sampling, which consisted of posting volunteer advertisements in community centers and on an online community website, and through snowball sampling. Five participants identified as male, seven identified as female, and they were aged 21 to 37 years. The socioeconomic status of respondents varied, though most had attained some higher education. Specifically, this article explored the “under-examined aspects of both self-injury and emotion work” (2012:442).

Chandler noted that accounts of life experiences, broadly, were framed according to sociocultural context and thus self-injury in practice may also be framed accordingly. She focused on the practical, embodied components of self-injury; and on reframing themes surrounding controlling, releasing, and eliciting emotions through the lens of “emotion work” (Hochschild 1979). A dialectic between control and release was identified, whereby some respondents expressed using self-injury to release overwhelming emotions, thereby regaining control. Others used the sensations elicited from self-injury as a means of controlling their emotions, selves, and sometimes their lives generally.

Respondents also characterized self-injury as an “irrational” means of gaining rationality, which was ultimately founded on “the late modern desire for control, and the tensions between rationality and emotions” (Chandler 2012:449). The act of eliciting emotions that respondents discussed was likened to Hochschild’s “emotion work” (1979),

though Chandler denoted that the work self-injury does was more transparent than Hochschild's conceptualization. Respondents discussed the blurred relationships between what was being felt or not felt, what was being displayed to others as being felt, and what was communicated as generally meant to be felt. In other words, some respondents used self-injury to evoke "appropriate" emotional responses in situations where they thought they felt too much or not enough (Chandler 2012).

In an article that appeared six years later, Chandler (2018) defined self-injury as "practices (particularly self-injury in the form of self-cutting but including overdoses) that may or may not be construed as suicidal" (2018:2). The original plan of the study included face-to-face interviews with adolescents who had self-injured and "focus groups addressing the topic (but not personal experience)" with adolescents who may not have self-injured. However, Chandler found that it was difficult to find respondents to interview so the frame of the study was negotiated to include a qualitative online survey in lieu of interviews. As such, data was collected from 88 individuals between the ages of 13 and 16. Respondents were recruited from schools, and youth/health organizations, and protective measures were put in place to ensure the respondents safety. At the close of her section on ethical considerations, Chandler stated that anonymity would be broken only under severe circumstances, like, for example, if an individual posed imminent threat to any other "participants or another named young person" (2018:5). Specifically, this study assessed "how younger adolescents (particularly aged 13–16 years) accounted for their own and others' self-harm, including how this interacted (or not) with drug and alcohol use" (2018:4).

Chandler addressed the contradictory narrative surrounding secrecy and attention seeking in this article. Three themes surrounding this narrative were identified. First, respondents completely rejected “the idea that self-injury might be about ‘attention-seeking’” (2018:9). Second, respondents suggested “that ‘some people’ did self-harm ‘for attention’ and that this was wrong” (2018:9). Third, respondents presented “more nuanced accounts, which questioned the negativity attached to the notion of ‘attention-seeking’” (2018:9). As such, this dialectic between secrecy and attention seeking appeared to manifest as a result of the general mainstream narrative that self-injury was both dangerous and a “sensitive topic.” In conclusion Chandler asserted that the normalization of keeping self-injury a secret due to stigma surrounding the idea of injuring oneself for attention was a barrier to receiving help if and when it was needed and thus probably did more harm than good, despite best intentions (Chandler 2018).

Brossard (2014) defined self-injury as any “intentional and repeated self-aggressive activity, subjectively performed to relieve ‘emotional malaise,’ without the intention of committing suicide (suicidal attempts), getting sexual pleasure (sodomasochism), or pursuing some esthetic goals (body art). It typically consists in self-cutting, self-burning, or self-hitting” (2014:558). He conducted in-depth interviews with 70 people (61 female) between the ages of 15 and 30 who identified as having self-injured at some point in their lives, current or past. Forty-five respondents were recruited through francophone internet forums and 25 were recruited from one of two French Psychiatric hospitals for adolescents, though patients labeled “psychotic” were not allowed to be interviewed. Most of the interviews were conducted face-to-face, but “additional data [included] messages over the Internet or blogs, published or informal

autobiographical texts, e-mail exchanges, and medical records” (2014:560). In this study, Brossard viewed self-injury through a Goffmanian lens to describe how self-injury could “fit into the fabric of everyday life” in what he called a “daily self-injuring process” as a way of managing emotional processes through the intertwining of real and imagined interactions. Specifically, Brossard’s research explored how this emotional work occurs (2014).

He described self-injury as a multi-stage liminal cognitive/emotional process which led to a wound if each of the following stages were met. In the first stage, a misunderstanding occurred in an interaction, which led to an “embarrassment” (Goffman 1967), or “not knowing how to behave while feeling rage, sadness, anxiety, [...]” (Brossard 2014:562). To avoid spoiling the social interaction (Goffman 1969) the embarrassed individual would “save face” (Goffman 1967) by not reacting to the situation. No internal resolution of feelings from the embarrassment transformed the interaction into a “triggering event” (Brossard 2014).

The embarrassment would trigger a loop in the internal conversation (Cooley (1964 [1922]) whereby the “individual’s mind focuses, wanders, extrapolates, rehashes” (Brossard 2014:562) the interaction. This led to an “autonomization of thought” which then led the individual through thoughts and/or memories that were no longer connected to the triggering event. Brossard stated that “the autonomization of thoughts sometimes updates subjectively negative aspects of the individual’s social trajectory, especially events that are considered socially as ‘traumatic’” (2014:563). This could lead to an “emotion/interaction loop” (2014:572) in which the emotional response experienced during the embarrassment escalated with the remembrance of the trauma, through

association to the emotions that the trauma had produced. Those could include physical sensations such as nausea, difficulty breathing and numbness. Individuals would become incapacitated and unable to perform their social roles. Understanding this as a form of “emotional deviance” (Thoits 1985) made them think that their feelings were abnormal, and encouraged a sense of loneliness, either “in the literal sense or through disengaging from interactions” (Brossard 2014:564) for fear of being alienated.

The next stage led individuals to search for equivalences, or “practices that could potentially stop the autonomization of thoughts through an “emotion work” (Hochschild 1979)” (2014:564). Brossard held that there were three reasons individuals chose to practice self-injury over alternative means of ending thought autonomy. First, practical ease; emotional incapacitation made it impossible to engage in alternative equivalences. Second, material ease; lack of access to alternative equivalences. Third, efficiency; self-injury could provide instant gratification where alternative equivalences required time (Brossard 2014).

In the final stage, individuals rejected alternative equivalences and prepared for self-injury. This began with mental preparation, which included envisioning, or staging, the scene of the injury. Brossard noted that “the simple fact of imagining while preparing an injury can partially relieve interviewees’ anxiety, precisely because at that moment they are doing and/or thinking about something else” (2014:568). Following mental preparation was physical preparation, which led to the self-inflicted injury. As the process evolved, triggering events lessened in intensity, autonomization of thoughts gave way to thought loops of self-injury, which became the preferred emotion work equivalence, and preparation became habitual. Finally, individuals became socialized to the interactional

processes within everyday life that could lead to a daily self-injuring process. In discussion, Brossard (2014) noted that what has often been pathologized and medicalized as obsession and compulsion in the minds and lives of self-injurers can be re-conceptualized through this sociological explanation of the evolution of a process of thought autonomization. Figure 1 below was pulled from Brossard’s article and provides visual representation of the evolutionary process of thought autonomization and its role in the creation of a daily self-injuring process, which normalized the practice in the lives of respondents (2014:569).

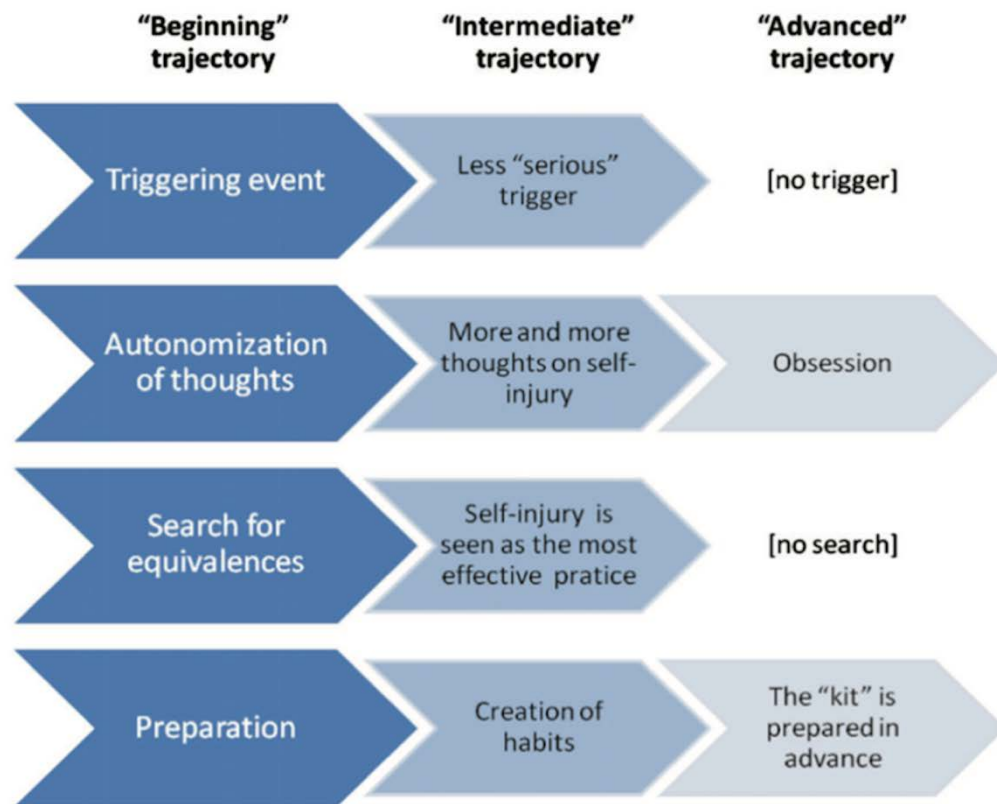


FIGURE 1: Evolution of the Self-injury Process

Taken from Brossard, Baptiste. 2014. "Fighting with Oneself to Maintain the Interaction Order: A Sociological Approach to Self-injury Daily Process." *Symbolic Interaction* 37(4):569.

Adler and Adler (2011) defined self-injury as “deliberate, nonsuicidal destruction of one’s own body tissue” (2011:1). Their book *The Tender Cut: Inside the Hidden World of Self-Injury* is a monograph of the most recent manifestation of the social phenomenon. Data was collected longitudinally over the course of 10 years, and drew from over 150 in-depth interviews with self-injurers and also “bulletin boards and Usenet groups, [...] e-mail communications” (2008:35), internet chat rooms and web communiqués, face-to-face and telephone interviews (Adler and Adler 2011). These data contributed to the prior publication of three articles which respectively explored the social organization of loner deviants (2005), demedicalization of the practice (2007), and cyber self-injury subcultures (2008). In the first study, Adler and Adler (2005) drew from social constructionist theory (Best and Luckenbill 1981) to explain that self-injurers occupy placement in one of two types of deviance. They were classified as “loners, who lack the regular association with fellow deviants and have no membership in a deviant subculture, and individual deviants, who are the actors and objects of their behaviors, yet socialize with others like them” (Adler and Adler 2005:345). In the second, their “analysis casts self-injury as a complex process of symbolic interaction rather than as a medical problem, with broader implications for its changed social definition from a psychological form of mental illness to a sociological form of deviance” (2007:539). Finally, in the third, the cyber world was described as “an ephemeral space of creation and destruction” (2008:50), which offered self-injurers a place to communicate and form relationships with others. They focused on stigma, and juxtaposed solid and virtual social worlds to discuss how self-injurers navigated their identities, with specific regard to the modern versus the postmodern self.

Kokaliari and Berzoff (2008) defined self-injury as “purposeful, non-life-threatening self-inflicted injuries without suicidal intent that aim to alleviate emotional distress. [...] Nonsuicidal self-injury most often involves the arms and legs but may also include the abdomen, genitals, and breasts” (2008:259). The authors collected data in two phases using mixed methods. In the first phase, a survey was distributed to 400 students at an elite, liberal arts women’s college. Self-injury is believed to manifest from “trauma, borderline psychopathology, major disruptions in attachment, and major psychiatric disorders” (2008:259). As such, the survey screened for pathology, and exempted anyone from the study who met the criteria for borderline personality disorder, post-traumatic stress disorder, and insecure attachment styles. One hundred and sixty-six students returned the survey, and 91 of those reported practicing self-injury. Of those 91, 10 were selected to participate in in-depth, semi-structured interviews.

[S]tudy questions included personal experiences with self-injury, the values of the families in which they had been raised, and the degree to which each family valued self-reliance, independence, and autonomy. Questions about possible contagion, objectification of the body, and how self-injury can be related to wider social issues were also included (2008:262).

Respondents were between the ages of 18 and 23, “Eight were White, 1 was Asian, and 1 was Biracial (White and Native American)” (2008:262). Their sexual orientations, class backgrounds, family backgrounds, family education backgrounds, and parent’s professions growing up were diverse. The majority of respondents reported their parents were protective. Further, every respondent had higher than a 3.0 grade point average. The authors viewed the respondents’ self-injury through a Foucauldian (1979, 1980, 1984, 1990 [1978]) lens to explore the psychosocial functions that self-injury served in a nonclinical population of college students (Kokaliari and Berzoff 2008).

Invoking discourses of discipline and surveillance (Foucault 1979, 1980, 1984, 1990 [1978]), respondents understood their self-injury as having been shaped by their families' collective aspirations for independence and autonomy. Most of the respondents reported that production was encouraged over all else, and emotions were ignored. The women also spoke of the need to be physically disciplined and controlled, or "perfect," like men (Kokaliari and Berzoff 2008). Most often this was projected onto controlling their bodies through various means including playing sports, engaging in anorexia and self-injuring. This physical control represented success. Further, many respondents appealed to the cultural goals of independence and productivity as foundational to their use of self-injury to better fit into the structure of Western society. In order to regulate their own emotions, respondents injured themselves, thereby inverting the irrationality of their emotions, and creating a space for rationale to focus on their priorities. Specifically, they related the need for emotional relief surrounding the pressure to be perfect. Self-injury provided instant gratification which allowed them to process their distress quickly and without the help of others. In this way, self-injury was enacted as a form of self-surveillance, which afforded respondents asylum from entrapment of medicalized labels, and also allowed them to perform in their environments.

Inckle (2014) defined self-injury as "any action where the intention and purpose is to cause direct and immediate pain and/or damage to oneself but without suicidal intent" in order to relieve, control, or comfort emotional distress from "feelings, memories, and experiences" (2014:4). Data for this study was drawn from a larger postdoctoral project that explored self-injury from a holistic and harm-reduction perspective (Inckle 2007). For the project overall, Inckle conducted interviews with 16 individuals who had

experience with self-injury, which included offenders, non-offenders, and mental healthcare providers. “Feminist (Oakley 1981), participatory (Inckle 2007), and user-led/survivor approaches to conducting research (Faulkner 2004; Sweeney, Beresford, Faulkner, Nettle, and Rose 2009) and narrative and life history methods (Rubin and Rubin 2005)” (2014:6) were employed in this study. It specifically explored the experiences of three men who participated in the research project and aimed at challenging “‘dominant commentaries’ regarding gender and self-injury and to open up avenues for improved understanding and responses to males who hurt themselves” (Inckle 2014:7).

Inckle listed three reasons for the assumption that self-injury is more prevalent among women, and thus overlooked in men. First, women have historically been labeled more susceptible to mental illness based on biomedical definitions that claimed female bodies were biologically “problematic” and caused madness. Second, despite waning claims of biological vulnerability, gender role norms affect both the way that each gender has been socialized to cope with distress, and the way self-injury has been conceptualized. Women have been socialized to perform femininity by not externally expressing feelings of anger or aggression, and instead to turn these feelings internally against the self (i.e. “acting in”). Men, on the other hand, have been socialized to perform masculinity through external expressions of anger and aggression (i.e. “acting out”).

Emotions have been fundamentally tied to feminine gender norms, and thus, have been pathologized in traditionally masculine cultures. Diagnoses of mental disorder have followed this cultural narrative and women have typically been diagnosed with internally-focused disorders, such as “borderline personality disorder, anorexia, and

depression” (2014:8). Men, on the other hand, have typically been diagnosed with externally-focused disorder, such as “behavior, conduct, antisocial, and risk-taking disorders” (2014:8). As such, women have been labeled “mad,” for “acting in,” while men have been labeled “bad,” and criminalized, for “acting out” (e.g., rate of incarceration of men vs. rate of diagnoses of women). Inckle stated that self-injury has been viewed through the “acting out/in” duality, which was folly, as the practice functions as both. Self-injury was a form of externalized violence against the self, which provided those who engaged in it a means to “control and regulate their inner worlds, feelings, thoughts, memories, and distress without recourse to others” (2014:8).

The third reason Inckle gave “for the falsely assumed prevalence of female self-injury” (2014:8) aligned with gendered roles underlying vulnerability and power. She stated that self-injury has been conceptualized as a response to marginalization. Women were expected to experience more physical powerlessness with fewer resources to challenge the external power. On the other hand, male emotional vulnerability was denied, ignored, policed, and suppressed. Thus, traditional gender roles juxtaposed the role of physical and emotional vulnerability, as did self-injury. Inckle stated that poor male health statistics support the claim that males were generally less resilient to adverse life experiences than females. Further, vulnerability in women was expected so there was less risk of “identity damage” (Goffman 1967). Men, on the other hand, were expected to present themselves as invulnerable and able to protect others, so there was heightened pressure to remain silent about self-injury and also dismissal of any visible signs of self-injury.

The gendered definitions of self-injury, the gendering of help-seeking behavior, and the stigma and misunderstanding surrounding self-injury combine to decrease

the likelihood of male self-injury being recognized or men and boys seeking help. The bodily norms of masculinity add to this concealment (2014:15).

The men in the study described self-injury as a response to the pressure to conform to traditional masculine roles that normalize violence and stoicism; a coping mechanism that provided a sense of control, and “self-possession” (2014:10); an ambivalent source of self-punishment, experienced as both deserved and stigmatizing; a distraction from adverse life experiences; a way of negotiating social status through presentation of injuries as “macho” (2014:12); and, as a way of generating a sense of compassion for the self.

Sandoval (2006) defined self-injury “as any incident where an individual has attempted to deliberately alter or destroy body tissue without suicidal intent in an effort to gain relief from overwhelming emotions. This includes, but is not limited to cutting, burning, scratching, hitting, biting, and pinching” (2006:218). Sandoval specifically explored what Favazza (1998) called “superficial” self-injury. She was not specific about her methods and procedures of study as this article proposed a theoretical frame for further study. In the process of developing this framework, Sandoval observed (and conversed with) Latinas who were first generation college students “from immigrant families [whose] parents had worked their way out of the working class and tentatively into the ranks of a tenuous entrepreneurial class or into the middle class” (2006:217). Following her observations, Sandoval used Gloria Anzaldua’s writing to develop a theory around why minority females may practice self-injury. This reconceptualization was hoped to provide individuals new ways of coping with the mark of self-injury and what led into it. Specifically, she focused on the way that self-injury “can be understood in this context as a way to reconcile disjunctures and dissonance among [...] class and racial

identities, [which] moves the focus of self-injury away from individuals and onto societal structures” (2006:221).

Sandoval (2006) found that the majority of research on self-injury focused on exploring stereotypical populations and conditions surrounding self-injury, and thereby neglected the experiences of other populations of people who may have history with the practice. Most of the women she encountered experienced intense mixed emotions concerning conflicting roles related to their statuses as a student and as a daughter. They dismissed their own struggles, particularly with school and social pressures, and expressed gratitude for their family members’ sacrifices that afforded their educational attainment. Sandoval found that silence, often portrayed as silence surrounding sexual or physical trauma predicated self-injury. She compared these individual traumas to the spoken, collective traumas of immigration that were vicariously experienced by the young women she observed. They expressed that they did not deserve support in relief of their individual struggles because their personal labors paled in comparison to the legacy of their collective struggles.

Sandoval used Gloria Anzaldua’s “concepts of Coatlique states and a new mestiza consciousness” to explain how self-injury can be experienced “as a possible venue for facilitating a transition to less dangerous methods of coping” (2006:222). She used symbolic references to metaphorically describe the liminal space that separates the Mexican/U.S. border, and which has been characterized through the lens of displacement. This translated as an internal state where discordant role identities split from one another. This “Coatlique state” is further represented in activities that interrupt balance in life and “are often rooted in the stress of living with cultural ambiguity” (2006:222). Sandoval

compared the women's desire to physically injure their selves to a "Shadow Beast" that rebels against suppression. She concluded with the idea that self-injury, when viewed through this lens, could serve as a space of transformation, thus a rite of passage, rather than a symptom of pathology, which could facilitate less dangerous modes of navigating discord surrounding, and within, their sociocultural environments.

SELF-INJURY: CONCEPTUALLY LIMINAL AND "BORDERLINE" HARM REDUCTION

In sum, qualitative sociological research has framed self-injury in terms of liminality. Those who self-injure were explained less as mentally ill, and more so as social constructions existing along discursively constraining, dualistic continuums. Presson and Rambo (2016) defined several of these continuums, which were centered around pathologies of self-injurers. Respondents used biographical work to define their location along such lines as sanity, attention-seeking, mastery, a self-injury spectrum, and a degree of harm. Gradin Franzén and Gottzén (2011) discussed that self-injurers positioned themselves ambivalently as both normal and pathological due to their self-injury. Chandler (2012) explained that respondents spoke of their injuries as a form of embodied emotion work (Hochschild 1979), and specifically that self-injury worked on emotions within a dialectic of control and release. They also drew on discourses surrounding rationality, judging themselves as rational or not depending upon the appropriateness of their emotions. Chandler (2018) also studied adolescent's responses to the notion that self-injury was implemented as a way of seeking attention, and noted that their accounts actually revolved around keeping self-injury a secret.

Brossard (2014) explained a liminal emotional process that led into respondent's self-injury. Importantly, he reconceptualized "obsessions" as beginning with social embarrassments that respondents could not resolve internally, which claimed autonomy over the individual's mind. Self-injury cut through the thought loops and provided relief. Adler and Adler described self-injurers as loner deviants (2005) and argued for the demedicalization of self-injury (2007). They claimed that the practice was, for some, a chosen form of social deviance rather than psychological pathology and found within internet communities, disembodied relationships between self-injurers could encourage a state of coherence rather than separation (2008).

Kokaliari and Berzoff (2011) discussed self-injury in young women from the perspective of Foucault's panopticon. Self-injury was described as a form of self-monitoring which was structured by the threat of constant supervision. It was also claimed to relieve emotional distress from their socialized ambitions to be perfect. Inckle (2014) discussed the often-neglected topic of self-injury in men. She described that men are overlooked because the culture of masculinity in the West supports violence, stoicism, and power over the self. Self-injury presented a way of fitting into the culture, coping with denied emotions and engendering positive self-regard, in some cases. Finally, Sandoval (2006) theorized that self-injury could be a transformative rite of passage through collective trauma and racial/class disjunctures which could ultimately encourage harm reduction as Latinas navigated their discordant sociocultural environments.

CONCLUSION

Literature, and Western culture generally, are teeming with contradictions surrounding self-injury and those who engage in the practice, which can produce more questions than solutions to a growing public health concern. Overall self-injury is viewed from a dualistic standpoint, centered between blows from sometimes contradictory and oppositional constructions of the concept. From the inside out, self-injury is framed psychomedically as an individually-centered problem, but it is unclear just how pathological it may be, and what is required for repair. From the outside in, self-injury is sociologically framed as a by-product of larger problems between the individual and society that manifest physically on the individual's body, and can provide escape from overwhelming thoughts and emotions, social pressure, and alienation. These concepts engage dialectically with one another, which creates a paradox. Inherently, self-injury is a means of escape and/or resistance to sociocultural conditions that both spurn and spawn the practice.

As such, over-reliance on preconceived individual-level ideas of, and solutions to, self-injury can neglect larger insight into the self-injury phenomenon overall. Therefore, it stands to reason that re-conceptualizing self-injury through the lens of a response to greater social issues may provide valuable insight into the foundational reasons some may engage in self-injury.

CHAPTER THREE

THEORETICAL FRAME

The Edge... There is no honest way to explain it because the only people who really know where it is are the ones who have gone over. The others—the living—are those who pushed their control as far as they felt they could handle it, and then pulled back, or slowed down, or did whatever they had to when it came time to choose between Now and Later... But the edge is still Out there. Or maybe it's In... [The edge is] a means to an end, to the place of definitions. —Hunter S. Thompson, *Hell's Angels: A Strange and Terrible Saga* (1966)

Edgework is a sociological theory of voluntary risk-taking first developed by Stephen Lyng (1990) based on the works of Karl Marx (1976 [1932]) and George Herbert Mead (1950 [1934]). Lyng is a parachutist who draws from his own and others' experiences with the sport in order to understand the appeal of engaging in high-risk behavior as a leisure activity. The term edgework is borrowed from Hunter S. Thompson (Thompson 1971) who used it in the context of gonzo-journalism, where, for example, he combined extreme drug and alcohol consumption with driving to, attending, and reporting on the 1968 Democratic National Convention. The idea for Thompson was to push the limits of how many intoxicants he could consume and still be able to function as a reporter.

Edgework, for Lyng (1990), consists of a “vocabulary of motive,” or features common to activities, skills, and sensations which define the experience. Edgework activities “all involve a clearly observable threat to one's physical or mental well-being or one's sense of an ordered existence” (Lyng 1990:857). As such, individuals who engage in edgework practice “knowingly court the danger of physical or mental injury but deploy context-specific expertise as their means of avoiding such injury” (Rajah 2007:198). The edge, or “boundary line,” is defined in many ways. As the line separating life and death,

sanity and insanity, consciousness and unconsciousness, etc., to push too far—essentially falling off—would mean transgression into a state of powerlessness where injury or death is likely to result. The point of edgework is to avoid such consequences and “maintain control over a situation that verges on complete chaos, a situation that most people would regard as completely uncontrollable” (Lyng 1990:859). The edge, then, is centered within a paradox that inverts the reality of the moment.

The underlying motivation for engaging in edgework activities manifests through disenchantment with modern life. Founded on a synthesis of Karl Marx’s concept of alienation (1976 [1932]) and George H. Mead’s concept of self, including the “I” and the “Me” (1950 [1934]) “risk-taking and adventure activities provide a refuge for social actors confronting a formal institutional environment that does not fully meet their needs” (Lyng 2005:6). Edgework provides practitioners opportunities to procure and apply “finely honed skills and experience intense sensations of self-determination and control” (Lyng 2005:5). Successful negotiation of the edge then becomes a way of creating meaning, and thus, taking control of one’s own identity. Through pushing one’s limitations, the individual plays an active part in shifting their self-perception, thus (re)gaining personal agency otherwise denied them through societal and sociocultural constraints.

For Marx, most of our work life in capitalist society is a product of oversocialization—over routinized and over determined. For Lyng, serious leisure activities become sites where the performance of self is unscripted and self-determined. Through taking voluntary risks that involve flirting with the edge and facing death, actual or otherwise, one *knows* one is alive. Thus, “edgework shifts the focus away from fear,

arousal, and preoccupation with death and toward the spontaneous, anarchic, impulsive character of the experience” (Lyng 1990:864).

For Mead (1950 [1934]), the self is comprised of two components, the I, and the Me. The I is the acting self as subject, the one that is alive and apprehending experience. The Me is the self as an object, or personal comprehension of the self as a “thing” perceived by others, in a role for instance—me the daughter, me the partner, me the researcher. The self is a perpetual process, emergent from the ongoing dialogue between the I and the Me(s). “I” listen to the many voices of the “Me(s)” and finally make choices about the actions I will make based on which “me” “I” want to enact. This is an ongoing process changing from second to second. Because of the intense nature of edgework activity, a great deal of focus and attention is required. When a participant voluntarily undertakes high-risk behavior, the conversation stops. Edgework annihilates the “me,” leaving only the “I.” The goal becomes survival, and there is no ambivalence about it. “As a form of experiential anarchy, edgework seems to be the direct antithesis of role behavior in the institutional domain” (Lyng 1990:875).

Thus, there is an inherent allure that draws some individuals to voluntarily engage in high-risk activities. Acting as a means to an end, edgework “involve[s] ‘sensual dynamics’ that give the experience a deeply passionate, magical character” (Lyng 2005:6). Edgeworkers rely on specific skills and competencies, which are described as instinctual. They have been referred to as a form of “mental toughness” and described in terms of “survival capacity” (Lyng 1990). These capacities are believed to be possessed by only a select few and who often feel a powerful solidarity with one another. For this reason, Lyng (2005) calls edgework an experience of recognition. Further, many who

become adept in one area of edgework often try their hands at others, which is referred to as “crowding the edge” (Lyng 1990).

The sensations associated with edgework are paraphrased here:

1. Self-actualization, realization, and determination. Individuals act from instinct, and experience a “purified and magnified sense of self” (1990:860)
2. Fear that fades, and is replaced by a “sense of exhilaration and omnipotence. Having survived the challenge, one feels able to deal with any threatening situation” (1990:860).
3. Altered perception and/or consciousness. One is highly focused as they approach the edge. One’s perception of time may skew, either speeding up or slowing down.
4. A sense of control, sometimes experienced as “oneness” with essential “objects” involved in the activity or within the environment.
5. Hyperreality. For many skydivers, free fall is experienced “as much more real than the circumstances of day-to-day existence” (1990:861).
6. Ineffability. Words do not do the experience justice. For this reason, many edgeworkers refuse to discuss their experiences. Luckily, that is not always the case.

Literature on the topic thus far has explored edgework as a form of escape and resistance from alienation and oversocialization within Western culture generally. Lyng (2005) notes that empirical studies often support edgework as “a vehicle of escape from social conditions that produce stunted identities and offer few opportunities for personal transformation and character development” (2005:6). For instance, Rajah (2007) explored the role of edgework-resistance in violent intimate relationships. Drug-involved women used edgework-resistance to escape oppression “by whatever means and to whatever purpose—to secure critical resources, to enhance physical safety, to police a subjectively important symbolic boundary” (2007:196). They were able to experience the “embodied pleasure of self-determination while drawing on contextually-based and embodied knowledge to calibrate the balance between the risks and rewards of

resistance” (2007:201). Ferrell (1993) explored the sensuality of creativity intersecting illegality within the practice of graffiti writing. Lyng stated of Ferrell’s work:

Refusing to succumb to negative emotions of shame, guilt, or fear, law violators in the grip of the adrenalin rush and other edgework sensations thumb their noses at social control agents who seek to inculcate such negative emotions as a way to achieve goals (2005:7).

Finally, Newmahr (2011) reinterpreted edgework through a feminist perspective in an article that claimed sadomasochism (SM) can be perceived as a form of collaborative edgework. She noted that researchers have often mistaken male overrepresentation in risk-taking activities as validation that voluntarily taking risks is an inherently masculine practice. This assumes that edgework incorporates only masculine values such as individualism, productivity, rationality, passion, etc. In response to this, Newmahr stated that, “Through SM, women confront, withstand, flip, appropriate, and symbolically survive violence. One reading of this is as a celebration of violence, but it can also be read as an active defiance of cultural pressures to live in fear of violation” (2011:704).

Other studies have explored the role of edgework within what Giddens (2000) and Beck (1992) have termed the “risk society.” Citing Reith’s (2002) work on drug use as edgework, Lyng (2005) states, “the insecurities of the risk society are reflected in almost every aspect of social life, from the dangers we confront in work and consumption to the uncertainties involved in leisure activities and the maintenance of our bodies and health” (2005:8). As such, individuals are socialized to embrace risk even as institutions argue for hyper-rational management of risks. Lois (2001) drew from ethnographic data to explore the emotional culture of search and rescue work. She developed “a stage model

of edgework, focusing on gender-specific strategies for managing the intense emotions involved in rescue work” (Lyng 2005:11). Kidder (2006) explored:

[H]ow the creativity and spontaneity of courier labor allows messengers to become emotionally attached to their job. Bike messengering brings the thrill-seeking of leisure pursuits into the workplace, which creates an authentic self intimately tied to the occupation-an exceedingly difficult feat in an increasingly rationalized system of labor (2006:31).

As a concluding note, these two perspectives converge to create what Lyng (2005) terms “the edgework paradox.” As a way of liberating oneself from the deadening constraints of society, edgeworkers meet the demands of risk society with voluntary risk-taking, thereby conforming to societal expectation. Lyng (1990) states of the practice:

It is certainly strange that people voluntarily place themselves at risk even as public organizations endeavor to reduce the risks of living in modern society. It is even more startling to realize that these people value risk taking because it is the only means they have for achieving self-determination and authenticity. The same society that offers so much in the way of material "quality of life" also propels many of us to the limits of our mortal existence in search of ourselves and our humanity (1990:883).

CHAPTER FOUR

METHODS AND PROCEDURES

INTRODUCTION

Data for this thesis was drawn from two sources: qualitative sociological literature on self-injury, and in-depth interviews with adults who identified themselves as former self-injurers. I analyzed these data and coded them for recurrent themes.

SAMPLING PROCEDURES

Existing Qualitative Sociological Studies

Elsewhere in this thesis I presented information from existing qualitative sociological research studies as literature. In the following chapter, the text from these studies was treated as data and coded for themes that suggested edgework. Specifically, I focused attention on what respondents from each study were reported to have said regarding their self-injury.

In-Depth Life History Interviews

Additionally, I conducted in-depth life history interviews with 11 people who self-identified as survivors of self-injury, and who agreed to participate in an in-depth interview regarding their past history with self-injury. This research design specified that respondents self-identify as survivors of self-injury who would be willing to discuss their past histories with the practice. Former self-injurers were specified for three reasons. First, it was believed that interviewing former self-injurers would reduce the risk of emotional distress that could arise from discussing a topic that has been characterized as sensitive and potentially dangerous to explore. To further safeguard against potential negative effects, a locally-licensed psychologist offered one free visit to respondents who

experienced any suffering as a result of being interviewed (see Appendix E for a letter from the assisting psychologist). Second, Tennessee state law requires that researchers report any knowledge that someone is currently or is planning to hurt themselves or others. Thus, it was deemed appropriate to interview former self-injurers in order to avoid this situation. Third, it was thought that people would be more apt to talk about something that could be stigmatizing from their past rather than a stigmatizing activity that is taking place in their present.

Recruitment for this study was accomplished through purposive and snowball sampling. Volunteer flyers (see Appendix D) were posted around the University of Memphis campus, in local coffee shops situated around the University of Memphis area, and in the personal office of Dr. Cliff Heegel, the assisting psychologist. In order to participate in this research study, it was required that respondents be at least 18 years of age. Participation was voluntary and confidential. Those who participated in an interview were encouraged to give my contact information to anyone that they may have known who was both at least 18 years old and who also self-identified as a former self-injurer.

INTERVIEW PROCEDURES

Respondents contacted me through information provided on the volunteer flyers (Appendix D). We then agreed upon a time and location for the interview. Ten interviews were conducted face-to-face and one was conducted over the phone. While respondents who elected face-to-face interviews had control over the setting of their interview, most chose the privacy of an office reserved for interviews located on the University of Memphis campus. There were two participants who preferred being interviewed at safe and mutually agreed upon locations off campus. The one respondent who chose to be

interviewed over the telephone was notified that I could neither control nor obstruct a potential breach of privacy while the interview was in progress based upon their chosen location, however, I did so on my end by staying in a private location.

Each respondent was given a copy of the consent form (Appendix A) via email prior to his or her or their interview. I also reviewed the consent form with my respondents prior to beginning their interviews in the event they had questions concerning any part of the interview process. Upon receiving approval from each respondent, I digitally recorded their consent to be interviewed and the interviews themselves. My respondents and I filled out a short demographic survey (see Appendix B for cover sheet; see previous section for specific information) which included choosing a pseudonym to use in lieu of their given name. Respondents also received a business card of the assisting psychologist prior to the start of the life history interviews.

The interviews were guided by an in-depth questionnaire (Appendix C) that provided structure and helped ease respondents into the dialogue process. All of my respondents spoke freely about their lives and experiences with self-injury, thus I was able to ask probing questions surrounding the information they provided to questions from the guide. Interviews were expected to last anywhere between 45 minutes to two hours, but typically took between one hour and a half and three hours to complete.

INTERVIEW SAMPLE DEMOGRAPHICS

TABLE 1: Interview Respondent Demographic Information

Age	Gender	Sexual Orientation	Race/Ethnicity	Level of Education	Job History
28	Woman	—	white/ —	B.A.; current M.A. student	Service industry; Teaching/Childcare; Student/Research
28	Woman	Heterosexual	white/ Hispanic	HS Diploma	Service industry, mostly Supervisor positions
26	Man	Homosexual	white/ —	Some College; current undergraduate student	Service industry; Teaching/Childcare
30	Man	Heterosexual	white/ Scottish descent	HS Diploma	Service industry; Environmental/Lawn-care; Teaching/Childcare
27	Man	Homosexual	white/ German descent; Non-Hispanic	M.A.; current Ph.D. student	Service industry; Student/Research
24	Gender Fluid	Bisexual	white/ American	Some college; Vocational training	Service industry; Health and/or Beauty
52	Woman	Heterosexual	white/ Scandinavian descent; American	Ph.D. ABD; current Ph.D. student	Secretarial; Student/Research
28	Man	Heterosexual	white/ Non-Hispanic	Some college; Vocational training	Service industry; Health and/or Beauty
28	Woman	Heterosexual	white/ European descent	M.A.; current Ph.D. student	Service industry; Teaching/Childcare; Student/Research; Civil service/Applied Social Science
28	Man	Heterosexual	Native American	G.E.D.; current vocational training	Construction
29	Woman	Homosexual	white/ —	B.A.	Service industry; Teaching/Childcare;

					Health and/or Beauty; Entertainment
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Table 1 presents the demographic information I gathered from interview respondents. Ten of the 11 respondents were aged 24 to 30 years. There was one outlier, a respondent aged 52 years. Five respondents identified as men, five respondents as women, and one as gender fluid. The sexual orientations of respondents varied. Six respondents identified as heterosexual, three as homosexual, one as bisexual, and one did not identify with a specific sexual orientation. All of my respondents identified themselves racially as white. Three positioned themselves as ethnically tied to some European ancestry, two identified as American, one as Hispanic, and another as Native American. Three respondents identified with no ethnicity.

The level of education and job history of respondents varied the most in this study. Educational attainment ranged from G.E.D. certification/High School diploma to current Post-Doctoral student. Job history varied as well and was coded by category in order to protect the identities of my respondents. Nine of my respondents reported previous service industry jobs (i.e. retail and restaurant, etc.), one of whom reported holding mostly supervisor level positions. Five respondents reported working in professional student/ research jobs (i.e. graduate assistant, analyst, etc.), and four reported previous jobs in teaching/childcare (i.e. children’s sport coach, babysitting, etc.). Three had held jobs in a health and/or beauty related field (i.e. biomedical or alternative medicines, cosmetology/aesthetics, etc.). One of my respondents worked in entertainment (i.e. acting, music, etc.); one held secretarial jobs (i.e. clerical/office work, etc.); one reported working in environmental/lawn-care jobs (i.e. farm hand, landscaping, etc.); one

reported work in civil service/applied social science (i.e. police officer, social work case management, etc.); and finally, one respondent reported working mostly in construction.

SAFETY PRECAUTIONS

This research was approved by The University of Memphis Institutional Review Board prior to gathering volunteer interview respondents. A waiver of signed consent (see Appendix F) was granted so that my respondents would have less chance of being identified by signatures connecting them to my research. Respondents were made aware that they were free to terminate the session at any time, and they were given full control over whether or not their interviews were included in the data. Digital recordings of the interviews were secured in a password protected file folder. Transcriptions of interviews were stored in another, separate password protected file folder. Further, the only two individuals with access to these locked files were myself and my faculty advisor, Dr. Carol Rambo.

Due to the sensitive nature of the study there was potential for emotional risk. In hopes of ameliorating any lasting negative emotional affect, respondents were offered one (1) free counseling session with Cliff Heegel, Ph.D., a locally practicing, licensed psychologist. Service descriptions were included in the consent form (Appendix A), and a business card was provided each respondent upon meeting for the interview. Further, the interview questions (Appendix C) were screened by two mental health professionals, Cliff Heegel, Ph.D., and James P. Whelan, Ph. D., the Chair of the University of Memphis Institutional Review Board, and Director of Psychological Services at the University of Memphis.

ANALYTIC PROCEDURES

Every participant agreed to having their interview recorded. As such, interviews were recorded using a Philips Voice Tracer DVT8010 Digital Voice Recorder. Interviews were transcribed by myself and a transcription service. Transcriptions were analyzed using a grounded open-coding process that was issue-focused and concentrated on notable, recurring themes (Weiss 1994). Each transcription was further coded to narrow the focus of the analysis, integrating similar excerpts from respondent cases to draw attention to the most relevant themes for this study (Weiss 1994). In the chapters to come, I discuss these themes and their significance in determining the existence of edgework in the narrative accounts of self-injury.

CHAPTER FIVE

FINDINGS

INTRODUCTION

My goal for this research was to explore whether self-injurers used the language of edgework to frame their experiences with self-injury. In my theoretical chapter, I described the “vocabulary of motive” that accompanied edgework activities, skills, and sensations (Lyng 1990). In this chapter, I explored the occurrences of themes of edgework as a vocabulary of motive within the discourse of the existing qualitative literature on self-injury and within my interviews. I started by identifying edgework themes within the discourse of self-injury research. I then addressed interview respondents’ descriptions of self-injury, edgework, and associated themes.

INSTANCES OF EDGEWORK IN THE EXISTING QUALITATIVE RESEARCH ON SELF-INJURY

None of the existing research directly made use of the concept of edgework as a vocabulary of motive for self-injury. Meanwhile allusions to edgework were replete throughout the self-injury literature. The examples I presented as edgework themes frequently overlapped one another, each containing aspects of the others. I identified the following themes within the literature on self-injury: a response to alienation/oversocialization; a way to regulate the internal conversation; negotiation of boundaries between extremes; skill development; preparation; self-actualization, realization, determination; altered perceptions and/or consciousness; a sense of control; hyper-reality; and experience of recognition.

A Response to Alienation/oversocialization

The literature on self-injury often presented self-injury as a response to a society which did not meet the needs of its people. Gradin Franzén and Gottzén (2011), when discussing the central place of the razor blade as a symbol in the self-injury community, commented that it is similar to the straps, chains, and straitjackets in British punk culture which was “understood as symbolizing a feeling of being in bondage by society.” (2011:288). Sandoval (2006), while explaining some of the struggles of Latinas living in U.S. society, stated: “The shadow beast is the rebel inside that refuses to take orders, refuses to be tamed by both Mexican/Chicano culture as well as Anglo and heteronormative cultures. . .” thus “the Mestiza lives in fear of being unable to suppress this monster, ‘barely keeping the panic below the surface of the skin.’” (2006:222).

Inckle (2014) discussed the social conditions in which self-injury arises. “[T]he traditional norms of masculinity are so pervasive that males report experiencing intense pressure to perform their identity in this way even when it conflicts with their inner feelings, experiences, and beliefs” (2014:5). Bareiss (2014), in a narrative analysis of self-injury depictions in U.S. news, noted that the topic “is a story that recognizes causes of self-injury as the pressures and abuses that young people are expected to endure, but which absolves adults of repairing the sociocultural system in which problems are generated” (2014:294). Self-injury was framed as a product of “the responsibility of adolescents to conform to a social system that causes them to hurt themselves” (2014:279).

Kokaliari and Berzoff (2008) recorded respondents’ beliefs that Western society, generally, may engender and encourage self-injury. One respondent said, “I see Western

society, and I do not know exactly what it is about Western society, but I do see that there is something enabling [self-injury]. I mean, I do not think it is promoting it, but there is something that is causing it and enabling it to happen” (2008:264). And another said:

I am wondering if it says something about our culture’s need to deal with something on your own as opposed to deal with something with other people or with healthy means.... You can’t rely on other people to help you, and sort of like an independent self-sufficient mentality is pretty widespread (2008:265).

In an ironic twist on self-injury and society, Brossard (2014) noted a sociological paradox. In order to seem okay and negotiate the normative interaction order, self-injurers must turn to deviant or anti-social behavior to regulate their external affect.

A Way to Regulate the Internal Conversation

Brossard (2014) drew on interactionist theorists Cooley (1964 [1922]) and Goffman (1967) to make sense of the internal conversation process that accompanied self-injury. Brossard (2014) described social embarrassments leading to thought loops that claim autonomy over the mind. For instance, one respondent was reported to:

self-injure each time she makes a ‘mistake,’ even a little one, like using her phone when her parents have forbidden her to do so. And when her parents discover the ‘mistake’ she says she feels guilty, that she hates herself, that she is ‘a shit,’ and so forth ... until the wound (2014:563).

Self-injury, then, was described as cutting through the loops to end all internal conversation.

Negotiation of Boundaries Between Extremes

The literature often defined self-injury in terms of negotiating boundary-lines. Chandler (2018) discussed the “enduring power of discourse which serves to separate self-harm into ‘good’ or ‘bad’, ‘authentic’ or ‘inauthentic’, ‘private’ or ‘public’” (2018:3). Brossard (2014) described self-injury as a “*liminal* emotional state” where the

rational and irrational is negotiated. It is commonly understood that self-injurers negotiate with “going too far” and accidentally injuring themselves more than they intended. Too little and they do not get the desired effect, too much and the damage is permanent.

Presson and Rambo (2016) identified several exemplars in the identity work of those who self-injured. Participants spoke of negotiating “the sanity continuum,” whereby they located their own behavior relative to other self-injurers as sane versus insane. Another was the mastery continuum; at one end of the continuum was a competent self-injurer who was in control of themselves. For example, one respondent said, “It’s not as bad as people think. I know what I’m doing” (Presson 2014:49). On the other end, some self-injurers were characterized as not in control and in the throes of “addiction” or “compulsion.” Some forms of self-injury were located on a spectrum of pathological versus well-adjusted, or judged on the basis of the degree of harm they caused.

Skill Development

Many respondents described navigating boundaries with specific skillsets developed through their experiences with self-injury. For instance, Chandler (2012) noted Klonsky’s (2007) research claims that self-injury is “carried out in order to increase positive feelings, or decrease negative feelings” (Chandler 2012:444). Respondents validated these claims and framed self-injury as a way of “‘working on’ the self, via the management of emotions through the body” (2012:446). Specifically, accounts surrounded the “work” that some put into self-injury in order to effectively control, release, elicit, and create emotions. Anna discussed navigating the effectiveness of her

self-injury by changing the placement of her injury when it did not work for her the first time:

I was like ah, no ... ken, it's not happening, so I got my blade and I cut my other arm and ... it ... was, literally like I could feel it and hear it sortae like tearing open, [...] that was it, that was the one, it was like, it's worked this time (2012:449).

Chandler (2013) also highlighted pain as an invited resource. One respondent used pain from self-injury to navigate the space separating life and death, and feeling versus numbness:

[I]n a way it is life affirming [...] it's like a bit of a, jump start or something you know it's like trying to, it's trying to be alive, it's trying to live and like, experience, emotion or pain or, rather than just being, sort of, numb (2013:11).

Others discussed using pain from self-injury to elicit “endorphins, chemicals and adrenaline [...] causing a ‘buzz’ or an improvement in their mood” (Chandler 2013:10).

Others still, used self-injury to navigate social boundaries surrounding gendered understandings of pain, which also served the purpose of enhancing their self-concept.

One woman stated, “it was more, kinda, macho swaggering kinda thing [...] which sounds really daft, but, it, it made me feel, em, less of the victim actually” (Chandler 2013:8).

Similarly, Inckle (2014) discussed that the “split between inner-self and outer performance increases stress, emotional vulnerability, and isolation” (2014:5) in men who negotiated discordant role identities surrounding sociocultural definitions of masculinity, emotions, and self-possession. Injuries could become external expressions of gender socialization in the West, thus leveraging their bodies provided them the means of negotiating their social status. One respondent described his skill in navigating the culture of masculinity with his self-injury:

There were times I had black eyes, busted lips, when I would hit myself I would tend to hit myself in the face a lot, quite violently, and I would have looked like somebody who had been kicked around the place by people. I always had excuses: “What’s that?” “Oh, I fell” . . . I was doing martial arts at the time, or there were times when I wasn’t, and people still thought I was, so I used to just say, “Oh’, you know, I got it in the club” (Inckle 2014:16).

Adler and Adler (2011) talked about the development of medical skills in managing long term self-injury. Some respondents discussed learning how to stitch themselves or using innovative means of caring for themselves so as to avoid medical interventions that could become alienating or stigmatizing. Gradin Franzén and Gottzén (2011) stated that respondents positioned themselves as “survivors, as people who are able to deal with hardships ‘ordinary’ people do not have to worry about” (2011:285). In these examples, respondents talked about self-injury as a means of developing skillsets to effectively navigate their environment. This is comparable to edgeworkers “exercise of the particular skills required to discover [the limits of edgework performance]” (Lyng 1990:859).

Preparation

Respondents indicated that self-injury sometimes required a minimum of preparation. Brossard (2014), in his discussion of the self-injury process, described both mental and material preparation as a stage of self-injury. He denoted that this process could include remembering prior experiences, mentally rehearsing, and physically staging. Staging might entail laying out instruments, towels, antiseptic, and other props. He said of one interview respondent:

Elsa, a twenty-year-old journalism student, used to cut her wrist. She then put some blood on her face and watched herself cry in a mirror. While self-harming made her feel better, looking at her blood mingling with her tears increased her relief. This staging beforehand requires preparation: waiting to be at home when

her mother has gone out or to be in an enclosed area with a mirror (Brossard 2014:567).

Adler and Adler (2011) discussed that some respondents created “kits,” which consisted of instruments for injury and cleanup, to carry with them in case the desire to self-injure arose throughout the day. They also detailed respondents “emotional patterns of enactment” (Adler and Adler 2011:85). Respondents described “savoring” their experiences by drawing them out, or journaling or listening to music prior to the experience, which “amplified” their emotions.

Self-actualization, Realization, Determination

Respondents in the literature often discussed self-injury in terms of enhancing personal regard for themselves. Chandler (2013) noted that respondents “described the physical pain generated by self-injury as leading to an improved sense of self” (2013:12). She further relayed that “pain can be understood as reintegrating the mind/body/self rather than destroying it” (Chandler 2013:12).

Inckle (2014) quoted one respondent’s explanation of self-injury alleviating feelings of guilt and shame by altering his level of concern for himself. Mark explained that “Afterwards there would have been this overwhelming sense of compassion for myself. It was a really strange experience and a very, very, deeply moving experience at times, particularly when I would be very violent with myself” (Inckle 2014:13).

Altered Perceptions and/or Consciousness

It was mentioned earlier that Chandler (2013) discussed accounts of biochemical reactions which took place within respondents’ bodies when they injured themselves. They spoke of a “buzz,” which improved their mood. Additionally, Rollins (2007) noted that ritual “body-play” which involves what would be termed self-injury, generates

euphoric and positive states. Rollins, citing Favazza's 1996 work on self-injury, states: "In cultures in which body modification is socially sanctioned, self-harm is often associated with a trance-like state, and it begets awareness of oneself and one's god(s)" (2007:76). Adler and Adler noted this pattern in the discourse of some respondents as well, and discussed that self-injury could lead to "a feeling of dissociation, moving into a trancelike state" (2011:86).

A Sense of Control

Much of the existing literature on the topic, thus far, mentions self-injurers' perceptions of feeling in control. They may or may not be in control, every bit as much as volunteer first responders or bike messengers. Kokaliari and Berzoff (2008) discussed how Western cultures expectations for high productivity both create and support conditions that overwhelmed respondents. Self-injury was described as inverting this process, allowing respondents to focus on their tasks, thereby supplying an "illusion of control over [their] emotions" (Kokaliari and Berzoff 2008:265).

Adler and Adler (2007) discussed that some respondents' self-injury demonstrated "rationality, agency, and control over their behavior rather than a pathological powerlessness" (2007:555). One respondent described planning her self-injury:

A: I don't like being impulsive. I like making decisions, choosing how I'm going to live, how I'm going to do everything. It gives me a sense of control.

Q: How would you plan it? How far in advance would you start thinking about it?

A: Anything from a few hours to a few days. Depending on how long I can hold it off for. (Adler and Adler 2007:554).

Hyperreality

Chandler (2012) discussed one respondent, Belinda:

Thus we have some elaboration here of the idea that self-injury might ‘transform’ emotional pain into physical pain. For Belinda, self-injury is described as a way of distracting, if not stopping, confusing thoughts and feelings by providing an alternative focus. Importantly for Belinda, the bleeding, painful arm is framed and perhaps experienced as something that is more ‘real’ (2012:450).

In Chandler’s description of Belinda’s experience, other themes from edgework were featured, including regulating the internal conversation and altered perceptions and/or consciousness. The “buzz” described by Chandler’s (2013) subjects, and the trance-like states described by Rollins (2007) and by Adler and Adler’s (2011) participants, could also be interpreted as possible descriptions of hyper-reality.

Experience of Recognition

The literature reported respondents’ identification with others who self-injured. Adler and Adler (2008) discussed that relationships built through internet communities could afford self-injurers “greater self-acceptance, decreased estrangement from society, and decreased social isolation” (2008:40). They quoted a college freshman named Erica:

You’ve been there; you know what it’s like. I have traits in common with other members of the community: being sexually abused, being a perfectionist, having an ED [eating disorder]. Always like, trying to help other people, doing community service, volunteer work, I’m really into that. Like everything they say on those Websites is completely me. I don’t think it’s all cutters; I think it’s the majority of cutters. I just happen to fit. So it makes me feel more connected to the community as a member (Adler and Adler 2008:40).

Similarly, Inckle (2014) discussed that “men commonly deal with issues of physical and emotional vulnerability in ‘solitary discourses and practices’” (2014:14). She discussed that respondents had talked about their self-injury with friends, and quoted Joseph:

I still have that thought like my mate's [reaction] as teenagers, "Sure, it happens." And although it was a blasé kind of way of saying it, as teenage boys and sort of early twenties and that, [...] it was a recognition of shit happens and you deal with it and that's okay. Which is a far more evolved wisdom than many people have reached nowadays, with their condemnation [of self-injury] and such like! (Inckle 2014:15).

This recognition that "it happens [...] and you deal with it and that's okay" is demonstrative of the solidarity felt by edgeworkers, such as skydivers (Lyng 1990), in their acknowledgement of mutual experience.

RESPONDENTS' DESCRIPTIONS OF SELF-INJURY, EDGEWORK, AND ASSOCIATED THEMES

There is no standard definition of self-injury. The conflicting definitions of self-injury in the literature were reflected in my interview respondents' descriptions of their self-injury. Every respondent reported using multiple methods or mechanisms to injure themselves, and there was no method of injury that every respondent employed. Further, there were discrepancies between what was considered self-injury and what was not. The largest discrepancy I noted revolved around the use of drugs or alcohol. Many, but not all respondents, reported to have used drugs or alcohol. Some were adamant that their use was self-injurious, while others were adamant that it was not. Of those respondents, some noted that they had "overdone it" with drugs or alcohol on occasion, but that it was not intended in a way that aligned with their motivations surrounding self-injury, and thus was not self-injury. Others referred to use of drugs or alcohol as providing emotional relief that was less injurious than other forms of self-injury they had implemented. Still, other respondents were ambivalent, taking different viewpoints depending upon the context of the discussion.

Notwithstanding these differences, each of Favazza's (1998) three types of self-injury were represented in my interview sample. Every respondent reported to have engaged in superficial or moderate self-injury at some point. Descriptions included hair pulling, scratching, rubbing parts of the body, cutting, burning, and use of drugs or alcohol. Respondents discussed having used a variety of instruments to create these injuries. For instance, one respondent, reported cutting with blunt objects, specifically a piece of flint, while others reported using knives, razors, shards of aluminum cans, or other sharp objects. Other respondents reported friction burning by rubbing the skin with objects, while there were some who reported burning with open flames or lit cigarettes.

Following this, slightly more than half of the respondents had engaged in stereotypic self-injury. There was little disparity between these injury types, which often consisted of head banging, or "slamming." Men more often reported self-hitting and/or running into walls than did women. There was also one respondent who reported an experience with major self-injury. "3" described suffering "some kind of episode" or "some sense of depersonalization" wherein he used his "fingernails to peel the skin off my face, head, neck, and shoulders." He did not remember much from the event or what led into it, but recalled that people said it looked like he had been involved in a traffic accident. He noted that this sounded reasonable, and said that he told people he had been hit by a car until his wounds healed and he was no longer questioned about them. He reported that he did not receive medical treatment for this injury.

All of the respondents discussed some form of treatment for their self-injury. The reports of receiving medical treatment for their physical injuries were scant. Most treatment was often located within the mental healthcare system. As such, respondents

generally located themselves between two perspectives regarding mental healthcare resources. On one side were supporters of therapy and clinical intervention. This category was comprised of those who reported having had personal agency in the decision to pursue mental healthcare resources. On the other side were those who were forced into treatment. Those individuals more often reported negative outcomes and, as such, negative thoughts and emotions surrounding their experiences. Some of those individuals had experienced both sides of this continuum and were either uncertain of their feelings or had transformed their perspective through positive experiences following their negative experiences.

In the following sections I provide examples of the edgework themes interview respondents drew from when discussing their self-injury. As was demonstrated in my literature findings, these themes frequently overlapped one another. The edgework themes I found in the narrative accounts of my interview sample were: a response to alienation/oversocialization; a way to regulate the internal conversation; negotiation of boundaries between extremes; skill development; preparation; self-actualization, realization, determination; altered perceptions and/or consciousness; a sense of control; crowding the edge; and experience of recognition.

A Response to Alienation/oversocialization

Respondents often discussed their self-injury in terms of being a response to their social environments. Jess reported that her self-injury primarily took the form of friction burning and cutting. She also reported hitting, or “banging,” her limbs against things, ripping out her hair and eyelashes, and sticking safety pins superficially under the skin on her fingers. She stated that she began injuring herself at 13 and described the progression

of her self-injury as taking place once every few months to weekly by the time she was 17. In her interview, she drew on the vocabulary of alienation/oversocialization to explain her reasons for self-injury when she claimed that the media imposed on her contradictory and unrealistic expectations for living in Western culture. This, in turn, was thought to contribute to the untenable nature of some of her relationships. She discussed a period of time when she did not self-injure, and compared it with a period when she did. Jess said:

I was an exchange student in Bolivia and had no self-injuries because I was away from everything that I considered as triggering. And I found, like, really meaningful friendships in another country, even with a language barrier. So, it was hard, but it was like an adventure at the same time. So, it was, like, kind of this grand distraction. And then, because I did that, I had to do my senior year with a class that was a year younger than me. And I went from being in Bolivia doing all this humanitarian work—I worked in an orphanage for kids with developmental disabilities; I helped teach English to college kids; I worked in the burn unit in the hospital. I came back to my tiny little town, and in high school, like, I'm not doing anything for anybody. I don't have the friendships that I had because, you know, because all those folks have graduated. And my mom is still a jerk.

Jess further contrasted the difference between living in Bolivia and returning home when she said, “It’s like you feel like you’re always at risk of losing something socially, so you self-sacrifice in order to try to hang on to it.” Lily, who discussed a history with eating disorders as an adolescent but did not intentionally begin injuring herself until her early 20s, described feeling powerless over her environment in her interview. She expanded on Jess’s thoughts with: “So I can continue to do the things that are expected of me in life, I have to hurt myself and that’s me taking control over the fact that I have to sacrifice.”

Snarky Kitty, who reported that her self-injury manifested through pulling out hair, scratching, and picking scabs, discussed that she felt compelled to be “compliant” in her adolescence, otherwise people would “turn their backs” on her. This led to her feeling

“shut down” and “emotionally chaotic.” Similarly, Kat, a gender fluid respondent who began self-injuring between the ages of 12 and 14, described feeling pressured to be “perfect.” They said, “I had developed a way to make it seem like I was happy, but I wasn’t. But because I was, like, the star child of my family, I always wanted to be perfect.” They described cutting with a straight razor, scratching with paper clips, and also of using anorexia to manage weight because “... I then started to put, like, a lot of importance on my self-image. [...] I felt, like, ‘Okay, I need to then do these things to make it feel like I fit in with everybody else.” Amanda, who began cutting herself with a safety pin and eventually a pocket knife, also described wanting to “fit in” in high school. She said:

You want to relate so bad; you want to fit in so bad... Honestly, you’re in your own world; in your own mind, [...] you’re just lost in your own mind. You’re lost trying to find where you’re trying to go, or where you’re trying to fit in; you’re consumed by it.

Male respondents also discussed the relationship between their self-injury and the desire to “fit in.” “3” characterized his self-injury as manifesting through cutting, burning with cigarettes and open flames, piercing, and punching himself in the face and head. He reported that he first began injuring himself when he was 13 or 14 while working at a camp for kids one summer. He said that his aim in cutting his arm with a pocket knife was to relieve the “constant stress” from “lack of sleep and possibly some elements of the environment.” Some of these environmental elements were associated with being bullied because he was “the new kid who didn’t fit in.” Felix, who began injuring himself in middle school, in 7th or 8th grade, said that he was “looking for attention in all the wrong ways.” He reported cutting himself, burning himself with cigarettes, choking himself until he passed out, injecting drugs, and experiencing periods of anorexia, which he

associated with being on a competitive swim team. The first time he injured himself he used a butter knife to saw three rows of cuts into his arm. Felix reported that he did not like it, but continued injuring himself. He said:

I was the gay kid, so I was bullied a lot. That definitely... me being gay definitely had a huge influence on this [self-injury] because I naturally gravitated toward the kids that were like... not the normal kids at school, like, the alternative kids at school. The kids that were into music and that would smoke pot; kids that were more, just, into the alternative lifestyle... those were the kids that actually accepted different people. I didn't fit in with the football players and the baseball players 'cause that just wasn't who I was... So, me being gay definitely drew me toward that crowd.

He further explained regarding being part of an “alternative” crowd:

Of course, social media blew up back then... you were on MySpace, you were texting your friends all the time... You could MySpace [sic] and you could see that other people were bragging about how many cuts they had cut themselves that day, how deep their cuts were...

In these examples, Felix described finding solace in a group of people who accepted him, which allowed him to escape being bullied, but also encouraged that he injure himself to cope with this type of alienation.

A Way to Regulate the Internal Conversation

Many respondents discussed self-injury in terms of providing something to focus on, distracting them from the internal conversation. Tobias reported frequently finding his mother unconscious from drugs when he was a child. Once he found her unconscious after a suicide attempt. He was one of two respondents who had never cut themselves. He claimed to black out with his first experience with drugs, his preferred method of self-injury, and said that the “thrill” of not remembering or knowing what happened suited his needs. Self-injury was a mechanism for “letting go of all inhibitions, and to just really not have any worries at all... and like, go to a place where I am not in control anymore, in a

sense.” He said that he had a lot going on in his life, many stressors, and that “something internal argued that it was okay,” which “overrode the inner knowledge that this [self-injurious drug use] can lead to something bad.” In this way, Tobias drew on the vocabulary of regulating his internal conversation when he claimed to end all internal conversations by blacking out with drugs.

Felix reported that his self-injury moved into drug use at 17 when his mother committed suicide. He said that the reasons for injuring himself changed when this happened. He stopped cutting for “attention” and began using hard drugs, specifically shooting up methamphetamines, for the “mental escape,” or to “silence the thoughts.” Michael reported cutting himself, “slamming” his head into walls, punching walls and himself in the face, and also shooting up drugs, specifically heroin. He said that the main goal of injuring himself was punishment, and that the ritual surrounding his self-injury was a way to “put my mind in different place.”

Amanda began injuring herself in the 8th grade as a form of rebellion when she and her mom moved from a small “three stop-light” town to a larger city. She reported that her self-injury progressed as she got older. She said:

I would get into an argument with my boyfriend, I would definitely bang my head against the wall a few times, a few different instances, because, again, I just felt like I don’t know what’s happening and I need to divert what I’m feeling and what’s happening. I’m going to just freak the fuck out for a second.

She later expanded on this “need to divert what I’m feeling.” She said:

Those kind of racing, chaotic thoughts, that was different than... well it was just different. It was a different kind of feeling, I guess. It was different circumstances. I never just sat there and thought it out, ‘Okay, I’m going to do it today. So-and-so said something to me, and my mom said something to me, and I’m going to hurt myself later about it.’ It had to be *something real extreme*, something that made me feel real extreme, to make me want to do it.

In these examples, Amanda described “racing, chaotic thoughts” as being attached to the “extreme” emotions that made her want to injure herself. Further, she alluded that in order to end the emotions that made her feel “extreme” she must also stop the thoughts.

Negotiation of Boundaries Between Extremes

Several respondents made use of the vocabulary of “negotiating boundaries between extremes” when they stated that self-injury provided a way of exploring opposing extremes or pushing their limitations. Snarky Kitty talked about negotiating “feeling” when discussing picking her scabs. She said, “It’s so weird because it hurts! It doesn’t feel good to do it, but there’s just, like, this compelling desire to rip that thing off... and just tear it away... to feel something.” Amanda expanded on this when she described “testing the boundaries of pain” with her self-injury. She said:

A: What I remember, it kind of felt like a deep cat scratch. There wasn’t a whole lot of blood. I mean, it was a safety pen... Unless I was just stabbing myself, running it across my skin, with the safety pen, now that I look back, it was nothing; a young girl just trying to figure out how to hurt herself, testing the boundaries of it.

Q: Testing the boundaries of what?

A: Just feeling pain and trying to figure out how to deal with it, I guess.

She also discussed the line between pain and relief when she described finding her preferred method of self-injuring, which also involved “manning up.” She said:

What I remember with the safety pin was being a little too scared. I don’t know why. The minute I got that knife was like, quick with ease. The safety pin was actually—I had the scars from the safety pin, I think. When I think about it, they were more rigid, like little baby cuts, you know? I always wanted to feel some fucking pain.

She further explained:

I was like, ‘Oh shit, that’s the real thing—this knife is really going to fuck me up. But damn, that was so easy. Damn, that was so smooth.’ And you know, it felt better in a sense, because I felt like I was actually making some leeway on

distracting my mind, you know? I felt like it was cleaner in a sense, I don't know why, like a cleaner cut.

Michael reported that before he ever injured himself, he “was always playing around with it in my head. It was always potentially gonna happen.” He described the difference between the first two times he cut himself:

Two huge different feelings of like, being really depressed... the feeling after binging on cocaine all night and drinking on top of it. It was just terrible... and just... just like, that feeling of *despair*. And then, on xanax, it was more like I wanted to play with myself, and see what I could do, and see what it felt like, and it was kind of an experiment, like, ‘let’s see...’

In this description, he differentiated between his emotions and thoughts, which were each tied to the specific drug that he was using at the time that he decided to cut himself.

Summer, who reported a history of “not eating,” breaking a finger, playing with fire, and punching herself, used a vocabulary of emotion management to explain her choice of self-injury method. She contrasted cutting as a way of “cooling down” from being “amped up,” with choking, which raised her adrenaline, making it easier to deal with situations involving self-blame and shame. Similarly, Clark, who reported hitting himself, running into walls, and scratching himself, preferred to cut himself with a piece of flint. He said: “...the object was kind of symbolic of the injury. You’re using a dull object, and you get a little bit more like a scraping, a duller pain than a laceration with a sharp object.”

Further, every respondent mentioned the line separating life and death in their interview at least once. Very often, this line was discussed in terms of suicide. Some admitted to having been suicidal themselves, which included periods of ideation and/or planning. Some had considered suicide as a solution to discord in life, but reported that it never became a serious consideration. Some oscillated between opposing extremes

depending upon the context of the situation being discussed in the interview. Further, as mentioned, multiple respondents discussed having experienced the suicide, or suicide attempt, of someone close to them. For Tobias, the blackout that he experienced with his self-injury was defined as a “line,” or the point of separation between life and death, consciousness and unconsciousness.

Irrespective of suicide ideation or consideration, interview respondents most often alluded to being “anti-suicide.” By “anti-suicide” I mean, rather, that they described wanting to not die, or not wanting to kill themselves. For instance, Snarky Kitty, who discussed feeling perpetual “melancholy,” said “I don’t think about killing myself... I mean, there are times when I think, ‘it would just be nice for this whole thing to be over...’” She further explained that she would not cut herself since, for her, it was “too scary because it could mean death. If it could mean death, I don’t want to go there.” In comparison, Kat said:

Most people see self-harm as, ‘Oh, okay, you’re trying to kill yourself.’ There were instances that I did want to kill myself, but I *didn’t* want to do that because I was very fearful of dying. But people just lump self-harm immediately with being suicidal. I wasn’t totally [suicidal]!

I noted the largest difference in the respondents’ relationship to suicide was associated with their gender. Men were more apt to discuss serious consideration of suicide than were my other respondents. One respondent, “3,” reported that he had died at least one time prior to our interview. He reported that his brush with death was an accident from a drug overdose. “3” did not describe his drug use as a form of self-injury but characterized it as “addiction” instead. He stated that it was not his intent to kill himself by overdosing, and that regardless of his desire to die at times, he could “injure myself but could not end myself.”

On the other end of this spectrum, Clark, who reported to have “picked up” self-injury in a treatment center he had been institutionalized to for having written a suicide note, said: “I’ll still have suicidal thoughts, but if I have an urge to cut I’m not going to follow through with that.” He expanded this thought with the sentiment: “My suicidal thoughts aren’t to self-injury; my thoughts are to... I mean, my thoughts are to... some injuries have the idea of continuing.” In these examples, respondents appealed to using self-injury to navigate the space between life and death. This may be likened to Lyng’s statement that the “immediate goal of one’s actions in edgework cannot be regarded as trivial. The point is to survive, and most people feel no ambivalence about the value of this goal” (1990:881).

Skill Development

Similar to the literature, respondents discussed developing skills to navigate the discernible effectiveness of their self-injury. Kat said:

The razors were like quick, sting-y. Like, you didn’t feel it. It just hits you. I guess that’s why I preferred that more than scratching with paperclips. It was, like, instant and you felt it and stuff. With a razor it took a little bit to get to where I actually felt it for me.

In this example, Kat claimed that she enjoyed using the razor over the paper clips because it was less physically painful, but it also created the good feelings associated with self-injury more quickly.

Respondents also talked about the relationship between their self-injury and developing skills to help them in their everyday lives. Summer said that certain modes of her self-injury were meant to “take my mind off of crying.” Jess, likewise, said her overall goal with self-injuring was “to feel pain, to be able to not cry and to breath and sleep.” Lily expanded on these ideas when asked the same question. She said, “I felt tired

afterwards and I couldn't sleep before that. I couldn't sleep. And so, that was... That was definitely a motivating factor after, moving forward. I stopped crying and I could sleep." When asked to explain what being able to sleep after she injured herself meant to her, she said, "It worked." Michael also spoke of sleep when describing what followed the first time he cut himself, "I went to sleep... after the cocaine... I finally just went to sleep. I was able to go to sleep." In this way, well-timed self-injury provided some respondents the ability to manage their physical responses, which also allowed them to manage their social worlds.

Preparation

Some respondents described preparing for their self-injury prior to the act itself, or they discussed having a specific ritual surrounding their self-injury. Felix differentiated between the ways that he prepared for his self-injury according to the specific mode of injury. When cutting himself, he, like others in the literature, would prime himself for the experience by listening to music. He would then cut himself in his closet. Planning for his methamphetamine use was described as more "social," and was associated with the idea of obsession surrounding drug use.

Those who discussed their drug use as a form of self-injury were more apt to describe a specific, fixed routine surrounding preparation. For instance, after being involved in a car accident at 18, which he described as "pretty bad," Tobias was prescribed pain killers for his injuries. He said he discovered then that using pain killers "really does numb everything, like, kind of emotionally and physically as well." He said that after healing from his injuries associated with the accident and returning to work, he continued using the drugs, and "that was when it became sort of ritualized." He said:

It was like, go work a shift, go stop by the drug dealer, get enough to get through that, and then, like, you know, go home, take a pill, eat a little snack, have an energy drink, go back to work. And then, it got like, kind of, became a routine. I would say that went on for probably... 3 or 4 years.

Tobias' self-injury expanded to include using heroin, at which point he reported that it became "routinized" and involved "a very ritualized prep, carrying it out." He said:

I always had to have my little tools, but I always snorted, I didn't shoot up, so it wasn't that much [to prepare for]. You know, I would make sure I was setting aside time... I would have my specific straw that I would use. And I would have, like, if I was at work I would have to have a paper towel to wipe down the back of the toilet seat, so I could snort off of it.

Respondents also discussed their chosen mode of self-injury as a means of preparation for injuring. For instance, Snarky Kitty reported that she would sometimes keep her scabs after pulling them off, returning to look at them later. The scabs were characterized as trophies. Others said their mode of self-injury itself was preparation. Jess said that the reason she preferred friction burning over other types of self-injury was that it was easy to hide and "could be done anywhere." Felix said the same thing about burning himself with cigarettes, which became his "thing for a while." In this way, respondents planned their everyday lives around their self-injury which is similar to the development of skill that edgeworkers often count as "most valuable" to the edgework experience (Lyng 1990).

Self-actualization, Realization, or Determination

Some respondents discussed experiencing a heightened sense of self with their self-injury. "3," who stated that he had a "very confused image of myself" as an adolescent, said "if you can stand it, then you become more capable... transcending yourself to become something else." Similarly, Summer said that when she choked herself she felt that, "I'm alive and I can take on anything." These descriptions were

similar to the idea that with edgework the “ego is called forth in a dramatic way” which can leave practitioners with a “purified and magnified sense of self” (Lyng 1990:86).

Altered Perceptions and/or Consciousness

Respondents discussed the feelings associated with their self-injury in ways that mirrored the literature. Many framed their experiences in terms of biochemical reactions which have been associated with self-injury. Summer reported that an adrenaline rush followed choking herself. “3” said that his aim in self-injuring was “to cause myself actual pain, not from somebody else but from me. And it worked. It was a relief. It was a distraction. The pain caused a rush of endorphins that, you know, made me feel... better.” Amanda expanded on these explanations when she discussed that self-injury “tingles all over” and said that it felt:

Almost like a high, in an instant. This is like a short one; it was like a burst of — and that was pain I was feeling. I was turning that pain into making myself think it was making me feel good, you know? At least that’s what I was trying to do. I was sad, and I’m angry, and I’m going to just make myself feel good for a minute by causing pain to myself, even though it was pain, and pain typically is bad and not good. And I mean, again, it’s going to direct my feelings elsewhere and that’s what’s going to make me feel good: thinking about something else, focusing on something else, other than anger, depression, inadequacy and you know, just all of that.

In these examples, respondents highlighted that their reactions to their self-injury altered their perception of their environments, allowing them to focus on alternative physical sensations rather than the negative feelings they experienced prior to their self-injury.

Other respondents talked about the entire experience surrounding their self-injury as a way to alter their perceptions and/or consciousness. Michael, who described constructing a ritual around his self-injury, which he called “tribal,” said:

I would put the blood on me, on my face... across my forehead and stuff... and, you know, smear it on me... but my body language... I mean, I'd be... whatever I'd be doing, I'd be doing motions. Like, praying motions...

He described these praying motions as “more like cursing... *something*.” When asked why he enacted these rituals, he said:

I don't know... Something about blood, man. I don't know, I just like it. I like to... I like the look of it... and also it had something to do with... [shooting up]. Watching the blood, you know, fill up. And it was, like, really mesmerizing... to me... That's what we are... blood flow. There was one time that I just, I wouldn't let the blood clot and it was just all over me.

In this example, Michael described blood as representative of life, which he covered himself with.

A Sense of Control

Every respondent mentioned control in their narrative accounts. Jess reported that her self-injury gave her control over her emotions. She said:

Like, the physiological stuff that comes with experiencing intense emotions, that I could shut down. Like, ‘if I do this, I can breathe again. If I do this, I'll stop crying. If I do this, I'll be able to go to sleep.’

She also reported using self-injury to hurt herself more than others could hurt her, which gave her a sense of control over her self-sacrifice that was mentioned earlier. Amanda described feelings of helplessness and being surrounded by chaos leading up to her self-injury. She said she would injure herself:

... anytime I felt like I was losing control of a situation or that I couldn't control it and it was making me feel like I can't handle this; I can't deal with this; I'm going to hurt myself to redirect what I'm feeling and be able to focus on what I'm feeling; which was the feeling of pain.

Summer said, “It was always about control for me.” In her account she discussed being “hyper-controlled” by her family as an adolescent. She said that her family

foundation lacked “stability” and described the conditions surrounding her first experience with self-injury at the age of 14:

Mom had kicked me out multiple times that year. She had... It was my freshman year of high school. She had confiscated some of my writings: some notes I had passed; some poetry; some artwork that I had done for art class, and she had got my brother to take those from me, and she actually called a crisis counselor on me for no reason! Because, like, I hadn't drawn in the eyes on one of the portraits I had done for class, and supposedly that means that one is suicidal or something else.

She said of this incident specifically that she “was losing control of everything [...] and, like, I literally felt this pressure in my brain,” which self-injuring helped to alleviate.

Similarly, as discussed earlier, respondents talked of using self-injury to “let go of control” over their “chaotic” environments, which contributed to a feeling of personal agency in their lives.

Some spoke of being able to control their urges to self-injure. Summer said that the reasons surrounding her self-injury changed over time. When at first, she injured to gain control over her environment and emotions, later her goal was just to stop self-injuring because she felt like the “compulsion had control.” Jess also said that in the past she had felt as though injuring herself was not a choice. After one severe incident in which she questioned the need for stitches, she enrolled herself in a program to help with her urges. She said that since then, she has injured herself but that she has a choice now. Jess said of the last time she self-injured, “I never felt like, ‘this is what I have to do.’ But it was like, ‘I want to shut this feeling down fast.’” In these examples, Summer made the choice to stop injuring herself in order to feel in control of herself, and Jess made a concerted decision to regain control of her feelings quickly through making the choice to self-injure.

Crowding the Edge

Most respondents discussed engaging in other forms of physical activity, such as competitive swimming, roller derby, rugby, rock climbing, yoga, kickboxing, and martial arts, like Jiu-Jitsu and Aikido. Some of these activities were specifically compared to self-injury. For instance, “3,” when asked if he had any experience with self-injury related organizations said, “physical training... and different martial arts because they build a tolerance to pain, intentionally.” He further elaborated that both self-injury and martial arts “develop focus.” Summer said of her experience with martial arts:

With Taekwondo, the whole idea is that you can engage in what is maybe seen as acts of violence as a way to... um... kind of like disarm and lower the violence that’s happening [in one’s environment]. It’s all very, this is something that if you’re in a situation where you have to protect yourself, you do this, and it’s controlled violence with an emphasis on blocking and putting someone... stopping someone from hurting others. It’s moreso that than, how can I knock this person out?

She further compared her Taekwondo practice with self-injury, stating:

In both situations, you realize you may get hurt, but you’re being extremely focused. You learn the right way to do it so that you can release, or you can reduce, the risk, and reduce permanent damage. You have to have extreme amounts of focus while you’re doing it and if something happens [if something goes wrong], then you need to relearn. Maybe you didn’t really have that [skill] down like you thought you did.

There were other respondents who discussed their affinity for body modifications. Kat claimed that she had 10 tattoos, 15 piercings, and three brandings. Likewise, Snarky Kitty said in her interview, “I bet you wouldn’t guess that my whole back is covered in tattoos.” In these examples, respondents appealed to the idea that edgeworkers may often try their hands at other forms of edgework practice.

Experience of Recognition

Every respondent, except one, mentioned knowing someone else who had self-injured. Many described these other individuals as personal friends. Some had injured with others; some had been taught or shown how to injure in specific ways by others; some had interacted with other self-injurers in an institutional setting, such as rehabilitative mental health treatment; and some had participated in organizations, such as To Write Love on Her Arms, or internet chatrooms associated with self-injury. This stated, the processes of learning how to self-injure and of exploring different forms and methods of self-injury were very individualized for each person. While respondents' social spheres often intersected with other self-injurers, the majority of respondents indicated that their self-injury was typically an individual process that they honed by themselves.

As such, respondents often mentioned a feeling of solidarity between themselves and others who had a history with self-injury. Amanda spoke of the relationship between herself and her best friend in high school. She said that the two of them knew each other self-injured, which made it a "norm" for them:

It was never like, "Let's sit here and cut together." It was never like that. But at the same time, we knew. It was never kind of like, "Ooh show me," or "Let's help each other." It was kind of like we knew the other one was going to do it regardless, you know? We knew it was our way of coping and we weren't going to sit there and try to get in the way of it.

Jess stated it was odd how she had come to know others who had self-injured. She said:

We figure out how to find each other. I feel like usually it's the other person, like, I either see visible signs or they reveal something to me. So, then I feel comfortable with them, but I don't think I sought them out. And I don't think I was ever the first person to initiate to talk about it...

Clark told a story of bonding with a woman whose scars were visible. The two of them never talked about self-injury, but he claimed to identify with her. He said that he initiated a conversation with her, where he would not have otherwise, because, “I knew I could relate to her. She was the same type of different as me. I was like ‘Oh, you’re going to get me.’ All my jokes were funny. It was great, you know, because I was comfortable.” These instances could be likened to Lyng’s statement that “edgeworking capacities are possessed by only a select few and who often feel a powerful solidarity with one another” (1990:860).

CONCLUSION

Within the narrative accounts of my respondents I identified multiple edgework themes; and many of them intersected, crossing the boundaries of one another in most cases. Further, most of the edgework themes, as a vocabulary of motive for self-injury, were mutually identified in both the literature and my interviews, including: a response to alienation/oversocialization; a way to regulate the internal conversation; negotiation of boundaries between extremes; skill development; preparation; self-actualization, realization, determination; altered perceptions and/or consciousness; a sense of control; and experience of recognition. In the literature I identified the theme of hyper-reality. Within my interview sample I identified the theme of crowding the edge. As evidenced through the qualitative research literature and my interview samples, self-injury can sometimes be usefully conceived of as edgework.

CHAPTER SIX

DISCUSSION AND CONCLUSION

SELF-INJURY AS EDGEWORK, FROM THE INSIDE OUT

The Benefits of Framing Self-injury as Edgework for those who Self-injure

Psychologists view self-injury as individual pathology. Reinterpreting self-injury as edgework can help a self-injurer reframe his, her, or their, understanding of the activity. Instead of viewing it as pathology and something to be ashamed of, it can be viewed as a mechanism that, given the context of the situation, is autonomous, creative, effective, and at times, empowering. Self-injury is not the best outcome, arguably, but viewed through the lens of edgework, self-injury is understandable—not pathological, not something to shame, not something to stigmatize.

Understanding how self-injury can be interpreted as edgework opens up a number of helpful narrative horizons that may not otherwise be considered if you are someone who self-injures. Understanding self-injury as *a response to alienation/oversocialization* means that the self-injurer can see themselves with more compassion, that they are not at fault. In many cases, it is common, unsurprising, not disturbing and ultimately legitimate. Further, being cognizant of self-injury as a form of edgework which serves to *regulate a negative internal conversation* means that individuals may use self-injury as a means of creating “mindfulness,” in a sense, which is defined as “a mental state achieved by focusing one's awareness on the present moment, while calmly acknowledging and accepting one's feelings, thoughts, and bodily sensations” (New Oxford American Dictionary 2010).

If an individual frames self-injury as a process of *negotiating the boundaries between extremes*, he, she, or they might have a better understanding of when to “reign it in.” If they can recognize where the edge is, they can cultivate *skillsets*, be *prepared*, and not cross the line. Perhaps, more importantly, they can recognize when a line has been crossed and come back to the edge, or even retreat safely away from the edge to the other side.

Those who self-injure, on occasion, speak of being proud of having crossed the line and come back, and for surviving despite difficult times, which cultivated a sense of *self-actualization, realization, and determination*. This product of edgework can, after a fashion, lead “to an improved sense of self” (Chandler 2013:12), and *a sense of control* over situations where they may otherwise feel powerless. This sense of control must be considered with some caution. Like with skydivers, first-responders, and bike messengers, the sense of control may be an illusion.

The Benefits of Framing Self-injury as Edgework for Those who Treat Self-injury

As it stands, self-injury is treated as an individual-level problem that is associated with emotional issues, behavioral disorders, mental illness, and suicide. Individuals are grouped together and marked according to these labels. It is recognized that self-injury may manifest from unresolved and/or ongoing trauma, however, these social factors can be overlooked because of the way Western society functions in general. First, trauma is stigmatized. Even though we acknowledge that trauma happens, we are also informed that it is not supposed to happen, therefore those who are traumatized, or hurt, or grieving, or experiencing emotional responses for whatever reason are often alienated in any number of ways. Secondly, which is separate from but works in tandem with my last

point, we as a society value individuation, productivity, rationality, passion, etc. There is nothing wrong with these values, however, those who self-injure, according to literature and my interviews, may find themselves in an arena that polarizes these values thereby neglecting their complementary values, such as community, receptivity, intuition, compassion, etc.

These cultural values exacerbate the social problems we try to alleviate. Currently, the aim of treatment for self-injury is to stop the behavior. While it does make sense to stop creating new wounds before delving into the problems that lead to self-injury, what may happen sometimes is we get so wrapped up in these cultural values that we neglect the individual's experience and thereby neglect the root cause of the symptoms that we treat, which may or may not worsen these symptoms. Regardless of visible manifestation, metaphorically, if the roots remain corrupted, then the person may still be experiencing the underlying issues relative to their self-injury, whether the symptoms are seen or not. It matters that self-injury is viewed as edgework because edgework is a sensory experience, which means that it is inherently associated with an emotional, and therefore, an obscured process.

As noted above, self-injury as edgework can be viewed from a perspective of "mindfulness." According to Dr. Jon Kabat-Zinn, who "developed [the] Mindfulness Based Stress Reduction (MBSR) program at the University of Massachusetts Medical Center:"

Mindfulness practice is ideal for cultivating greater awareness of the unity of mind and body, as well as of the ways the unconscious thoughts, feelings, and behaviors can undermine emotional, physical, and spiritual health. The mind is known to be a factor in stress and stress-related disorders, and meditation has been shown to positively effect a range of autonomic physiological processes,

such as lowering blood pressure and reducing overall arousal and emotional reactivity (http://www.mindfullivingprograms.com/mbsr_background.php).

Some forms of treatment for self-injury already incorporate mindfulness techniques, thus there may be a slimmer gap between what is perceived as “sickness” and “health” than initially meets the eye.

As such, edgework, from the perspective of treating self-injury, may offer individuals the option to reduce harm by *crowding the edge*. That is, perhaps, instead of forcing individuals to give up their self-injurious behavior without providing them with something to take its place, edgework can fill that void in a number of ways. Therapists could suggest other edgework activities that are more socially acceptable; and treatment facilities could implement edgework options as a portion of their treatment plans to offer self-injury edgeworkers a viable way to address internal concerns that facilities may be ill-equipped to reach otherwise.

Further, self-injury, when framed as edgework, casts a much more positive light on self-injury contagion. As an *experience of recognition*, self-injury may offer people, who have been categorized as loner deviants (Adler and Adler 2005, 2008), an opportunity for connecting with others. Self-injury edgeworkers may share a common bond based on each other’s ability to understand the ineffable experiences of one another. This could engender positive feelings of solidarity, which could therefore encourage personal growth in lieu of its converse. Lastly, self-injurers, who may desire some form of treatment but do not make it there, may be able to educate themselves with knowledge of self-injury as edgework in order to recover for themselves, if everything else they’ve tried “just doesn’t cut it.”

The Benefits of Framing Self-injury as Edgework for Researchers

Self-injury, as it stands now, is often viewed from a culturally biased perspective. While the definitions of self-injury are ambiguous, the social identity of the phenomenon is negatively polarized. That is, self-injury, and by extension, self-injurers, are negatively viewed most of the time in spite of the positive things associated with the practice (e.g., settling paralyzing emotional states so that the individual can do what society expects of them). Self-injury re-envisioned as a form of edgework may cut through this separation, which can engender the re-organization of cognitive dissonance in some individuals who self-injure. Edgework theory offers researchers the novel idea that self-injury, instead of being something to pity or stigmatize people for, actually makes sense and is a good thing sometimes. It offers researchers a frame for developing the idea that self-injury can be a point of strength and courage and survival in a world that may, however unintentionally, “beat the shit” out of people and then deny that something like that would happen to someone who injures themselves. And, it offers a tool to researchers, who do recognize that some self-injurers are trying their best with the resources allotted them. As such, personal agency could be encouraged in individuals who may have had their freedom to act autonomously taken from them somewhere along the way.

The Benefits of Framing Self-injury as Edgework for those who do Research on Edgework

Reconceptualizing self-injury as edgework offers edgework theory the chance to “not overdo it.” Lyng (1990) noted that the sensations experienced during edgework activities encourage that one constantly push their limitations, which contributes to elitist notions concerning the survival capacity of edgework practitioners. That is, according to

the original theory of edgework, practitioners contended that one must have “the right stuff” to do edgework, and going over the edge implied not that the practice was dangerous, but that the individual was inadequate in his general ability to do edgework. Instead of being something that is meant to push the boundaries further and further, self-injury as edgework can provide an example of the ways one can go over the edge, perhaps softening the elitist notions that have encompassed the application of edgework experience as it stands.

Newmahr (2011) discussed in her article on SM edgework that:

A degendering of the edgework concept requires a challenge to this particular skill emphasis, as well as on the broader masculinist values of independence, physicality, and control and conquest. A feminist model can recognize a wide range of skills, including social-psychological and interpersonal skill sets, such as trust, expressiveness, emotion management, perceptiveness, self-awareness, introspection, and self-restraint (2011:691).

If we incorporate Newmahr’s ideas concerning degendering edgework, then self-injury as edgework speaks to the wisdom of pulling oneself away from the edge as well. In practice, what taking this wisdom into account does is recognize that people make mistakes. People can do dangerous things and make mistakes and come back from it. This is the point of edgework, finding the edge and learning how to navigate it well.

Limitations and Future Directions

Due to the small number of respondents, and the lack of diversity within my sample demographics, no generalizations can be drawn from these data. Meanwhile, though the sample was small, my respondents’ interview responses very much resembled those in the existing literature on the topic. Notably, the literature I have cited draws from not only the U.S., but also Canada, the UK and other European countries. Thus, the findings I have drawn from this research may have wider applicability across different

sociocultural settings. Specifically, edgework as a vocabulary of motive for self-injury may be found in the discourse of self-injurers elsewhere.

Future research would do well to study a larger sample and to incorporate a wider variety of individuals who participate in the self-injury phenomenon. It would be interesting to compare the responses of people from a broader range of sociocultural backgrounds, particularly because I noted in this study that there were fewer differences between respondents than is typically recognized. For instance, the 52-year old white woman had very similar things to say about her experiences surrounding self-injury as the 28-year-old Native man had to say about his, despite the differences in their modes of injury; and in their generational, ethnic, and educational/professional backgrounds.

Finally, within the psychological literature, self-injury has been associated with borderline personality disorder. The term borderline is defined as “a line marking a border; a division between two distinct (often extreme) conditions: *the borderline between ritual and custom*” (New Oxford American Dictionary 2010). Within the qualitative sociological literature, self-injury is framed as a *liminal* practice which centers individual’s “betwixt and between” opposing extremes. Thus, one can infer that self-injury is, in and of itself, borderline and liminal.

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APPENDIX A
INFORMED CONSENT FORM

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Self-Injury and 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 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 Victoria Gaines of University of Memphis Department of Sociology. She is being guided in this research by her faculty advisor Dr. Carol Rambo. There will be other people on the research team assisting at different times during the study with transcribing the interviews, coding the interviews, and analyzing and writing up the results of the study.

WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this study is to listen to survivors of self-injury tell their life stories to understand how former self-injurers view the role of self-injury in their lives. We are interested to see if three themes occur: stigma, silence, and misunderstandings. Other themes may occur in the interviews, and if so, we would report on those as well. For the purposes of this study, self-injury is defined as the intentional act of harming or inflicting bodily tissue damage on oneself without the intent of killing oneself. Examples of this are self-cutting, burning, branding, bone breaking, hitting, scratching, hair pulling, and banging one's head.

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 Principal Investigator, you should not take part in this study. If you are a personal friend of the Principal Investigator, 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 one-time free 60-90-minute crisis evaluation with a

locally licensed psychologist with 30 years of experience treating people with self-injury experience is available. If needed, the psychologist will offer recommendations for further treatment and referrals to community resources. 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 Principal Investigator's ability to control the privacy within your physical location during the phone interview. The Principal Investigator 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 Principal Investigator 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 Principal Investigator 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 participate in a one-on-one interview with Victoria Gaines, the Principal Investigator. This interview may be conducted by phone or face-to-face when possible. The interview will consist of a conversation between you and Victoria where Victoria will ask you some questions regarding your past experience with self-injury. You may choose to skip any questions or end the interview at any time.

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 you may have some negative emotional responses. If you feel the need to meet with a counselor due to any distress caused by the interview process, a one-time 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 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. The research team includes Victoria Gaines, her supervisor Dr. Carol Rambo, transcribers, and coders. Other researchers may be given access to the de-identified data in the future, subject to review and approval by the appropriate Institutional Review Board.

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 Principal 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 requested. The recordings will be stored on a password protected jump drive. Transcripts will be made for each recording, however, only a pseudonym (false name) will be used. These will be stored in a locked filing cabinet and on a password protected jump drive. Your interview will be de-identified which means that 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.

Only the Principal Investigator will know for certain who you are. However, even with identifiers removed and broad descriptors used, your individual story might be recognized by anyone on the research team who knows you and your story. Because the consent form would be the only record linking identifying information to you, the Principal Investigator 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 Principal Investigator decides to stop the study early for a variety of scientific reasons.

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 Principal 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. You do not give up your legal rights by participating in this study.

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 Principal Investigator, Victoria Gaines at vlgaines@memphis.edu or 1-901-230-4081. If you need to report a study-related injury, or if you have questions, please contact the IRB Administrator at irb@memphis.edu or 901-678-2705.

If you have any concerns regarding integrity and ethics in research and scholarship at the University of Memphis, please do not hesitate to call 901-678-2705 or email irb@memphis.edu. The confidentiality of anyone who contacts the office will be protected under the Whistleblower Protection Act. Working together we will promote the highest standard of integrity and ethics in research and scholarship. 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). All the transcriptions will be de-identified.

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 emotionally comfortable and as confidentially secure as is possible. If you opt for telephone interviews, the investigator 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 investigator's end of the conversation.

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.

By participating in the recorded interview, you are agreeing to the terms of the consent document. In lieu of a signed consent form, we request that you verbally consent to participating in this research during the recording of the interview.

If you would like to receive the results of this study, contact Victoria Gaines at ulgaines@memphis.edu or 1-901-230-4081.

APPENDIX B
COVER SHEET

Pseudonym_____

What is your current age?

What gender do you classify yourself?

What is your sexual orientation?

What race(s) do you classify yourself?
What ethnicity?

What is your highest level of education?

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

Where did you live 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? (Examples include 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?

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?

(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)

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

VOLUNTEER FLYER



Volunteers Wanted for a Research Study

Self-Injury and Life History Study

Purpose of study: The purpose of this study is to listen to survivors of self-injury tell their life stories to understand how former self-injurers view the role of self-injury in their lives and their perceptions of others' responses to self-injury. The participant will be asked questions about her or his personal experiences with self-injury, outlook on the past, and outlook on the future. For the purposes of this study, self-injury is defined as the intentional act of harming or inflicting bodily tissue damage on oneself without the intent of killing oneself. Examples of this are self-cutting, burning, branding, bone breaking, hitting, scratching, hair pulling, and banging one's 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 Victoria Gaines of the Department of Sociology by phone at 1-901-230-4081 or by email at vlgaines@memphis.edu.

APPENDIX E

LETTER FROM ASSISTING PSYCHOLOGIST

Members of the Institutional Review Board:

I am writing this letter in support of the Self-injury and Identity study proposed by graduate student Victoria Gaines.

I am a licensed psychologist in private clinical practice in Memphis. One of my areas of expertise is self-injury. I have over 25 years of clinical experience working with clients who self-injure.

I spoke at length with Ms. Gaines and her advisor, Dr. Carol Rambo, about self-injury in general and the nature of her specific study in particular. I have read over her interview questions for the participants. It is my professional opinion that this project is unlikely to cause any serious harm or significant disturbance to the participants.

Ms. Gaines will provide my contact information to every study participant. I will see for one pro bono meeting any participant who wants help in dealing with emotional distress caused by participating in the study. This meeting will focus on assessing and treating the distress. I will provide a referral for additional treatment if it is needed.

I am also making myself available for consulting with both Ms. Gaines and Dr. Rambo should either of them have any concerns regarding the safety or stability of any of the study participants.

Please contact me if you have any questions for me.

Cliff Heegel, Ph.D.

NPI# 1417992298

Mailing address:

Cliff Heegel

4728 Spottswood #361

Memphis, TN 38117

cliff.heegel@gmail.com

(901) 763-0999 (office)

(901) 881-3027 (fax)

APPENDIX F

WAIVER OF SIGNED CONSENT

Waiver of Documentation of Informed Consent

45 CFR 46.117(c)

The Institutional Review Board (IRB) may consider waiving the requirement for obtaining documentation of informed consent if the following conditions are met. To request a waiver, justification for the waiver should be included in the IRB submission and should address each of the criteria listed below.

1. IRB may waive requirement to obtain a signed consent form for some or all of subjects if:
 - a. the only record linking the subject and the research would be the consent document and the principal risk would be harm resulting from breach of confidentiality; each subject must be asked whether subject wants documentation; or
 - b. the research presents no more than minimal risk and involves no procedures for which written consent is normally required.

2. In cases where documentation is waived, the IRB may require investigator to provide subjects with written statement regarding the research.

[Note that 1a above is not included in FDA. 1b is included in FDA and HHS regulations 21 CFR 56.109(c)]

APPENDIX G

IRB APPROVAL



Institutional Review Board
Office of Sponsored Programs
University of Memphis
315 Admin Bldg.
Memphis, TN 38152-3370

April 30, 2018

PI Name: Victoria Gaines
Co-Investigators:
Advisor and/or Co-PI: Carol Rambo
Submission Type: Initial
Title: Self-Injury and Stigma
IRB ID: #PRO-FY2018-253

Full Board Approval: April 27, 2018
Expiration: April 27, 2019

Approval of this project is given with the following obligations:

1. 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 submitted.
3. No change may be made in the approved protocol without prior board approval.

Thank you,
James P. Whelan, Ph.D.
Institutional Review Board Chair
The University of Memphis