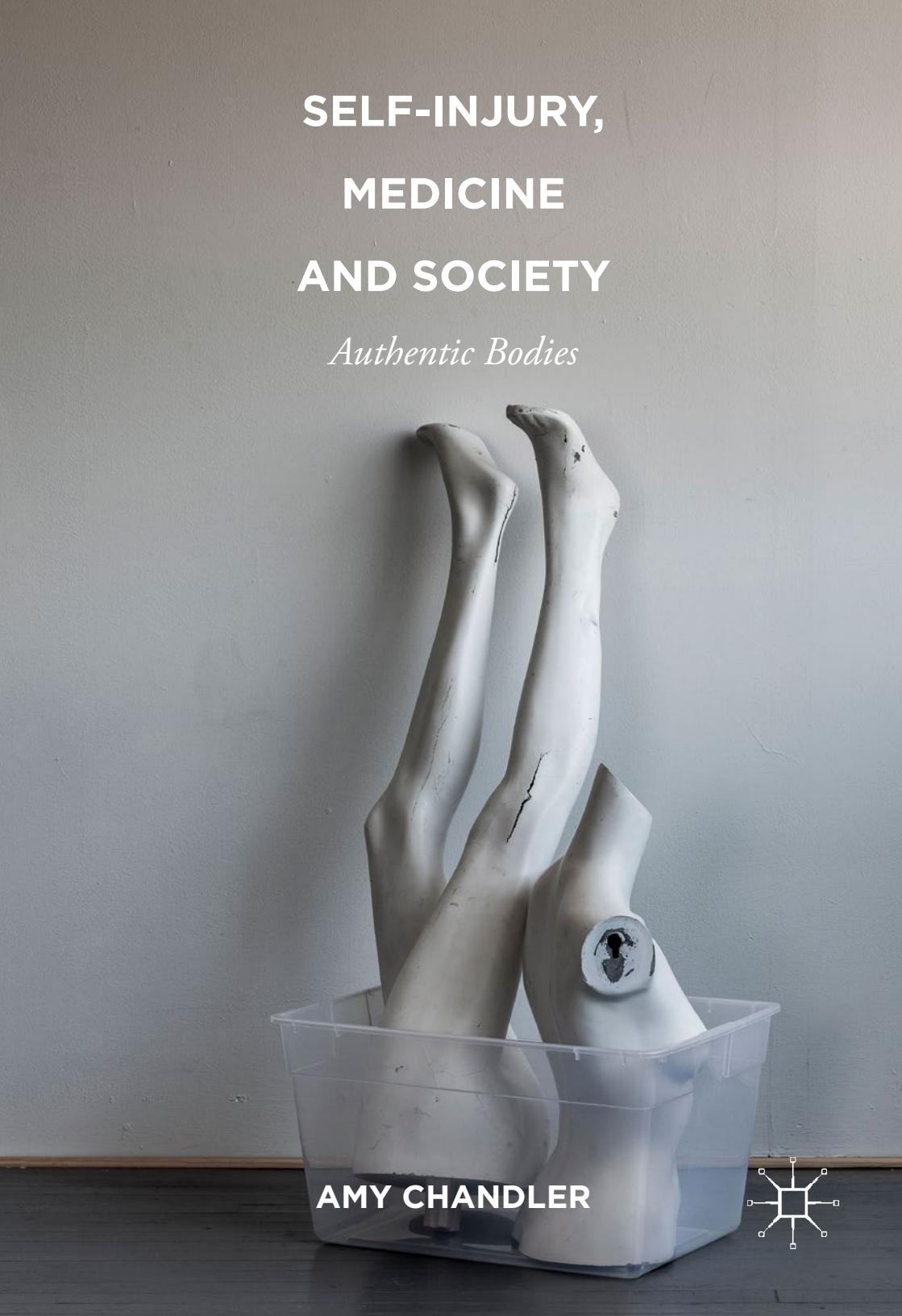
SELF-INJURY, MEDICINE AND SOCIETY

Authentic Bodies



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Authentic Bodies

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Note on Quotations

The transcribed text used in this book seeks to remain as close as possible to the way that participants spoke. As such, colloquial language is retained; in many cases—due to the location of some of the interviews—this includes Scottish dialect. Below is a list of common terms to help those readers who may be unfamiliar with some of the terms used.

'aye' = yes
'didnae' = did not, didn't
'dinnae' = do not, don't
'cannae' = cannot, can't
'couldnae' = could not, couldn't
'greetin' = crying
'ken' = know
'kindae' = kind of
'mair' = more
'nae' = no
'shouldae' = should have
'wasnae' = was not, wasn't
'werenae' = were not, weren't

Transcription Key

[…]	text has been removed
[---]	speech/recording was unclear
…	short pause in talk
[pause]	longer pause in talk

Contents

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Introduction: Constructing and Situating an Embodied, Sociological Account of Self-Injury

I think it's, it's really difficult to get somebody to, sort of, use alternatives, because it's such a powerful thing, because it involves the body so strongly and […] the actual cutting and the, the blood thing and, there's not much else that can kind of, stand in for that really. (Rease, 28, 2007)

On the surface I wasn't feeling particularly distraught or any- you know, hysterical or anything, it was just, I was wondering what it would do, I was wondering what it would do to my skin, how much it would hurt. (Francis, 25, 2007)

The twenty-first century is unfolding with an escalating epidemic of young people resorting to self-harm as a means of coping with pain and turmoil. (Plante 2007: p. xiii)

This book is about accounts of self-injury, of bodies and of the role of sociology in helping to deepen our understanding of what self-injury is, how it functions, and why people might do it. The quotes from Francis and Rease, above, indicate, in different ways, the centrality of the body to the practice of self-injury. Rease's account highlights the importance of corporeal, tangible aspects of self-injury—cutting skin and flesh, the resultant blood—in

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explaining why self-injury might be difficult, for some, to replace as a 'coping mechanism'. Rease's explanation resonates with findings from clinical research which have, so far, struggled to develop 'effective' treatments for people who self-injure (Warner and Spandler 2011). Francis' narrative gestures to the importance of embodiment in a different manner, suggesting an exploratory orientation towards his body. Self-injury for Francis is framed as a way of testing out bodily responses and limits in order to discover what his body could do, and how it might feel if he did certain things (burning) to a part of it (his skin).

Both Francis and Rease's accounts indicate the complex ways in which 'the body' is implicated in narratives about self-injury; in some senses being objectified and separated off, with the self *acting upon* the body. These narratives point to a dualistic understanding of 'the self' with body and mind framed as separate from one another (Crossley 2001). Studying the manner in which accounts about self-injury implicate 'the body' opens up important routes through which to interrogate the ways in which bodies and embodiment are understood in different social and cultural contexts. This book is also, then, about accounts of embodiment, and the role of self-injury in helping to expand our understanding of what bodies are, and how people in late modern, 'Western' societies conceptualise and narrate their bodies, and their selves.

An increasingly dominant explanation for self-injury is that it is a method of coping with difficult emotions (or with 'pain and turmoil'): as illustrated in the final quote at the start of this chapter, taken from Lori Plante's *Bleeding to Ease the Pain* (2007). This is one example from a plethora of books which followed the publication of Favazza's landmark B*odies Under Siege* (first published in 1987) which aim to explore the meanings of self-injury. These books are often aimed jointly at clinical and popular audiences, reflecting the wide appeal of the subject matter, and the sense that the practice is esoteric and difficult to understand. The starting point of many of these works reflects a position of horror and disbelief at the types of practices that self-injury (or *self-mutilation*) can involve. In these accounts, self-injury is clearly framed as something that 'other people' (never the reader) do. Thus, description and discussion is often oriented towards helping readers to understand self-injury from the perspective of those who carry out the practice. However, the language

that is used is often sensational and dramatic, serving to highlight the distinction between reader and 'self-injurer':

> Carving the tender, vulnerable flesh of her arms – the only part of her body she considered beautiful – was a way of mapping the pain she felt inside. (Strong 1998: p. 22)

> Self-mutilation is undeniably unsettling to everyone who comes into contact with it. (Favazza 1996: xvi)

Such a position (of shock and horror) is not limited to literature on self-injury written, as Plante's and Favazza's, from clinical or, as with Marilee Strong's *A Bright Red Scream* (1998), journalistic perspectives. Patricia and Peter Adler, who have produced one of the most comprehensive sociological studies of self-injury, note in the acknowledgements of 2011's *The Tender Cut*, that their research on the topic had been difficult: 'There was nothing fun or funny about exploring the lives of the self-injurers portrayed in this book' (p. ix). They go on to warn the reader that the contents of the book may be read as 'gruesome, morbid, and depressing' as well as 'fascinating, revealing and important' (Adler and Adler 2011).

I would agree that self-injury *can* be all of those things. However, *Self-injury, Medicine and Society* represents an attempt to move past this position of shock and horror, towards one of intellectual and appreciative engagement with the practice of self-injury, and the social and cultural contexts in which it takes place and is constituted as a phenomena. This is not to say that the subject of self-injury is not *potentially* gruesome, morbid, depressing, shocking or alarming, it clearly is to many people. However, in order to appreciate and understand self-injury I will suggest that we need to move beyond this response. Indeed, it is imperative that we critically explore *why* such responses might arise in the first place. Such an orientation involves not just attempting to understand self-injury from the perspective of those practising it, but also to examine how self-injury is understood more broadly. To ask what cultural narratives and scripts people who self-injure draw upon to explain, or justify, their actions. To explore the

ways that these narratives are understood by those who live with, care for or treat those who self-injure. This book addresses *both* the accounts of people who have self-injured, *and* socio-cultural narratives about what self-injury is and what it means. In this way, I hope to avoid individualising self-injury, and rather to develop a broader understanding of self-injury within a specific historical period (late modernity), and within particular socio-cultural contexts ('Western' industrialised societies, particularly the UK and the USA).

My discomfort with the 'othering' perspectives of many who have written of and researched self-injury undoubtedly arises from my personal involvement with the subject matter. As someone who has 'self-injured', I find it difficult to share the positions of shock, horror and disbelief articulated in many accounts of self-injury. While my own experiences with cutting, burning and hitting are not necessarily equivalent to those of others', these experiences do shape how I respond to accounts about self-injury. In particular, I am perhaps less easily 'shocked'—I have lived with self-injury for over 20 years, it has become more mundane than exotic. Perhaps a further result of this is that—unlike Adler and Adler—I *do* find some aspects of self-injury funny. Humour has been an important part of my research, and of the relationships I developed with participants. Further, humour remains an important resource through which I continue to manage the visible signs of my own involvement with self-injury.

Lisa McKenzie (2015) has written about her discomfort in relating moments of laughter and humour shared with those involved in her ethnographic study of council estate life. She worried about the way in which humour might be seen by others as normalising deeply problematic activities—in her case the use of crack cocaine. Humour is a deeply telling device, which can mark our status as an 'insider', acting as a way of deflecting or coping with subject matters that might otherwise be distressing (Sanders 2004). However, in contrast to McKenzie, I am less comfortable with claiming an 'insider' identity. While I am clear that I share some experiences with others who self-injure, and these experiences have certainly shaped my research and writing; to call myself an 'insider' would be disingenuous. For a start, self-injury—as we will see—encompasses a hugely diverse range of practices and positions. There is

not really much to be 'inside' of—it is not geographically specific, and it is not practised only by a particular group of people. Indeed, a running theme in this book is that self-injury resists easy categorisation—though there are significant attempts to fix the meaning of self-injury, and these will be critically explored. Further, the very fact that I have spent over ten years studying self-injury academically means that my understanding and experience of being someone who has self-injured is far from typical. I have been hugely privileged to be able to study an issue so close to my own experience; and I have profited directly from this study, in a way that is not possible for many.

Context and Identity

The contexts in which self-injury takes place, and the identities of those understood to be *self-injuring*, are more contested and variable than is usually acknowledged. For instance, several scholars have charted the way in which self-injury came to be understood as a largely female—perhaps feminine—endeavour, over the course of the twentieth century (Brickman 2004; Millard 2013). In the twenty-first century, self-injury continues to be marked as a practice of girls and women, rather than boys and men. However, surveys of young people—a key source of knowledge about self-injury—consistently find that between one quarter and one-third of those reporting self-injury identify as male. Depending on the definition of self-injury used, the proportion of men reporting self-injury can be even higher. Despite this, research—sociological and otherwise—has consistently focused on women and girls, often without problematising this. For instance, Adler and Adler's otherwise comprehensive sample was 85 % female. However, qualitative research *in general* often struggles to recruit men (also noted by McShane 2012). I would suggest that the pre-existing cultural framing of self-injury as 'feminine', and the reliance on online message boards (which are used more often by women) (Hodgson 2004) leads to researchers accepting unbalanced samples and concluding they reflect the gender ratio in the general population. In turn, studies which focus on predominantly female samples serve to further affirm assumptions about the 'typical self-injurer' as female.

There is another, relatively unacknowledged bias in the vast majority of sociological research on self-injury, including my own. As well as being generally focused on female bodies, sociological research has also tended to address White bodies. Arguably, this bias reflects the demographic makeup of those who predominate in (most) statistical surveys of the prevalence of self-injury, though as we will see there are important reasons to question these surveys. Self-injury (and self-harm) in the USA and UK is not carried out solely by White people, and, as we saw above, certainly not only by women and girls. Adler and Adler note that their sample was diverse in this manner, but race and ethnicity do not feature heavily in their analysis. *Self-injury, Medicine and Society* addresses self-injury among men and women, with a higher proportion of men than most other qualitative studies. Race and ethnicity was not a focus, however, and is not tackled in anywhere near the depth it should have been. Future research—particularly from within sociology—would do well to address this lack.

Although there are clear similarities in the way that self-injury is understood in the UK, the USA, and other Western, industrialised societies, there are also important differences that have been little explored. In particular, the existence of diverse healthcare systems, and cultural variations in the practice of psychiatry and psychiatric diagnosis, may have significant impacts on the experiences of people who self-injure and the meanings they attribute to self-injury. The advent of online communication and information sharing makes it harder to draw clear lines between the experiences of, for instance, someone cutting themselves in Birmingham, Alabama, or Birmingham, England. However, the digital age has not entirely erased national boundaries, and there remain concrete differences in how healthcare is accessed and organised. Leading from this, although individuals living on either side of the Atlantic may well share ideas and explanations for their cutting in online forums, the responses to their self-injury in the offline world are necessarily different. In this book, I *begin* to interrogate the ways in which different healthcare and psychiatric systems might shape accounts, ideas and understandings about what self-injury is, how it is done and what it means.

Measuring and Naming Self-Injury

The practice of self-injury is increasingly widely recognised and known: discourse about self-injury, and self-harm, has increased exponentially over the last 20 years. Alongside this, have come growing concerns that there is an 'epidemic' of self-injury, particularly among young people (Barton-Breck and Heyman 2012). As with other 'conditions' or 'disorders', such as multiple personality disorder and eating disorders, it is difficult to say with any assurance whether more people are actually engaging in self-injury, or whether this impression leads from increased knowledge about and identification of the practice (Hacking 1995). Though unlikely, it is entirely possible that rates of self-injury have not risen, but instead are being more readily identified, or more readily *named.* As Hacking's (1995) work on multiple personality has demonstrated, measuring and naming apparently novel categories of person or types of illness is a complex endeavour indeed.

While questions about the prevalence and extent of self-injury among general populations are difficult to answer: the way in which research has addressed such questions is instructive. There is evidence to suggest that current understandings of what self-injury is and who self-injures were shaped in part by a small group of psychiatrists working in the USA in the 1960s. This work laid the foundations for enduring assumptions that the majority of people who self-injure are female, White, 'attractive', young and middle class (Brickman 2004). Chris Millard (2013), in a detailed examination of the construction of self-harm in psychiatric literature post-1945, has argued that the work of these early 'pioneers' led to self-harm being equated solely with self-cutting, rather than other self-injurious practices. The legacy of this construction of self-injury as involving particular practices is significant, and may explain why certain types of people (men, Black and minority ethnic people) have come to be excluded from research on self-injury.

The way in which clinical research and clinical practice has shaped, and continues to shape, understandings of what self-injury is, and who is more likely to carry out the practice are a central focus of this book. As noted above, clinical contexts vary significantly between the USA and the UK, and as such, different working ideas about what self-injury, or

self-harm, mean also vary between practitioners working in these different contexts. A particularly problematic difference has arisen in the definitions of self-injury and self-harm used by researchers working in the USA and the UK.

In UK health research and policy, the term *self-harm* refers to 'self-injury or self-poisoning, irrespective of the apparent purpose of the act' (NICE 2011). Though based in the UK, I use the term 'self-injury'. This reflects an early concern with focusing on external injuries that were not overdoses. When I first began to investigate self-harm, back in 2002, I found that most research using this term actually addressed self-poisoning and recruited samples of patients from Accident and Emergency departments. In the UK, patients who are admitted to hospital for 'self-harm' are overwhelmingly (around 80 %) those who take overdoses of prescription medication (Bergen et al. 2010). However, community studies in school settings, which began to emerge around the start of the twenty-first century, suggested that most young people who reported 'self-harm' said they had cut, burnt or hit themselves. As cutting was also my own 'preferred' form of self-harm, I was keen to investigate the experiences of others (apparently the majority) with a similar preference. In this book, I continue to use the term 'self-injury' to refer to practices that generally include: cutting, burning and hitting the outside of the body. Definitions are always problematic, and with self-injury/self-harm the issue of 'naming' and 'categorising' what is and is not self-injury/self-harm is highly charged.

In the USA, health research and policy is more mixed in its use of terminology. The last decade has seen a shift towards the use of the term non-suicidal self-injury (NSSI). NSSI refers to injuries to the outside of the body, and—aside from the motivational label 'nonsuicidal'—is comparable to the term self-injury, used in this book. In each case, self-poisoning, or overdoses are excluded. There is little doubt that the increasing use of NSSI is associated with intense activity among some researchers and psychiatrists, aimed at having the term included in the American Psychiatric Association's Diagnostic and Statistical Manual (DSM). Another term, deliberate self-harm (DSH), is also used in US literature (primarily within psychology) (Gratz et al. 2015). Confusingly, in the US DSH is equivalent to NSSI, whereas in the UK, as I note

above, self-harm (or DSH) refers to self-injury *and* self-poisoning. This has led to some cases where US researchers draw on UK research on self-harm (most of whom will have self-poisoned) to extrapolate to samples of individuals engaged in NSSI (Chandler et al. 2011). There are important reasons why this is problematic: (a) the samples of people involved may have very different characteristics, aside from the use of different methods of self-harm; (b) the embodied experience of self-cutting, burning or hitting can be understood as distinct from self-poisoning; (c) the meanings that self-cutting, burning or hitting has for individuals may vary substantially from meanings associated with self-poisoning. These phenomenological diversities are a key feature of the accounts which are analysed in the following chapters.

Much of the debate around definitions has occurred within medicine (De Leo et al. 2004; Muehlenkamp 2005), with occasional interventions from sociology and historians of medicine (Brickman 2004; Gilman 2013; Millard 2013). However, enduring clinical narratives about what constitutes self-injury, and the categories of person seen as most likely to engage in the practice, have important implications for wider ideas and understandings, which have been little explored. Medical knowledge of self-injury is not discrete, and does not remain within the clinic: it leaks out. For instance, despite claims that self-injury has become 'de-medicalised' in the twenty-first century (Adler and Adler 2011), explanatory accounts of self-injury continue to be influenced and shaped by medical understandings of bodies and emotions. In this book I will argue that in a number of important ways, people's accounts, and even practices, of self-injury can be seen to be shaped by clinical, biological and *neuro*biological discourse (Chandler 2013; Millard 2013).

Clinical Boundary Setting: Medicalisation, De-medicalisation and Re-medicalisation

Clinical researchers are closely engaged with developing and testing different approaches to treating and understanding self-injury, and the practice is undoubtedly viewed as clinically significant and 'of concern' in a range of medical settings: from General Practice, to Accident Emergency

Departments, to Psychiatry. In the American Psychiatric Association's fifth edition of its Diagnostic and Statistical Manual (DSM-5), published in 2013, self-injury entered a new phase of medicalisation, with the inclusion of the *proposed* diagnostic category of 'Non-suicidal self-injury' (NSSI) (American Psychiatric Association 2013). The development of this new diagnosis was contentious and much debated by some within psychiatry and suicidology (De Leo 2011). Its use continues to be resisted, particularly by clinicians working in the UK. However, reflecting differences in definitional preferences, NSSI has been more readily accepted by US-based researchers. Indeed, the development of this diagnostic category crystallised the long-standing disjuncture between psychiatrists working across the world, but particularly between those in the USA and the UK.

As noted above, the UK has historically preferred the broader and less motive-focused term 'self-harm' (or sometimes, 'deliberate self-harm') (NICE 2004). Over the last few decades, an increasing gap has arisen in the preferred terms used by psychiatrists working in these subtly different cultural contexts as evidenced by trends in terms used in psychiatric journals (Claes and Vandereycken 2007). With the DSM-5's formalisation of the proposed diagnostic category of NSSI, the differences in how self-injury and self-harm are understood in the UK and USA is likely to widen. In Chapter 5, I critically analyse the text of the proposed diagnosis, and argue that it fails to reflect in a meaningful way the embodied experiences of people who self-injure on either side of the Atlantic.

However, in contrast to the intense attention and work concentrated on self-injury by the medical profession, some sociologists and patient or 'survivor' groups have argued that self-injury is becoming (*or should be*) de-medicalised in the twenty-first century (Adler and Adler 2007, 2011; Cresswell 2005a). This argument highlights the contradictory nature of contemporary understandings about self-injury. While on the one hand, concerted efforts are being put into claiming the practice as pathological, and a feature of psychiatric disorder; on the other, it is claimed to be a subcultural fashion statement, a choice, often carried out in the absence of any identifiable psychiatric diagnosis. This latter argument was somewhat challenged by the criteria of the (proposed) diagnosis of NSSI, which suggests that anyone who injures themselves intentionally more than 5 times in a 12-month period is *potentially* psychiatrically disordered.

Nevertheless, in popular and academic (including some clinical) accounts, it is argued that self-injury might be better understood as one of a broad range of self-harming practices, many of which should *not* be viewed as pathological (Clarke and Whittaker 1998; Inckle 2007). Throughout this book, I engage closely with these tensions, exploring some of the ways in which imagined boundaries between 'lay' and 'professional' accounts of self-injury are unsettled. This is made apparent through narrative analysis of the accounts of people who have self-injured, as well as critical appreciation of accounts written by others about what self-injury means. There is clear evidence in each of these of the appropriation of both 'lived experience' *and* biomedical discourse to generate a culturally acceptable account of self-injury.

Bodies, Embodiment and Self-Injury

Bodies or 'the body' can be seen as central to the practice of self-injury. Any attempt to understand what self-injury means, how and why it is experienced in different ways, must attend to the social construction of bodies. Leading from the centrality of bodies to the practice of self-injury, and the broad 'turn' towards embodiment in the social sciences, sociological analysis of self-injury has begun to engage with theoretical work on embodiment and emotions. This is particularly evident in Kay Inckle's work in *Writing on the Body* (2007), which explored the narratives of six women who had engaged in what she termed 'body marking' (incorporating self-injury as discussed in this book, alongside other practices such as tattooing, piercing and branding). Inckle's analysis challenges the way in which certain types of body marking are deemed pathological and others decorative, suggesting that there are important overlaps between self-injury as defined here, and body modification. Inckle engages closely with corporeal aspects of body marking, including a detailed discussion of the way in which pain features and is used in accounts about these practices.

Patricia and Peter Adler also address the role of the body in *The Tender Cut* (2011). In the book, they highlight a number of themes which recur across literature on self-injury: the importance of control; the idea of

self-injury as a release; the role of emotional states, especially anger, frustration and stress. Importantly, they discuss the accounts of their participants regarding the practical aspects of self-injury: tools (or 'the kit'), wound placement, and the process leading up to and following an act of self-injury. This work diverges from many other academic treatments of self-injury in presenting data on the corporeal and felt aspects of self-injury, issues which are more usually overlooked. Similar themes are raised in McShane's *Blades, Blood and Bandages* (2012), which presents an analysis of both ritual and stigma in accounts of self-injury, in each case noting the position and role of the body.

Sociological work on the body is rich, and as such offers numerous potential tools through which to further expand understanding about self-injury and the role of bodies and embodiment. In particular, theorisation on the nature of bodies and embodiment has highlighted the intensely problematic nature of attempts to focus in on 'the body' in separation from 'the mind' or from 'emotions' (Crossley 2001; Williams and Bendelow 1998). However, much existing academic discourse on self-injury falls into the trap of dualism, frequently discussing bodies, minds and emotions as unproblematically separate categories. In contrast, both elsewhere and in this book, I argue that the accounts of people who self-injure serve to both reinforce *and* unsettle dualistic notions of a separate mind and body (Chandler 2013). This finding, I will argue, allows us to situate contemporary understandings of self-injury within a particular socio-historical context. A context in which *what bodies are* is ever more uncertain and unstable, and yet dualistic conceptualisations of mind and body as separate remain surprisingly resilient (Shilling 2003).

The uncertain, fluid nature of embodiment is elaborated by increasingly popularised advances in scientific knowledge about the nature of bodies and biology. Nikolas Rose has been prominent in arguing that people living in late modern, industrialised societies are increasingly framing their understanding of self and body in biomedical, or more specifically, *neurochemical* terms (Rose 2004; Rose and Abi-Rached 2013). Such an approach directly upsets dualism, and the separation of body, mind and emotion becomes increasingly untenable—boundaries are breached by hormones, neurons and even genetics. In this book, I engage with the corporeal aspects of self-injury both in terms of the material,

felt, and seen nature of the practice and in terms of the way in which these aspects are narrated. There is evidence, as I will demonstrate, that discourse about self-injury is not immune from the turn towards neuroscientific, hormonal or molecular understandings of human behaviour and human bodies (Novas and Rose 2000).

In the pages that follow, I highlight the continuing role of medical science and clinical perspectives in shaping the ways in which bodies, and embodied practices such as self-injury, are understood. This discussion incorporates wider debate within the sociology of health and illness regarding diagnosis, and the contested biomedical basis of psychiatric disease (Phillips 2006; Rose and Abi-Rached 2013; Stepnisky 2007). I argue that self-injury breaches a number of boundaries between psychiatry and general medicine, further problematising an already uncomfortable relationship. This transgression can be seen in the narratives of people who self-injure, as they struggle to account for a practice that is variously classed as: self-directed and agentic, one of a range of (chosen) 'coping mechanisms', emerging out of early childhood trauma, evidence of disordered thinking, indicative of unbalanced 'brain' chemicals or hormones. These narratives I argue reflect wider challenges facing people in late-modern societies attempting to account for 'mental' illness in an increasingly (neuro)biological world (Fullagar 2009; Rose 2004, 2009).

Authentic Bodies, Authentic Selves in the Twenty-First Century

One of the principal arguments of this book is that authenticity is central to understandings about self-injury in late-modern, industrialised societies. Authenticity is a complex concept, and one which sociology has grappled with in discussions about the nature of late modernity and identity (Erickson 1995; Giddens 1991; Meštrović 1997). The concept has broad relevance and use, having particular resonance for anthropology (Fillitz and Saris 2013), and with significant contributions from philosophy (Ferrara 1998; Taylor 1991) and literature (Trilling 1972). Accounts of social life that address authenticity have emphasised the moral nature of the concept (Vannini and Franzese 2008): inauthenticity is clearly

marked as negative, bad and wrong (see e.g. Hochschild 1979). However, while inauthenticity is reviled, it is also argued that it is a key feature of late modernity. This is seen in sociological critiques of the rise of branding, and big business, or McDonaldisation, which is framed as deeply inauthentic and, therefore, deeply problematic for society and, indeed, for humanity (Meštrović 1997; Ritzer 1996). Alongside the apparent rise of inauthenticity is a growing veneration, or fetishisation, of authenticity in popular culture, and especially among subcultural groups (Fillitz and Saris 2013; Vannini and Franzese 2008; Vannini and Williams 2009). Writing in the mid-twentieth century, Theodor Adorno argued against the *jargon* of authenticity, with talk about authenticity emerging as a veil, obscuring economic exploitation with imaginary ideals of 'freedom' (Adorno 1973). Thus, in late-modern, industrialised societies, authenticity appears as a prized form of cultural capital that is, simultaneously, increasingly hard for anyone to embody or achieve. Further, through critical theorists such as Adorno, we have important cause to question the very notion, indeed the very *reality*, of authenticity.

Throughout this book, I reflect on the extent to which self-injury might be understood as, at least in part, a response to the conflict between a desire for authenticity and the increasing difficulty of embodying, or experiencing an authentic self. This has been proposed in relation to other embodied practices such as tattooing, piercing and body modifications (Pitts 1998; Riley and Cahill 2005; Sweetman 2000). As with the treatment of self-injury I develop, these analyses have highlighted the sensate, embodied and visceral nature of such practices, arguing that this very embodiment offers a challenge to the disembodied, unreal quality of late-modern life (Baudrillard 1998). However, at the same time certain forms of body modification have been analysed as an *in*authentic, perhaps patronising, attempt to appropriate apparently more authentic cultures, via dramatic bodily practices such as scarification (Pitts 2003; Turner 1999). More sympathetic readings of body modification in late-modern, industrialised societies suggest they might be framed as a *challenge*: both to capitalist, consumerist societies deemed utterly inauthentic and to the individualisation and disembodiment entailed by increasingly mobile, digitally connected communities (Pitts 2003; Sweetman 2000). Authenticity in these analyses retains an amorphous, contradictory and contested quality.

With regard to medicine, and especially psychiatry, authenticity or 'real-ness' acquires a further layer of significance (Pickard 2009). The 'reality' of mental illness has long been subject to question, bolstered by the lack of 'objective, physical' evidence of disease (Hacking 1998; Szasz 1960). In accounts about self-injury, anxiety is often inferred regarding the extent to which the practice is 'really' indicative of mental illness, or whether it is merely a fad, a 'passing phase' or something that an individual will 'grow out of' (Adler and Adler 2011; Scourfield et al. 2011). Thus, while in some accounts, self-injury is said to be a method of expressing unspeakable distress, at the same time the very 'reality' of this distress is questioned (see also Crouch and Wright 2004). This is familiar ground for psychiatry, which as a discipline continues to be marked by internal and external debates about the reality of mental illness, and the extent to which the distress psychiatrists respond to and treat is 'real' or 'situational' (Hacking 2013; Laing 1960). These debates frequently invoke problematic, dualistic distinctions between individual and society, biology and culture, mind and body.

As touched on above, discussions abound as to the 'real' prevalence of self-injury, paralleling similar debates as to the 'real' extent of eating disorders, depression or—in Ian Hacking's example—multiple personalities (1995). While this book makes no attempt to answer questions about the 'reality' of self-injury, what will be explored is the extent to which self-injury itself, in a range of senses, is *understood* to be 'real' or 'authentic'. Is self-injury seen as more, or less, real if a person experiences no pain during the act? Is self-injury more, or less, real if it was learned (or *copied*) from a friend? Is self-injury more, or less, real if it is displayed, or revealed to others? Such questions are raised, alluded to and debated throughout accounts about self-injury, among those who have self-injured, as well as among professionals. The 'reality' of self-injury is very much contested.

Narrating Self-Injury: Notes on Methods

> Indeed, it would seem that the act of harming one's own skin by cutting it up and tearing it apart speaks with a 'voice' so sheer that it is virtually impossible for anyone to bear witness to it. Arguably, then, there is

> something about this 'voice' that defies witnessing, even as it insistently demands it. (Kilby 2001: p. 124)

> For Monaghan (2002: 507) 'the body's primary relationship to the world is practical' and the body of the researcher as well as those of research participants cannot but constitute the primary body of meaning-making. (Waskul and Vannini 2006: p. 9)

Research and writing about self-injury is expanding steadily. Two significant sociological studies of the practice can be seen in Adler and Adler's *The Tender Cut* (2011), and McShane's *Blades, Blood, Bandages* (2012). The present book builds on these nascent analyses, extending them in important ways. A key departure is that the arguments developed in *Self-injury, Medicine and Society* draw on a *critical* engagement with the narratives of people who have self-injured. Accounts of self-injury are treated as situated, partial and shaped by cultural meanings, and structural possibilities (Riessman 1993). At times, both Adler and Adler and McShane are frustratingly credulous in their analysis of accounts of self-injury. Descriptions of the practice are taken at face value, rather than treated as artefacts of social interaction, of particular contexts and relationships, and of socially constituted meanings. My more *in*-credulous treatment arises from a particular position: that of being someone who has also self-injured and who is, therefore, painfully aware of the partial and contextual nature of attempts to articulate the practice of self-injury.

This position is by no means unique (e.g. Hewitt 1997 also identifies as having self-injured), nor does it offer an unproblematic insight into the lives of those who took part in the research I draw on: the contentious nature of 'insider' research has been much debated (Merton 1972). Experiences and interpretations of social phenomena can vary greatly and assuming sameness between researcher and researched is problematic (Abell et al. 2006). However, while I do not claim an insider status in relation to the topic, I am clear that my experiences inevitably shape how I analyse and interpret the practice of self-injury, and this includes the importance of my embodied experiences of self-injury and living with a self-injured body (Stanley and Wise 1993). As such, I remain critical about my own analyses of self-injury, as well as the accounts of others. I present a particular story in the pages that follow, and it may not be one that is shared by others who self-injure—or indeed by other sociologists!

The arguments set forward in this book are based on ten years of qualitative, sociological investigation into self-injury and self-harm. The research I draw on has entailed an enduring interest in narrative, and the ways in which wider social, historical and cultural contexts—micro and macro—shape what can be said about self-injury, and how what is said is understood by others (Plummer 2001; Riessman 1993). Narrating what is an inherently, intensely embodied experience is necessarily challenging. Self-injury—like pain and illness—is often framed as being inarticulate, beyond words, supra-verbal (Scarry 1985). As the quote from Kilby, above, indicates, the practice of self-injury may seem impossible to witness. Asking people to talk about a practice that apparently defies words can then be a delicate task, and was certainly a daunting one for a novice researcher.

Most of the narratives referred to in *Self-injury, Medicine and Society* were generated during a research project about the 'lived experience' of self-injury, carried out between 2005 and 2010. During this project, 12 people aged between 21–37 took part in two in-depth interviews about their lives, along with their explanations, theories and ideas about the nature of self-injury—both their own and other people's. Alongside this, I draw on accounts from a 2014 study which explored understandings of self-harm among much younger people, mostly aged 13–17.

Although, like much qualitative research, the original sample of 12 people was relatively limited, those who took part were a fairly diverse group, who described very different backgrounds. They shared a common experience, and that was that at some point in their life they had all cut themselves, and they identified this as self-injury. However, the accounts they provided of their practice of self-injury varied greatly: some indicating that they had cut themselves on just a few occasions, others describing a range of different self-injurious practices engaged in regularly over many years. During the course of the book, much will be revealed about these participant's lives, and their ideas and understandings about their practice of self-injury. On occasion, I have omitted or altered identifying features of the accounts, in order to preserve anonymity. For the same reason, I will not provide a biographical sketch of each participant. However, in order to avoid unnecessary repetition, and to guide the reader, a list of participants, along with their age, gender and

country of residence can be found in the Appendix. All names are of course pseudonyms.

Alongside this core data, I draw on a second project which in 2014 followed-up themes identified in the earlier project with a group of 88 people aged 13–26, most of whom were aged 14–17. This second project explored the accounts of younger people who had self-harmed, using a broader definition, though all but one of those who took part reported engaging in self-cutting. Again, participants were diverse—describing a wide range of self-injurious practices. Eighty-seven of the participants took part in a qualitative online survey which allowed people from around the world to take part. In practice, the majority of those who reported a location were living in the UK or the USA, reflecting the profile of users on the websites I used to recruit. Four of the survey participants and one additional person also took part in an in-depth interview with me. In contrast to the broad and exploratory nature of the first study, the second project produced more structured and focused data, with participants encouraged to reflect specifically on the meanings of self-harm and how these contrasted with drug and alcohol use.

Alongside accounts of 'lived experience', I also refer to publically available media and online sources, published research, as well as some of the many popular books written about self-injury from the 1990s onwards, in order to demonstrate the different ways in which self-injury is framed, described and constructed in different national, cultural and clinical contexts. As part of this, in Chapter 5 I undertake a detailed analysis of the text of the proposed criteria for NSSI, published in the DSM-5 (2013).

As noted at the start of this introductory chapter, the research, analysis and theoretical discussion in this book is unavoidably shaped by my own experiences with self-injury. Following feminist methodological approaches (Stanley and Wise 1993), all those I interviewed were aware that I shared with them the experience of having cut myself, and identifying as someone who had self-injured. At times in the interviews, we discussed shared ideas and experiences, or I used my own stories to encourage discussion, or explore particular issues. The focus on bodies and embodiment emerged in part from my own experiences, which led me to identify a relative lack in existing discussions of self-injury. This lack was 'the body', and the bodily repercussions and results of

self-injury: bruising, inflammation, blood, scabbing, scarring, pain. Other absences that my own, embodied, experiences led me to identify were the material contexts of self-injury: blades, heat, knives, tissue and sterile pads, blood stains, steri-strips, sutures. In short, my personal experience with self-injury has led me down avenues of investigation that I might have otherwise avoided or overlooked.

Overview of Book

This book has been written with two purposes in mind. My primary aim has been to advance an in-depth, theoretically and corporeally grounded examination of narratives about self-injury in late-modern, 'Western' societies. Alongside this, I use the detailed study of accounts about self-injury to contribute to ongoing debates within sociology regarding the nature of bodies and embodiment, and the relationship between clinical and popular discourse about bodies, emotions and selfhood. The chapters that follow address different aspects of these inter-related aims. In most cases, I hope, the chapters stand up to being read alone, as well as working together to develop a detailed, in-depth and thoroughly critical examination of understandings about self-injury, medicine, authenticity and embodiment in late-modern, Western societies.

The chapters are designed to start with 'the body', and move gradually towards a broader view of how self-injury is understood socially and culturally. Necessarily, my perspective moves 'in' and 'out' with the body fading in and out of focus as I explore the ways in which it is narrated by individuals, and how these accounts relate to interpersonal, social and historical contexts. Chapter 2 faces the corporeality of self-injury directly, demonstrating the importance of an embodied approach to understanding self-injury. Through case studies which examine stories told about 'the first time' people self-injured, and a detailed exploration of the role of pain in narratives about self-injury, I illustrate the orientation towards bodies, embodiment and self-injury that is then expanded upon in the remaining chapters.

Chapter 3 turns to accounts about the role of emotions in understanding and experiencing self-injury. These were often framed by participants

as separate from, but relating to the 'inside' of the body. Such accounts reflect wider dualistic orientations which construct the body as having an interior/exterior: a skin which contains fluid, moveable, feelings (Ahmed 2014). Emotions/feelings are shown to be simultaneously embodied in these accounts: emotions can be *controlled* via the outside of the body; they can be *released*: through tears, through blood, through pain.

In Chapter 4, I move 'outwards', addressing the visibility of self-injury, examining how this is managed in interpersonal contexts. In this chapter, I critically explore how hiding and secrecy have become privileged moral narratives about how to be a self-injured person. This analysis begins to engage more closely with the way in which medical practice can shape experiences and meanings of self-injury. I highlight the way in which participants drew on ideas about 'help-seeking', presenting accounts of rational, self-directed care of wounds, or instrumental use of health services. This is contrasted with tales of 'attention-seeking', a closely related way of understanding self-injury that is revealed, or made visible, to others. Attention-seeking, however, has significant negative implications—moral and practical. While initially treated separately, I demonstrate that tales of seeking help, and tales of seeking attention feed into one another.

Chapter 5 moves further outward, addressing the role and influence of medicine in shaping understandings about self-injury. This includes reflecting on the meanings and implications of the way in which self-injury is represented in the diagnostic criteria for NSSI in the DSM-5 (American Psychiatric Association 2013). I incorporate a historical and sociological perspective, which critiques the way in which sociology has addressed the role of medical authority in shaping the meanings of self-injury. At the same time, I argue that medical dominance of these meanings has never been complete. My analysis suggests that self-injury might be better understood as simultaneously influenced by clinical activity which seeks to (further) medicalise the practice, *and* as shaped by cultural processes which de-medicalise it. In sum, I suggest that these processes are not as separate as they may first appear. Lay narratives which claim self-injury as a 'chosen' 'coping mechanisms' are nonetheless drawing on increasingly popularised scientific discourse about the functions of bodies and emotions.

In the final chapter, I expand on a series of themes relating to authenticity, addressed at various points in the first five chapters. The concept of authenticity, I argue, provides a fruitful way of understanding a range of inter-related explanations for self-injury. The threads I draw together include: a concern with the 'reality' of emotional states; a desire to have distress recognised and validated; the role of biology and 'the body' in supporting claims to be authentically distressed; the position of biomedical, particularly neurochemical, narratives in shaping accounts which attest to the authenticity of self-injury, as experience, or as legitimate psychiatric disorder.

I want to finish this introductory chapter with a quote from an interview with Rease, one of the research participants.

> *I keep saying this, like, your body isn't yours, or your interpretation of it, or … you know* ***you use self-harm as a way of gaining control and then somebody takes all that away from you.*** *I mean even if it's not like literally taken away from you* ***they take it away from you by misinterpreting it, or, interpreting it, for their own gains,*** *you know so they don't have to deal with it. (Rease, 28, 2007 (emphasis added))*

This is a caution for me, and a caution for you, the reader. As I note above, the words in this book, the interpretations and framings of self-injury that I offer are mine. I draw, as sensitively and 'authentically' as possible on the words of people who have been generous with their experiences and time. However, I may not always provide 'their' interpretation of self-injury. This is further complicated by the time that has passed since I first started talking to others about their self-injury. My views and interpretations have developed and moved, shaped by the different people I have spoken to, as well as my own changing circumstances. I hope, however that this book is not entirely 'for my own gains'. It is certainly not offered so that I do not have to 'deal with it', and I offer it in the sincere hope that it will contribute to efforts to 'deal with it' in ways that are sensitive, open and questioning, and which acknowledge the crucial role of the social.

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2

The Injury and the Wound: Facing the Corporeality of Self-Injury

Introduction: Facing the Self-Injured Body

> Myth: If the wounds aren't bad, it's not that serious.
> Fact: The severity of a person's wounds has very little to do with how much he or she may be suffering.[1]

A core argument of this book is that corporeality has to be attended to and in*corporated* into sociological analysis of self-injury. In this chapter, I demonstrate some of the many ways in which bodies are central to the experience of self-injury and what it is understood to mean. Sociological theories of embodiment offer valuable tools through which to think through self-injury, its meanings and its functions. By carrying out an initial exploration of accounts of self-injury which directly attend to material, corporeal aspects, I seek to ground the remainder of the book in the *lived* body (Williams and Bendelow 1998). This approach draws on phenomenological theorists in locating the body as a key site for 'lived experience' (Crossley 1995; Leder 1990; Merleau-Ponty 2009 (1945)). We experience and perceive *through* the body: we are in the body and we

[1] http://www.helpguide.org/articles/anxiety/cutting-and-self-harm.htm Accessed 3/6/2015.

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are bodies. Self-injury is a practice which is especially interesting in this respect, as it involves acting upon bodies, and through bodies: the body of the person self-injuring is both actor and acted upon. Thus, I argue that any attempt to understand self-injury *must* attend to the bodily aspects of the behaviour, as it is a behaviour which inherently involves, implicates and affects the body.

The self-injured body, in written accounts, is a complex entity: it can be objectified, 'worked on', sensual, embodied. It can be dramatically visible and intensely felt. It can also be absent. Self-injury, in many accounts, is about *emotional* distress—it is more than the sum of its (physical) parts. The quote that introduces this chapter is an example of commonly repeated advice which cautions *others* to avoid focusing on physical wounds: these may not 'truly' reflect the emotional distress being experienced by the self-injuring person. The meaning behind such cautions tends to affirm that wounds which are 'minor' may still indicate great distress. An opposite caution—where 'severe' wounds may indicate minimal distress is rarely present. Perhaps the physical wounds have *some* meaning then—they cannot be fully dismissed even where they should not be focused on excessively.

The framing of self-injury as both about, and not about, physical injuries raises questions: what is the relationship between emotional distress and physical injury? How possible is it to distinguish between emotional pain and physical pain? Why is emotional distress framed in some accounts as more significant than physical distress? If emotional distress *is* more significant, why do people who self-injure inflict physical injuries? Attempts to explain and understand self-injury which disavow a focus on either emotions or (physical) injuries are, I suggest, reflective of an enduring and unhelpful dualistic orientation towards bodies; one that has deep cultural roots, and which results in analyses which necessarily neglect key aspects of the practice and meaning of self-injury.

Cartesian dualism is often referred to critically in sociological analysis of 'the body'—pinning much blame on Descartes for his famous, oft-repeated maxim 'cogito ergo sum' (I think therefore I am). With this phrase, Descartes is charged with severing the soul, mind or identity from the body, and clearly privileging the former as more important—the soul/mind as 'true' seat of the self (Turner 1996).

Theorists argue that this intellectual move both represents and affirms discursive dualisms which associate the mind with more highly valued characteristics including: masculinity, culture, cognition and rationality. In contrast, bodies are allied to more 'base' features: femininity, nature, emotions and irrationality. The discursive split between mind and body, reason and irrationality, nature and culture—and indeed masculinity and femininity—has been robustly critiqued (Crossley 2001; Grosz 1994; Shildrick 1997; Williams and Bendelow 1998). Authors writing from a range of traditions—philosophy, feminism, sociology—have demonstrated the empirical and theoretical limitations of dualistic perspectives.

A sharply controlled disciplinary divide between biology and society has also been posited as contributing to the (apparent) historical omission of bodies from sociological analysis (Shilling 2003). As an infant discipline, sociology sought to mark itself apart from the physical sciences, whilst at the same time emulating their approaches and applying them to the study of society. As such, the realm of biology—the physical body—was deemed the subject matter of biology and not sociology. However, in the late twentieth century, sociology famously 'turned' towards the body, with a rapid proliferation of scholarship that addressed the ways in which society and social organisation got 'under the skin' (Shilling 2003; Turner 1996; Williams and Bendelow 1998). Early theorists of the body demonstrated that bodies were intimately shaped by the social conditions in which they lived (Turner 1996). They showed that the meanings and functions attributed to bodies were culturally variable, subject to the constraints and possibilities of social structures and contexts.

Feminist scholars were pivotal in further undermining the perceived distinction between sociology and biology (Birke 2000; Martin 2001). Feminist studies of science have shown that 'objective' readings of human bodies were anything but. Linda Birke, for instance, demonstrated the multiple ways in which human biology was premised on the study of the human male, simultaneously eliding and reifying sexual difference. Similarly, Emily Martin (1991) dramatically illustrated the ways in which scientific descriptions of human conception were shaped by changing ideas about women. The character of the 'egg' metamorphosed from bashful damsel in distress, who was conquered by an active, virile sperm,

to a threatening femme fatal, who captured hapless sperm. While these changing metaphors reflected scientific discoveries about the more reciprocal nature of conception, they were also clearly marked by sexist, culturally proscribed ideas about men and women. Feminist analysis has, then, further cemented the importance of sociological (and anthropological) analyses of biological realms previously thought to be 'off limits'. However, despite these significant advances in the social scientific study of bodies and embodiment, scholarship that addresses self-injury has a disturbing tendency towards either avoiding, or reproducing dualistic approaches to bodies, emotions and selves.

Sociologists of embodiment have been forced to face the limitations of dualism. Once bodies are considered through a critical, sociological lens, they become less solid, more uncertain if not quite 'melting into air' (Marx and Engles 1997; Shilling 2003). The solidity of the body is further undermined by social, economic and technological changes in the twentieth and twenty-first centuries. Such changes have led many social theorists to argue that bodies are now subject to unprecedented possibilities in terms of our ability to change, alter and improve them (Featherstone 2000), whether through plastic surgery, dieting or body modification. Undoubtedly, a position which suggests bodies are almost infinitely malleable and controllable is one of privilege. Many of the early pioneers in the 'sociology of the body' were white, male and able-bodied, and their positions of privilege were reflected in the arguments that they were able to develop (Turner 1996: p. 4).

The orientation towards self-injury set out in this chapter and the next both reflects and seeks to challenge dualistic understandings of bodies, minds and emotions. In doing so, I draw especially on the work of Elizabeth Grosz (1994) and Nick Crossley (2001), each of whom have sought to move theory beyond dualism. My analysis draws on an embodied understanding of bodies and emotions, one which acknowledges the fallacy inherent in trying to separate out emotional states from embodied experience or embodied practice from inchoate 'feeling'. Grosz's use of the metaphor of the Moebius strip (a three-dimensional figure of eight, which turns in on itself, making it impossible to discern the 'outside' and 'inside' of the object) is particularly useful when considering self-injury, a practice which unsettles notions about boundaries between the 'outside'

and 'inside' of the body. At the same time, the practice of self-injury is often narrated by drawing on language of 'depth' and 'superficiality'—which rather suggests that perhaps there *is* some kind of boundary, though undoubtedly raising questions about where 'it' begins and ends. Grosz uses the Moebius strip to challenge the idea of a separate, privileged 'psychical interior'. This parallels my own task of challenging the privileging of disembodied, 'emotional' explanations for self-injury.

I argue that it is unwise to dismiss the body when trying to understand self-injury, a perhaps unanticipated result of explanations (illustrated in the quote at the start of this chapter) which privilege emotional distress and attempt to minimise the role of 'the wound'. If we take a phenomenological orientation towards self-injury then we must engage intimately with the sensate aspects of the practice (Vannini et al. 2014): the feel of blood and flesh; the smells, sounds and sights that accompany the act of cutting skin with a sharp object or burning flesh; the swell of heat to an injury site. If we are to understand why someone would cut, burn or hit themselves, and why they continue to do so—we need to engage with what the practice entails and what elements of that practice are understood to mean. We must engage with the body.

Beginning to Explore the Self-Injured Body

How to engage with and explore the self-injured body presents another challenge. Indeed, the extent to which we can really engage with bodies is limited. Many aspects of embodied experience are often framed as beyond language, inarticulate. How possible is it then to study embodied experience in any kind of *authentic* manner? A narrative approach offers a way to circumvent this concern. While embodied *experience* may be relatively inaccessible, stories, accounts and tales of bodies—and of self-injured bodies—are available and hugely amenable to sociological analysis. The approach taken in this book is not one which seeks to answer questions about 'how self-injury feels'—instead, I engage with how people talk and write about 'how self-injury feels'. The way that people account for self-injury is understood to be related, but not equivalent to, the experience of self-injury. Further, understanding the way in which

self-injury is narrated sheds light on sociocultural constructions of self-injury, and of bodies.

Examining accounts of self-injury reveals increasingly regular patterns in how the practice is narrated. This includes stories about 'the first time' a person self-injures. Such stories can be seen as especially significant—they might address frequently asked questions about self-injury such as: 'why would you *do* that to yourself'? 'where on earth did you get the idea to hurt yourself in order to feel *better*'? That stories about 'the first time' evidence regularities demonstrates the importance of social and cultural context in understanding self-injury. Stories about self-injury circulate, they are told and re-told: between friends, online, in therapy rooms. They are not neutral, they are not 'authentic'—they have to be understood as versions of events, artful constructions of what might have happened, packaged up for particular audiences (Gubrium and Holstein 2009; Holstein and Gubrium 2000; Loseke 2001).

Sociologists Adler and Adler have argued that self-injury first began to grow in 'popularity' at the end of the 1990s and beginning of the 2000s. There is evidence, certainly, of growing awareness and discussion of self-injury, as references to the practice in popular media began to emerge and proliferate over this period (Bareiss 2014). Two examples below are taken from UK magazines (one aimed at young women, the other at teenaged women), collected back in 2002 when I first began researching self-harm academically.

> It began with small cuts on my arms. I didn't know at the time, but when you cut yourself the body releases hormones to help it deal with the trauma and these give you a natural high. I was convinced I deserved to be hurt so I didn't mind the pain. Every time I felt emotional and weepy, instead of having a cry I'd cut myself. (Katie Foulser, 2002, in *Top Santé* Magazine)

> One day I was looking at a safety razor on my bedside table—I don't know what made me do it, but I picked it up and made the tiniest nick in my arm with it. For some reason, I felt so much relief. It was like I was punishing myself for everything that had happened to me and I thought I deserved it. ('Laura', 2002, in *Mizz* magazine)

These accounts—now almost 15 years old—provide a useful starting point for the remainder of this chapter. They highlight a number of important features about how self-injury is understood and discussed in public settings; providing hints about potentially shared ways of accounting for self-injury, how and why *it* might start. Magazine articles such as these offer resources for people to understand their own practice of self-injury. The excerpts above share common themes found in other first-person accounts about self-injury (which now proliferate online, as well as in print): the act of cutting is associated with a release (of hormones in this case) or relief; cutting is carried out in response to 'trauma' or something 'that had happened to me'; cutting was a form of punishment: 'I deserved' to be hurt.

Each of the above accounts address the 'start' of self-injury: both 'Laura' and Katie indicate that they did not know, or fully understand, what they were doing when they first cut themselves. Adler and Adler (2011) argue that this kind of 'naive' initiation into self-injury was more common in the 1990s and before, but less common at the dawn of the twenty-first century. However, my own analysis casts doubt on the view that those who began to self-injure in the twentieth century 'did not know' about self-injury, and did so entirely naively. Indeed, a historical perspective indicates that, while self-injury as we know it has become more widely reported in the last couple of decades, it was certainly not unheard of in the earlier twentieth century (Millard 2013). Occasional glimpses are offered in unusual places. Millard noted that Dick Hebdige referred to certain subcultural groups having a 'penchant for self-laceration' (Hebdige 1979). While Simone de Beauvoir, writing in the 1940s, referred to the 'common' practice of self-mutilation among young women (Beauvoir 1953). I suggest that naive accounts about self-injury need to be understood within wider sociocultural discourse about the practice, and particularly in relation to charges of 'inauthenticity' which may be assigned to those who 'copy' the practice from others (e.g. see Crouch and Wright 2004 and discussion in Chapter 4).

The self-injured body is also clearly present in the magazine accounts, and this further unsettles disembodied or sanitised analyses of the practice. Katie indicates that she 'did not mind the pain'. The absence or presence of pain, and how pain emerges, in accounts

of self-injury provides another way in which the importance of bodies and embodiment can be explored, and through which authenticity might be affirmed or denied. In the remainder of this chapter, I advance a critical, embodied analysis of accounts about 'the first time' participants self-injured, followed by consideration of the role of pain in narratives about self-injury.

Narrating the First Time

Stories about the first time that a person self-injures can tell us much about the available cultural scripts through which self-injury is made meaningful. They demonstrate the central role of the body in accounts about self-injury, and through this, how the self-injuring body/person is understood. These stories are undoubtedly tied to experience, but it would be a mistake to suggest that stories of self-injury allow us unfettered access to the occasion itself, to the 'inner-workings' of the mind and body that first self-injures (Atkinson 1997; Williams 1984). However, the proliferation and sharing of common stories about the genesis of self-injury (to paraphrase Williams 1984) may also shape the way that self-injury is taken up and practised by others, further underlining the importance of critically examining these accounts.

That self-injury was 'discovered' by chance is a common way in which the 'first time' a person self-injures is explained. This is seen in Laura's account above, where she notes 'one day I was looking at a safety razor on my bedside table—I don't know what made me do it'. Adler and Adler argue that 'discovery' of self-injury is more common pre-1996, after which the practice became more widely known, making it less likely that individuals might not 'know what made me do it'. In this section, I introduce similar findings from accounts generated in 2007, and advance an alternative explanation for the existence of 'accidental' discovery stories. In doing so I draw on data collected in 2014, which found younger people continuing to maintain 'accidental' discovery stories. 'Accidental' discovery, I suggest, is an important facet of an 'authentic' narrative of self-injury.

Stories of Discovery

> *The first time I did it, I didn't actually know self-harm existed. Which sounds really odd. But em, I'd sort of accidentally cut my finger with, eh, a pair of scissors? And, kinda went, hey that felt good. You know.[---] bemused by that so kinda, mental[ly] thought to self- do that again later and see how it feels y'know! Heh. So later on I kinda went and did it on purpose. Just on my finger a little. Then, again later on. I was downstairs in [unclear] it was all very, very, controlled, I'd got all the kitchen knives out, in a row, and sort of, cut my wrists. And it sounds like a total fucked up thing to do, but it, kinda, was a really positive thing, it really made me feel better. (Rease, 28, 2007)*

Above, Rease provides an account of 'the first time' that she cut herself. She is clear that this was initially accidental, but 'felt good'. This initial experience led to her experimenting 'later on' with kitchen knives. Rease's account overall was one which emphasised the positive nature of self-injury, though her wider narrative included body dissatisfaction, family breakdown, a mother who drank excessively, bullying at school and feelings of depression: *'I really struggled, like, to keep myself alive, to keep myself afloat, and that [self-injury] really helped'*. Cutting was framed as intensely positive, allowing her to manage a range of problems. Rease went on to describe further experimentation where she was, rather literally, testing the limits of her body and very much learning to self-injure in a way which would help her to 'cope' whilst not endangering her life:

> *… the skin just burst, and, was really deep, so I went into shock, which is a really odd feeling, but, again this is fucked up again, it was one of the best feelings I've ever experienced. […] I also realised at the time though, that I needed to be more careful, cos I realised how dangerous it could be, that I had to be a bit more, controlled about it, and know what I was doing. So. Anyway, […] so that kinda helped me cope for a few years. (Rease, 28, 2007)*

While Rease's narrative of 'the first time' parallels those found in popular accounts of self-injury among young women, it also—crucially—contrasts starkly with the out-of-control, 'impulsive' self-injury described in much of the clinical literature. Rease describes a planned, agentic and controlled self-initiation into self-injury, one that she framed as clearly

'positive'—*'one of the best feelings I've ever experienced'*. These feelings are discursively linked by Rease to bodily sensations, providing graphic detail of a 'deep' cut which led to particularly intense feelings.'Accidental' stories of discovery were also provided by some of those who took part in the survey in 2014. Participants were asked to write about when they had first self-harmed, and some used the free-text box to provide more detail: Leon wrote *'At 12, discovered it calmed me down when I accidentally cut myself on a knife'*. In an email interview, Katie offered the following elaboration of how she began to self-injure:

> *The first time I self-harmed was when I was younger, I would give myself a carpet burn when I was angry, and it made me feel better. A few years later I cut because I was really angry and it helped. It's then become an addiction, every time I feel down I feel that I have to do it.* ***I'm not sure why I thought it would help****, but it just came to my mind, sort of like second nature. (Katie, 15, 2014) (emphasis added)*

Note here that Katie uses similar language to that used by 'Laura' back in the 2002 magazine article which is quoted above. Katie and Leon's accounts indicate that 'accidental' discovery of self-injury continues to be part of some people's stories. This suggests a fairly enduring 'formula story' about self-harm. Formula stories are a concept used in narrative research to highlight the existence of widely accepted explanations for social problems (Loseke 2001): 'as formula stories pervade a culture, people increasingly use them to make sense of their lives and experiences' (p. 107). In this case, it seems that the story of 'accidental discovery' has endured despite significant challenges—namely widespread knowledge about what self-harm is, and what it is understood to do. How and why are young people telling such stories well into the twenty-first century?

Before the First Time: The Primordial Origins of Self-Injury

Katie's account suggests that, as well as not being 'sure' why she had thought self-harm would make her feel better, she began to do something 'like' self-harm when she was 'younger'. Locating the origins of self-harm

in early childhood experience was an important feature of some of the narratives provided in the 2007 study. While clinical accounts of self-injury often tie the practice to experiences of childhood *abuse*, the narratives I am addressing here did not include this feature.[2] Milly, for instance, provided a narrative thread which tied her teenage practice of self-cutting with much earlier self-harmful practices. Crucially, this was not a tale of abuse or neglect, but rather told of Milly's orientation towards and use of her body:

> *I used to bang my head off the wall, when I was younger**. I don't know why, I don't know why at all**. And I always, had an immense problem with picking spots, any cuts, or grazes, I would pick at, and I would pick at till they got infected. And when I was little my mum used to put [bandages] on me, in bed, big massive gauze things […] I don't know how my mum and dad coped with the frustration of me doing this. So much so, and I don't know if this was when I was about 10 or 11, because my body was trying to fight the infection, I used to get these little nodules on my head, almost like glandular, cos they're obviously trying to combat all this stuff. So I've got a lot of scars, of just me being stupid when I was little, and picking at my spots […] I used to bang my head on the wall. **I don't know when, the… actual self-harm started**…. (Milly, 28, 2007) (emphasis added)*

Milly identifies the 'problem' of self-injury as beginning with these early experiences of head banging, and skin picking. The start and the end of this excerpt are bracketed by the phrase: *'I don't know'*. Milly's account differs slightly from those above, which express a lack of knowledge about why they chose to cut themselves. In contrast, Milly suggests that she cannot remember at what point her self-harming became 'actual self-harm'. By 'actual' self-harm I took Milly to mean skin cutting, as opposed to banging her body, or picking her skin. Milly discursively separates these early experiences from 'actual self-harm', but her narrative provides a clear link, suggesting cutting was a *continuation* of her earlier practices.

[2] Evidently, just because (sexual) abuse was not raised does not mean it was not part of participants' stories. However, for most—but by no means all—sexual abuse was not part of the stories told to me as part of this research. This differs from the greater focus in other studies, e.g. McShane 2012, and Inckle 2007 where the majority of participants did report histories of sexual abuse.

With her earlier practice she is not sure 'why', while her latter cutting she is not sure 'when'.

Mark, interviewed in 2007, provided a similar narrative which explicitly linked teenaged self-injury with childhood experiences of, in his case, eczema. Like Milly, this account addressed the embodied features of scratching and bleeding as a child and cutting and bleeding as an adult: for Mark, these were both framed as 'positive'. This differed from Milly's account which indicated these were more of a 'problem'. In both cases though, these early childhood experiences with skin-breaking practices were framed as frustrating and upsetting for parents.

> *I guess it's linked to eczema, I've always had eczema as a kid, really bad eczema. My brother has it worse, mine's pretty much cleared up, but certainly as a kid—scratching, incredibly satisfying, you know that feeling … which Mum, did everything to stop us, and she's right, cos we would scratch until we bled. … And that would always have that positive association with bleeding, cos it went with, release of pain, you know pain relief. So if you're, you'd scratch and scratch and scratch and scratch, and eventually you'd break the skin, and, and, it would stop, it would heal over and it would be worse than ever, you know—ahhh! Em … probably the scratching, and the cutting always felt just like that, … only, … more acute [effective?] in terms of you'd feel the skin [Mark went on to discuss sensations experienced during tattooing]. (Mark, 33, 2007)*

Mark is more explicit about the embodied similarities between skin-cutting and scratching his eczema-affected skin, relating both of these to a 'release of pain'. Accounts such as these both affirm and deny readings of self-injury as pathological. Mark frames self-cutting as a—relatively—normal practice if compared with a—normal—experience such as scratching itchy skin and experiencing relief. In contrast, Milly's account might be seen as framing her teenage self-cutting as tied to an earlier, but more inexplicable, engagement with practices that might be understood as self-harmful and *pathological*.

Media reports about teenaged self-injury have recently begun to express concern that many young people report 'starting' to self-injure at very young ages (Goodchild 2004). Responses to the 2014 survey could provide further 'evidence' of this: seven participants reported they had first cut themselves at the age of 8 or 9; eleven participants reported first

hitting themselves either aged 9 or under, or *'Since before I can remember'* (AJ, 14). However, attending to narratives about self-injury, and *potentially* self-injurious, embodied practices (skin picking, scratching, rubbing), complicate questions about 'when' self-injury 'starts', and 'what' self-injury 'is'. Participants in 2007 and 2014 provided accounts which tied teenaged and adult practices of ('proper') self-injury to earlier, childhood experiences with their bodies. Drawing on links with childhood body practices, appears to be a common way in which individuals are able to make sense of self-injury: it is something I *always* did, really. These narratives also allowed participants to explore exactly *what* self-injury was—at what point childhood experimentation became 'real self-injury'.

At this point, I want to return to the question I asked above, and expand it slightly: why is it important for people who self-injure to tell stories which locate the practice in early childhood? What work are narratives that locate self-harming practices in the distant past doing? What function does locating self-harm in the past have for individuals? If such accounts are taken at face value they might be read as 'evidence' that self-harm *is* a deep-rooted practice, biologically determined, or programmed in early childhood and perhaps particularly tied to early childhood trauma (Gallop 2002). Other responses highlight the huge pressures that children are increasingly subject to, with childhood self-injury being mobilised as evidence of this (Hilpern 2013). Each of these interpretations of early childhood self-injury may be compromised, or at least unsettled, by a critical, narrative, embodied analysis of accounts of 'the first time'.

Authenticating the First Time

In this section, I set out one potential answer to the above questions about the work that narratives that locate self-injury in the distant past do. These accounts are doing more than simply accounting for or describing self-injury; they are also, I would argue, providing an account of *authentic* self-injury. The idea that self-injurious impulses pre-existed any knowledge of 'real' self-injury can be seen as representing an attempt

to defend against accusations that self-injury might have been copied, and—therefore—be inauthentic. The association between 'copying' self-injury and 'inauthenticity' is evident in earlier qualitative studies with younger people. Crouch and Wright (2004) carried out a rich, detailed investigation of accounts of self-harm in an in-patient psychiatric facility. A key finding was that young people distinguished between different types of self-harm, and different types of 'self-harmers'. A group that was particularly castigated were those who were understood to have copied the practice of self-harm from others.

The issue of copying was also evident in Milly's account, where she provided a story about a challenge to the authenticity of her self-injury:

> *I was about 16 or 17, that there was a girl at school, who was very open about her self-harm, and she used to do it with razor blades. And it wasn't that I thought it was cool, or maybe I did, with hindsight … em … she was making a statement, and I was just like wow, that's a fucking amazing statement to make. And, … I can't even remember the first time I did it, in fact yes I do. I did it on my knee, I picked a razor blade out of a Bic razor, and Jesus Christ they're fucking difficult to get out [laughs] … em, and, … yeah, I did it on my knee, and then I did it on my leg.. and … didn't think anything of it, at all. I think I possibly told a couple of my mates, and they were just like, oh you're just being daft. And the proper stuff, like the really deep stuff, probably kicked off when I was 17* […] *the girl, that I was friends with, at school, turned round and told me that I was being an idiot because I was copying her. And at the time, I was like—shit … this kind of [pause] scraping the arm up the wall thing, it had been there for a long time, and I'd not been able to manifest it in this cutting way before, and yes—if I hadn't met her or hadn't seen what she'd done, then I might not have gone along that route at all …. (Milly, 28, 2007)*

Here Milly provides a self-critical, reflexive account of the development of her self-injury as a teenager. Milly notes that her friend accused her of 'copying' and suggested she was being an 'idiot' for doing so. This indicates that to 'copy' a practice or style is seen as somehow less valid than not to copy, an issue which is reflected in other accounts about self-injury (Crouch and Wright 2004), and is also raised in research about youth subcultures (Force 2009; Vannini and Williams 2009). Milly responds in the interview by rejecting the charge of copying, emphasising that other

forms of self-injury 'had been there for a long time'—though she admits that she might not have begun to cut herself if she had not seen her friend doing so. This is a complex position to maintain, whereby Milly is acknowledging some amount of 'copying', which she indicates opens her up to accusations of being 'an idiot', but she defends against this by claiming that her self-injury has roots in early childhood. It is possible, then, that some of the other stories told which locate self-injury in early childhood practices (skin picking, scratching eczema, carpet burns) are carrying out similar narrative work: cementing and demonstrating the *authenticity* of self-injurious acts for the individual.

Jay, writing in 2014, was clear that she had known about self-injury prior to trying it herself. She wrote that she had read about it in a magazine article, and was aware generally why people might self-injure before trying it herself. However, her account of beginning to harm herself, at the age of 13, indicates some anxiety about naming what she did as 'self-harm'. Jay draws on the relationship between her initial practices of self-injury—scratching with a paperclip—with wider views about what self-harm 'really' was—cutting. This account parallels Milly's in referring to a greater level of comfort in identifying herself as someone who 'self-harms' once she had started to cut herself.

> *I definitely thought of what I was doing as self-harm right from the start- I remember going online and looking things up when I first started hurting myself as a way to cope- but I also didn't really feel justified in thinking that until I started cutting myself much later on, I suppose because the damage I was doing wasn't really very permanent but then also because there was/is this idea of using 'self-harm' and 'cutting' interchangeably in the media. It was sort of this feeling I had of, 'well this is technically self-harm but it's not really fair to say that, because most people would use that term about people who cut themselves and I don't do that, so if I think of myself as a self-harmer I'm making myself out to be worse than I am, which is [attention seeking] [horrible] [etc*[3]*] (Jay, 16, 2014)*

Milly and Jay's accounts both allude to the importance of the 'first time'—and the later evolution of self-injurious practices in contributing to the

[3] This is a direct excerpt from an email interview with Jay, and the square brackets are hers.

authenticity of the act. Each participant engaged in extremely critical self-reflection—Milly talking of charges she was copying, Jay fearing that she was 'attention-seeking' or 'horrible' for claiming an identity that may not be seen as matching what she did to her body. These accounts unsettle arguments provided (as in the quote at the very start of this chapter) that the 'severity' of wounds is irrelevant. Jay went on to emphasise that although the injuries were *'superficial'* initially, her *'feelings were awful'*, very much echoing this sentiment. At the same time—like Milly—she highlights the significance of wound severity in shaping her account of the 'first time' she 'self-harmed'.

Identifying and providing an authentic account of 'the first time' can be challenging—both for individuals who began to injure themselves during the 1990s, and younger people who began to self-injure well into the twenty-first century. The narratives discussed here emphasise the morally charged character of attempts to identify 'actual' self-injury, as well as the centrality of bodily practices in making up what 'actual' self-injury entails. Given the significance of charges of 'copying', and of Jay's acute awareness of what 'others' considered to be 'actual self-harm'—how possible is it for younger people, who began to injure themselves in the twenty-first century (potentially in greater numbers than ever before) to construct authentic stories about self-injury?

Are Younger People Engaging in 'Less Authentic' Self-Injury?

Adler and Adler argue that since 1996 it has become less likely that those who begin to self-injure will do so entirely naively (2011: p. 57). They note that among their respondents, from 1996 onwards accounts increasingly acknowledged prior knowledge about self-injury. This view is supported—in part—by responses to the 2014 study, where several participants, such as Jay, noted that they had first come across self-injury through classes at school, TV programmes or magazine articles.

An important challenge to Adler and Adler's claim is found in accounts from the 2007 research. Those taking part in the study were mainly aged in their late 20s and early 30s at the time, and were reflecting upon events

up to 15 years previously, in the early 1990s. As discussed above, several participants provided accounts where they 'discovered' self-injury 'by accident', or claimed that they just 'did not know' why they had started to injure themselves. However, for Francis and Mark, the account of their initiation into self-injury was more complex. Both *initially* described discovering self-injury themselves, but then later retracted this. For instance, when I first asked Mark whether he had come across self-injury prior to starting, he replied resolutely: *'absolutely not'*. I would suggest that the strength of his response indicates the importance of accounts which value 'self-discovery' and disavow 'copying'. However, both Mark and Francis altered their position during their interviews, noting that they *must have* been aware of self-injury before they began self-injuring, and that this may well have informed their own behaviour.

Francis spoke about this hesitantly, indicating embarrassment that his self-injury might have been influenced somehow by the music he was listening to at the time:

> *I was listening to, I was reading Marilyn Manson's autobiography, and, and I was sort of, sort of start- and there's bits where he is sort of, you know, sort of raked broken glass over his chest [A- yeah] and, and that and burnt himself and stuff like that and, I don't know there was definitely, […] I can't remember it actually, thinking, oh, I've read this in a book, so I'm gonna do it now, but, I don't, there was none of that, but it was, it does seem a coincident- and like, too much of a coincidence that I was also reading that, listening to a lot of Marilyn Manson stuff [pause]. And also, and also happened to be one of the sort of, … few times that I've, have self-injured, [A-yeah] em, and I don't know whether it's sort of, [pause] you know what, I suppose why I'm slightly embarrassed is, sort of get to that, is that, I'm really against, … these notions of, like in the US when you've had, things like White Zombie was banned because they thought that, kids were killing themselves. (Francis, 24, 2007)*

Francis and I went on to discuss the difficulty we had both experienced in reflecting on the potential impact of music and subculture on our practice of self-injury. I noted that my parents had been concerned that listening to *Nirvana* had somehow contributed to my depression and self-injury. At the time I remember rejecting this accusation vehemently, making similar arguments to those we saw above, where I located my 'depression' in a time which

pre-dated my discovery of bands like *Nirvana*. What is important here is that these considerations were experienced by Francis as 'embarrassing', and by me as also 'difficult'. I would suggest that the embarrassment and difficulty leads from the association between 'copying' and 'inauthenticity'.

In Mark's case, this issue was ironically highlighted by the case of Richey Edwards, erstwhile member of the band, the *Manic Street Preachers* (see also Steggals 2015). In 1991, Edwards was very famously accused of 'faking' by journalist Steve Lamacq, following which he dramatically cut the words '4 Real' into his arm, in the journalist's presence. Taylor-Batty (2014) suggests that this was 'the first public instance of an act of self harm being equated, in contemporary popular culture, with integrity and authentic expression' (pp. 60–61). Mark's account, which was very much co-constructed with me, drew on the story of Richey Edwards (Manic) to reassess his initial claim that he had 'absolutely not' heard of self-injury before first cutting himself.

> *Mark: just thinking about, sorry, you're, of course—Richey Manic—I can't date that, it must have been about the same time.*
> *Amy: yeah it was, I was talking to one of my interviewees yesterday about this, cos she says that she, was quite into the Manics when she was self-harming*
> *Mark: yeah, first band I ever saw live*
> *Amy: but she, she never ever told anyone she was a Manics fan, because they would always be like—'oh, well that explains that [her self-injury] then doesn't it' and she, we had a really interesting conversation [M—right] about it cos she gets very angry about that kind of suggestion, cos it's like kind of very dismissive, and,*
> *Mark: yeah, copy cat*
> *Amy: like oh that's not real pain then because you were copying*
> *Mark: which, which was int[eresting]—cos it was 4 real [A—yeah, yeah absolutely] wasn't it, that's exactly what he carved, in an interview with [A—I'm not sure] it wasn't Steve Lamacq it was somebody … I'll look it up when I go home; cos actually no you're right that does—even though I'd never come across it before,* ***I must have come across that*** *[A—yeah] that must have been when I was about 15/16 [A—yeah] so, … that must have been ticking away there as well. (Mark, 33, 2007) (emphasis added)*

The interviewee I refer to here is Rease, who I had spoken with the previous day about the *Manic Street Preachers*. This exchange demonstrates

the centrality of my own experiences and views in shaping the data. I was interested in and asked about issues around copying since they were meaningful in relation to my own 'story' of self-injury. Like Milly, I maintained a precarious narrative whereby I was keen to avoid charges of inauthenticity, especially around copying, but I was equally aware that I had 'copied' self-injury—getting the idea to 'try it' from an interview I read in 1995 in a magazine with a member of the British band, *The Wildhearts*. At the time of the interviews, however, I was unclear about *why* I was so keen to avoid charges of inauthenticity, relating these to more general concerns I had about the 'reality' and 'seriousness' of my 'mental health problems'.

Adler and Adler are undoubtedly correct that self-injury is more commonly known since the 1990s, making it increasingly difficult to maintain narratives which are based around spontaneous self-discovery. However, the analysis above unsettles two assumptions that are made by Adler and Adler. Firstly, I question the extent to which stories about 'spontaneous self-discovery' of self-injury should be taken at face value. There are important reasons to query such accounts, as there is a significant amount of 'face' to be maintained by providing a genesis story about self-injury which does not include 'copying it' from elsewhere. Further, the accounts from interviews in 2007, and indeed the story of my own initiation into self-injury, raise questions about how 'naïve' individuals starting to self-injure in the early 1990s really were, especially given scattered evidence which points to the existence of very similar practices in the earlier twentieth century (Beauvoir 1953; Hebdige 1979; Millard 2013). Adler and Adler do acknowledge the role of subculture, and the existence of self-injury within certain subcultures prior to the 1990s. However, their analysis seems to potentially exaggerate the distinction between self-injury pre- and post-1996, as well as treating young people involved in such subcultures as entirely separate from 'the mainstream'. This seems a rather simplistic characterisation, reflected in their labelling of particular participants, "Lois, the goth" (p. 58), for instance. One wonders who chose these labels, and how far the researchers reflected on the meaning of these for the participant, and for their analysis.

Notwithstanding my reservations about Adler and Adler's analysis, it is clear that self-injury *is* more widely known about in the twenty-first

century: references to the practice have proliferated in popular culture—TV shows, films, celebrity gossip magazines. Despite this, narratives of 'the first time' continue to emphasise self-learning and 'primordial' self-injury, and—as Leanne notes here—reject suggestions that popular culture might encourage self-injury.

> *A lot of adults think music we listen to is pro-self-harm/suicide/alcohol/drugs. It's not true. Music helps us. Music helped me so many times. I listen to punk rock, hardcore, post-hardcore. Music has helped me more than any of my friends. (Leanne, 16, 2014)*

The association between self-injury and particular subcultural groups is contested (Gradin Franzen and Gottzen 2011)—which may relate partly to the delicate relationship between subculture and authenticity (Force 2009; Williams 2006). As this section has begun to demonstrate, there are similarly difficult intersections between cultural understandings of self-injury and authenticity. If self-injury is seen to be engaged in for reasons of 'fashion' or 'group membership' then the individual is particularly open to charges of inauthenticity, 'copying', and 'attention seeking'. This may provide some explanation as to why some who self-injure continue to emphasise self-discovery, rather than identifying difficult and potentially embarrassing links between their own practices and those of others.

So far, we have begun to consider some of the bodily practices which are understood to 'make up' self-injury, and how these are related to tales of the 'first time'. In the next section, we delve more deeply into accounts of the embodied experience of self-injury, considering the way in which feelings and sensations associated with self-injury are articulated.

How Did It Feel? Narrating the Sensate Self-Injured Body

> it is because no-one can know what it feels like to have my pain that I want loved others to acknowledge how I feel. The solitariness of pain is intimately tied up with its implication in relationship to others. (Ahmed 2014: p. 29)

In considering accounts of the sensate self-injured body, narratives of pain have particular relevance. In my research, pain emerged as a central concept in discussions of self-injury, but the way this materialises in accounts varies. The importance of pain in narratives of self-injury has been little discussed. Where pain is addressed, accounts tend to be treated in a straightforward manner. McShane, for instance reports that one participant 'controlled internal psychological pain, by inflicting external physical pain' (2012: p. 93). This is a common way in which self-injury is described. However, in presenting the account as a description of 'what happened', the matter of pain, and the rich cultural meanings it can have, is skipped over. Similarly, the dualistic manner in which such accounts invoke 'the body'; distinguishing between the 'internal' and 'external', whilst implicating 'physical' pain in having the power to affect 'emotional' distress is unacknowledged. Here, I build upon initial thoughts I presented in an earlier paper (Chandler 2013) in order to develop a more nuanced understanding of the role of pain in accounts of self-injury.

Pain, Culture and Bodies

Pain is a word dense with meanings, which are subject to a range of social and cultural influences (Das 1996; Morris 1991). One example of this is the way in which articulations of pain are shaped by gender. Gillian Bendelow's (1993) study of 'everyday' understandings of pain found that women were simultaneously viewed as more able to withstand pain (seen to be a result of biologically distinct experiences such as menstruation and childbirth) and also less able to cope with it (as a result of females being framed as 'the weaker sex'). This insight underlines the importance of approaching accounts of pain critically, and attending to the role of wider cultural meanings, such as gender, in shaping what kind of narratives are possible.

Bodies are central in how pain is articulated and described. Veena Das (1996) has reflected on the role of bodies, and communication, in our attempts to understand the pain of others. She addresses the experiences of women who were raped during the conflicts surrounding the creation of the Indian nation, and asks whether the pain residing in the bodies of

these women could ever be 'known' by men. This raises broader questions, which Das acknowledges, regarding the extent to which we can ever know another's pain. In some work—such as Elaine Scarry's (1985) on torture—pain is framed as intensely negative, inarticulate, unknowable. In contrast, Das reflects on the ways in which pain can be communicated and communicative. When we use language to say 'I am in pain', she suggests, this is an invitation to understand the pain in another's body. Of course, as Das notes, an invitation can be declined.

Research suggests that the ability to tolerate pain is valorised for both men and women in contemporary Western societies (Bendelow 1993; Morris 1991). However, this privileging of stoicism and strength, and indeed the role of cultural meanings more generally, is rarely acknowledged or engaged with when clinical research attempts to ascertain the extent to which self-injury 'hurts'. One example of such clinical research can be found in a paper by Russ and colleagues (1992), which sought to test—under laboratory conditions—whether people who had self-injured had 'objectively' different pain thresholds. Russ and colleagues' sample included 22 patients diagnosed with Borderline Personality Disorder, 11 of whom reported feeling 'no pain' during self-injury and 11 who said they did feel pain, along with 6 'normal' controls. The experiment involved testing how much pain participants could withstand, using the 'cold-pressor test'—where participants submerge their hand into iced water, and see how long they can keep their hand there. Perhaps unsurprisingly, those who reported 'no pain' during self-injury were also able to withstand the cold-pressor test for longer. According to Russ and colleagues, and many subsequent papers which cite the study approvingly, this finding may provide evidence for neurobiological differences between groups of self-injuring patients. Such experiments are problematic however. They fail to replicate in any meaningful way the experience of self-injury—the social contexts in which self-injury (and pain) occurs. Further, they do not engage at all with the diverse meanings that a performance of 'pain tolerance' might have for the participants they study.

Another example of curiously simplistic approaches to pain in clinically oriented research on self-injury is found in survey studies which ask people who have self-injured to indicate whether they did, or did not, experience pain during self-injury (e.g. Murray 2005). Qualitative

accounts of pain and self-injury demonstrate the futility of such studies. Pain is not easily defined; and the associations between pain (or lack of it) and self-injury are grounded in wider cultural discourse about what pain, and the ability to 'withstand' pain might mean. In particular, there are important reasons why people might minimise or downplay experiences of pain during self-injury—not least that feeling 'no pain' may be a marker of 'authentic self-injury' for some.

In the next section, I offer support to the above by illustrating some of the complex ways in which the concept of pain is used in narratives about self-injury. These accounts underline the difficulty of identifying 'pain' as opposed to 'pleasure'—with dualistic modes of thought once again failing to adequately describe lived experience. Narratives of pain also serve to further illustrate the role of embodiment, and the cultural construction of bodies, in shaping accounts of self-injury. Articulating a lack of pain during self-injury is shown to offer another resource through which people who have self-injured can affirm the authenticity of their practice. Self-injury that 'does not hurt' can be used as evidence of a severely disturbed mental state which may help to counter claims that a person has 'just copied' the practice from others, in a superficial and inauthentic manner. Alternatively, self-injury can be framed as relatively painless by drawing on biomedical language of hormones or pain-relieving chemicals. Such an approach underlines the 'reality' of the practice, fixing sensations in biology and generating a more understandable account for non-self-injuring 'others'.

Pain, or Pleasure?

> The intentional tissue destruction has a purpose, but self-mutilators are not masochists. Masochists find pleasure in pain, while self-mutilators use pain as a means for relief (Clarke and Whittaker 1998; Hicks and Hinck 2008: p. 409)

you think it's [tattooing] gonna hurt, and it does fucking hurt, but you know what?! [smiling] It's, you know. Em … It's not something I'm overly into, I'm not a practicing masochist or anything like that! [Amy laughs] em … but it

does, it does, whatever … neuro-receptors are open, it, fills them, satisfies them. (Mark, 33, 2007—describing similarities between tattooing and cutting)

As alluded to in the quotes above, and as will be expanded in this section, self-injury has a complex association with pain and pleasure, one that is complicated by the figure of the 'masochist'. While it may seem incomprehensible to some, accounts of self-injury can and do emphasise positive feelings and sensations associated with the practice. In some cases, such accounts might be interpreted as being about 'relief'. However, a more detailed consideration of how phenomenological, sensate experiences of pleasure and pain are narrated undermines straightforward attempts to separate off pain as a means of achieving either 'relief' *or* 'pleasure'. I argue here that it may well be both, and accepting self-injury as *potentially* pleasurable must be part of an embodied, contextual understanding of the practice.

However, articulating pleasure when discussing self-injury can be a challenging endeavour. Injuries, wounds and illness are framed in the popular imagination, and in academic writing, as clearly associated with pain; and pain is in turn clearly marked as unwanted, negative and damaging. This is reflected in work such as Scarry's (1985) *The Body in Pain*, which critically analysed the meanings of pain in relation to torture, and Frank's (1995) *The Wounded Storyteller*, which focused on accounts of living with chronic illness. Torture and chronic illness are both examples of pain that happens to an individual body involuntarily. Self-injury, I would argue, is a very different form of bodily practice and embodied being, and this has important implications for understandings of pain.

As discussed above, self-injury involves the body as both actor and acted upon. Injuries are in most cases understood and experienced as self-inflicted, by definition. In this sense, self-injury shares some similarity with practices such as body modification and sado-masochism (SM). Indeed, despite the uncomfortable relationship that self-injury has with SM (and masochism in particular), when considering the embodied experience of pain, and the problematic pain/pleasure dualism, there are significant similarities. Accounts of both self-injury and SM play each involve *voluntarily* 'inviting' pain into lived experience and in some

cases deriving pleasure from this (Newmahr 2010). I discuss here two ways in which the challenge of articulating pleasure in self-injury can be navigated: (a) through an emphasis on the *difference* between self-injury and sexual masochism; (b) through the use of biomedical terminology to *justify* the pleasurable feelings self-injury is said to evoke (Scott and Lyman 1968). In doing so, I contrast narratives of self-injury, pleasure and pain, with Stacey Newmahr's analysis of the (perhaps surprising) way in which pain and pleasure are articulated in accounts about SM play.

Narratives of pleasure and self-injury were often used in the interviews to reflect more generally on the distinction between pain and pleasure, with the concept of masochism being employed to do this. Mark referred to physical sensations which were pleasant, but still painful. His account wrestled with definitions of pain and pleasure, seeking to distance his behaviour and feelings from what he termed "*masochism*."

> *… you know, you take an area, rub it with a [---] em, … You do that [demonstrates cutting action] with a [unclear] with a sharpened or, or—[pointed?]--implement, yeah, I mean that's not painful [pause] and I don't think, [pause] It's not masochist, … or my understanding of masochism, is that it is the pain, and it's not, but it's not there, cos it's, it is a pleasurable sensation, cos it's so it's, yeah, sorry! Heh. It does hurt the next day though. (Mark, 33, 2007)*

The issue of masochism was also raised by Craig (*'I'm not really masochistic in any, kind of way'*) and Rease, who suggested that self-injury was seen by others as masochistic for women but not for men. She argued against this noting that for her self-injury was not painful and in fact actually felt '*good*'. Newmahr (2010) identifies similar tensions in accounts of SM practices which attempt to frame objectively painful acts as 'not painful'. Interestingly—like Rease and Mark—there was a tendency among the majority of Newmahr's participants to disavow any 'enjoyment' of pain per se. Instead, elements of pleasure are foregrounded and 'injuries' are reworked as 'not painful'. Newmahr suggested that this reflected the ethically challenging nature of SM practices—which clearly go against moral imperatives to 'do no harm'. If no 'pain' is caused, then no 'harm' is caused either—or at least, the 'harm' is 'not as bad'. It is possible that

with self-injury something similar is occurring, as individuals attempt to make sense of the sensations that occur when they injure themselves. With self-injury this issue is further complicated by (to draw on another dualism) the individual themselves being *both* 'aggressor' and 'victim'.

While narratives which frame self-injury as pleasurable can be considered subversive, it is important to consider what work these accounts are doing. A simplistic analysis might suggest that self-injury is framed as positive in response to wider societal discourse which seeks to frame the practice as deviant, disordered and distressing. However, this argument reproduces dichotomous relationships between normality and deviance; order and disorder; pleasure and pain. Further, such arguments reflect an oppressive, top-down analysis which calls into question the accounts and experiences of people who have self-injured, leading from a normative view that self-injury could not *really* feel good and *must* hurt. Indeed, in many ways the argument that self-injury feels good is *less* subversive than accounts which embrace pain and make it central in explanatory narratives.

In some cases, accounts of pleasure and self-injury invoked a particular form of body: a biomedical, neurochemical assemblage, which could be artfully manipulated in order to evoke certain biological responses. Mark, Rease and Justin all implied that positive or 'pleasurable' sensations were the result of biochemical changes in their bodies, brought about by self-injury. As we saw above, Mark suggested that *'whatever, … neuro-receptors are open, it [cutting], fills them, satisfies them'*. As well as considering links between tattooing and self-injury, Mark also compared injuries inflicted during fights to self-injury suggesting that these were similar *'the adrenaline is flowing […] so the physical sensation I think is pretty much the same'*.

The role of endorphins is highlighted both in clinical literature and lay accounts in order to explain either the efficacy of the practice (e.g. why self-injury 'works') or the generation of pleasurable feelings. Rease described cigarette burns as feeling *'wonderful, like bubbles'*, and suggested that 'endorphins' might play a role in explaining such positive sensations. Endorphins were named frequently among young people taking part in the 2014 survey, and with much more authority than the more tentative suggestions of those interviewed in 2007–8.

> *I self-harm because I like to see blood flow from my body, it makes me happy (endorphin release). Also because it helps me get on with things in my life. (Dean, 15, 2014)*

Each of these examples situates embodied feelings of pleasure in terms of a biochemical body—one affected by a 'rush', or an 'endorphin release'. Suggestions that self-injury 'released' endorphins, or generated a 'rush' of (variously) adrenaline, hormones or dopamine featured in accounts in both 2007 and 2014. However, the assured and common use of such language among participants in 2014 may suggest that endorphins especially, but more broadly, biomedical framings of self-injured bodies, are becoming more entrenched as an acceptable and reasonable way of accounting for the sensations associated with self-injury. Indeed—online advice *and* clinical commentary each un-problematically reproduce narratives which explain self-injury using biomedical theories (Hicks and Hinck 2008; Stanley et al. 2010).

> The brain releases substances called endorphins (has similar effects to morphine) that work as pain-killers when you hurt yourself. Endorphins can also cause a pleasant physical sensation and can become addictive. So, some people SI to produce feelings of euphoria[4]

It is important to note that despite the proliferation of endorphin-related explanations for self-injury, the clinical evidence for such explanations is fairly sparse. Investigations into the potential biological mechanisms involved in self-injury is an evolving and uncertain area (Kirtley et al. 2015). Studying the production of endorphins during self-injury is methodologically fraught, and involves having to extract cerebrospinal fluid from patients. As such, most studies involve very small samples of individuals who have received psychiatric diagnoses and are under psychiatric care. These groups of patients may not be comparable to the majority of those who self-injure who do not receive clinical psychiatric care. The tentative and exploratory nature of clinical research in this area is not always reflected in either lay accounts or in papers which

[4] http://www.psyke.org/faqs/selfinjury/ (accessed Nov 2015).

summarise literature on self-injury. For instance, Hicks and Hincks (2008; p. 409) report without qualification that 'a release of endorphins … contributes to the feeling of relief'. The case of endorphins is one we will return to in Chapter 5 when we consider addiction.

Less markedly biomedical, other accounts use related language referring to a 'rush' or a 'buzz' that is generated by self-injury. While in some cases this was tied to specific bodily processes (adrenaline, endorphins, serotonin, dopamine) in others the 'rush' or 'buzz' were used more descriptively.

> *I self-harm to feel alive again and to focus on only one thing. I don't feel happy anymore, nor sad, just empty. When I break the skin, it fills me with this exciting rush and distracts my mind. (Greta, 13, 2014)*

> *I definitely remember kind of, you know, getting sort of a rush, from it, you know if you were feeling a bit down and you kind of just, you know, saw the blood and then you'd be like, […] give you a kind of rush […] I guess like, just sort of seeing the blood kind of always made me feel a bit kind of, like, … good. (Justin, 28, 2008)*

Justin associated these feelings, in part, with biochemical understandings of the body, implicating *'adrenaline'*. However, in addition he tied these feelings to the material, visible blood that was revealed or released when he cut himself. Other participants also talked positively about the more visible bodily aspects of their behaviour. Leanne wrote *'after a while you just cut to watch the blood'*, while Keely suggested that 'seeing' blood was an important motive for self-injury. Importantly, Keely and Leanne suggested that this was associated with feeling 'alive' or 'real'.

Rease, in a quote I introduced at the very start of this book suggested that one of the reasons that self-injury was so difficult to stop, was because she could think of nothing that was really comparable in terms of bodily sensations and effects:

> *I think it's, it's really difficult to get somebody to, sort of, use alternatives, because it's such a powerful, em, thing and because it involves the body so strongly and, … but it's, you know like the, … the actual cutting and the, the blood thing and, there's not much else that can kind of, stand in for that really. (Rease, 28, 2007)*

The idea that self-injury can be pleasurable, it can feel good, was an important feature of the accounts of many participants across both studies. It is perhaps significant that although not all participants referred to the sensate aspects of self-injury in such positive terms, none mentioned any particularly *negative* feelings or sensations. Even those who said that they did feel some pain during their self-injury did not describe this as a negative experience. This was put clearly by Francis, who said that self-injury caused him pain, but that this was '*a good pain, not a bad pain*'. I will discuss this further in the next section, however I want to emphasise here that attending to the pleasurable and positive aspects of the practice of self-injury—an issue which is only really accessed by attending to the embodied nature of self-injury—could help to explain why, once started, people continue to self-injure, and why they might find it difficult to (want to) stop.

Tracing the Physical/Emotional Boundaries of Pain

As we have seen, attending to narratives about pain and self-injury forces us to engage with definitions and meanings associated with pain itself. This also involves facing the corporeality of self-injury, and addressing the problematic distinctions between 'emotional' and 'physical' pain which are often invoked. Narratives about the embodied experience of self-injury both defy and draw upon such distinctions.

In this section, we turn to accounts which emphasise the experience of unambiguous 'physical' pain, with this framed as central to the practice of self-injury. An increasingly common narrative about self-injury describes it as a functional method of coping with 'emotional pain' by either converting or transforming it into 'physical pain'. This narrative—perhaps another 'formula story'—is reproduced in clinical and academic literature (Jacobson and Gould 2007; Solomon and Farand 1996), lay discourse on the internet (LifeSIGNS 2005) and in news reports (Bareiss 2014). Participants in both studies talked (or wrote) of using self-injury to conceal, change or eradicate 'emotional pain' via the infliction of 'physical pain'. These accounts reflected an awkward dualistic orientation towards emotions and bodies, indicating both a distinction between

'emotional' and 'physical' pain, as well as an inextricable relatedness—evidenced through the effect that physical injuries were said to have on emotional states.

Talk about using self-injury to displace emotional pain was articulated in subtly different ways. Harriet, for instance described self-injury as *'masking'* the *'other pain'* saying *'you'd forget about the other pain you were in cos you're like—oh, my arm hurts or whatever'*. Craig made a similar suggestion, also invoking the idea of control: *'if your arm's hurting for whatever reason, then that gives you something more to con- to worry about, and something that you can probably control.'* For Craig and Harriet, the physical pain of self-injury was framed as a distraction from 'other' pain, or worry.

Others talked of physical pain being *easier* to deal with than emotional pain:

> *but, again what I was saying about the […] having something physical, to, … deal with […] rather than dealing with, the kinda metaphorical stuff […] but having something physical, and having … having a physical pain, to deal with, was easier than dealing with, the, the pain that you couldn't put your finger on […] so [–––] not that it took it away, but, it was still really helpful. (Milly, 28, 2007)*

> *… the blood reminded me I was still alive I was very depressed the physical pain was easier to deal with then the emotional pain. (Laura, 16, 2014)*

A striking feature of these accounts was that the 'other' pain was not always explicitly named as 'emotional'—as in Laura's account—but rather as 'other' (Harriet), or 'metaphorical' (Milly).

Younger participants in the 2014 research talked about the importance of pain in a manner that had not come up in 2007–8. They wrote and spoke of *needing* pain and of feeling addicted to it. For instance, in response to a question about what messages she would give to other young people about self-harm, Katie wrote:

> *I'd tell them that it becomes addictive, to the point where you feel you NEED the pain, where it hurts inside so much until you SH [self-harm] and for a*

minute it goes … then comes back worse, kind of making it a bit pointless, but when you need it, that goes out the window. (Katie, 15, 2014)

Katie's account emphasised the importance of (outside/physical) pain as a way of combatting the 'inside' pain. Though she frames this as ultimately futile—the 'inside' pain returns—she argues that the desire to stop 'inside' pain, even momentarily, is so great that it is experienced or at least *excused* as addictive (Scott and Lyman 1968).

Distraction and control were present also in Sarah's account, which suggested the 'pain' self-injury generated was distracting, as well as being a sensation that she could be in control of, at least at first. Sarah went on to suggest—as did many in 2014—that she lost control and 'became addicted'.

It makes the pain fade away for a little … it lets you control the pain. The pain distracts you. It feels good. At first I was trying to display the pain I felt on the inside, onto the outside, but then I became addicted and couldn't stop. (Sarah, 15, 2014)

The role of addiction in narratives about self-injury will be addressed in more detail in Chapter 5. What I want to address here is the way in which these accounts articulate distinctions or boundaries between the 'inside' and 'outside' of the body, and between 'emotional' and 'physical' pain. In different ways, talk about the experience and importance of 'physical' pain during self-injury draws on wider cultural meanings of pain, and how this might be related to, or conceived as separate from, emotional distress.

In general, when pain is discussed in social scientific literature, it is in relation to 'physical' pain (Frank 1995). Leder (1990) writes of the 'dys-appearing' body—the body which comes problematically to the foreground of perception only when something is wrong with it, and our experience of (physical) pain draws attention to this. This 'physical' pain is said to be experienced as obliterating a sense of self, and actions are taken to remove the source of pain. A sense of pain as world-ending is also present in the work of Scarry (1985), on torture, and Frank (1995), on living with chronic illness. With self-injury (and indeed, with SM

practices), this analysis of pain as uninvited, intrusive and obliterating becomes more complicated. Accounts of the role of physical pain in relation to self-injury might be better understood as 'invited' or *voluntary* dys-appearance, enacted in order to distract from, cope or deal with emotional pain (Chandler 2013).

These accounts appear to rest securely on a view of emotion and physicality as separate: emotional pain and physical pain can perhaps be exchanged, or transferred, but they *are* different. However, the accounts of emotional-physical pain transference simultaneously allude to a more integrated view of the body. Actions taken to the 'outside' of the body affect (indeed improve, if only temporarily) the state of the 'inside' of the body, where emotions are framed as residing. This preliminary examination of narratives about the role of 'physical' pain in self-injury unsettles dominant discourses which un-problematically infuse 'physical' pain with the power to alleviate 'emotional' pain or otherwise help someone to 'feel better'. Importantly, we can see that bodies are being constructed in these accounts in particular ways: they have an outside, and an inside; they *contain* amorphous, upsetting 'feelings', which are nonetheless affected by material 'real' chemicals, hormones and biological processes. Pain itself becomes difficult to pin down—and while distinctions between emotional and physical pain are referred to, in terms of embodied experience the boundaries are certainly blurred.

The Absence of Pain

Alongside the narrative that self-injury 'transforms' emotional pain into physical pain, another common account suggests that people who self-injure feel little to no pain during the act. Clinical research has suggested that people who self-injure have higher pain thresholds, compared to those who do not self-injure; and there have been some studies which have attempted to identify biological reasons for this apparent difference in pain tolerance (Gratz et al. 2011). However—as noted above—there are important sociological and epistemological reasons to question these studies. Certainly, among those who self-injure, many suggest that self-injury does not 'hurt'. As we have seen, this can be articulated in terms of

self-injury being pleasurable, and therefore 'not painful'. However, others frame the sensations experienced during self-injury as an absence. While clinical researchers (and others) tend to take such accounts at face value, in this section, I critically explore what work such accounts might be doing, and how they relate to wider cultural understandings of pain, bodies, distress, self-injury and authenticity.

Anna was clear that she felt no pain at all during her self-injury—suggesting this applied both to the cutting she had engaged in since her late 20s, and her teenaged self-battery. In clinical literature, experiencing no pain during self-injury is often attributed to dissociation or depersonalisation, terms which Anna said she had only recently become aware of, when I asked her about it. Dissociation is particularly raised in clinical literature as being associated with self-injury and sexual abuse (Brodsky et al. 1995). Broadly, it refers to an individual feeling disconnected from their body or self, in extreme cases this is likened to an out of body experience. Anna talked about being in a different *'mental state'* when she cut herself, suggesting that this affected how much it hurt:

> *So, there is definitely a difference between … I dunno whether it is as I say if it's a situation or … mental state, or whatever, but there is definitely a difference, between … like being cut or being hurt or whatever … and and, cutting yourself, definitely … I mean and there's some difference in the pain threshold. (Anna, 33, 2007)*

Anna and I discussed this further, contrasting self-injury with other accidental injuries. I suggested that self-injury might hurt less because it was an *expected* injury, but this idea was rejected by Anna:

> *… because if you were sitting like now, calm and kinda fine, to take, a razor blade to your arm … or or wherever, I bet you wouldnae be able to do it … whereas … I dunno … like, it's like you go into this zone or something I just … I always say that, like when I cut myself there's something inside me and it has to I have to get it out … and that's the only way I ken of to get it out, it's like there's evil, in me. That sounds so bizarre, but [pause] heh and it's like a battle for control between me and this whatever's in me and that's the only way I can get it out and so it's definitely [long pause] I dunno … [unclear] I'd say yer in a different—state, different place, whatever mentally.*

Anna emphasised again the 'different state'—suggesting that self-injury would be impossible for someone who was calm. Elsewhere, Anna reflected on the relevance of pain to those she saw as 'copying' self-injury in psychiatric in-patient settings. She suggested she could not understand how those who 'copied' self-injury could go through with it, since it must hurt them. This narrative strongly implied that those who 'copied' were different from her, not in the same 'mental state', with absence or presence of pain forming part of what made up 'authentic' self-injury.

Anna's account also invoked the idea that something 'inside' needed to be 'got out'. Although she used terminology (evil, battle) which was particularly dramatic (and would no doubt be interpreted quite differently from a psychiatric perspective), the same sentiment is reflected in less dramatic terms by other participants when talking about 'release' and lack of pain.

> *it was like there was just no pain whatsoever but it's like, I mean, like I say I mean I have low pain threshold, but, like, sec- I stuck the Stanley knife and stuff into my arm it was like, there was just nothing—there was no pain (A—mhm) it was like, it was like as if I had kinda removed myself from my body, em, and it was just like, it was like as if I was sorta standing behind myself watching myself, actually doing it, but I didnae actually feel any pain (A—mhm) and it was like, I could see the blood and stuff eh, but it was just like there was no pain whatsoever, em, because I kinda done all sorta five of them at the one time eh? (A—yeah) em, so it was kinda like, it was just kinda weird. So there was just nae pain eh, or at least, there just seemed like there was nae pain, at all. (Robert, 33, 2007)*

Harriet also spoke of feeling no pain when she dissociated and injured herself. Anticipating the more dominant biomedical narratives provided in 2014, she drew on the language of (neuro) 'chemicals' to explain this lack of pain.

> *I think it's different at different times, cos sometimes … I've just, totally out of it, and I'm dissociating a lot, I don't feel it. But other times, I do […] so it just varies but, I think like, sometimes you don't, you don't feel as much pain as you'd think you do […] it's like, cos like when I was trying to explain it to a group of, of like school kids I was like, explaining about how like there was like, like all these chemicals in your brain that get released […] so that it acts as like*

> *as a pain killer when you're, when you're doing it so you don't, you don't actually feel the pain that you think you would. (Harriet, 26, 2007)*

Gavin wrote of '*the euphoric feeling that your brain releases to counteract the pain*' contributing to the addictive qualities of self-injury. Neurochemical narratives of *addiction* to pain and/or self-injury were reasonably common among participants in 2014, a theme which had not emerged at all in 2007 and which has not been critically explored elsewhere. In Chapter 5 this is examined in more detail.

Where self-injury was framed as 'painless' this was accounted for in different ways. For some, dissociation or being in a particularly distressed state of mind was a proposed explanation for this lack of pain. In other cases, biomedical terminology was employed, with talk of 'natural' painkillers, neurochemicals or over-riding pleasure (euphoria) which counteracted any 'physical' pain. The bodies that participants invoked when they spoke of pain and the practice of self-injury varied, though drawing on similar dualistic understandings of relations between emotion and corporeality, inside and outside.

Constructing the Self-Injured Body

> We extend our hopes and fears over our biomedical bodies to that special organ of the brain; act upon the brain as on the body, to reform, cure or improve ourselves; and have a new register to understand, speak and act upon ourselves—and on others—as the kinds of beings whose characteristics are shaped by neurobiology. (Rose and Abi-Rached 2013: p. 223)

In this first chapter, I have begun to chart some of the ways in which self-injury, and self-injured bodies are narrated. Through this, we begin to get some sense of the shape and form of the self-injured body, as it emerges in accounts of those who have engaged in self-injury. These accounts draw on cultural scripts in order to make sense of the experience of being a person who (has) self-injured. The body-self that is injured or altered in the process is one which might be understood as a *biochemical assemblage*. I draw on the work of Nick Fox (2011) here—who has developed

the Deleuzean concept of assemblage in relation to health, illness and the body. Through this, we might characterise the self-injured body as a biochemical assemblage, made up of a complex array of materials—biological or otherwise—along with cultural meanings (Fox 2011), *and* pre-existing narratives or formula stories (Loseke 2001). From this perspective, the self-injured, self-injuring body can only be fully understood in relation to wider networks of meaning: the *idea* of neurochemicals (especially endorphins); the *notion* of emotions as tied to and yet separate from biological bodies; the cultural *meanings* that 'pain' has, which defy attempts to objectively study the sensations associated with self-injury. There is also evidence, within these accounts, of the role of other elements in the assemblage of the self-injured, self-injuring body: the different material tools that are employed in self-injury: razors, knives, hammers—these shape the self-injured body, as well as the phenomenology of self-injury, and the meanings which are attached to these practices and experiences.

Knowledge of self-injury, and of self-injured bodies, emerges as crucial—particularly in terms of authenticating the self-injured self. Narratives about the 'first time' continue to emphasise a *lack* of knowledge about self-injury, prior to 'trying it'. Those who 'admit' prior knowledge do so cautiously, indicating awareness that charges of 'copying' might de-legitimate their experience of self-injury. The tension between acting rationally, consciously, based on prior knowledge about what self-injury is, how and why it works, or acting irrationally, or unconsciously, without prior understanding about self-injury, is one that will be returned to in later chapters. This tension represents and reflects the contradictory nature of authenticity in late-modern societies: where authenticity is simultaneously sought after, and increasingly difficult to 'achieve'. Narratives about the primordial origins of self-injury—via tales of early childhood orientations towards the body, represent an attempt to authenticate experience and identity.

Self-injury—as others have noted—also involves learning and practising (Hodgson 2004)—developing individual, embodied, 'knowledge'. The stories introduced here address the way in which knowledge about self-injury can be individually developed through practice and experimentation on and with the body. At the same time, practices involved in self-injury are shaped and given meaning by broader narratives about bodies,

what they are and how they function. Notably, in this chapter, tales of neurochemicals were prominent. Accounts of self-injury drew on ideas of bodies as made up of internal, neurochemical substances which could be manipulated through damage to the body's external surface: the skin. Aside from tales of the 'origins' of self-injury, accounts of neurochemicals offer another means of legitimating the experience and efficacy of self-injury. Further than this—and setting aside questions about whether endorphins are 'really' released during self-injury—I would propose that if self-injury is understood as shaped by neurochemical flows and releases, then the embodied experience of self-injuring may in turn be experienced through this lens, with these associated meanings. The existence or not of something called an 'endorphin' becomes less relevant than the fact that it is understood to exist, and to affect bodies, pain thresholds and mood-states.

To an extent, such accounts of self-injury—as neurochemical assemblage—offer support to Rose's thesis of neurochemical selves (2003). However, in considering pain, it may be that there are deeper historical associations at work, particularly in terms of the contested pleasure/pain dualism and how it is understood to play out through and in the body.

> I shall simply say that pain is the consequence of a defective relationship between objects foreign to us and the organic molecules composing us; in such wise that instead of composing harmoniously with those that make up our neural fluids, as they do in the commotion of pleasure, the atoms emanating from these foreign objects strike them aslant, crookedly, sting them […] Still, though the effects are negative, they are effects nonetheless, and whether it be pleasure or pain brewing in us, you will always have a certain impact upon the neural fluids. (Sade from *Justine* 1797, quoted in Morris 1993: p. 231)

Morris argues that in the work of Sade, on sexual violence and pain, emergent medical knowledge was important in shaping how pain was conceived. This offers an instructive parallel in the analysis developed throughout this chapter, where I argue that practices and meanings associated with self-injury are *also* shaped by (bio)medical knowledge. Morris' analysis has immediate relevance to the way in which bodies are in turn given meaning:

> when Sade's libertines talk about pain as an event of hollow nerve fibres and neural fluids, they invoke a vision in which mind and soul have disappeared into matter. (p. 232)

In a similar way, narratives of self-injury can be seen to refer to a thoroughly *material* body. Accounts of self-injury speak to an inextricable relationship between 'physical' and 'emotional' pain; the artful use of surface injuries to enact 'internal' changes in mood-state; or to the 'transformation' of emotional pain into physical pain, Amorphous, intangible 'emotional pain' is substituted with sharp, bloody, tangible physical pain. Contemporary, late-modern accounts of pain and neurochemicals often speak—albeit in a dualistic manner—of a 'mind and soul' that are thoroughly bodied, material. Such accounts parallel the emergence and rise of biomedically grounded talk about 'the brain' as the seat of the self (Rose and Abi-Rached 2013).

The construction of the self-injured, self-injuring body as having an 'inside' and 'outside' evokes an enduring dualistic orientation towards embodied experience. When talking of pain, participants frequently drew on dualistic motifs—pleasure versus pain, emotional versus physical, in order to develop coherent accounts of the sensations evoked by self-injury. In Chapter 3, this analysis is further extended, as we turn more explicitly to the way in which the 'internal' world of self-injury is narrated. Chapter 3 leads us through an examination of how 'the emotions' are almost uniformly located as 'inside' the surface of the body. Self-injury is framed as offering a way of 'releasing' what is inside, allowing it to seep, leak or perhaps more dramatically 'spurt' out.

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3

A Critical View on Emotions and Self-Injury

On the Centrality of Emotions

> *I now had a coping mechanism, for coping with – not being able to know what to do with my emotions, not knowing how to help people. And not knowing who to talk to, I had this coping mechanism that I could use to stop, everything, because then I could concentrate on, you know cleaning up wounds, and you know feeling that throbbing pain in your arm, you're like, I'm alright, I'm still alive kind of thing. (Milly, 28, 2007)*

Emotions are central to many accounts of self-injury in the early twenty-first century. As we saw in Chapter 2, even where the focus is explicitly upon 'the body', emotions creep in. Prominent explanations frame self-injury as a way of 'coping' with problematic emotions; emotional distress is said to underlie any and all self-injurious acts. Emotional aspects of accounts of self-injury have been examined in depth by sociologists and social theorists (Brossard 2014; Chandler 2012; Horne and Csipke 2009). However, these accounts tend not to problematise (and indeed may contribute to) the authority of purely emotional explanations for self-injury. There are exceptions. A study of US print media reporting

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about self-injury queried the dominance of explanations which framed self-injury as an individualistic form of 'coping' (Bareiss 2014). Bareiss argued such readings of self-injury elevated the importance of personal choice and minimised social factors (such as childhood abuse) which might contribute. I would add that framing self-injury as an individual 'choice' also avoids engagement with broader structural and cultural conditions which enable and indeed encourage self-injury: poverty, inequality, cultural narratives which valorise 'suffering in silence', and interpersonal contexts which prohibit or discourage expression of negative emotions.

A narrative study of the accounts of young people engaged in therapeutic treatment (Hill and Dallos 2012), suggested medical narratives and explanations for self-injury were also uncritically reproduced in individual accounts. Like Bareiss, Hill and Dallos are critical of the normative framing of self-injury as 'coping'—suggesting this diverts attention from the 'relational and emotional difficulties' which lead to young people needing to 'cope' (2012: p. 473). Hill and Dallos' analysis unpicks the vital importance of interpersonal, family contexts, and for the participants in their study, early experiences of trauma. However, by focusing mainly on treatment-engaged young women, they reproduce a fairly 'typical' sample (Chandler et al. 2011), and this limits their ability to speak to experiences of self-injury among other groups who may be far less likely to be engaged in psychological therapy: men, people living in poverty, Black and minority ethnic people (Watkins 2012). Additionally, leading from their disciplinary perspective (psychology), the analysis focuses on the family and close intimate relationships, including little engagement with the wider cultural scripts and structural conditions in which such relationships play out.

In this chapter, I build upon the above insights to develop a critical sociological analysis of the use and construction of 'emotion' in narratives about self-injury. In doing so, the analysis delves deeper into what many participants characterised as the 'inside': the amorphous, hard to pin down 'emotional' aspects of self-injury. Emotions in this analysis remain embodied: the analytic gaze is on the embodied person. However, my focus here is on how emotions are articulated, narratively tied to bodies, and how these are related to interpersonal and structural contexts. An embodied perspective allows me to address two

further issues that have not been clearly articulated in previous work on self-injury and emotions. Firstly, I engage with the role of medicine, and professional narratives, in shaping the way emotions emerge in accounts of self-injury. Secondly, I argue that the concept of authenticity is important in understanding why emotions have become such a dominant frame of reference when addressing self-injury. This latter argument leads from an analysis which demonstrates the relevance of authenticity both to accounts of self-injury (as we began to see in Chapter 2) and to accounts of emotions in late modernity (Hochschild 2003b; Meštrović 1997). This chapter extends theories of emotional management (Hochschild 2003b). My analysis re-incorporates a concern with bodies and embodiment—a presence which was explicit in Hochschild's early formulation of emotion work (Hochschild 1979), but which has become increasingly *absent* in more recent uses of the concept (see for instance, Theodosius 2006).

Emotions in the Clinic

In clinical research on self-injury, embodied emotions emerge in a curious manner. Much clinical work frames individuals who self-injure as suffering from emotional dysregulation (Anestis et al. 2010; Gratz 2007; Gratz and Chapman 2007), using self-injury as a 'maladaptive' form of affect regulation (Nock 2009). A smaller, but nonetheless substantial, series of studies has examined biological antecedents to self-injury. As we saw in Chapter 2, this includes attempting to account for the 'physical' sensations associated with self-injury (particularly lack of pain), as well as seeking to isolate biological processes which might explain why self-injury apparently successfully alters affect (emotional states) for some people (Kirtley et al. 2015). There are overlaps between these research programmes, and an examination of these illuminates inextricable overlaps between emotions and biology, feeling and (physical) process. However, while sociological and feminist researchers have expended a great deal of energy in destabilising cultural binaries such as these, clinical research appears to have little compunction with the unproblematic separation of emotions from bodies, and indeed feelings from social context.

One of the most limiting features of clinical research addressing self-injury is that 'the social' is often almost entirely absent, particularly in studies which seek to replicate emotional distress in laboratory settings (Gratz et al. 2011). There are, then, a number of 'absences' with regard to different disciplinary perspectives on self-injury and emotion: sociology has tended to foreground emotion and society; psychology privileges emotion and the individual; biological psychiatry addresses physical, biological processes. None of these offers anything that looks like a 'complete' view of self-injury, and as such each discipline provides only a partial explanation for the efficacy and function of the practice—cross disciplinary communication is rare (Chandler et al. 2011). As a sociologist, I am perhaps ill-equipped to successfully incorporate these different disciplinary perspectives (indeed, I will leave that task to someone else). However, what I do offer here is a critical examination of the way in which emotions are narrated by researchers and theorists writing from each of these perspectives. I will develop this further, drawing links between the ways that emotion and self-injury are constructed in these accounts, and theoretical writing on authenticity and emotion in late modernity (Giddens 1991; Meštrović 1997).

The Clinic, and the Clinical, in Everyday Emotional Life

As we began to see in Chapter 2, both lay and professional discourse about self-injury is increasingly infused with neurobiological language. Neurobiological ways of knowing have a particular relationship to emotion: Nikolas Rose (2003: p. 54) has suggested that emotional or mental health complaints are attributed more and more to malfunctions in the physical brain. Following this, individuals are more likely to 'define key aspects of one's individuality in bodily terms … and to try to reform, cure or improve oneself by acting on that body' (2003: p. 54) a view Rose terms somatic individuality. Arguments analogous to somatic individuality have been used to account for the proliferation of physical treatments for mental illness, in particular pharmaceuticals (Fullagar 2009; Lyon 1996), though this argument is not without its critics (Abraham 2010). Alongside this, these (contested) changes are said to have wider

impacts in shaping the way that 'emotional' problems are understood and interpreted in 'everyday life' (Stepnisky 2007). Applying Rose's concept of somatic individuality to accounts of self-injury as *embodied* emotion work may offer some indication as to why self-injury is accounted for in certain ways: in particular, the use of biomedical terminology to explain the efficacy of the practice. In this chapter, I explore the extent to which accounts of self-injury might be interpreted as non-pharmaceutical methods of 'working on' the self, via the management of emotions through the body.

Alongside 'neuro'-narratives, work by Simon Williams (1998b) offers another resource through which to think through the emotional and embodied aspects of self-injury. Williams argued that the competing desires for control and release, along with the inherent uncontrollability of bodies, are reflected in 'performances' of health in late-modern societies. Reflecting contradictory understandings of what it means to be healthy, health is seen to require both control and release. These arguments are related to understandings about what it means to be emotionally healthy. For instance, Lupton's (1998: pp. 47–48) exploration of lay understandings of emotions found that emotional control was valued, but usually alongside the *need* for emotional release and expression. Motifs of control and release are also prominent in accounts of self-injury. As such, we can begin to see how understandings of self-injury, what it is and how it works, can reflect contradictory socio-cultural understandings of (emotional) health, simultaneously expressing the need/desire for both release and control.

The complex way in which emotions are regulated in social life was analysed historically by Norbert Elias (2000). Elias argued that over time, the expression of public emotions had become more constrained. Drawing on examples from etiquette books, Elias charted the way in which emotional expression was increasingly inhibited, deemed unacceptable—particularly in public spaces. This was also shown in the move away from publically acceptable displays of violence, an issue addressed by Foucault in *Discipline and Punish* (1991). While both Elias and Foucault have been challenged on methodological grounds, their work remains valuable in considering the ways in which historical changes can shape the articulation and expression of emotion (and violence) in social life.

This chapter charts some of the diverse ways in which emotions are present in narratives about self-injury. While 'coping' with problematic emotions is an important theme, this chapter addresses two other, related, ways in which those who self-injure incorporate emotions into their accounts. First, I address emotions and embodiment, through an analysis of the use of bodily metaphors around release, flow and control. A focus on such language emphasises the inherently embodied nature of self-injury, and emotions, as well as highlighting the important role of wider cultural discourse about embodied emotions in shaping explanations for self-injury. The second section discusses the role of emotional invalidation and expression in accounts of self-injury. This analysis builds upon Brossard's analysis of the role of interpersonal contexts and local emotion rules in contributing to the maintenance of self-injury (2014). In so doing, the social nature of self-injury is firmly established, moving the focus away from 'pathological' individuals, towards interpersonal and cultural contexts which can be seen to make self-injury possible, meaningful and necessary. The final section summarises and extends my thesis on self-injury as embodied emotion work (Chandler 2012).

Release and Control: Embodied Emotions

In Chapter 2 we saw that 'release' was employed in biomedical explanations of self-injury, particularly in relation to an 'endorphin release' but also in terms of a 'release' of blood. Emotions are also frequently 'released' in explanations of self-injury, and sometimes the 'release' may be thoroughly embodied. Indeed, how possible is it, really, to phenomenologically demarcate releases of tension, stress, emotion, endorphins and blood? In order to further explore, and better understand why the concept of release is so attractive, to so many, this section will examine some of the different ways in which 'release' or 'relief' are used in accounts of self-injury.

Throughout the following pages, I address talk about self-injury, release and control. However, it is important to highlight that labelling these concepts as relating to *emotion* is contestable. As we have already discussed, 'releases' may also be tied discursively, and perhaps experientially,

to biological processes which are often viewed as both 'separate' from and related to emotional states. Indeed, explicit talk about particular emotions—or even general emotions—was rare. This finding may offer support to psychological theories about the alleged emotional inarticulacy of individuals who self-harm (Gratz 2007). However, I would suggest that equally it reflects a general *cultural* inarticulacy when it comes to emotional states (Brownlie 2010), as well as leading from the rather particular context in which these accounts were collected: a research conversation between two people—myself and the participant—who had met only once or twice before. While for some people a confidential interview with a relative stranger may provide a space in which to explore emotions, for others this may not be the case and it would be unfair to expect 'full and frank' emotional disclosure in research interviews. Indeed, some have questioned the desire among qualitative researchers to 'get at' the emotional life of participants, suggesting this blurs professional boundaries—between researchers and counsellors (Hewitt 2007). Further, and of particular relevance to one of the core themes of this book, the idea that emotional accounts are somehow 'more *authentic*' has been critiqued (Birch and Miller 2000).

Controlled Release

Anna and Harriet, two participants in the 2007 research each used the concept of release alongside that of control when describing acts of self-cutting. Anna's account was one of those which was striking in *avoiding* direct mention of emotions—talking instead of releasing 'whatever it is'; of gaining control *in general*, rather than emotional control specifically.

> *… it was like right, regain control, this is what I'm gonna do, I'm gonna cut myself, well it wasnae as calculated as that … but cut myself … and I cut myself, my right arm, I cut myself and it just wasnae, … it wasnae deep it was just, ken what I mean it was just, crappy cuts. This is gonna sound so bad em … and so I covered it up … and 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, but it was like it was happening to somebody else, but, that was it that was the one, it was like, it's worked this time*

that fine, d'you know what I mean? But it's … it's like, it's like being there but not being there […] and it's, like, releasing something … and then when that whatever it is is released then your sortae regaining control [pause] s'what it's all about, it's all about, control. (Anna, 33, 2007) (original emphasis)

In each of her interviews Anna emphasised the importance of control, and of 'being in control'. For Anna, control was something to be strived for, and self-injury, by 'releasing' something, was a tool which enabled her to *'regain'* control when she felt she was *'losing it'*. Control was a positive, valued state, and this contradicts somewhat Simon Williams' argument which implies control is 'not pleasure' (Williams 1998b: p. 422). Indeed, Anna's narrative offers more support to Deborah Lupton's analysis, which suggested that there is a widespread belief that too much emotional control is 'potentially damaging' (1998: p. 70); a view which apparently co-existed with an understanding that control over one's emotions was desirable. Leading from this, Anna's valorisation of control, and her use of self-injury to 'release' (something) in a controlled manner makes sense. Certainly, for Anna, loss of control was framed as dangerous and potentially damaging.

Harriet described her self-injury as being a way of *'releasing tension'*. In particular, she emphasised that this meant relieving *'physical feelings of anxiety and stress'* such as *'tension headaches'*. The weight that Harriet placed on the physical symptoms of her distress is notable. As we saw in Chapter 2, a preference for physical, tangible pain as opposed to more ephemeral emotional feelings is a central theme in many accounts of self-injury. I would suggest that this relates, in part, to wider cultural scripts which privilege physical symptoms over mental health (Bendelow 2009). Consideration of accounts of self-injury which draw on this type of script may offer some indication as to why physical symptoms are often responded to more seriously, accorded more weight than those classed as 'emotional'. This may relate to physical, visible wounds being understood as more easily controlled than emotions, or feelings.

I need to do it, just to, kind of relieve that tension inside and I'm like, and the longer I kind of put it off, like, I know it's gonna be worse, whereas if I kind of like do it, earlier, then it's like … it's, I can take control. [….] Whereas if I kinda leave it, it gets like, out of control more. (Harriet, 26, 2007)

Here, Harriet's account frames self-injury as a means of taking control, rather than being overwhelmed by a build-up of tension 'inside'. She expressed this by suggesting that currently, she self-injured sooner rather than later, as she was able to enact greater control, rather than 'leaving it' which would lead to more 'out of control' self-injury. Again, this reflects themes in Lupton's analysis of cultural discourse about emotions, which affirms the need for 'controlled release', rather than letting things 'build up' and 'explode' (Lupton 1998). Harriet alludes to the 'danger' of 'leaving it' too long, which was addressed by others. For instance, Craig described self-injury as *'trying to get some kind of overload of emotion out'*, saying that alcohol use had served a similar purpose. Indeed, Craig suggested that had he *not* used alcohol, then his self-injury might have been *'less, frequent […] and it may have been more, violent, … Because I think it would've tended to build up […] until it got completely, impossible to deal with'*. Poignantly, Craig reflected that although he had not injured himself for many years, he still only had *'a few outlets for it […] it has to come out somewhere […] and I'd rather injure meself than other people'*.

Accounts of self-injury, control and release highlight the importance of context. Craig's talk about 'outlets' to release his 'excessive' emotions, and his preference for hurting himself rather than others, speaks to normative values about dealing with emotions in an 'appropriate' manner. This offers a further qualification to Williams', and Elias', broad cultural analyses of changing emotional rules and expectations. In summarising the views of a general population sample regarding appropriate expressions of emotions, Lupton suggested that:

> The notion that one should attempt to express one's emotions rather than keep them 'within' the body/self was generally supported, unless the emotions were negative and destructive, the context was seen to be inappropriate or such expression might hurt other people. (Lupton 1998: p. 70)

Such sentiments were evident among those who had self-injured, with negative emotions being framed as particularly problematic, and needing to be 'dealt with' away from others. Brossard's (2014) analysis also highlights this. He argues that among his participants self-injury was often described as a way of maintaining social relations, by 'privately'

addressing negative emotions which arose from interpersonal difficulty. A further example is provided by Milly, whose narrative suggested a long-term commitment to finding 'more appropriate' ways to be 'emotional', drawing on notions of control and release. She recounted a recent example where she had been able to 'release' her emotions appropriately—crucially, for Milly this meant away from other people:

> *I get this kind of well of emotion, and I don't know where it's come from, so I'll kinda, I took myself away from that situation, my family were sitting watching the football, and I took myself away from that situation, because I just, I wanted to get this, this kinda tears out. Went out the back, had a cigarette, let the tears flow, kind of, … that was that, nobody knew, came back in, plonked myself down, and, you know I was thinking about it rationally. (Milly, 28, 2007)*

Milly suggests that the emotions were 'got out' via her tears and no one knew: it was 'private'. Later she explicitly contrasted this with her earlier self-cutting, noting she saw episodes of crying as a *'release … in the same way I used to see self-harm as a release'*. This mirrors accounts of others' self-injury, especially involving cutting and the parallel 'flow' of blood. Accounts from participants in the 2014 research indicate that concepts of control and release remain important metaphors in accounting for self-harm. Keely wrote of injuring herself in order to *'feel relief/release when seeing the blood'*; Sidney suggested they *'tried healthier methods of releasing my built up emotions but they would never work'*. These accounts acknowledge that self-injury may not be viewed as 'healthy', while also affirming the efficacy of self-injury—it 'works'. The success of the practice of self-cutting is linguistically tied to the embodied aspects of cutting: blood is *released*, it *flows*, it is 'let out'. At the same time, this 'release' refers too to emotions—sometimes explicitly, and other times less so.

Being in Control, and Out of Control

Accounts of 'release' and 'relief' tend to frame self-injury as a method of enacting control over, variously, the body, the self, emotions, feelings or—more vaguely—'it'. For some participants, self-injury was described

as a form of 'being in control' in the absence of talk about release or relief. In contrast, others used the concept of control in a different manner, suggesting that the practice of self-injury itself could be or become 'out of control'. This was often articulated through the use of language related to addiction: urges, impulses.

Belinda's account emphasised the importance of 'being in control': she said that her self-injury was *'something that I sort of have control over feeling'*. Her account contrasted the *'concrete'* feelings she said she experienced through self-injury with the confusion of what she described as her *'inside'*. Belinda seemed to suggest that she had little or no control over the *'inside'* of her self: she described this 'inner' state vividly, using the metaphor of a busy, traffic-logged city on two separate occasions:

> *… in my head and in my body it's like a huge, like, em, London traffic where like, just, it's so busy and there's cars and there's people and it's so busy and so noisy sometimes, it's just so confusing, and you can't hear yourself think, or get anything straight or just make everything stop and slow […] it's all over the place. (Belinda, 21, 2007)*

Self-injury, Belinda maintained, was more concrete, and this was a preferable feeling. The distinction between inside and outside was also relevant to Rease's comparison between her acts of self-cutting, and experience with taking overdoses of prescription medication. Rease noted that she preferred *'outside things'*, and that *'inside things … freaked [her] out'*. In comparing an overdose that occurred when she was 17, with self-cutting, she noted that the latter was 'controllable' and therefore less likely to 'freak her out'.

> *there was one night that I couldn't sleep, and I was feeling really panicked, and I self-harmed [by cutting] and I didn't feel better, and I just kinda lost it so I started rummaging about and found all the pills that I keep in the house, and just downed them all. And then I got a bit hysterical and kinda lost it a bit, cos- I freaked out at what I had done. […] I don't really like, inside things? It sounds a bit nutty but, like, the self-harm is on the outside, and it's controllable, but obviously I didn't know what these pills were doing to me, so, I was really freaked out about that. (Rease, 28, 2007)*

In Rease's account control is experienced in different ways, according to the type self-harming practice, and the way in which 'the body' is involved. The body that is invoked here has an inside and an outside, with the inside marked by Rease as less controllable than the outside. She contrasts the visible, tangible injuries resulting from her cutting with the unknown, invisible damage that the pills may have been doing to her 'inside'. This highlights the importance of corporeal aspects of different forms of self-injury/self-harm, indicating how differences between practices may have significant impacts on how they are experienced and on their functions for individuals. Rease and Belinda each noted the 'outside-ness' of self-injury: cutting the skin is visible, tangible, the effects are readily seen and assessed. In contrast, as Rease attests, overdoses are invisible, inside, unpredictable: they allow for much less control.

Younger participants taking part in the 2014 research also indicated that self-injury was understood as a method of enacting control. Jane (aged 15, 2014) suggested that she self-injured because *'I need to be in control of something when I can't control myself'* in a similar vein, Fiona wrote that she self-harmed *'If I feel out of control or numb, to feel in control'*. Jay, who took part in an email interview, wrote that control was important in a range of ways to her practice of self-injury. Here Jay writes about the time when she was initially starting to cut herself, referring to a wider situation where school was very difficult due to conflicts with teachers:

> *So there was a lot of anger around that, and also a lot of lack of control, and where other kids might have hit back by being aggressive, or breaking rules etc., I'd just never been that sort of person and the idea of breaking any rule was just so out of the question it wasn't even considered. So when my self-harm started it was definitely a way of getting back at them, getting the anger out, regaining control type thing, and also kind of a call for help because I was really in distress mentally (and my home life wasn't great either). Since then, I would say a need for control is definitely still a main cause, and also as a kind of concession if I'm not coping- e.g., when I would have really stressful days at school, I would want to express that I was feeling bad, and I would enjoy, kind of, the pain and the act of it, and so it would be like 'if I self-harm, I can get through class X because I've given myself more control and it's a choice, not me being forced to'. (Jay, 16, 2014)*

Jay provides a narrative which clearly marks the practice of self-injury as being a way of 'regaining' control, or enacting control when other aspects of her life felt less controllable. Importantly, Jay's account draws in a range of complementary explanations for her practice of self-injury, some emotional, others less so. Self-injury in this particular narrative is clearly framed as being related to 'coping with emotions', but Jay links this with uncontrollable interpersonal contexts, and an orientation towards emotional *expression* as well as 'private' management of negative feelings.

In contrast, other accounts from 2014 attested to *losing* control of self-injury. Sometimes, accounts of being both in and out of control were provided. Ruth noted when writing about reasons for self-injury: *'This is something I can do to control myself, though sometimes, it makes me feel out of control. -sometimes, I just do it, even when I'm feeling ok.'* Others spoke of feeling 'addicted' to self-injury, or suggested that one of the risks of self-injury was that it could become 'out of control'.

> *Self-harm can very easily spiral out of control because it is addictive and there are constant urges to cut deeper and every time you survive a cut the next will be worse […] I feel as though the first cut is never the last and as soon as you start you need external help to stop all together. It is easy to feel like you can control it but that is rarely the case. (Nick, 17, 2014)*

Nick's account draws in the importance of accessing 'external help' in order to stop self-injury, reproducing dominant clinical narratives which frame self-injury as a disorder of impulse control requiring (medical) treatment. Less explicitly, some accounts gestured to the need to 'control' self-injury. Nickie wrote: *'I used to do it every two weeks; this happened for about three months but now I'm trying to gain control and I'm getting better.'* Discourse about self-injury being 'out of control' infers a sense that the practice is compulsive, addictive and requires control. In some cases, as with Nick, this leads to a view that 'external help' is necessary in order to 'stop all together'.

Losing control of self-injury was less often discussed by participants in the 2007–8 interviews, though there were exceptions. Both Justin and Craig alluded to cutting themselves when drunk, and framed these instances as relatively 'out of control'. Across both projects, self-injury

under the influence of alcohol was associated with less control, enactment of greater 'damage' than might otherwise occur. However, a view of self-injury as addictive or compulsive was less present in 2007–8, though participants did occasionally refer to 'urges' and for Harriet this was a more prominent aspect of her narrative. Here, Harriet and I discuss the role of 'urges' and why psychiatric medication 'worked' to remove these:

> *Harriet: What's it [medication] doing in your brain? To make you kind of go 'no, I'm not doing' just taking away those urges I'm like …*
> *Amy: Absolutely. So is that how you feel, the, the kind of experience, that it's, it's like an urge?*
> *Harriet: Yeah, you're just like … I really want to do it, you're like, and you're just like, you get really, like, anx- I get really anxious, and like, oooh, I need to do it I need to do it, just to, kind of relieve that tension inside and I'm like, and the longer I kind of put it off, like, I know it's gonna be worse, whereas if I kind of like do it, earlier, then it's like, … its, I can take control.*

As Harriet continued to reflect on her 'urges' to self-injure, she suggested that one way of taking control was to injure herself earlier, before the tension got 'worse'. This echoed the discussions above where if tension, emotions or 'it' were not released (or relieved) then they would become 'worse'—more violent, harder to control. Control is a significant motif in accounts of self-injury. Participants' use of the notion of control invokes a particular construction of bodies, emotions and embodiment. Emotions and urges are situated 'inside' and marked as potentially 'out of control'—emotions may 'build up' and 'explode' if they are not 'released'. Control in these accounts is enacted through the 'outside' of the body in ways which are visible and tangible: a cut, burn, bruise or—more rarely—tears. Emotions emerge as embodied through both the impact of corporeal actions and neurochemical interventions: through medication, in Harriet's example, endorphins, for others; and for all, through the act of injuring the outside of the body.

The bodies constructed in the accounts above are thoroughly embodied, with emotions and bodies intertwined and inextricable. Individuals spoke or wrote of enacting (emotional) control through practising self-injury on and with their bodies. Importantly, the more detailed accounts discussed here highlight the role of interpersonal contexts in contributing

to either excessive emotions (which need controlling) or a sense of feeling out of control of social and interpersonal circumstances (with self-injury offering 'something' that can be controlled, at least). Narratives about the use of self-injury as a response to emotional or interpersonal lapses in control point to the ways in which society and culture 'get under the skin' in quite tangible, visceral ways. In the next section, we will turn more explicitly to the role of interpersonal social contexts in contributing to and shaping emotions, feelings and states that are associated with self-injury.

Expression and Invalidation: Turning Away from Emotion

The metaphor of 'release' which is referred to so frequently in accounts of self-injury relates closely to the notion of 'emotional expression'. Indeed participants across both studies drew on the language of 'expression' when discussing their practice of self-injury. A key difference between release and expression is that where release can be seen to refer to an individual sensation or experience, expression more directly implicates others—expression invites a *response*. This is more clearly apparent if we consider the concept of invalidation. Emotional expression can be invalidated: while others may respond in a nurturing, affirming or sympathetic manner; equally, they may *not* respond, and they may turn away or ignore the expression. Emotional release on the other hand does not invite a response (or risk lack of response) in the same way—emotional release is better understood as an end in itself.

While some participants described their self-injury as a form of 'emotional expression', others talked about emotional *re*pression. Particularly in the 2007–8 research, participants' life-story narratives often tied the practice of self-injury to experiences of emotional repression and invalidation, especially in childhood and adolescence.

Self-Injury as Emotional Expression

The idea that self-injury might be a form of emotional expression is found across academic and popular literature on the topic. Clinical

research addresses this through the notion of 'emotional dysregulation' which frames people who self-injure as having difficulty identifying and processing emotions (Gratz 2007). The accounts of people who have self-injured both confirms and unsettles this view. While some do appear to avoid naming emotion (remember Anna's talk about letting 'it' out; or Belinda's busy, traffic filled street/head); others are clearly able to articulate emotional states eloquently—yet they still argue that self-injury can be a successful way of 'dealing with'—releasing, or expressing—these emotions. Crucially, in some accounts, expressing emotions via self-injury is framed as problematic (even pathological), perhaps reflecting dominant clinical perspectives. In other cases, there are attempts to normalise the practice, particularly through comparisons with more socially acceptable, but equally embodied, forms of managing emotional states: alcohol use, eating or exercising, for instance.

Harriet, who was engaged with a range of supportive and psychiatric services, provided a complex account which simultaneously challenged pathological framings of self-injury, but at the same time acknowledged that using self-injury to express 'pain' was problematic.

> *I was like feeling so bad and I couldn't, … understand what was going on inside me I was like hurting so much, but I couldn't express that pain and I couldn't understand it, but by causing it physical pain, I could see the scars on my arm and, I could understand that, and the pain that created it's like – it's kinda like a way of masking the other pain, it's like, because that pain, … was like there, you'd forget about the other pain you were in cos you're like – oh my arm hurts or whatever. (Harriet, 26, 2007)*

Harriet suggested that self-injury was a way of 'expressing' internal pain that she was struggling to understand. The corporeal aspects of the practice of self-cutting are foregrounded here—the visual scars, the embodied, 'physical' pain, which served a dual purpose: both more readily understandable and a form of distraction from the 'other' pain. Harriet also talked of self-injury being, sometimes, the only way she was able to express anger:

> *… when I can't express any anger it's like, it's easier just like, if I just go and cut myself because that's the way to – no other way of expressing it. It's like, people*

like [say] 'no, but you've gotta tell us when you're angry' and I'm like 'oooh, I can't do it!' cos like, it's just too hard for me to … to like say it … it's like I think I'm scared of people's reactions about saying, like I'm like angry with you about that.

Harriet alludes here to the importance of interpersonal and cultural context: anger, particularly when directed at 'someone' is framed as especially difficult—Harriet describes herself as 'scared' of how others would react when her anger is directed at them. In this case, self-injury is used as a substitute for expressing anger towards others: Harriet describes cutting herself as a way of expressing anger instead of having to communicate it explicitly, and face negative reactions. In this way, Harriet is able to avoid upsetting social order, and seeks to maintain interpersonal relationships (Brossard 2014).

Some authors have suggested that gendered norms of emotional expression explain why young women appear to be more likely than young men to self-injure (and conversely why men predominate in suicide statistics) (Payne et al. 2008). Certainly, the expression of anger in women is said to meet stronger disapproval than among men (Lupton 1998; Schrock and and Boyd 2006). Anger was named far more often by women in both studies. However, it was raised by men as well, and in not dissimilar ways. Justin spoke of a similar 'fear' to Harriet regarding his feelings of anger: *'so that anger's still there, like, it's still there but it's, it's trying to find kind of ways of, kind of getting it out without, you know, taking it out on me or anyone else.*' Justin went on to recount an altercation he had in a bar, citing this as evidence that he still struggled with feelings of anger: '*that sort of made me aware that you know it's still, … still there, you know […] just feel that kind of, you know, real, like real anger, it's quite scary really.*' I introduce this example not to dismiss arguments which point to the gendered nature of emotional expression, but to highlight that gendered emotion rules are more complex than simply 'OK for men; not OK for women' (see Simon and Nath 2004 for another perspective which supports this).

Anger is also an important part of my own practice of self-injury, or rather, my reflection on my practice of self-injury. Over the period where I was carrying out interviews in 2007 and 2008 I was also undertaking fortnightly psychotherapy, paid for by my research expenses and designed to provide me with 'emotional support' during fieldwork which

was expected to be 'difficult'. This experience had unexpected effects on the process of the research. In particular, the conversations I had in therapy sessions were pivotal in me considering the potential importance of anger, as this was an emotion that I personally had struggled to 'name' or acknowledge in myself. The process of reflecting on this in my psychotherapy sessions undoubtedly shaped some of the conversations I had with participants. The discussion with Harriet, reproduced above, is a fairly explicit example of this as it was prompted by me directly asking whether Harriet ever got angry.

Donna wrote about fairly overt attempts by others to 'control' her anger when she was younger, with her narrative explicitly drawing this into her ongoing experiences with self-injury:

> *Always suffered issues with my anger, for no apparent reason. Forced to attend anger management sessions between age 10–11, this taught me (if anything) to not express my anger. This caused me to suppress my feelings and turn them inwards rather than hurting those around me I started hurting myself. I didn't originally realise that I was self-harming. I started self-harming 'with intent' on [in] 2008, everything just crept up on me and I started to punch myself in the face because I wanted to hurt. In the last 6 years my self-harm has developed significantly, I now predominately cut but still punch myself when it's more convenient. I often feel angry or frustrated for a large variety or reasons, this can trigger my self-harming tendencies. (Donna, 17, 2014)*

As well as providing a further example of the way in which anger emerges as something that can be expressed via self-injury; Donna's account highlights an inclination to focus on the expression and management of anger, rather than the 'causes' of angry thoughts and feelings. This can be seen in clinical responses to self-injury which frame the practice as a maladaptive form of emotional regulation. In these cases, people who self-injure are taught more 'appropriate' methods of dealing with strong emotions—often anger (Gratz 2007). Less often does discussion or focus rest on what it is that may be causing these feelings—the focus is maintained on the individual, 'pathological' person who is self-injuring, rather than the potentially problematic, social and cultural environments in which they live. Indeed the 'anger' experienced by individuals who self-injure—particularly if diagnosed with borderline personality disorder (as Harriet

had been) is invariably framed in psychiatric literature as 'inappropriate anger' (Bjorklund 2006). As a sociologist, such labelling of emotions raises significant questions about how anger—or any emotion—comes to be understood as appropriate or inappropriate.

In the next section, I turn to narratives about the contexts in which emotions are experienced, managed and expressed by those who self-injure. This analysis allows a more critical, sociological examination of the ways that certain emotions—especially those marked as 'negative'—come to be seen as unacceptable.

Emotional Repression: The Role of Interpersonal Emotional Cultures

Using self-injury to 'express' emotions, or pain, was a common explanation across both studies. In contrast, feeling 'unable' to express emotions was discussed more often in the detailed, life-story accounts from the 2007–8 interviews. The space provided by these unstructured interviews likely provided greater opportunity to reflect on and explore reasons *why* self-injury might be used to express feelings. These accounts often recounted experiences which related to the idiosyncrasies of interpersonal emotional cultures within families.

Francis talked about feeling *'incapable of, feeling emotion, just completely numbed'* during the time in his life when he had self-injured. In the face of 'numbness', self-injury for Francis was introduced as a way of *'feeling, pain, you know feeling pain 'cos it was something'.* Significantly, Francis indicated he felt it was 'wrong' that he did not have other feelings, since he was going through a family breakdown at the time.

> *I wasn't, getting upset and crying about it, I wasn't, em, you know, … I was sort of self-containing it, I was containing it really and sort of, you know, [pause] not expressing it I suppose, and … I think I've been, … and so I was sort of, … I felt it wasn't right, or, it felt wrong, to be, to have, to know, that I should – that I'm upset, to know that these things have upset me, but not, but the, you know I'd learnt, or I'd got into the habit of really, … not displaying that. (Francis, 25, 2008)*

Francis was markedly hesitant in talking about these issues, which perhaps reflects a difficulty (which I would share) in talking about emotions, and especially in articulating feelings that Francis suggests were not 'normal'—they were not 'right'. Francis indicates discomfort in being able to identify feeling 'upset' but not able to 'display' this. Elsewhere in his interviews, Francis elaborated on reasons why he may have felt unable to express emotions—especially negative ones. He suggested that 'self-pity' in particular was discouraged in his family, with his mother especially encouraging the children to 'roll with the punches'. Francis related the following in an explanation of why he found it difficult, initially, to go to a counsellor (therapist):

> *I guess one of the things, … that I was thinking, was along the lines of, being told [by a counsellor], 'oh that's a terrible thing to happen you must have been really upset' or whatever, you know that's, sort of gives you room for self-indulgence really or feeling sorry for yourself, whereas if, you know, you sort of, roll with the pun – play it down, which is sort of my mum's style of things.*

In such a context, where emotions are acknowledged 'internally' but an individual feels that there is no 'appropriate' outlet, self-injury can become more understandable as a 'private' or 'hidden' method of 'getting out' (or releasing, as above) these feelings. Additionally, the visible, corporeal aspects of the practice—the wounds and marks that are generated—provide a further layer of meaning which Francis reflected upon: *'[it] might be that, … em, you know it's sort of trying to, create, … sort of a, a wound for pain that your, sort of feeling internally, that you can't express, that you can't sort of visualise.*'

Emma described a similar family environment where talking about or expressing feelings that were negative was discouraged. She said that she spent two years *'not talking'* when she was a teenager, saying that this was her way of *'dealing with'* depression. Emma associated this with her family, who, she said *'didn't let things out'*. She related a series of different stories which expanded upon this issue. For instance, she told me that her mother never expressed emotion, and had not cried at a family member's funeral–which Emma described as *'weird'* framing this as an example *par excellencé* of her mother's emotional repression. She also recounted

various occasions where her mental health had been particularly poor, indicating that this was never talked about explicitly by her parents. In the following excerpt, Emma talks about a time when she had been discharged from an inpatient stay in a psychiatric hospital:

> *I used to play cards with my mum in the evenings.' Cos I was, quite upset about the break up, just everything happening at once, I was a bit of a mess. And I used to play scrabble with my mum in the evenings 'cos I never went out for about a year, 'cos I didn't know anyone in [city] anyway …. You know, my hands would be shaking so bad, with the anti-depressants that I could hardly put the tiles down … That's kind of the way in my family, nothing is talked about, so …. Em … she was just quite happy to erm [laughs ruefully] she was just quite happy to, sit and play cards with me. (Emma, 37, 2007)*

Emma said that an important part of the gradual (and continuing) improvement in her mental health was related to her '*learning to cope with emotional stuff a bit better, […] by expressing it, which, is totally alien to them* [her parents]'. Emma described an atmosphere in her household which discouraged emotional expression, framing this as a major contributing factor to her mental health problems. She also noted that her brother had also suffered from mental health problems but that he had otherwise '*managed to escape it*'. Emma spoke of a conversation that she had with her brother about this, who maintained that he was better able to express himself because of his relationship with his partner, who had helped him to learn how to express himself rather than *'clamming up'*.

Tales about families which discouraged expression of negative emotions were common among the 2007–8 participants. Interviews with younger people in 2014 also addressed this, with these discussions focusing particularly on the importance of hiding self-injury. Benjamin suggested that although his parents knew about his earlier self-injury, he was not comfortable discussing this with them:

> *I don't like bringing it up, what's happened. And it would still be awkward like if we were watching a film and there's self-injury in it, I'd feel really awkward about it. (Benjamin, 17, 2014)*

> *My mum knows the main bits of what's going on, but I don't tell her all the details, and if she ever finds anything out, 90% of the time school is involved with that. (Katie, 15, 2014)*

Self-injury itself—as well as the emotions around it—is framed as something to be kept hidden and avoided in intimate family settings. While parents might 'know', this is not an issue that is discussed 'openly'. As Katie notes, in her case, self-injury is something that is communicated to her mother by her school—not by Katie herself. In part, this may lead from the close association between self-injury and 'extreme' negative emotions—with the hiding of self-injury and attendant emotions leading from a more general repression of knowledge about such 'difficult' issues. Brossard (2014) suggests that this can be understood in terms of self-injury functioning to 'maintain the interaction order'. By offering a way in which strong negative emotions can be 'released' or 'dealt with' privately, self-injury is framed as providing a way of addressing such emotions without entirely repressing them, but equally, not requiring others to know and therefore not alerting intimates that something is 'wrong'. Participants across both studies spoke of wanting to avoid 'burdening' others with their negative emotions, and this was often used as an explanation for why self-injury might offer a more reasonable response, rather than upsetting others.

Emotional Invalidation

While the accounts discussed above addressed emotional cultures within families which discouraged the expression of negative emotions, other participants provided narratives that referred to acts by family members that might be more accurately termed emotional invalidation. By this, I mean that stories were told where emotions or feelings were communicated to others (expressed) and this was ignored or minimised by others. For three participants—Anna, Rease and Emma—this followed an act of self-harm (cutting or overdose).

Throughout both of her interviews, Anna characterised her mother as being particularly dismissive of her feelings and her struggles with mental ill-health. In part, she attributed this to her mother's concerns about 'keeping up appearances', suggesting she was keen to keep Anna's mental ill-health a 'secret' from others. Here, Anna talks about finally revealing to her mother that she had self-injured. At this time, Anna was in her 20s, and this exchange happened during a stay in a psychiatric ward:

She never speaks about it, never ever, she'll if I mention it she's like 'ohhh, I don't want to know!' She just, [hands over ears], so, it's just no mentioned, it's never spoken about, she's not got a clue what I've been through, not a clue, when I was in hospital I finally told her that I self-harmed … and she went 'well, we'll be stopping that then won't we'. (Anna, 33, 2007)

Anna was clear that this dismissive attitude was not recent, or focussed solely on her self-injury, but that her mother had always been like this. For instance, she recounted how she had told her mother about starting her menstrual periods, to which her mother had responded: "*"oh, I thought that might happen" and that was it! That was the whole conversation!'* Anna found this situation especially intolerable because her mother apparently believed that they were *'best friends'*.

Emma, as discussed above, described her family as incredibly uncommunicative. However, she also talked about trying to '*protect*' her parents, by not telling them about the worse aspects of her mental health. In the following excerpt Emma recounts trying to prevent her parents from finding out about an incident of self-injury:

I tried to keep that from them, the biggest [pause] but my mum went up to visit me in, … cos I did that when I was in the [psychiatric hospital], and my mum came up to visit me, when I was, I'd been taken to the [general hospital], em, … and she appeared in the [general hospital], while I was trying to phone my dad, cos he was supposed to come and visit me that day. I was trying to phone him to say not to come. [laughs]. And er, … my mum walked in and just went 'What in God's name have you done to yourself' [laughs] And I'm like … that's a strange reaction, you know, I've just seven stitches in my arm, and em, my stomach pumped, and em, you know, … you're, almost blaming me. (Emma, 37, 2007)

This particular excerpt from Emma's interview is interesting, suggesting that Emma herself did not feel 'to blame' for her self-injury. Certainly, this account suggested that she had expected a more sympathetic response from her mother; instead feeling 'blamed' for what she had 'done' to herself.

Emma herself pointed out the contradiction between her desire for better communication with her parents, and her attempts to hide her self-harm from them. This was paralleled in her self-injurious behaviour,

whereby on one hand she described this as an expressive act, but on the other she was careful to keep the scars and wounds hidden. Despite being clear that she herself struggled to communicate about these issues, Emma talked about becoming increasingly exasperated by her family's inability to do so either:

> *As long as I can remember, em, we've never had a discussion about, [pause] anything, of great import. You know, we'll talk about the weather, we'll talk about em, … my dogs, we'll talk about, how lovely my nephew is, but eh, even, you know after, 10 visits to the, the [psychiatric hospital] […] you know my parents, I would go walking with my mum, and she would, she would sort of, very, very awkwardly sort of, … just kind of stammer out 'So how you doing' [chuckles], and that would be it […] you know, 'Are you, still on the medication?' … no I, Jeez is that all you can, ask me about? […] you know, after all I've been through! [Laughs] all you're worried about is whether I'm still on the medication or not! (Emma, 37, 2007)*

Rease also described her family as responding in what she saw as a woefully inadequate manner following an overdose:

> *… I woke my Dad up and I'm like, you know, 'Dad I've done this really stupid thing'. And it wasn't a suicide attempt. At – sort of extension of the self-harm, or, panic, or, the self-harm not working, and thought mebbe, something might. So I woke him up, and just like, em. So I got an ambulance, and, got my stomach pumped and stuff, and but, again, em, nothing came of it. Can you believe how much my family doesn't talk! [laughs], it was ridiculous! (Rease, 28, 2007)*

What is clear from these narratives is that Rease, Anna and Emma all speak of feeling that their distress was not *validated*. All described responses (or lack of responses) which are framed as being inadequate. These problematic responses are especially acute when considered alongside the parallel narrative about the difficulty that many said they faced in expressing or communicating their distress. A common story emerges whereby individuals who have 'problems' expressing themselves, and especially expressing negative emotions, describe having their attempts at expression (self-injury, self-harm) invalidated, overlooked or ignored.

Emotion Work: Emotions and Social Life

> It seems that individuals themselves are beginning to recode their moods and their ills in terms of the functioning of their brain chemicals, and to act upon themselves in the light of this belief. (Rose 2003: p. 59)

The accounts discussed above can be understood as particularly embodied articulations of 'emotion work' (Hochschild 1979). Hochschild's original formulation of emotion work was pivotal in the sociology of emotions: demonstrating in concrete ways how social context shaped emotional experience and expression. Like 'the body' emotions have a rich sociological history (Denzin 2007; Turner and Stets 2005; Williams 2001). However, Hochschild's theory of emotion work was (probably) the first to explicitly engage with the work that individuals must 'do' to their emotions in order to maintain social order.

Hochschild developed the concept of emotion work, or emotional management to describe the conscious processes engaged in by individuals to ensure that their emotions are appropriate to the 'feeling rules' of a given social context. She distinguished this from instances where individuals 'act' out emotions in order to attempt to 'fit' a situation, emphasising that '… the emotion management perspective fosters attention to how people try to feel, not, as for Goffman, how people try to appear to feel' (Hochschild 1979: p. 560). One example of this is a bride actively trying to *make* herself 'feel happy' on her wedding day. Across several publications Hochschild articulated a number of ways in which individuals might 'work on' their emotions to ensure that they matched social expectations. In a study of air hostesses she argued that emotion work had become commodified in the rapidly expanding service industries (Hochschild 2003b); while subsequent studies have charted the emotion work carried out within families—particularly for women, facing the 'second shift' of family and paid employment (Hochschild 2003a). In *The Managed Heart*, Hochschild described how air hostesses controlled their feelings of rage and animosity in order to present a pleasant and personable face to customers who in many cases induced these feelings (2003b: p. 25). The methods that the air hostesses used included a wide range of cognitive and

bodily techniques; the important factor in all of these was that the 'emotion management' must go undetected in order to be successful.

There are three significant similarities between self-injury and the forms of emotion management Hochschild discusses: firstly, self-injury, like other forms of emotional management, is described by some people as functioning to 'work on' and alter emotional states; secondly, many people who self-injure hide their self-injury, just as those practising emotional management also seek to do so *without being noticed*; finally, Hochschild's participants described a range of *embodied* methods of doing emotion work, which could be compared to self-injury. At the same time, it is important to underline that the use of self-injury as a method of 'emotional management' is not universal. While some accounts, as we will see, fit this model very well—others do not. In particular, in Chapter 4 we will address self-injury which is framed as being oriented towards communication and validation of emotions, rather than the alteration of emotional states.

Brossard (2014) has written in detail about the emotional and interactional elements of what he terms the 'self-injury daily process'. Drawing on interviews with 70 people who had self-injured, Brossard developed a theory of the way in which self-injury was used to 'maintain the interaction order', particularly within family life. Self-injury was described by participants in Brossard's research as a way of dealing with feelings of guilt, embarrassment and anxiety. Guilt and embarrassment are particularly social emotions—leading from the social meanings ascribed to given acts, to imaginations of how 'others' would perceive the individual. For example, Brossard refers to Elianor, who reports that she injures herself 'each time she makes a "mistake" even a little one […] she hates herself, [and feels] that she is "a shit," and so forth … until the wound' (p. 563).

While Brossard highlights the cognitive, 'internal dialogue' that may occur in the lead up to self-injury, he focuses less explicitly on how and why the embodied practice of self-injury serves to effectively address these problematic emotional states. Hochschild's (1979) original formulation of emotion work suggested that there were three broad techniques through which people carry out emotion work: cognitive, bodily and expressive. She was clear that practically separating these was impossible.

However, subsequent theorisation has tended to focus on analyses of feeling rules, rather than the techniques used by people to 'do' emotion work. Where techniques are examined these are generally cognitive or expressive types of emotion work (Bolton and Boyd 2003; Theodosius 2006). Bodily methods are less often addressed (Knights and Thanem 2005)—though in some work, the embodied nature of emotions is occasionally noted (e.g. Theodosius 2008). Indeed, although sociological work on emotions increasingly acknowledges embodiment, much existing writing on emotion work engages very little with embodied methods that individuals might use to 'do' emotion work. This mirrors a similar trend in writing on self-harm, where the bodily practices of 'doing' self-harm, and how these are accounted for and understood, are frequently under-examined.

What Is an 'Appropriate' Emotion? On Feeling Rules in Family Life

An important aspect of Hochschild's theory of emotion work is her identification, and emphasis on the contextual nature of, feeling rules. Feeling rules, according to Hochschild, become particularly evident when they are broken, or not met. Thus, in the example of the wedding day, above, the 'rule' that one should feel happy when getting married is illuminated most starkly by a bride or groom who feels reluctant or sad. I would suggest that in the cases discussed above the 'feeling rules' illuminated by participants' accounts were that one should not feel, and certainly not display, negative emotions. This supports Brossard's analysis of self-injury as a method of maintaining the interaction order, particularly within families. However, what we can also see is that if negative emotional expression is discouraged, it can leave individuals with no way of knowing 'what to do' with strong, negative emotions. This can be seen, for instance, in Harriet's argument that she had '*no other way of expressing*' anger, aside from self-injury. Several participants discussed using self-injury as a way of managing feelings of anger towards others, by 'taking it out' on themselves.

I think, sometimes I'm like angry with other people, but I can't, express that anger with them […] so I take the anger out on myself, in self-harm. (Harriet, 26, 2007)

While the role of families in repressing or invalidating emotions was certainly highlighted by some, others were very clear that they felt their family was in no way 'to blame' for their behaviour. Mark and Milly in particular stressed this point, and it may also be significant that both Harriet and Robert seemed reluctant to talk about their families, despite alluding to problems.

Interpersonal, family-related factors are increasingly identified as significant in clinical studies of self-injury (Wedig and Nock 2007). However, these tend to neglect broader social and cultural factors which might shape norms and practices of emotion within families. Such issues *were* raised by participants though: Milly, Rease and Dinah all referred to cultural norms which discouraged emotional expression. Dinah talked about *'the total Scottish culture, British culture, but you're keeping things to yourself, not wanting to worry other people'*. Rease and Craig conveyed similar stories about not wanting to 'burden' other people with their problems or emotions.

Milly talked at length about the problems she felt she had regarding 'appropriate' emotional expression. She said that in the past she felt she had 'inappropriately' expressed her emotions, and went on to discuss the challenges of expressing emotions *enough*, but not doing so 'inappropriately':

I'm lucky that I can, em … I can go through those emotions without feeling too … em, … detrimental towards myself […] 'cos I know, society these days is just so, [pause] 'one must not show one's emotions' […] to the world kinda thing. And I'm not really showing them to the world but, I'm just … making sure that I'm still allowing myself to be human. (*Milly, 28, 2007*)

Milly's discussion relates to theoretical debates around understandings of (emotional) control and release and the importance of broader sociocultural beliefs about this (Lupton 1998; Williams 1998a). As such, there appears to be some suggestion then that the lack of emotional expression described in some families could relate to wider social and cultural

attitudes towards emotional expression. Feeling rules in families must be understood as reflecting more widely established cultural norms of emotional expression. This tends not to be reflected in clinical studies, which instead frame individual families as dysfunctional (Sim et al. 2009).

Working on Emotions

Hochschild's concept of emotion work helps to illuminate narratives about self-injury by drawing attention to the 'work' that is implicated in accounts about the practice. Several participants talked about acts of self-injury where they had to 'work at' the practice in order to effect some level of success. These accounts help to unsettle, contextualise and embody, trope accounts of self-injury which talk of the 'transformation' of emotional pain into physical pain, or the 'relief' offered by the act of cutting. To ensure that self-injury is 'successful' may require some effort.

Anna in particular illustrated this issue graphically, suggesting that during an episode of cutting her initial cuts 'did not work':

> *… last week, the week before, whenever it was when I cut myself last. It was pretty scary I have to say. Because I cut myself, there was like half a dozen or so on this arm, and I was like 'ohhh … noo, it's no worked its nooo …' and I went back and I did one, and then I did another one and it just went – whoohhhe. It opened up and it was deep, ken it was like right in deep. (Anna, 33, 2007)*

Anna suggests—as did others—that the depth of the wound was an important marker of success. Several participants talked or wrote of the need to inflict deeper and deeper wounds as their practice of self-injury 'progressed'. This was raised by Rease, who talked about her self-injury increasingly *'not working'* which had led, she suggested, to an overdose, and fantasies about cutting off some of her limbs. The idea that self-injury might sometimes 'not work' also came up in a discussion I had with Harriet:

> *Harriet: I found, it's a lot easier, to cut my leg, than it is to cut my arms, I can go deeper on my legs, for some reason, […] yeah, you can like totally like, [unclear] go into it. It's like, trying to cut my wrists is like a nightmare it's like – it doesn't work!! [both laugh] you're like 'grrrr why won't it work?' and I found*

that your wrist, it, closes up straight away (A – yeah OK) you cut and, within like, half an hour it's closed itself up […]
Amy: So is it sometimes, kind of, do you feel sometimes that you need to go to a certain deepness, do you know what I mean […]?
Harriet: Sometimes, you just get your blade and go like that and that's it (A – mm) and sometimes I would just go like tiny little scratches all on my arm it's just like, it just act, like, drawing that blade across your arm it's like, it feels good, but they're like, they fade away really so it's like, when you've done it it's like you'll feel these little lines, but then it just disappears

This exchange highlights the different ways that self-injury can be experienced and practiced. Harriet's account suggests that an aim of her self-injury might sometimes be to produce 'deep' cuts, and that she is sometimes unable to do this. At the same time, she emphasised that this was not always the case—sometimes *'little scratches'* might be enough, and could *'feel good'*. Harriet also spoke of the different tools used (she described finding razor blades the 'best' tool to use, whereas knives did not 'work'), and cutting different areas of the body.

In order for self-injury to effectively 'release' emotions or re-establish control, participants described a significant amount of corporeal, practical labour. For some, there was a suggestion that over time, the 'work' involved, and the wounds created by self-injury worsened.

I really didn't want to get worse, it sort of still progressed, a little, even without me realising it. So there's definitely some natural urge for the severity or whatever to slowly progress, though from where I can't really speculate. (Jay, 16, 2014)

Clinical perspectives have little to offer in terms of explaining this 'progression', aside from the rather bland speculation that those who self-injure gradually become 'desensitised' to the practice. However, young people writing in 2014 drew on the notion of addiction in order to explain 'urges' to cut more deeply over time. This seemed to provide a way of understanding and articulating changes in the practice of self-injury.

I would suggest that 'progression' might also be understood in terms of becoming proficient at the embodied practice of self-injury—learning about the limits of the body; the types of wounds that can be

inflicted and managed; the effects that different modes of self-injury are understood to have on emotions and the embodied self. This is perhaps more mundane than the formal language of addiction, and also—importantly—indicates that 'will' may not be entirely absent. In Chapter 5 we will return to the issue of addiction, and reflect further on the role of such language in accounts of self-injury.

Emotion Work as Narrative Resource

Attending to accounts about the *corporeal work* that goes into ensuring the success of self-injury is important. However, a narrative approach can also illuminate the *narrative work* that is being done when self-injury is described as a form of emotion management. The narrative function of discourse about emotion work was highlighted in a paper by Frith and Kitzinger (1998) which addressed women's accounts of unwanted sexual encounters. Frith and Kitzinger argued that women used narratives of emotion work to position themselves as active and responsible, rather than 'victims'. Their analysis was critical of other treatments of emotion work which tend to treat participant accounts as unproblematic evidence that 'emotion work happens'. Certainly, this type of credulous orientation towards accounts is seen often in previous sociological analyses of both self-injury and emotion work. In contrast, Frith and Kitzinger highlight that the ability to control or manage emotions is culturally valued, and therefore stories about controlling or managing emotions may be doing far more interactional work than merely reporting that such control was effected.

In terms of self-injury, examining emotion work as a narrative resource challenges clinical approaches which have sought to uncover biomedical explanations for how self-injury works as a method of emotional management. In particular, a narrative approach challenges attempts to locate individual, often internal, pathologies which may explain why individuals use such a 'maladaptive' method of controlling their emotions. Examining the narrative function of 'emotion work' talk also runs counter to existing sociological analyses of self-injury, which also tends to view such talk as indicating that the work is done, and stops there (Leaf and Schrock 2011; McShane 2012).

The accounts discussed in this chapter highlight the importance of examining the corporeal 'work' that can be involved in embodied methods of doing emotion work, such as self-injury. This 'work' was central to some explanations for self-injury, demonstrating that even when not directly attached to economic activity, emotion work can involve (physical) labour. This analysis of self-injury also emphasises the relative lack of attention given to other embodied methods of doing emotion work, *and* of the practice of self-injury. Indeed, much existing work tends to light upon either bodily practice or emotional states, without addressing in any depth how these two 'separate' fields are anything but.

So what 'work' do narratives about self-injury as a form of emotional management do? They speak to broader cultural values which prize rationality over emotionality, and control over chaos (Williams 1998b). Self-injury is framed in clinical research as 'impulsive' and 'out of control' (perhaps 'addictive') (Jacobson and Gould 2007), accounts which show self-injury as a method of controlling emotions, or 'releasing' overwhelming emotional states provide a counter-narrative which aligns self-injury with rationality and indeed 'normality'. Where self-injury is described as 'just my way of coping', accounts seek to normalise the practice of self-injury and reject ideas that it is inherently pathological. However, at the same time we should be wary of uncritically embracing such explanations. As Bareiss (2014) cautions, this narrative is dominant in US print media discourse, and it may have the unhelpful side-effect of re-focusing self-injury within an individual, but as an individual 'choice' rather than an individual 'pathology'.

Examining the ways in which embodied emotion work is used as a participant resource (Frith and Kitzinger 1998) by people who have self-injured affords an important, further layer of analysis, offering further affirmation of the importance of embodiment in emotional accounts, as well as adding a more nuanced analysis of emotion work itself. Many participants drew upon narratives incorporating embodied emotion work to justify and account for their use of self-injury to manage their emotions. They did this in two inter-related ways: framing self-injury as rational, and drawing on biomedical language to lend authority to their accounts.

Emotion work was used as a way of presenting self-injury as a rational—if not always successful—response to problematic emotions and situations.

> *… sometimes I start to panic about things, and the only way I can stop panicking about it and think rationally about it is … cut myself [pause] it just like, I dunno it makes me just stop I suppose and then, it's like right ok, deal wi' it. (Anna, 33, 2007)*

Participants frequently set up self-injury as a method of gaining control over otherwise uncontrollable or intangible feelings. In this way, their accounts reflect dominant, dualist understandings regarding the irrational nature of emotions (Jackson and Scott 1997; Williams 1998b). These accounts challenge clinical interpretations of self-harm, which more usually frame the practice itself as irrational and impulsive (Redley 2010). Thus, participants portrayed themselves as ultimately rational, capable actors who were addressing—albeit in an unconventional manner—unwanted, undesirable emotions.

In many accounts, the embodied nature of self-injury was framed as central to explaining the efficacy of the practice in improving emotional states. In these cases, participants often drew upon technical, biomedical language. Using such language could be seen as an attempt to lend weight to accounts of self-injury which, as noted above, is more usually framed as irrational and impulsive.

> *Self-harming releases serotonin and when that isn't being released, we feel depressed. Some people lack that chemical altogether. People start to crave that happy numb feeling from cutting or burning. (Lorna, 16, 2014)*

By framing self-injury as a practice which acts upon the body in 'concrete' ways—affecting endorphins, serotonin or adrenaline flows—such accounts appropriate the power of biomedical narratives about bodies. These narratives reflect the increasing encroachment of biomedical explanations into accounts of emotions and emotional life (Rose 2003; Stepnisky 2007).

Biomedical accounts of self-injury, and those which emphasise rationality over emotions, each incorporate enduring and powerful dualist modes of thought (Crossley 2001; Williams and Bendelow 1998). Explanations of self-injury that privilege rationality over excess emotionality suggest that these states are opposed and mutually exclusive. Similarly, where narratives about self-injury are embodied through the use of biomedical language, biomedicine and physicality are also privileged over more intangible emotions. Thus, although self-injury is increasingly associated with 'emotional problems' in both clinical literature and media discourse, individual accounts of the practice complicate this understanding. These accounts *do* implicate emotional issues, but self-injury is offered as a rational, biomedically justified response, grounded in practical actions (cutting, burning or hitting). Perhaps significantly, self-injury is framed as generally more successful, or preferable, to other potential responses: such as talking, or 'cognitive' emotional work. In this way, self-injury might be seen to broadly mirror biological approaches to understanding 'mental' illness, approaches which some have warned might lead to the 'silencing' of 'entire realms of life' (Stepnisky 2007: p. 203). Simultaneously, focusing on self-injury in terms of individual emotional problems could well 'silence' attempts to examine wider social processes that might contribute towards, or shape potential responses to, such problems.

Authenticity, Emotions and Bodies

> *It's like you're, cut off from people. So I felt like that, and the, the self-harm brought me back to life […] self-harm would kinda wake me up, and just make me feel so much better. (Rease, 28, 2007)*

Underlying the accounts of emotions and self-injury discussed in this chapter is an implicit concern with authenticity, with the 'real-ness' of emotions. Francis, for instance, talks of his uncertainty about his feelings at a time of interpersonal upheaval; self-injury he suggests, might have offered something more tangible to signify the distress he felt he *ought* to be experiencing, but was not sure of. Corporeality plays a significant

role here: Francis highlighted the role of 'pain' generated by the burns he inflicted, as well as the visible marks that were left behind. Similarly, Belinda spoke of the 'concrete' nature of self-injury, as compared with the amorphous, harder-to-pin-down nature of her feelings.

The accounts of some participants highlighted the importance of maintaining emotional control, and using self-injury as a method of enacting control. They spoke of self-injuring to 'release' emotions privately, away from others. Dinah alluded to what she suggested might be a peculiarly Scottish culture of not wanting to 'burden' other people with her problems. These accounts run counter to some sociological theories of emotion, which argue that society is in fact *more* permissive with regard to emotional displays and communication (Wouters 1989). I would suggest that the case of self-injury offers an intervention into this debate. While we might accept that there has been some aspects of informalisation or diversity in the extent to which we can be emotionally expressive, accounts of those who self-injure suggest that this only goes so far. When we are concerned with emotions that are perceived as negative, there appears to remain, for some, a strong assumption that these are not 'acceptable' in many—perhaps any—social settings.

Authenticity has an important position in the sociology of emotions. An early critique of Hochschild's thesis on emotional management problematised the implied split between an 'authentic' emotional self and the 'false' emotional self which developed in capitalist, marketised settings (Wouters 1989). In a different vein, Meštrović (1997) has bemoaned the development of what he terms postemotional societies, characterised by the recycling of emotions, particularly in 'public displays' articulated through the media. While seemingly disparate, each of these debates grapples with the *potential* for emotions to be 'fake', as well as the grave importance attributed to 'genuine' emotionality. This offers some explanation for why those who self-injure might seek to 'show' their emotional (intangible) distress in a visible, physical wound.

Cultural narratives circulate about the precarious and questionable nature of emotions: they can be faked, 'put on', or exaggerated to 'get attention'. Such narratives, I would argue, contribute to the enduring devaluation of 'mental health' as compared to physical health. Bendelow addressed this in *Health, Emotion and the Body*, suggesting that

contemporary practices of biomedicine, and in particular evidence-based medicine (EBM), tend to prioritise biology over models of disease which draw more widely on factors which would incorporate social context. Bendelow notes that in particular, EBM tends to reject patients' own accounts of illness as 'subjective and unreliable' (Bendelow 2009: pp. 6–7). We can see evidence of this in clinical research on emotions and self-injury which seek to quantify and measure emotion, or which search for biological explanations for the emotional functions those who self-injure report.

In this chapter, we have seen that talk about emotions and self-injury did not refer to solely individual, internal conflicts, though emotions themselves were generally framed as residing 'inside' the body. We also saw how interpersonal contexts which might invalidate or repress attempts to communicate about emotions were employed in participants' attempts to make sense of their self-injury. For some, wider cultural norms about being emotional 'appropriately' were alluded to. What I want to underline here is that, while emotions are often taken to refer to internal feeling states, or at most intimate, interpersonal relationships, a great deal of social scientific work has underlined cultural, social and structural factors which shape emotional experience, available emotional scripts and emotional expressions (Ahmed 2014; Freund 1990). In Chapter 4, we move 'outwards' again, to develop an examination of how the visibility of self-injury is said to be managed in social contexts. As we will see, although self-injury may be described as a way of demonstrating the existence of (emotional) distress, the act of revealing physical evidence of self-injury can itself be subject to charges of 'faking'.

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4

Visibility, Help-Seeking and Attention-Seeking

Visibility and Self-Injury: The Meaning of Scars and Wounds

> It is no longer the traditional obscenity of what is hidden, repressed, forbidden or obscure; on the contrary, it is the obscenity of the visible, of the all-too-visible, of the more-visible-than-the-visible. It is the obscenity of what no longer has any secret, of what dissolves completely in information and communication. (Baudrillard 1983: p. 131)

In the previous two chapters, we have addressed sensate aspects of self-injury, taking a focus on the body and on emotions, whilst highlighting the ways in which these are (a) intrinsically related and (b) situated within and shaped by social and cultural contexts. In this chapter, we focus more on those contexts, and especially the way in which self-injury is accounted for within interpersonal relationships—both with intimate (and not so intimate) friends and family, and in the context of healthcare. Our focus here is on the central importance of the visibility of self-injury—of the obscenity of the 'all-too-visible': of self-injury which comes to be *seen*.

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I will show that there are strong *moral* aspects to the concealment and revelation of self-injury. As such, I characterise self-injury as obscene, not out of a value judgement of my own, but by way of acknowledging the significant social and moral risks borne by those whose self-injury becomes seen, becomes visible.

The act of self-injury can be a dramatic visual spectacle, the aftermath often leaving marks which may be noticed, hidden or ignored by 'others'. The meanings attached to self-injury vary according to how visible the practice, or its aftermath, is, and whether it is seen or hidden. Further, the wounds and scars—when seen—are subject to interpretation. Cuts may be 'bad', 'pathetic', 'disgusting', 'not bad enough'. These meanings vary, depending on the observer, and what they 'know' about self-injury.

Many accounts of self-injury frame the practice as secret and hidden: the visible consequences—scars, cuts, bruises—are covered with jewellery and clothing; their existence fiercely guarded. According to some sources, injuries are 'always' carried out in 'private' away from the gaze of others (McAllister 2003). People who self-injure are characterised as ashamed, stigmatised and reluctant to seek help (Adler and Adler 2007). This narrative is repeated often, and rarely questioned (Adler and Adler 2011; McShane 2012). In this chapter, I seek to examine this narrative critically. I will demonstrate the way in which narratives about 'hidden' self-injury emerge in clinical accounts and the stories of people who self-injure. Hiding self-injury is indeed emphasised often by people who self-injure. I will ask why this is. Why should self-injury be hidden? Why might it be important to tell a story about self-injury as private and secret? The answer is often 'stigma' (Goffman 1968b; McShane 2012). McShane argues that self-injury is both a character and (in the case of scarring) bodily stigma. In terms of the former, she suggests that those who self-injure are understood to be 'individually responsible', therefore culpable. This apparently is the 'main reason for the display of animosity' towards those who self-injure (2012: p. 102). While I agree that perceptions of responsibility are important in how self-injury is understood, responsibility does not go far enough in explaining why self-injury is stigmatised, and why it elicits such negative responses from others. In what follows, I will set out a number of analyses that go beyond 'stigma' in understanding the nature and mean-

ings of self-injury and how its visible presence is managed. In doing so, I focus more critically on the role of visibility and 'the body'.

To address these issues, this chapter directly faces self-injury which is *not* hidden. Accounts of self-injury that is revealed, or displayed, unsettle more dominant accounts of private, hidden and stigmatised self-injury. Individuals who do 'reveal' their self-injury run the risk of being labelled 'attention-seeking'. This is a pejorative (stigmatising) term, aimed at minimising the attention-needs of individuals who self-injure, framing their practice as 'manipulative' and designating any received 'attention' as undeserved. In clinical literature, the idea that self-injury might be 'attention-seeking' is in some cases summarily dismissed (McAllister 2003). It is argued that self-injury is 'never' about attention-seeking, because it is 'always' hidden. These accounts parallel narratives provided by many who have self-injured which similarly insist upon the hidden, private and secret nature of self-injury. At the same time, many other clinical studies argue that some self-injury appears to be clearly oriented towards others.

> Self-mutilators mutilate for various reasons: to run away from feelings, to feel pain outside rather than on the inside, to cope with feelings, to express anger towards the self, to feel alive, to turn off emotions, to gain control, to express to others that they need help and to manipulate situations and people. (Hicks and Hinck 2008: p. 410. Emphasis added)

Self-injury is displayed, revealed or said to have been carried out to influence (or 'manipulate') another person (Nock and Prinstein 2005). In this chapter, I attempt to reconcile these contradictory narratives. I argue that these competing views on the way in which self-injury is managed in interpersonal situations emerge due to the existence of a complex array of wider cultural narratives which discourage negative emotional expression, frame self-injury that is revealed as 'attention-seeking' and manipulative and valorise 'suffering in silence'.

Visibility in the Clinic

The 'others' who may see self-injury include close friends and family, healthcare professionals, acquaintances and 'strangers'. How the visibility of self-injury is managed is shaped by the relationships between an individual and the people they are with. In some cases—such as 'formal' help-seeking for wound care, self-injury may be necessarily revealed to others with whom there is no pre-existing relationship. For many people who self-injure, such encounters are experienced as traumatic. A common story about self-injury takes the form of a 'horror story' or 'travesty account'—where help is sought for self-inflicted wounds and the response from healthcare professionals is brutalising, dismissive or abusive (see also Baruch 1981 for an analysis of travesty stories). These stories have been told for over 30 years (Cresswell 2005; Jeffery 1979), and they continue to be told, despite rapid expansion in 'knowledge' about self-injury (Hawton et al. 2011). The (often intensely) negative reactions that occur when people 'seek help' for (or reveal) self-injury provide a further layer in understanding why competing discourses of silence and manipulation, secrecy and attention-seeking endure.

The visibility of self-injury is both under-theorised and pivotal to understanding the practice phenomenologically and sociologically. That self-injury leaves *potentially* visible marks and scars which must be managed, and which—if seen—have particular meanings, is important in understanding the practice and aftermath of self-injury. Visibility itself has significance both historically and in contemporary, late-modern societies (Brighenti 2007). Visibility, observation and measurement were central to Foucault's analysis in *The Birth of the Clinic* (1973). As such, visibility—and particularly the visibility of sick/injured bodies—can be seen as closely tied up with the historical development of medicine, medical authority and power. Foucault argued that modern medicine was made possible by the physical co-location of multiple sick bodies in the first hospitals. These early hospitals were significantly 'bad' for health—unhygienic, insanitary, disease ridden, and the early medics had little in the way of effective interventions to offer patients. However, as doctors began to observe and routinely measure the sick bodies they managed, so they were able to develop knowledge, enact authority and exercise power.

Observation and visibility remain significant productive mechanisms of power in medical knowledge and practice. Research continues to highlight the diverse ways in which physical symptoms, visible, measurable signs are privileged over—for instance—patient reported symptoms (Mol 2003). Bendelow (2009) has argued that an orientation towards physical, biological and visible symptoms is especially detrimental for those experiencing distress or illness marked as psychological or 'mental'. Psychiatry exists in an almost permanent state of ontological 'crisis' due to its continued inability to locate reliable, measurable, visible markers of the diseases it treats (Pickersgill 2014; Whooley 2014). This is seen currently in the ongoing debates regarding whether psychiatric research should continue along symptom/disease models, or radically alter the approach to search and study only measurable, biological indicators (Insel 2014). Despite uncertainty within psychiatry, the influence of neurological discourse on lay understandings of mental illness has been significant, though not without contest (Fullagar and O'Brien 2013).

The contested, yet powerful, character of visibility within medical practice broadly, and psychiatry specifically, makes up part of the backdrop of the analysis presented in this chapter. Understanding responses and meanings attached to the self-injured body requires engagement with the wider meanings of visibility to medical practice. In particular, 'mental' illness is an especially contested area of medical practice because, depending on which lens we are looking through, 'it' can remain frustratingly *in*-visible. There are (still) no blood tests, or brain scans, that will effectively authenticate an individual's experience of emotional distress (Moncrieff 2008).

Stigmatised and Symbolic Bodies

What is seen and not seen is important in shaping social interaction. Despite my unease with the frequent and often under-theorised use of the concept, stigma remains highly relevant. Sociological analyses of accounts of self-injury have charted the numerous ways in which the stigmatising nature of self-injury shapes the management of self-injured bodies, and the experience of being someone who has self-injured. McShane argued

that participants in her research avoided social situations, wore concealing clothing and felt ashamed of their status as someone who self-injured, because they had internalised a notion of self-injury as stigmatised. Self-injury, she suggested, was clearly 'felt stigma' in these cases. McShane (2012), Hodgson (2004) and Adler and Adler (2011) have each noted the way in which those who self-injure describe using 'cover stories' or attempting to 'pass'—to appear 'normal' and avoid knowledge of self-injury being revealed. Self-injury that is hidden can be understood as a discreditable stigma, while self-injury that is revealed—in certain contexts—may cause the individual to become discredited, stigmatised, marked as 'other' (Goffman 1968b). That self-injury is stigmatising has, then, been well established. However, as I note above, less developed are explanations as to why self-injury should be stigmatising—aside from McShane's brief reference to 'individual responsibility', and suggestions about the association between self-injury and 'madness'. These associations provide a useful starting point for understanding the social meanings of self-injury. We can go further, though, in unpicking and critically analysing what such associations mean, and how they emerge in relation to self-injury. To do otherwise runs the risk of 'accepting' self-injury as inherently stigmatising—leaving far less room to offer or develop alternative readings.

Viewing self-injury as stigmatising may contribute to a negative, narrow view of what self-injury *can* mean. Framing self-injury as shameful and stigmatising closes down alternative explanations and experiences which might interpret the scars, wounds and marks of the practice differently (Chandler 2014). An alternative perspective is offered in Kay Inckle's (2007) analysis of what she terms *body-marking*. Inckle uses the term body-marking to incorporate self-injury and body modification, seeking to unsettle potentially unhelpful binary distinctions between 'pathological' and 'decorative' injuries. While I would argue that there *are* significant differences between self-injury and more 'decorative' practices such as piercing and tattooing, Inckle's analysis provides a provocative way in to considering alternative readings of self-injury.

This chapter examines accounts about the way in which self-injury is negotiated in social life. I interrogate two parallel, closely related, forms of narrative: tales of seeking help, and tales of seeking attention. Drawing

on these morally charged motifs, allows an analysis which challenges (moral) boundaries between hidden and visible self-injury, between help and attention, between deserving and undeserving. The role of stigma is more implicit in this analysis than that found in other sociological treatments of self-injury. I use the diverse accounts participants provided of negotiating 'help' for self-injury to critically explore the ways in which the visibility of self-injury is managed. While stigma is relevant, I argue here that it is not sufficient.

Tales of Seeking Help

Help-seeking is a complicated issue, much discussed in medical literature, and within the sociology of health and illness (Biddle et al. 2007; Pescosolido et al. 1998). Lack of help-seeking is frequently framed as 'a problem'—and particular groups of people, and types of condition, are highlighted as being especially *problematic*. For instance, men of all ages, and young people of all genders are said to be less likely to seek help than other groups (Biddle et al. 2006; O'Brien et al. 2005). For men in particular, this is one of several factors that is thought by some to contribute to the lower life expectancy that men in most countries enjoy as compared to women (Courtenay 2000). Mental illness is seen as especially difficult to 'seek help' for, joining other 'stigmatised' conditions whose presence evokes shame in individuals. Like self-injury, the origin of the peculiarly stigmatising nature of mental illness in general, often remains underexplored, accepted at face value—something to 'fight' rather than critically understand.

Self-injury is also framed as being an issue for which people are reluctant to seek help. Studies have suggested that the rates of self-injury recorded in official hospital statistics are 'the tip of the iceberg' (Doyle et al. 2015). Indeed, with regard to self-injury (as opposed to self-harm, a broader category encompassing overdoses) rates of 'formal' help-seeking are likely fairly low. Eighty percent of those who present at accident and emergency (A&E) (in the UK) with self-harm have taken an overdose, with only around 15 % having cut themselves (Bergen et al. 2010). In contrast, community studies suggest the majority of people who identify as having

'self-harmed' say they have cut, burnt or hit themselves. However, these studies also report very low rates of help-seeking, with between 7 % and 12 % of those reporting self-harm indicating they sought (formal) help (Doyle et al. 2015; Hawton et al. 2002). Clearly there is a disparity, and one which suggests that people may be 'reluctant' to seek help for self-injury. This disparity between engaging in self-harm and seeking formal help also applies to those who take overdoses, but appears more marked when it comes to self-injury.

Research which is used to support the view that people who self-injure are reluctant to seek help tends to be based on data regarding referrals to A&E departments, or the accounts of individuals who have self-injured (Rowe et al. 2014). This simplifies a complex picture; one where the 'help' sought (or received) may come from a far more diverse range of sources than just A&E departments. Rowe and colleague's review suggested that among young people, informal sources of help were used more often—including friends and websites. Help for self-injury is further complicated when considering timing and purpose of the help sought. A&E admissions are likely to be the outcome of a particular act of self-injury; however, people may seek help 'for self-injury' at other times: because they want help stopping, are concerned about what their practice means or are worried more broadly about their mental health.

The term help-seeking implies an active role for the individual help-seeker. This active role may not reflect the experience of those encountering 'help' for self-injury, or indeed for many conditions. Indeed, the idea of 'help-seeking' individualises a process that is likely more complex, and certainly more social. Pescosolido and colleagues (1998) highlight this in their study of accounts of people about how they entered mental health treatment, identifying three broad narratives: choice, coercion and 'muddling through'. The next few pages address the different ways in which 'help-seeking' for self-injury was narrated. These accounts certainly reflect the complex picture indicated by Pescosolido et al.'s work, with individuals indicating explicit avoidance of 'help', telling stories of 'help' that was received but not sought and finally, accounts which depict a 'rational help-seeker'.

Avoiding Help: Self-Care of Self-Injury Wounds

Many, perhaps most, people who self-injure, especially where this becomes a regular practice, care for the immediate wounds themselves. In some accounts, caring for wounds is framed as an important aspect of the overall function of self-injury.

> *I had this coping mechanism that I could use to stop, everything, because then I could concentrate on, you know cleaning up wounds, and you know feeling that throbbing pain in your arm, your like, I'm alright, I'm still alive kind of thing. (Milly, 28, 2007)*

Milly emphasised the importance of the *'physicality of having something, to tend to and, and watching something physically heal'* which was *'a comfort, because then the mood was forgotten about'*. Rease also raised this, talking of the 'symbolic' importance for her of caring for and healing her own body.

> *The healing, the sort of self-healing, and I think a lot of people have said about that, that em, about the emotions that you, can't sort of see them, or, or feel them, and, deal with the pain of them, but, when you have like, scars and they're healing's like, you're looking after yourself, you're looking after the sort of mental stress that you're going through but in a, very, em, physical and [---] symbolic way that's a bit more, real, I suppose. (Rease, 28, 2007)*

Both Milly and Rease's accounts situated the importance of healing within a wider understanding of the meaning of self-injury as being oriented towards replacing 'mental' or 'emotional' pain with 'physical' wounds which both hurt in a different way, but could also tangibly be dealt with and 'fixed'. The *visibility* of this healing is important, but it cannot be meaningfully separated from the sensate, embodied aspects of both the act and the aftermath of the injury.

In other accounts, self-care is framed as something that is practised in order to avoid formal help-seeking, on the understanding that the wounds *should* have been treated professionally. In this way, narratives about the avoidance of formal healthcare nevertheless draw on medicine in order to construct an account which emphasises the seriousness of

the wounds, and the often heroic way in which the individual managed these alone without 'burdening' others. Craig provided a graphic account reflecting this.

> *I just felt awful, and […] just really woozy, and woke up and was basically stuck to the mattress, with blood, [laughs] cos what I figured out, was I just, sort of [used a] serrated bread knife and I just slashed my leg […] I'm not anatomist, so I'm not quite sure but, … tubes and stuff like that inside and erm, I actually ended up sewing it up, myself, 'cos I didn't want to go to hospital – I can't go to hospital, they'll lock me away, for being a mental! (Craig, 28, 2007)*

Craig's story was recounted humorously, and indeed many of the conversations I had in the interviews in 2007–8 were similar, with both myself and the interviewee using 'gallows humour': perhaps to dissipate tension that might otherwise arise when discussing issues which could be uncomfortable. There is a more serious subtext though, which serves to illuminate reasons why people who have self-injured might avoid formal help-seeking—even where the injuries may have been better treated by healthcare professionals. Craig joked that he had been worried about going to hospital, concerned that they would *'lock me away, for being a mental!'* While the story was recounted in a joking manner, this type of account is only possible because of wider—stigmatising—cultural narratives about the treatment of people with mental health problems, and ideas about what self-injury, in particular, might signify.

Other participants also alluded to fears about perceptions of others regarding their practice of self-injury, and concerns that they would be viewed as 'mad'. Francis reflected on this in detail, referring to an awareness, however vague, that self-injury and madness were related, and fears that he was 'mad' but did not know it.

> *I was worried that, […] I suppose I was worried that [pause] I was implicitly, no maybe no-one had ever tol-, told me about, you know no-one had ever actually said to me people who self-harm are nutters. But that was sort of like the implicit thing; that, you know self-harming something that, you do, you know, if you do it then you've got problems, you know, like … I didn't really feel like I had big problems, but I, there I was sort of, you know cutting and burning myself, so, that's what concerned me, was that […] oh what does it mean? Am*

> *I actually a nutter, but I don't know it sort of thing, you know. Cos that's the thing I mean mad, there's that, sort of famous, […] saying, that madmen don't know they're mad. (Francis, 25, 2007)*

These accounts clearly reflect ongoing stigma surrounding mental illness. Identifying oneself as 'mad' is not framed as a useful step towards getting help or assistance, but as a fearful, worrying state. For Francis, this was compounded by his feeling that he did not have 'big problems' and what this meant when trying to ascertain his mental health status. Such discussions relate to broader issues around the 'reality' of mental illness—is it more or less likely that distress is 'real' if there are few 'big problems' in someone's life?

Receiving Help: Help that Is Not 'Sought'

Reflecting Pescosolido and colleague's (1998) typology of pathways into mental health treatment, people who self-injured also gave accounts where they *received* formal healthcare, but did not actively seek it themselves. Particularly for younger participants, or those reflecting on experiences in their teenaged years, common stories included self-injury being 'discovered', and individuals being 'taken' to see a doctor. However, older participants also suggested that they were 'forced' into help-seeking by people with whom they had close personal relationships. Dinah described a difficult relationship with a boyfriend who she said '*made me go and see a psychiatrist*'. She reflected wryly on this, noting that '*ironically enough, he added to everything, you know, he didn't help, but he wanted me to go and do something about it!*'

Dinah's account of treatment in A&E also foregrounded her own lack of agency in using this type of 'help':

> *I mean I've probably been to the hospital about 5 or 6 times, there's probably times I can't actually remember to be quite honest. The only times, times where I ever got in a state, in a situation where people found me, was when I'd been drinking, so, you know, most of the time wasn't, I was never, I was [n't] doing it in front of other people and many people didn't know about it, and when they*

did find me, it was really bad and it was probably cos I was drunk I wasn't being care-, you know I wasn't being careful. (Dinah, 32, 2007)

This narrative emphasised that in general, Dinah kept her self-injury hidden—she cut and burnt herself away from the gaze of others. As with some others, alcohol use was an important feature of Dinah's story: in this case, intoxication led to her not being 'careful'—meaning that she was 'found' by others and 'taken' to hospital.

In a different way, Anna also spoke about having little choice about whether or not she was admitted to a psychiatric hospital under a 'section': this refers to the UK Mental Health Act of 1983, which allows a psychiatrist to admit a patient to hospital for monitoring, without their consent, if they are deemed a danger to themselves or others. *'It … was a case ae, well, there was nae choice […] I wisnae sectioned, […] It was just a case eh well it's for your safety so … go…'*. Referring to the same incident in her second interview however, Anna said she had been told that '*… if I didnae go in I was gonna get sectioned'*. Anna was clear that although she was not officially sectioned, she nevertheless felt that she had no choice but to admit herself to the hospital.

In Anna's case, it appears that legal sanctions were threatened—that she would lose her rights if she did not voluntarily admit herself to hospital. In contrast, Dinah's account indicated that she retained more control over her care—while she said she did seek psychiatric help at the insistence of her then-boyfriend, she rejected the referral to group therapy that was suggested. There are important differences between Anna and Dinah's situations which may help to explain why their accounts of 'receiving help' were so different. Anna was in her late 20s, had a small baby and had been diagnosed with severe postnatal depression and had—in her words—'*tried to kill*' herself. In contrast, Dinah was in her late teens, had no children, and was cutting herself for reasons that were not framed as suicidal. This comparison may offer some indication of the importance of the social identity of the person self-injuring, and the way in which this may influence how acts of self-injury are interpreted and understood by others.

The social identity of younger participants—particularly their age—appeared pivotal in shaping experiences of 'help'. Narratives about

control over the receipt of 'help' for self-injury spoke to a particular lack of autonomy. Several participants in the 2014 study, all of whom were aged 16 or under, talked of being 'sent' to doctors, psychiatrists or counsellors.

> *it wasn't my decision to see the doctor no, the person I told at school kept pressuring me and my parents to see the doctor eventually my parents decided that they would bother with my self-harm and took me to the doctors even though I didn't want to. The doctor basically said I needed to see a counsellor and put me through to one. I'm currently seeing two counsellors and I don't trust either of them. (Cara, 14, 2014)*

Cara's account indicated that formal, clinical 'help' was clearly seen as necessary by her school and (eventually) by her parents. Cara's declaration of her lack of 'trust' in either of the counsellors perhaps suggests that although she felt unable to resist the 'help' on offer entirely, she remained wary and distrustful within the consultations, resisting more subtly.

Survey participants also provided accounts which alluded to being 'forced' into treatment or receipt of help. Several spoke to a narrative which critiqued the idea of 'forced recovery'. This type of language may have alluded to a wider view of self-injury as addictive, or to the turn towards recovery seen in contemporary mental health policies (O'Brien 2012):

> *If a person is not ready to recover or does not want to recover, they simply won't and it's not right to force them. (Jamelia, 15, 2014)*

> *You can't recover if don't want to. This summer I was forced into it. In fall I decided I will cut until I decide to recover. (Leanne, 16, 2014)*

For many in the 2014 sample, this type of discourse did appear to be oriented towards addiction in particular, rather than mental health in general. A potentially problematic outcome of the use of addiction narratives when explaining self-injury is that it may result in a further focus on 'the wound' and on eliminating visible signs of disorder. Young people responding in 2014 talked of 'days clean' (from self-injury), or 'relapsing'

(by self-injuring). This type of language rather obscured other aspects of being someone who self-injures: emotional or mental distress, interpersonal problems, structural inequalities. Instead, the focus rests on the individual who self-injures—or does not. One way in which addiction narratives resist potential 'blame' is by framing self-injury as a compulsion, that cannot be addressed until someone is 'ready' to 'recover'. At the same time, this narrative individualises the 'problem' of self-injury, and obscures wider challenges that individuals may be living with.

Seeking Help: Taking Responsibility, Suffering the Consequences

Across both research projects, participants also provided stories which framed themselves as active and responsible seekers of help. However, all too often these accounts ended badly—with tales of broken confidences, brutalising responses and abusive treatment. On a more mundane level, people spoke of responses to attempts to seek help which were dismissive, or included charges of 'attention seeking'. Francis provided a particularly instrumental account of seeking help for self-injury, suggesting he told his family soon after his first act of self-injury, and also sought input from a GP. This differed from accounts provided by others, which tended to emphasise avoiding telling anyone for longer periods of time. Francis suggested that his sister's response, in particular, was difficult for him at the time:

> *I found [her response] quite, well at the time quite hurtful but, … well, you know, now it's quite sort of funny in a way cos she was just like "oh you know, so you do it – stop attention-seeking" sort of thing. (Francis, 25, 2007)*

Francis defended his sister's response by emphasising her own physical illness (she had been diagnosed with a severe debilitating condition in her teens), as a way of explaining why she would have little time for people who '*make their own problems […] in terms of, physical, injury and stuff*'. Francis described a family that were fairly open, and did discuss his self-injury. However, beneath this support and care were underlying negative attitudes towards both Francis' self-injury and 'self-pity' in general.

For others, keeping self-injury secret was framed as vitally important, especially for those taking part in the research in 2014, perhaps because they were younger and in almost all cases still living at home with parents. However, a common narrative emerged where help was sought, but privacy or secrecy was not maintained—confidences were broken. Here, Jay recounts the challenges she faced in managing an infection of one of her self-injury wounds:

> *I had an infection and was worried about it not clearing. The first time, I went to the school nurse- I thought everything went swimmingly until it transpired she'd phoned my head of year and my mother without telling me beforehand, which made me freak out quite a lot. The second time, I was still quite distrusting of the nurse and I knew she'd have to report it, so I was hesitant to go- I was also trying to keep everything quiet from mum, and I wasn't sure if I could even make a GP appointment on my own, so I ended up going to a Minor Injuries Unit at the local hospital, who basically said I was 15 and they couldn't see me there, I would have to go to another place much further away.. so I just gave up and decided to deal with it entirely on my own, because the fear I had of getting seriously ill was still less than my fear of going to the nurse. (Jay, 16, 2014)*

Jay's account highlights the challenges faced when 'seeking help', especially for those who are younger and have more uncertain rights to privacy. Jay frames herself as responsible and sensible, attempting to take care of herself independently, drawing on medical expertise when she recognised she had an infection. This attempt at responsible self-care is thwarted by a broken confidence which, Jay suggests, undermined her future help-seeking practices. Professional guidance for the care of young people who self-injure often includes the importance of informing parents or guardians, where possible, if self-injury is 'discovered' (Ealing Council 2014). This tends to relate to child safeguarding policies which frame young people as inherently vulnerable, and obscure individual differences in maturity between young people of different ages. Further, these policies can—as we see with Jay's account—have counterproductive effects. Such perversities are recognised more readily within young people's sexual healthcare; conversely, self-injury appears to emerge as far more terrifying, and dangerous, practice. However, such a view brutalises

individual experience, and may shut down and prevent young people from seeking and receiving nurturing support.

People who had attended A&E as a result of their self-injury often provided 'horror stories' about the treatment they had received there. Such accounts are common in other research about self-injury. These narratives frame the individual as a responsible 'help-seeker', and the staff and structures of A&E as responding brutally, unsympathetically, and in a manner which further diminishes mental well-being. A particularly evocative 'horror story' was related by Anna, who maintained that she would *'rather die'* than return to A&E for treatment for her self-injury *'seriously would rather just die, I wouldnae go through that again for anybody. It was, horrendous'*. Anna's narrative—which is dramatic, gory and compelling—is reproduced in full here, to convey some of the complexity and power of these types of account.

> *I always say, if an alcoholic gets or, or any drinker gets so drunk that that they drink till they pass out and the cut their head and, and need it stitched or whatever, they get treated, and if a drug addict takes a- an overdose, they get treated. And yet, … on, many occasions, I've needed either, antibiotics for an infected cut, or stitches or whatever, and you get treated like the lowest form eh life. It's just so bad. Last year I had to go into A&E cos I'd severed the artery in my arm, and the blood was just going wheeew, spurting out em … and we went in, and it was like wrapped in this totally blood soaked tea towel, went in and the, the triage nurse, sortae put steristrips on it, she says that'll hold it, I'll bandage it, 'til you get it seen. And I seen this doctor, and he put me in a cubicle, he looked it and he went "Oh, you did it" – "aye" and so then he moved me into this dirty cubicle, em, he'd left the screen open … while he was like looking at it and treating it and everything, left the curtain thing open … em, he refused to stitch it … and, the, the blood was just like, everywhere, it wouldnae stop bleeding, you shouldae seen it, he refused to stitch it, and he fought, and I mean literally fought, and fought and fought, he went through hundreds of steri-strips, because, they were just falling off … and I was like … You're just no in a place to argue are you, like mentally, physically, emotionally you're no in a place to argue, well I wisnae. And, I was, I was j-… and they wouldnae let Mike come through he had to sit in the waiting room […] So anyway, it ended up that … he steri-stripped it, and put a … one of these … sterile pad things over it, right, by the time I had got home that had burst off and it was bleeding again, so I*

just wrapped it up and left it, em … and, within like sorta 24 hours of that it was infected, […] I was so ill, ended up wi septicaemia. (Anna, 33, 2007)

This is clearly a *moral* story: Anna frames herself as 'powerless' in this encounter; a potential advocate and supporter—her husband—is removed from the scene, increasing her vulnerability. Anna is clear that this brutal, and ineffective, treatment has been enacted upon her because she had a *self-inflicted* wound. She suggests that the treatment she received was 'worse' than the way in which alcohol or drug users are treated, drawing parallels with other forms of 'self-harm' and suggesting that self-injury is viewed by healthcare professionals as especially problematic. Indeed, this is borne out by research with healthcare professionals, which has found that self-harm *is* viewed more negatively (Hawton et al. 2011; Jeffery 1979). Anna's account provides a graphic example of the repercussions of such negative views.

Central to this narrative is Anna's body. She suggests that she had to visit A&E in the first place because she was unable to control the bleeding of a severed artery on her own. This echoes the 'heroic' story told by Craig, above, and emphasises that outside treatment (as opposed to self-care) is only accessed as a 'last resort'. The doctor's disapproval of Anna's behaviour is played out on Anna's body, as he '*fought*' with the wound, attempting to close the laceration with steri-strips rather than sutures. Whatever the doctor's reasons for taking this approach, from Anna's perspective this was experienced as a further attack on her body, one that led directly to her developing an infection.

The doctor in Anna's case is framed as having a problem morally with the fact that Anna had created the wound herself. This was echoed in Emma's 'horror-story':

I have been discriminated against, cos I, I turned up, I'd cut my arm, and my stomach … and […] taken myself up to A&E and, er, [pause] they, … I had to get 11 staples, em, to, to sort of patch it up, and em, they didn't bother giving me anaesthetic or anything they just went, 'Well, you're a self- harmer', click click click. You know, it was, … I was just lying there going, 'You're not gonna give me anaesthetic' they went 'Nah, you're a self-harmer – you did this to yourself so, … don't really care' and I'm like, 'But – but you're just stapling me up

with nothing!' […] and I spent, you know I stayed overnight in the, the psych ward in the, [hospital] (A – mhm) and em, … I thought they were gonna, take me back into the [psychiatric hospital] again but they didn't, they just let me go. And eh, I went straight to college heh! (Emma, 37, 2007)

Like Anna, Emma is clear that the damaging and violent treatment she received from the medical staff was directly related to their negative moral interpretation of her self-injury: '*you're a self-harmer, you did this to yourself, [therefore we] don't really care*.' In each case, Anna and Emma interpret the actions of staff as suggesting that they 'deserve' such treatment, as they inflicted the wounds themselves. Both women also frame themselves as being thwarted in their attempts to responsibly seek help for wounds that they could not manage alone.

It Could Be Otherwise: Seeking Help and Receiving Care

In stark contrast to the brutalising, violent responses which emerge in the accounts above, many participants indicated more positive, hopeful interactions with professional healthcare. Frequently, these were compared with more negative experiences, which serves to underline the power of the 'horror stories' addressed above, as well as the enduring impact of poor instances of care:

Like, some of them are, like, not too, are kinda nice with you, and others are like really horrible […] just depends on who you see, but I think, the nurses usually are quite nice, but the doctors are like, 'We don't have time for people like you'[…] there's a load of nice nurses in there […] they're like 'Ohh, what did you, what happened', and 'What made you do this?' and, […] kinda really gentle with you […] which kinda helps. (Harriet, 26, 2007)

Harriet's account suggests that care varies, but emphasised that she did experience good, nurturing responses from some staff. Positive care in Harriet's account includes both being supported to talk and narrate her experience, and having her wounds and body treated 'gently'. Historically, and in some worryingly recent accounts, caring for those

who self-injure 'gently' was seen as potentially reinforcing manipulative behaviour. Qualitative research with healthcare staff working both in psychiatry and general medicine, indicates that there are enduring concerns that those who self-injure will 'keep doing it' if they receive a positive response (Hawton et al. 2011). This understanding has likely contributed to the continued emergence of 'horror stories' such as those provided by Emma and Anna.

Harriet's account demonstrates a way in which care for those who self-injure 'could be otherwise'. Some have argued that those who self-injure are disproportionately likely to have experienced abuse—childhood sexual abuse, domestic violence, physical and emotional violence and neglect (e.g. Kilby 2001). As such, it is argued, punitive responses to self-injury are an unjust additional abuse or violence. To a great extent, I support such arguments. However, I would also emphasise that (a) the relationship between self-injury and 'abuse' is not clear-cut or as strong as initially proposed (Klonsky and Moyer 2008) and (b) whether or not someone has experienced abuse, healthcare staff—and others—should be morally obliged to respond in a caring, nurturing manner—rather than one that is punitive, violent and brutalising.

Tales of Seeking Attention

Narratives about 'seeking-help' for self-injury are produced under the spectre of 'attention-seeking'. Harriet raised this explicitly, suggesting that her visits to A&E were queried by some healthcare practitioners, who suggested that she was '*just attention-seeking*'. Included in this section is a close examination of Harriet's account of help-seeking and attention-seeking, since this raises important inconsistencies in how each of these practices are understood, underlining the moral ambiguity of both. Further, by reflecting critically on my own role in interpreting and analysing Harriet's account, I highlight some of the moral tensions that can arise with regard to the meanings of self-injury. My position as someone who has self-injured necessitated sometimes uncomfortable reflections on my own practice of self-injury, and the—often unhelpful—meanings I, initially, ascribed to others' actions.

The concept of 'attention-seeking' emerged in radically different ways in the accounts of people who took part in both research projects. Indeed, I was surprised at how strongly people taking part in the 2014 research responded to questions about attention-seeking. It had emerged as a difficult and problematic issue in 2007, and I had rather optimistically thought that the powerful, negative framing of 'attention-seeking self-injury' might have dissipated somewhat. In the UK—and elsewhere—there have been high profile public engagement initiatives designed to 'stamp out stigma', to challenge negative interpretations about self-injury, particularly the view that it is 'attention-seeking'. Numerous websites and organisations argue that one of the most common 'myths' about self-injury is that it is 'attention-seeking'. However, despite these efforts, in the 2014 research the issue came up often, and frequently with an intensely negative framing. One of the issues I will explore in the next few pages is why 'attention-seeking' has endured as a way of understanding self-injury. I do this through a discussion of the very different ways in which participants across each study incorporated talk about 'attention-seeking' into their narratives.

Self-Injury Is Never About Attention-Seeking: We Hide It

Many people who self-injure maintain that their practice is kept secret and hidden. A common narrative in the 2014 research followed this, with younger participants emphasising that: they tried hard to hide their self-injury from others, no one know about their self-injury, it was private and not something they did for 'other people' to see. Omar, aged 15, wrote that it 'infuriated' him when people suggested that self-injury was 'attention-seeking' arguing *'if I wanted attention I wouldn't slice open my skin to get it'*. What was telling about many of the accounts of younger teenagers in 2014, was that they did not question the association between self-injury and attention-seeking, alluding—as did Omar—to the idea that self-injury was (still) firmly tied discursively to 'attention-seeking' by others. Similarly, in response to the same question (a statement section where young people were asked to respond to provocative statements

about self-injury, in this case 'People who self-injure are mostly doing it for attention') Rachel wrote *'I want to kick ppl who say this'*—again, crucially, these responses tacitly accepted (indeed confirmed) that people *did* 'say this' (or at least were imagined to do so). Other accounts merely emphasised the hidden nature of their own and others' self-injury. Michelle, for instance, wrote: '*Self-harm is NOT about attention. If it were, we wouldn't try to hide it so much.'*

Some of those I spoke with in 2007 also emphasised the ways in which they hid their self-injury from others. However, only two participants—Anna and Justin—provided accounts which suggested they actively hid their self-injury from 'everyone' at the time of the interviews. Anna and I shared a preference—at that time—for wearing long sleeves at all times, and 'never' showing scars or wounds to others. We developed a shared account of 'hating summers' because warmer weather inevitably led to questions about our choice of (inappropriate) clothing. However, we each maintained that such questions were preferable to having our scars/wounds on view.

Anna: I dinnae get any mair undressed than this, cos its just … pretty messy [---] Summers … I hate summers…
Amy: mm
Anna: … people are stripping off, and they're going, "Are you not too warm?" – "No, fine, great, nice today!" [laughs]
Amy: I spent the whole summer once working in a warehouse, where the uniform was either a t-shirt or a sweatshirt, and they're all like, "Are you not hot?", and I'm like "No, no, I get really cold!"
Anna: I know! [laughs] I'm always cold!

At the time of the interview, Anna and I both had 'recent' experiences with self-injury. Our bodies carried wounds, and red, recent scarring. Those participants who had a longer period of time between their interview and their last self-injury provided different accounts, though some—like Justin—nevertheless maintained the importance of hiding or concealing scars. Justin described a lengthy process involving scar minimisation treatment and tattooing, to ensure his scars were not visible. This process meant he was able to wear t-shirts in hot weather, whilst maintaining the

'secrecy' of his past self-injury. While we employed different methods and indeed had different types of marks to manage, Justin, Anna and I shared a concern with effectively hiding the existence of scars, wounds or marks left by self-injury.

In contrast, other participants talked of hiding their self-injury (both recent wounds and old scars) only in certain situations. Emma, for instance, said that she always covered her arms when visiting family, but not when around friends. Further, a minority provided accounts which suggested they rarely made an attempt to hide their scars or wounds. Stories about hiding, revealing, choice and lack of choice, were in general more nuanced in interviews as compared to the survey data. Those taking part in the survey were generally short, and definitive in their emphasis on hiding and secrecy. In some ways, this is an inevitable outcome of different methodological approaches, with the survey inviting shorter responses, and interviews encouraging more wide-ranging, complex accounts. However, I would suggest these differences also call into question the dominant narratives of self-injury which emphasise the 'private' and 'hidden' nature of the practice. I will suggest that 'hidden self-injury' is an *acceptable* account, one that is easier to provide and maintain, and one that is easier to hear. As such, it is provided more readily, and more regularly. This has the effect, however, of both obscuring alternative accounts (and practical approaches) of managing the visibility of self-injury *and* contributes to the negative moral framing that visible self-injury can encompass.

Harriet's account was particularly complex regarding how far she did—or did not—'hide' her self-injury. In many senses, Harriet suggested that she used different strategies to hide or minimise the visibility of her self-injury: hiding her arms and legs with clothing, changing where she cut herself in order to increase her ability to hide the wounds and accessing scar minimisation treatment.

> *[I] used to be mostly like cutting my arm and everything, and I think, the urges are like, really strong to like, totally slash your arms up […] and then like, but, if I do that, everyone's gonna know, and, so you can only use that in winter when you can hide it. So if I think I'm just like, 'Phew stop doing it where people can see!'. (Harriet, 26, 2007)*

At the time of the interview, Harriet said she largely restricted her self-injury to areas of her body that were easier to conceal. In particular, she was clear that she tried hard to hide her self-injury from her parents, noting that one of the best things about moving into her own home had been that she could cut herself more often without her parents finding out. However, while Harriet emphasised the importance of hiding her self-injury, especially from her parents, she also described an orientation towards help-seeking which was fairly active. As such, her account differed markedly from those provided by, for instance, Craig and Dinah, who talked of avoiding formal help in order to maintain the hidden nature of their self-injury. Across both projects, Harriet's narrative remains the most detailed account of using a wide range of formal and informal sources of 'help' or support. Harriet spoke of using drop in centres, helplines and different internet forums, working hard to find websites that were nurturing and supportive rather than 'triggering'. She described herself as deeply involved in medical treatment for her self-injury and related mental health problems. As such, she had weekly visits and phone contact with a community psychiatric nurse, she saw her GP, she saw a psychiatrist for counselling and medication reviews, she also described regularly attending A&E.

In the following, Harriet relates a story about a period of time where she went to A&E regularly. Unlike the accounts of Emma, Anna and Dinah who spoke of attending A&E rarely and only in extreme circumstances, Harriet did not conform to this more 'acceptable' mode of relating help-seeking for self-injury. I have, cautiously, labelled these accounts 'acceptable' and 'unacceptable' in part because of the way that I reacted initially to Harriet's very different story of 'help-seeking'. At the time I was surprised, if not shocked, to hear such a detailed account of 'seeking help' in so many ways, for wounds which—by Harriet's own account—were not always 'serious'. She noted that there had been times she had got to A&E and the wounds had 'closed up'. Harriet's story made me feel uncomfortable, and facing and unpicking my discomfort has been central to my analysis of this and the other accounts in this chapter.

I was like in A&E for self-harm, like, every week, from like April to the June, and A&E are absolutely fed up with me, and they're like going – 'You're self-harming,

just so you can come here aren't you?' and I'm like 'No' and they're like 'You're just attention seeking' and I'm like 'No, I'm not' like ooh. It's scary, cos, every time you self-harm, and, you, like, you call for an ambulance a lot of the time the police come out! And I'm like, OK! I'm like, what do my neighbours think, with the police coming out, and the ambulances coming out? And I'm like, 'Oh, my god!' Heh. Like, just not making a good name for myself round here! [laughs]. Police, stuff, out, like 2 police cars [---] outside my door! (A[sarcastically]-wow). (Harriet, 26, 2007)

I struggled with interpreting Harriet's account of help-seeking, and her insistence that she was 'not' attention-seeking. At the time of the interviews, in line with many of the younger participants in the 2014 research, I had a fairly negative view of 'attention-seeking' self-injury. I considered my own self-injury to have been 'hidden' and kept 'private', my arms were always covered, I had attended A&E just once in my life for wounds that had scared me because of their severity and my intoxication—paralleling the accounts of Emma, Anna and Dinah. As such, Harriet's fairly blasé description of driving herself to A&E, or calling an ambulance, seemingly every time she injured herself, sat uncomfortably with me. There is evidence of this discomfort in the above: Harriet enthusiastically related the drama of ambulances and police cars attending when she called for an ambulance; at the end of which I sarcastically responded 'wow'. In doing so, I was attempting to communicate to Harriet that I was not particularly 'impressed' with the story.

In hindsight, the transcript—and especially my response—is difficult to read and reflect on. I certainly did not evidence particularly 'good' interview practice in this case and had run the risk of making Harriet uncomfortable. This is clearly unacceptable; she had given me a great deal of her time, had welcomed me into her home and shared with me many difficult stories about her life, her mental health and her self-injury. Thankfully, Harriet did not seem to notice my attitude, and the interview continued to progress in a spirit of openness and sharing—on both sides. Indeed, I reined in my negative attitude and was able to ask Harriet more about her help-seeking practices without being quite so judgemental.

While interesting in terms of how 'not to' carry out an interview, this embarrassing excerpt is also incredibly revealing. As I noted above,

Harriet's interview has been pivotal in enabling me to critically analyse my own emotional, visceral reaction, and through this to critique dominant narratives that frame self-injury as '*not* attention-seeking'. Crucially—as evidenced in the excerpt above—Harriet herself rejected the label of 'attention-seeking' and maintained that her self-injury was 'private and hidden'—unless she needed 'help'. My initial response to Harriet's story demonstrates the complexity and moral stakes involved in categorising acts as either 'help' *or* 'attention' seeking. It should also lead us to question those accounts which emphasise 'secrecy'. Secrecy may be contextual and not absolute, and there are important reasons why accounts of secrecy may be provided. Individuals—like me—may be keen to avoid being charged with 'attention-seeking' and therefore may: (a) adapt the management of their scars and wounds and (b) be more inclined to provide accounts which reify secrecy and minimise occasions where self-injury may be 'less hidden'.

Harriet also provided a further illustration of the contradictory, and perverse, ways in which cultural expectations about self-injury and about emotional expression, served to impact on her ability to 'seek help'. Here, she speaks about her experience of being someone who self-injures and the difficulty she then had of getting her distress recognised without resorting again to self-injury:

> *… it's like sometimes it feels like, … you want, you go down and try and speak to somebody but it's like – but* ***you've not done anything so, they think, 'oh you're fine'*** *like, it's like sometimes like, well, if I do something then maybe people'll realise then that I'm hurting, inside […] and then they're like – but why didn't you come to us before you did it? It's like, well I tried to! But you wouldn't help me! […] so it's like, quite difficult, to know what to do […] but I think, it, … if I can work out how to properly say what's going on, they're more likely to help me … but it's sometimes you don't know … how to like express what you're … what you're going through without it like being, … sounding as if you're threatening them [with self-injury]. (Harriet, 26, 2007) (emphasis added)*

Here Harriet describes a Catch-22 situation, whereby she has been encouraged to seek help before she self-injures, but feels that her requests

for help are ignored or downplayed because she hasn't '*done anything*'. Further, if she tries to communicate that she wants to injure herself, she is accused (or feels accused) of being '*threatening*'. Harriet's account highlights that the use of self-injury as a method of 'demonstrating' internal pain to others can be intensely problematic. Along with potential charges of 'seeking attention', we see here an attempt to pre-emptively discuss self-injury interpreted as a 'threat'. This provides a further reason why accounts of hiding and secrecy might be privileged.

Accepting the Charge

Another set of accounts which undermine the idea that self-injury is 'never' about attention-seeking, are those provided by individuals who claim that they *have* self-injured 'for attention'. That some of the participants in the 2007 project did so was another source of surprise for me, particularly given my own view that most self-injury was 'hidden' and 'kept private'. Indeed, reflecting on these accounts caused me to consider more critically my own allegedly 'hidden' self-injury. For instance, as discussed above, at the time of the first interviews I maintained a self-narrative that I had 'always' kept my self-injury secret. However, on reflection this had not necessarily been the case. At one point, in my mid-teens, I had cut my face and hand—injuries that were inevitably seen by others. Further, throughout the time I injured myself, the wounds would be 'revealed' on occasion, sleeves would ride up my arm, people noticed, stories of explanation had to be provided, cats were blamed.[1] Thus, although I had been clear my injuries were never about 'attention-seeking'—they nonetheless did attract 'attention' and were not always 'hidden'.

Anna's overall narrative frequently emphasised how hidden her practice of self-injury was. However, when relating her earliest memories of self-injury she suggested that her motivation at that time had been to:

[1] 'The cat did it' is a popular way of deflecting questions about self-inflicted cuts, and has become a humorous, tongue-in-cheek 'meme' in internet discussion among those who self-injure. At one point, a self-injury support and information group produced 'awareness-raising' wristbands inscribed with the phrase.

> *get a bit of attention, and that sounds bad and it … like … that's no what the self-harm's about at all, it's not about getting attention because nobody knows about it […] But I think that that was. (Anna, 33, 2007)*

While Anna described this first incidence of self-injury as oriented towards seeking attention, she was adamant that this did not accurately describe her self-injury more generally. Anna also indicates the negative moral implications of this issue with the phrase *'that sounds bad'*. This raises, but does not answer, some of the important questions I highlighted at the start of this chapter: what is wrong with 'seeking' attention? Why does Anna suggest that this 'sounds bad' when recounting the story? I would argue that this relates to the negative moral status of 'drawing attention to oneself' or 'causing a fuss'. This was raised by others, for instance, when they justified their practice of self-injury as being a way of dealing with their own distress without 'burdening others'.

> *I didn't want to burden, anybody, including my friends, with any of my problems, you know obviously they knew what I was going through, but, they didn't know how to approach me because I was so stand-offish about it. Or I'd, kinda make light of it, you know. So … so I was constantly in [the] bathroom cutting myself and stuff. (Rease, 28, 2007)*

Cally also labelled her practice of self-injury as 'attention-seeking', writing:

> *I wanted attention. I was depressed, and wanted to die and having cuts on my skin was a sort of subconscious cry for help even though I didn't know it. (Cally, 17, 2014)*

This account echoed that of Milly, speaking in 2007, who suggested self-injury might sometimes be a 'subconscious cry for help'. In these cases, I would suggest that framing the desire for attention (or help) as *subconscious* serves to deny or minimise the agency of the individual telling the story. Again, it is important to question this: *why* is it important to avoid acknowledging agency when seeking help or attention?

Two other participants in the 2007 research also described their self-injury as being—at a certain time—oriented towards getting 'attention'. In both cases—and in common with Anna, and Cally, this 'attention-seeking' self-injury was located securely in the past. Robert described his early self-injury as *'more eh a cry for attention, more than anything, which sounds really pathetic now'.* Thus, like Anna, self-injury which was oriented towards getting 'attention' was marked as morally wrong, 'pathetic', undesirable. Robert was clear that his more recent self-injury was not about getting attention, but about expressing and trying to get rid of overwhelming feelings (in private).

Belinda suggested that her early acts of self-cutting had been about trying to draw attention to herself, to let people know that she was 'hurting'. She talked about this at length, and in her account seemed to be struggling with identifying herself as having used self-injury to 'seek attention': '*I hated to think that I was doing it for attention, even though I was doing it for attention. But I wasn't doing it for attention to be cool*.' As with the other participants, part of the way she did this was to emphasise that her recent self-injury was not about getting attention. Further, Belinda highlighted that although she had used self-injury to get attention, she had valid reasons for doing so—it wasn't *'to be cool'*. Belinda suggested that for her, self-injury was a necessary step, after years of being ignored when she attempted to communicate or seek help for the physical abuse that was occurring at home, or the bullying she experienced at school:

> *I mean I [exasperated laugh], if you try so many ways of getting people's attention, like, you tell people at school and then, they call the meeting with the principal […] and you tell them everything and then they just disregard you. How are you supposed to get people's attention?! How are you supposed to tell them? […] And that's why originally I started, cutting. Because I, wanted people to know […] that, you know, come on, listen to me and, and, in their eyes it seems a bit drastic, but if that's what I had to do! [laughs] You know, I just, I didn't know what to do with myself and I didn't know, what to think and what to feel, and, and I wanted people to believe me […] wanted people to listen […] or to notice or just to do acknowledge, or something! […] and that's originally, why I started. (Belinda, 21, 2007)*

In some cases then, self-injury was acknowledged to have been carried out 'for attention'. The way in which these accounts were constructed had several common features: 'attention-seeking' self-injury was located in all cases in the past, the attention was framed as being 'deserved' in some way and the accounts in most cases also indicated that 'attention seeking' was not an acceptable motive for self-injury. These were difficult narratives to provide—with individuals simultaneously acknowledging they had self-injured in an 'unacceptable' way, whilst also maintaining it had been necessary. In particular, and resonating with those accounts provided in 2014, distinctions were made between self-injury 'for attention' that was deserved, acknowledged to be 'wrong' and which happened in the past; and self-injury carried out by 'others' which was 'attention-seeking', not carried out for serious reasons, but rather for 'fashion' or 'to be cool'.

The Attention Seeking 'Other'

Across both studies, though more markedly in 2014, the spectre of the attention-seeking 'other' loomed large. Belinda alludes to this in her assertion that although she had self-injured 'for attention' it had not been oriented towards 'being cool'. Participants used this 'other'—who self-injured and displayed their wounds to be 'cool', or to gain undeserved attention or status—in order to authenticate their own practice of self-injury. The attention-seeking 'other' is in evidence elsewhere; for instance, in Adler and Adler's *The Tender Cut*:

> … self-injury could be the province of young, trendy youth who did it to be hip. Cindy … recounted how people showed others they were cool. "I know there's this one site you can go to—I think it's called bluedragonfly or something like that—where they actually sell self-harm bracelets, and if you have one of these bracelets, you're in a clique or something" (Adler and Adler 2011: p. 31)

Adler and Adler appear to take this account at face value, with their narrative suggesting Cindy provides evidence that such others 'actually

exist'. However, I would suggest it is fairly clear that Cindy is referring to 'knowledge' that is second hand, and conjectural. A quick search on Google indicates that such bracelets *are* discussed widely online, but largely in relation to eating disorders.[2] Further, the wearing of bracelets is described as a form of support, comfort and connection for individuals who feel isolated. Hardly the province of 'trendy youth'. What is more interesting about such accounts is the way in which they are used by those who have self-injured to construct an account of their own self-injury as authentic: not attention-seeking, and not done 'to be cool'.

The rejection of 'attention-seeking' as a motive for self-harm, and the demonisation of those who were framed as self-injuring in this manner, was particularly strong in the accounts of younger participants, provided in 2014. The vehemence of some of these statements about those who were viewed as self-injuring 'for attention' or 'to be cool' mirrored those reported by Crouch and Wright in a qualitative study of adolescent psychiatric in-patients (2004).

> cos I went for years without no-one finding out about my self-harming and I didn't want anyone to know about it, so that makes me angry, especially when I know some people that do do it for attention. (Sharon 2004: p. 194)

Crouch and Wright highlighted the paradoxical nature of young patients' views on self-harm, noting that many of the patients *wanted* 'attention'—or care, but felt unable to tell people if they had self-harmed, due to intensely negative views about 'attention-seeking self-harmers' that circulated on the ward. The young people on the ward also referred to a competitive element to self-harming, with distinctions being made between 'genuine' self-harm—that was clinically serious and required stitches—and self-harm that was not 'really' self-harm: 'I don't actually see what that [what peer did] as self-harming, 'cos self-harming is like actually proper doing some damage to you' *(ibid)*. These references to 'proper' self-harm being related to the bodily practices and damage involved reflect the accounts of Milly and Jay, discussed in Chapter 2.

[2] http://www.blisstree.com/2008/05/09/mental-health-well-being/know-thy-bracelets-red-is-pro-ana-blue-is-pro-mia-325/ see in particular the comments section (accessed 2/7/15).

These narratives similarly framed their own self-injury as only being, comfortably, 'proper self-harm' when it involved cutting of a particular level of severity.

These distinctions emerged in the accounts of young people who took part in the 2014 study: Leanne referred to '*a lot of fake self-harmers who make tiny cuts for attention*'. The majority of those taking part in the 2014 study entirely rejected the idea that self-injury was 'ever' about attention-seeking. However, a significant minority of participants, like Leanne, wrote about 'others' who did self-injure 'for attention'. The language used to describe these 'others' was often strong, and negative:

> *Although there are a few vile people who harm for attention, most of self-harmers really do have problems. (Gita, 14, 2014)*

Gita's response both labels people who self-injure for attention as 'vile' and suggests (paralleling accounts in Crouch and Wright's study) that they do not have 'real' problems; the implication being that those who self-harm and hide their practice 'really do have problems'. This account produces a dichotomous view of self-injury, attention, visibility and the authenticity of distress, which suggests that 'seen' self-injury is less 'real' than that which is concealed and therefore must have been carried out for more 'serious' reasons. This is evident in statements provided by other participants:

> *I, and many others, hide my self-harm habits from my peers, due to the social stigma attached. Anyone who actually does do it for attention does not, in my opinion, have any good reason to do it. (Andy, 16, 2014)*

> *I think of it like this: if you don't really know them and you know they are self-harming, it's for attention. If they talk about it openly in front of everyone, it's for attention […] but not everyone is doing it to get people's attention. (Greta, 13, 2014)*

> *people who self-harm do need attention but unless they are flaunting their cuts or bruises or whatever everywhere, most of them are hiding it under long sleeves and such, so they are not 'doing it for attention' as most people would not know about someone's self-harm unless they saw or were told. (Marissa, 16, 2014)*

The picture which emerges from these accounts is of self-injury which is visible being particularly open to charges of both 'attention-seeking' and inauthenticity. This provides further evidence as to why the charge of attention-seeking is one which most people who self-injure seek to avoid, or distance themselves from. By questioning the authenticity of self-injury, narratives against 'attention-seeking' construct a significant threat to the identity and self of those whose self-injury might become visible. This threat contributes to the dominant narrative of self-injury, which is that it is hidden, secret and 'never' about attention-seeking'.

Subverting the Charge

In contrast to the accounts described above, which upheld a negative reading of 'attention-seeking' a small number of people resisted or subverted this, arguing that 'attention-seeking' was not (always) a 'bad thing'.

Milly's narrative evidenced a rare degree of openness regarding her self-injury. She spoke of how *'obviously'* people saw marks on her arms and *'of course'* she told others following an act of self-injury. This contrasted starkly with the majority of accounts which emphasised the private nature of self-injury, with the practice framed as a closely guarded secret. Milly described some of her self-injury as being *'conscious, very conscious in retrospect, attention-seeking'*. However, she also said that:

> *a lot of the conscious effort is not to do with attention-seeking, this is how I see it anyway […] but subconsciously, there is something that is, crying out for help, and I didn't know how else to cry out for help that night. (Milly, 28, 2007)*

In Milly's narrative self-injury emerges as *both* a conscious act of 'attention-seeking' *and* a subconscious cry for help. This contradictory quality is important, I would argue, in highlighting the more complex, ambiguous nature of living with self-injury, and of the varied roles that self-injury might play in different contexts.

Milly's account does share some common features with those discussed above. She frames her act of 'attention-seeking' self-injury as justified

because she did not *'know how else to cry out for help'*, and she locates the act in the past. What is different is her mundane description of self-injury as being oriented towards getting 'attention' from others and her avoidance of any negative language when discussing this. For Milly, 'attention-seeking' was framed as 'normal' and 'obvious'.

Other accounts more directly critiqued the negative framing of 'attention-seeking'. Although the overwhelming direction of narratives provided by young people in 2014 was against 'attention-seeking', some participants suggested that the term 'attention-seeking' was itself problematic, and reframed it as 'affection-seeking'.

> *I know a lot of people see that it's a form of attention-seeking. Because people you do see openly self-harming, they may want attention, but the fact that they do want attention isn't because they're bad and they're an attention-seeker, it's because they have another … they feel the need for affection or something like that. (Benjamin, 17, 2007)*

In Benjamin's account, there are the beginnings of a more positive reframing of 'attention-seeking'. This was also alluded to by Nick, who suggested that *'most people who self-harm do not want people to find out, however it can be a nice feeling for people to ask about it because it feels like they care'*. Subtly, these accounts questioned the negative and dismissive framing of 'attention-seeking' addressing the reasons that attention (or care, or affection) might be desired, or 'needed'.

An even more subversive version of what might otherwise be seen as 'attention-seeking' self-injury was provided by Rease speaking in 2007. Rease related a time when she was aged 16 and, essentially, 'showed off' her recent self-injury. However, her account strongly rejected the idea that this was 'attention-seeking', arguing instead that it was a confrontational display of strength:

> *I think I did wear a short sleeved t-shirt to school once, and I had, … actually written something on my arm, em, with a razor blade, em, but it wasn't, like, sort of attention seeking it was just, I dunno, it was just [pause] I think it was partly em, I don't know if anybody else is like this with self-harm … Maybe it's just me, my tomboy-ishness, but, I've always kinda felt like a really weak*

> *person, and I always felt like, … self-harm was, it sounds weird but it's like, something I've achieved, like it was an achievement, and, … You know like the macho thing with like guys showing off their [unclear] and sort of going though, sort of, sort of trials or something or, burn themselves or cut themselves to show that their tough. There's a little bit of that. (Rease, 28, 2007)*

Rease's account is the only one provided across both studies which talks in detail and in such a challenging way about 'revealing' self-injury to others. Rease does not talk of her 'display' of her wounds as any kind of 'subconscious cry for help' but rather as a performance of strength and masculinity—subverting gender norms, as well as norms about how self-injury 'should' be managed.

Jay, who I interviewed in 2014 insightfully highlighted the difficulty that people who self-injure face in managing the visible manifestations of their practice. Jay's account starts to tackle some of the wider reasons why 'hiding' self-injury is so normative, and why more subversive narratives of 'displays' like Rease's appear to be so rare.

> *It's also, again, like revealing a really personal and private part of yourself to loads of people. And I don't really know how common this is, but I always felt under pressure to hide cuts/scars/*etc. *because it was something you had to do- even if I felt kind of okay with, say, wearing a t-shirt I felt like I was expected to hide self-harm, and that I should be doing it even if I didn't really mind about it, so I did- also, I felt like if I chose to take off a cardigan or sweatshirt or whatever in the summer because it was boiling hot, I was choosing to reveal cuts underneath and that was attention seeking,* etc. *(Which is obviously complete bullshit but it was still a fear).*[3] *(Jay, 16, 2014)*

Jay identifies *social* expectations about hiding self-harm. This in itself can be seen as a subversive (and markedly sociological) account. Unlike the majority of participants in the 2014 study, Jay does not emphasise the importance for *her* of hiding scars and cuts—but rather acknowledges that this is a societal expectation. Crucially, Jay—like Rease—identifies 'attention-seeking' as a way in which visible self-injury is likely to be interpreted by others. This indicates the strength and endurance of a cultural idea that visible self-injury is problematic, that it may indicate

[3] This is an excerpt from an email interview with Jay, the brackets and text in brackets are her own.

undeserved 'attention-seeking'. Such narratives leave little space for alternative reasons for 'display' such as Rease's challenging show of strength, or Jay's more mundane desire to cool down in the summer heat.

Navigating the Visibility of Self-Injury

This chapter has charted a range of different ways in which those who self-injure navigate the visible aspects of their practice of self-injury. The related motifs of 'help-seeking' and 'attention-seeking' have been employed, in part, to recognise the different reasons that people have for 'revealing' their self-injury, and also to highlight the morally charged nature of these accounts. I have suggested that those who self-injure necessarily draw on such moral narratives in order to develop understandable and acceptable accounts. The existence of these polarising narratives also serves to shape the practical, embodied experience of being someone who self-injures. If hiding and secrecy are valorised, this can affect where cuts are placed, and what is done with them afterwards. For the majority of those who took part in the two research projects, self-care and secrecy were framed as standard practice. This has to be understood against a backdrop of highly negative discourse around attention-seeking, as well as widely circulating 'horror stories' about treatment that may be received, especially in emergency healthcare settings.

The valorisation of hiding and secrecy is problematic and questionable. Numerous studies highlight this feature of self-injury (Madge et al. 2008), and the image of a teenager in long sleeves and bracelets predominates in media portrayals of those who self-injure.[4] The characterisation of self-injury as shameful, hidden and private is wide-ranging, and represents another formula story—a widely circulating narrative that is drawn on to make sense of the practice (Loseke 2001). However, there are significant grounds to question the 'hidden' nature of self-injury. In this chapter and the last, we have considered accounts which alluded to

[4] Indeed, it may be that long sleeves and bracelets are so ubiquitous as a sign of self-injury, that they could be used to signal self-injury to others, without revealing wounds: though this did not emerge as a feature in the accounts.

self-injury being ignored, rather than 'not seen', attempts at help were thwarted, attempts to communicate emotional distress were dismissed. At the same time, we have seen the moral costs of 'revealing' self-injury—the risks of being labelled an 'attention-seeker' being just one. A further danger faced by those who 'reveal' self-injury is that the authenticity of their practice of self-injury, and perhaps of their self, may come under attack. An accusation of 'attention-seeking' does far more than provide an unhelpful negative description of an act. An accusation of 'attention-seeking' potentially undermines any 'authentic' reason for self-injury. It minimises distress, questions 'emotional' pain. Thus, while self-injury—as we saw in Chapter 2 and 3—is frequently explained as being a way of 'showing' how bad someone feels, we have seen in this chapter that the act of 'revealing' can call into question the very feelings that self-injury is argued to be 'proving'.

With regard to self-injury, visibility emerges as a double-edged sword. The visibility of cuts, burns and bruises is said to offer a tangible marker to demonstrate otherwise hidden distress. At the same time, if these injuries become visible—whether by accident, because a person 'chooses' to wear certain clothing, or because they are seeking medical intervention—they are subject to moral judgement. Not only might they be labelled 'attention-seeking', but the veracity of the emotion said to underlie the act comes into question. At various points, I have suggested that this contradictory picture may relate to a wider devaluation of 'mental' distress as compared to 'physical' illness. In the following chapter, I interrogate this in more depth, turning to focus on the diverse ways in which self-injury has been conceptualised by medicine.

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5

Self-Injury, Biomedicine and Boundaries

Introduction: Medical Dominance and Biomedical Resistance

The analyses developed thus far have implicitly addressed the role of biomedical knowledge and clinical practice in shaping how self-injury is understood. In this chapter, I present a more explicit interrogation of biomedical ways of knowing about self-injury. The idea that self-injury is a *pathological* act that should come under medical jurisdiction has certainly not been without challenge. However, despite such challenges, biomedicine can be seen to have far-reaching impacts on how self-injury is understood. More than that, medical knowledge shapes how we understand our bodies and our emotional lives, and each of these has been shown to be central in how self-injury is narrated, and experienced. By directly facing, and critiquing, medical knowledge about self-injury, this chapter seeks to excavate some of the numerous ways in which medicine has claimed authority over self-injury. At the same time, I incorporate engagement with long-standing resistance to such claims.

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Medical Dominance

As we have seen at various points throughout the preceding chapters, stories told about the treatment of self-injury in medical settings often draw on motifs of horror, war and trauma. Anna's doctor 'fought' with her bleeding cuts; Emma's wounds were stapled without anaesthetic ('*you're a self-harmer: click, click click*'). The pathologisation of self-injury is frequently challenged by authors writing from a range of disciplinary perspectives, including sociology (Adler and Adler 2007; McDermott 2015; Millard 2013; Warner and Spandler 2011). Such authors question the way in which self-injury is defined, and highlight parallels with other, more socially acceptable 'self-harming' practices, such as alcohol use, body modification or engaging in extreme sports (Inckle 2007). Importantly, such challenges have also come from those with experience of self-injury, who have campaigned and advocated for better treatment: challenging and drawing attention to abusive and regressive treatment approaches such as enforced 'no harm contracts', and the types of demeaning, aggressive treatment described in Chapter 4 (Pembroke 1998; Pembroke et al. 2007).

Despite the presence of arguments which counter medical knowledge, the majority of writing about self-injury (even within the social sciences) is based upon insights from clinical research, written from an explicitly 'medical' perspective. Indeed, Chris Millard (2013) has argued that contemporary understandings of what constitutes 'self-harm' can be traced back to the work of a fairly small group of North American psychiatrists, publishing in the 1960s. Understandings about the 'typical self-injurer' have shaped subsequent research, leading to a concentration of studies on White, middle-class and female participants, further shaping what 'self-harm' is understood to be, and who is understood to be a 'self-harmer' (Chandler et al. 2011). This includes sociological studies, many of which have drawn on samples which are mainly female, and frequently college students (Hodgson 2004; Kokaliari and Berzoff 2008; McShane 2012). I would suggest that the acceptance of such biased samples reflects *and reinforces* the (clinically generated) picture of the 'typical self-injurer', as well as practical aspects of conducting qualitative studies on 'sensitive' issues.

We can see further evidence of clinical categories being taken for granted within sociological work on self-injury. For instance, although Adler and Adler acknowledge the lack of evidence regarding self-injury in non-clinical populations, they simultaneously appear to accept many of the conclusions of clinical studies. Adler and Adler argue that self-injury has *historically* been a medical, psychiatric category (2007, 2011), which has only recently been taken up by wider populations. According to their analysis, self-injury prior to the 1990s was primarily a 'psychological phenomenon' (2011: p. 200).

> … we show how the **population** of self-injurers has spread from a narrow, clinically conceptualized base into the broader reaches of the mainstream […] when **the behaviour spilled beyond** the psychiatric bounds, it took on sociological dimensions that were unaddressed by the clinical definition and framework. (2011: p. 22, emphasis added)

Adler and Adler suggest that (a) the population of those who self-injure *has grown* (spread) beyond a 'narrow, clinically conceptualized base' and (b) that (only) now that this spread has occurred, is sociology required to help explain and understand why those in the 'mainstream' might engage in self-injury. As such, their argument about the de-medicalisation of self-injury, its 'spread outwards' to other populations, incorporates a view that self-injury had previously been restricted to those patients (mainly female, White and middle-class) with psychiatric diagnoses. Yet, as they note elsewhere (2011: pp. 29–30), our knowledge about who self-injures is based on narrow, restricted evidence—dominated by clinical studies, with clinical patients. In short, we simply do not know how widespread self-injury was in general populations, prior to the community studies that commenced in the late 1990s.

In this chapter, I provide a detailed critique of Adler and Adler's position. The medicalisation, de-medicalisation and re-medicalisation of self-injury are, I suggest, more complex and nuanced than their initial proposition suggests. I will show that their analysis rests upon a problematic engagement with medical perspectives. By taking clinical accounts of self-injury at face value, Adler and Adler accept a view of self-injury as—latterly—related to psychopathology. This diminishes the complexity and

agency of those engaging in self-injury prior to their watershed of 1996, and curiously frames psychiatric disorder as unamenable to sociological critique. Clearly, this is a position that does not sit comfortably with sociology's rich history of questioning psychiatric knowledge, and seeking to understand those labelled as 'psychiatrically disordered' (Busfield 1989; Goffman 1968a, b; Pilgrim and Rogers 2005; Scheff 1966).

My analysis in this chapter argues that understandings of self-injury continue to be strongly shaped by medical knowledge, *and* that, simultaneously, self-injury has never been entirely securely medicalised. Drawing on recent work in the history of medicine, I suggest that self-injury has been a contested practice for at least a century: debates about the relevance of self-injury to psychiatry are long-standing. Further, the concerted, and continuing, efforts of psychiatric researchers and practitioners to shape the meanings of self-injury, and legitimate the practice as a psychiatric category, can be read as further evidencing *resistance* to (as well as acceptance of) a view of self-injury as a purely 'psychological phenomenon' (Adler and Adler 2011: p. 200).

The ambivalent, contested nature of clinical accounts of self-injury can be seen in popular representations of the practice in fiction, on screen and in media representations. Susanna Kaysen's *Girl, Interrupted* a 1995 novel that was reworked as a film in 1999 features a protagonist who is referred to as a 'wrist-basher' and held for a long period of time in an in-patient psychiatric unit, the focus of the majority of the story. While the film was set largely in a clinical environment, the broader narrative challenged (to some extent) the nature of psychiatric diagnosis and treatment. In *The Secretary*, we see Lee Holloway, the female lead, burning and cutting herself ritualistically, in secret. Crucially, at the start of the film Lee is shown being released from an in-patient psychiatric hospital, which underlines a view of self-injury as related to psychological disorder. However, as the film progresses Lee appears to successfully manage her self-injury in private, following her release from in-patient care, though the relationship between her practice of self-injury and her entry into a world of domination and submission within a personal relationship is perhaps in need of interrogation.

Further challenges to the apparent dominance of medical interpretations of self-injury can be seen in the activities of grass-roots self-injury 'survivor movements' (Cresswell 2005). In the UK in particular,

campaigners—most of whom have themselves self-injured—continue to influence the development of health policy and, to a lesser extent, practice.[1] Sociological research on self-injury engages only tangentially with such movements, via Adler and Adler's de-medicalisation thesis—whereby practitioners of self-injury argue that they 'choose' to self-injure, as a way of coping, seeking to normalise and legitimise their behaviour. However, existing sociological analysis demonstrates only limited engagement with long-standing resistance (Pembroke 1998; Pembroke et al. 2007) from those who have self-injured to medical (mis)-treatment, and medical labelling.

Biomedical Resistance

While there is clear evidence of resistance to clinical responses to, and interpretations of, self-injury; simultaneously, many explanations (as we have seen in the preceding chapters) draw on biomedical discourse. Thus, even where individuals or groups argue that self-injury is 'non-medical', that it should not be framed as 'pathological', the way in which accounts are constructed nonetheless rests on the language of biomedicine. In this chapter, I argue that biomedical ways of knowing, and forms of clinical care, are vital in shaping how self-injury is understood culturally and, leading from this, how it is experienced and narrated as an embodied practice. Participants frequently provide bio-technical accounts of the efficacy of self-injury, implicating endorphins, adrenaline: *the rush*. When navigating the management of their wounds, participants indicated they were affected by experiences in healthcare settings, and drew on widely circulating 'horror stories' about the care that those who self-injure are thought to receive in emergency departments. Finally, for many participants, accounts about self-injury grapple with notions of mental illness,

[1] In the UK the National Institute for Clinical Excellence's guidelines for the short and longer term treatment of self-harm include testimony from individuals who have self-harmed. However, their input is not uncontroversial, and Louise Pembroke—a particularly prominent activist and writer—has written powerfully of the challenges faced by 'survivors', many of whom were extremely critical of medical treatment of self-harm, of working with the clinically driven development of guidelines. Ultimately, Pembroke and some of the other 'service user experts' withdrew their support of the guidelines. http://www.soteria.freeuk.com/pembroke-jul.htm

disorder and distress, and with their attempts to 'show' this through physical wounds. Chapter 4 demonstrated the morally contentious nature of such endeavours. In this chapter, we consider the role that medicine has played in attempts to authenticate and name self-injury.

Medical sociology, via the concept of medicalisation, has addressed the way in which the scope of medicine has expanded, drawing in ever more aspects of life under its influence (Conrad 2007). Adler and Adler suggested that self-injury provides a counter-example, where a practice that historically came under the purview of psychiatry has increasingly been taken up by wider populations who are not 'medicalised' and who increasingly resist medicalisation (2011: p. 212): self-injury, they argue, has been or is at least *becoming* 'de-medicalised'. While compelling, there are important reasons to question this analysis; not least the entry, in 2013, of the proposed diagnosis of 'Non-Suicidal Self-Injury' (NSSI) into the American Psychiatric Association's (APA) fifth Diagnostic and Statistical Manual (DSM-5) (American Psychiatric Association 2013). The analysis developed in this chapter builds on Adler and Adler's original contention that self-injury has become de-medicalised (2007), but provides a broader examination of the implications of medical ways of knowing for cultural understandings of self-injury. To do this, I draw on Ian Hacking's work on 'looping effects'—which provides a framework through which to examine the ways in which 'medical' and 'lay' knowledge interact, implicate and influence one another (Hacking 1995).

A potential benefit of medicalisation is the de-stigmatisation of conditions, practices or states that might have been previously understood as 'bad'. This is argued to be the case with, for instance, alcoholism—previously framed as moral weakness, and later transformed into a medical category (Levine 1985). However, alcoholism is also a good example of the ambiguous and contested nature of medicalisation. Alcohol use, like self-injury, is a phenomenon which *might* be understood as a practice that is led by 'free will', chosen; as much as it is viewed a 'compulsive', 'uncontrollable' behaviour. The medicalisation of mental illness and addiction is further complicated, since each of these 'medical categories' are themselves recognised as being stigmatised. In this chapter, we will see that the meanings attached to self-injury draw on notions of both 'mental illness' and 'addiction'. Whether self-injury is or is not 'really' a mental illness, or an addiction, is beside the point: in this chapter, I critically

analyse the ways in which it comes to be understood in these ways, in the accounts of practitioners, documents such as the DSM, and of course among the accounts of those who have self-injured.

Medicine and Self-Injury in Historical Context

> … sociologists have more often documented the shift toward increasingly medicalised views of phenomena […] the populations and behaviors discussed here invoke a de-medicalised interpretation [… with self-injury becoming] a behaviour increasingly defined as characterised by voluntary choice. (Adler and Adler 2007: p. 560)

The relationship between medicine and self-injury is not straightforward and requires careful, critical consideration. Adler and Adler's contention that self-injury has become—at least partially—de-medicalised, rests on a number of potentially problematic assumptions. It is based on an understanding of self-injury as previously under the relatively unquestionable authority of the medical profession and, in particular, psychiatry, and now being characterised by 'voluntary choice'. In the following pages I introduce historical work which unsettles accounts of psychiatric dominance over self-injurious practices, as well as evidence from sociology and the literary world which provide clues that practices which are very similar in both meaning and corporeal action, have been practised (perhaps even 'chosen') by 'non-clinical' populations, well before the 1990s.

Following an examination of the degree to which self-injury has been historically medicalised, I turn to an examination of the extent to which it might be considered to have been 'de-medicalised' in the late 1990s and early twenty-first century. There is certainly much evidence to support this view, and I introduce narratives about self-injury which draw on alternative, non-medical, interpretations of self-injury. However, I will also show that medical knowledge, medical ways of knowing, remains important. Medicine continues to dominate how bodies and emotions are understood, and even subversive accounts of self-injury must set themselves up 'against' pathologisation. Thus, I argue that the de-medicalisation of self-injury is far from complete.

I then turn to what I am calling the re-medicalisation of self-injury. This builds upon the idea that self-injury has never been solely a 'medical' concern, and that the de-medicalisation of self-injury is similarly not absolute. Instead, I suggest that self-injury represents a contested area of medicalisation, with long-standing evidence of attempts at medicalising self-harmful practices, alongside evidence of self-harming practices occurring well away from the medical gaze. At the same time, I suggest that contemporary accounts of self-injury frequently utilise biomedical language to construct acceptable explanations for the practice. Further, there are clear signs that psychiatry is seeking to expand its authority and 'claim' over self-injury. The re-medicalisation of self-injury is, as I have indicated, epitomised by the inclusion in the DSM-5 of a proposed diagnosis of NSSI. This inclusion, and the diverse responses to it, demonstrates the existence of ongoing turf wars over the interpretation and response to self-injury. What is of vital concern is that these wars will be fought over the bodies of those who self-injure. Later in this chapter, I take up this issue, through detailed analysis of the proposed diagnostic criteria of NSSI, and a consideration of the potential implications of this attempt to formalise and legitimate psychiatric intervention into the lives of those who self-injure.

The Medicalisation of Self-Injury?

Adler and Adler's argument that self-injury has been de-medicalised rests on the assumption that the practice has been, historically, medicalised. Medicalisation is a central concept in the sociology of health and illness. It describes the process whereby 'everyday' practices or states come under medical scrutiny, interpretation and treatment (Conrad 1992). Many examples of medicalisation have been identified and critically analysed, including alcoholism, childbirth, hyperactivity in children and epilepsy. Medicalisation is said to reframe a condition or practice which was previously framed as immoral, transforming 'badness' into 'sickness'. Foucault has been an important figure in the development of theories of medicalisation, charting the manner in which medicine and psychiatry came to dominate and shape understandings of health, illness and madness (Foucault 1973, 1989).

There are three arguments which serve to undermine the view that self-injury has—historically—been medicalised. Firstly, a historical perspective suggests that debates and lack of clarity about the extent to which self-injury is a 'medical issue' are as old as psychiatry itself (Chaney 2011a). Secondly, we can see that the meaning of self-injury has changed over time, such that it becomes impossible to say with any certainty that 'self-injury was medicalised, and now it is not'. Finally, a critical view on the way in which self-injury has historically been constructed unsettles assumptions made about medical dominance over the meanings and responses given to self-injury.

A Historical Perspective

Sarah Chaney's research explores the writings and publications of early psychiatrists (or alienists), working in England from 1860–1914 (Chaney 2011a, 2012). Her work highlights the historical specificity of what we now understand as 'self-injury'. Early psychiatrists write of self-injury in a broad manner, using the terms to refer to a range of practices including vomiting, eating rubbish, biting, flesh-picking, cutting or removing part of the body (Chaney 2011a: pp. 280–1). In contrast to more contemporary understandings, cutting itself tended to be reserved for self-injuries that were understood as suicidal. Chris Millard's (2013) analysis of later psychiatric writing on self-harm provides some explanation of how the meanings associated with self-harm and self-injury altered over the twentieth century. He argues that through the intensive work of a surprisingly small, but influential, group of North American psychiatrists, self-harm came to be framed much more narrowly: referring to self-cutting among younger females.

Interestingly, both Chaney and Millard have highlighted discursive relationships between popular fiction and medical constructions and interpretations of self-injury. Chaney argues that the treatment of self-mutilation in Nathanial Hawthorne's *The Scarlet Letter* indicates parallels with the writing of early psychiatrists writing in the late 1800s. In both cases, self-*mutilation* was associated with selfishness, sexual guilt and religious identification. Such associations were used in the writings of early psychiatrists to debate the extent to which self-mutilation should be viewed as evidencing mental disorder or criminal act:

> Just as, in Hawthorne's novel, social and political commentary underpins the symbolic representation of Dimmesdale's guilt through bodily injury, so such interests also informed psychiatric discussion of the motivation behind self-mutilation, particularly those cases on the 'Borderlands' of insanity, in which moral (and legal) responsibility was attributed, despite the existence of unsoundness of mind. (Chaney 2011a: 287)

Such analysis highlights the way in which social factors—attitudes towards sexuality, religion, 'free-will' and the body—shape medical interpretation of self-injury. While there are significant differences, there are also important similarities between how self-injury in these early cases was described, and responses to self-injury in the early twenty-first century. Debates about the role of 'free-will' or compulsion continue in discussion about the potentially 'addictive' nature of self-injury (Pearce and Pickard 2010). Further, the location of self-injury on the '"borderlands" of insanity' in the nineteenth century reflects ongoing debates about what self-injury represents in the twenty-first century: passing 'fad' or evidence of unequivocal psychiatric disorder. The point here, is that from the earliest writings about self-injury from psychiatrists, there was a lack of consensus about the extent to which self-injury was an *authentic* representation of 'mental illness' and an appropriate focus for the burgeoning profession of psychiatry.

Chris Millard's analysis of the construction of the meanings and shape of contemporary self-harm (carried out by females, and largely relating to self-cutting) suggests that over the latter half of the twentieth century, medical views on self-injury solidified somewhat. During the 1960s, there were concerted efforts among psychiatrists to name and classify self-injury, and claim it as 'mental illness'. However, as both Millard (2013) and Brickman (2004) demonstrate, early psychiatric research and writing produced and affirmed a particular, highly gendered form of self-injury. Millard is critical of the way that an active group of psychiatrists working in the USA were pivotal in promoting one form of self-injury (cutting) as being the example *par excellencé* of what was then termed 'self-mutilation'. Psychiatric reports of the 1960s focused almost exclusively on self-injury as practised by 'young, attractive women' who were 'reasonably intelligent'. Indeed, Brickman notes how self-injury

carried out by men was framed as effeminate and set aside. She argued that this was necessary in order to make sense of the cutting carried out by young women, which she suggests could not be framed as 'aggressive' or 'masculine' because of prevailing—and enduring—norms about gender. It was easier, Brickman suggests, to reframe cutting as 'delicate' and feminine, than to view female patients as 'aggressive' and masculine. This move is reflected in one of the terms used at the time, 'delicate self-cutting':

> One could even question the naming of the disorder itself. Pao's terminology, 'delicate' self-cutting, clearly engenders connotations of frailty, daintiness and fragility and, after reading description after description of attractive, young females, one begins to wonder if 'mutilation' would be used so readily to describe wounded skin on a less appealing body. The very appearance of the delicate feminine skin being savaged must play some role in the shock and discomfort experienced by the health care professionals on the scene. (Brickman 2004: pp. 97–98)

The arrival of critical, thoroughly researched histories of self-injury serves to add nuance to previously simplistic, asocial analyses which drew problematic links between, for instance, self-mutilation in the Bible, and contemporary self-cutting (Favazza 1996; Gilman 2012). While practices that might 'look like' self-injury have undoubtedly been referred to and recorded for at least a couple of thousand years, the meanings that these practices have are different. Taking self-cutting alone, for instance, in psychiatric writing this evolves from being a marker of a likely suicide in the late nineteenth century (Chaney 2011a, 2011b) to a proposed syndrome found largely among young women in the mid-twentieth century (Millard 2013). Arguably, contemporary accounts of self-injury as a method of 'emotional release' mediated by endorphin rushes, or a sign and signal of distress can be viewed as distinct from earlier interpretations. These historical studies indicate that the meanings associated with self-injury have changed: emerging out of different historical periods, with varying, complex interactions between 'medical knowledge', culture and individual practices of self-injury. Such interactions continue to shape the way that self-injury is understood.

Encroaching Medicalisation?

The studies and clinical commentary analysed by Millard, Chaney and Brickman demonstrate that medical research and practice has addressed self-injury since at least the 1860s. However, these studies focus on individuals who were—mostly—psychiatric in-patients, already engaged in clinical treatment. Until the late 1990s, the only formal, medical knowledge that existed about self-injury was based on similar research, with similar patients. As such, for much of the twentieth century there was no evident attempt to incorporate a wide range of self-injurious practices, or self-injuring individuals, into medical treatment or control. Favazza's ground-breaking *Bodies Under Siege: Self-Mutilation in Culture and Psychiatry* (1996) could be read as representing an attempt to take a broader view to self-injury. However, despite covering an impressive range of self-*mutilative* practices, in diverse cultural and historical settings, the final chapter of the book focuses in narrowly on 'Western' forms of self-injury which clearly reflect the 1960s characterisation of younger, 'psychiatrically disordered' females self-cutting. Further, the treatments proposed by Favazza for such individuals are excessively individual and biomedical—proposing high doses of Selective Serotonin Reuptake Inhibitors (SSRIs, an approach which has so far failed to garner much 'success' in reducing rates of self-injury) (Hawton et al. 2009; Warner and Spandler 2011).

In contrast to the historical focus on self-injury among clinical, psychiatric patients, the late twentieth and early twenty-first centuries saw rising concerns and an expanding research focus on the practice of self-injury among young people in community settings. A series of self-report population studies were carried out in schools in the 2000s, finding that anywhere between 10 % and 14 % of school-aged adolescents were reporting having ever engaged in self-harm (the majority of which was self-cutting) (De Leo and Heller 2004; Hawton et al. 2002; Ross and Heath 2002). Surveys with college students have tended to report even higher rates, with up to 35 % reporting self-harm (Gratz 2001). Adler and Adler draw on such studies when they argue that self-injury began to 'spread outwards' from clinically treated groups to the general population. They suggest that this reflects

the 'de-medicalisation' of self-injury. This is a curious assertion, since the majority of the research that identifies and names this 'spread' is carried out by clinical researchers. The increasing identification of wider populations engaging in a practice that is framed as pathological could equally be seen as evidencing the *encroachment* of the medical gaze onto practices that previously had gone unrecorded and unremarked upon. Instead, Adler and Adler—and many others—argue that these studies offer clear evidence that self-injury is being practised more widely than ever before. This position belies the lack of evidence for such a claim. Prior to the first school-based community studies of self-injury, there is simply no data about what 'rates' among the general population might have been.

Further, while there are clearly high numbers of young people who are not engaged in clinical treatment reporting self-injury, there is also evidence that those reporting self-injury are being viewed through a distinctly clinical lens—in popular culture, in clinical research and in their own accounts. The practice of self-injury is viewed as evidence of psychological distress, and suggested responses involve clinical treatment in the form of talking therapies, or psychotropic medication (Klonsky et al. 2015; Zetterqvist et al. 2013). The focus of much recent clinical research has remained steadfastly on young people with only a handful of clinical studies attempting to study self-injury among general adult populations (Briere and Gil 1998; Klonsky et al. 2003). Rather neatly, recent clinical literature constructs a picture of who self-injures (young people, largely female) and what they do (self-cutting) that remains close to the characterisation of self-injury identified by Millard and Brickman in the 1960s, during the early stages of the 'medicalisation' of self-injury.

The De-medicalisation of Self-Injury

In the previous section, I discussed the contested nature of medical perspectives on self-injury. Drawing on historical research, I argued that a view of self-injury as previously a 'narrow psychological category' is an erroneous conclusion, which glosses over internal debates regarding the classification of self-injury as evidence (or not) of mental disorder. In this section, I turn to Adler and Adler's contention that self-injury is currently becoming de-medicalised.

De-medicalisation occurs more rarely than medicalisation, the most famous example being homosexuality, which was finally removed from the DSM in 1974, following concerted and long-standing efforts from gay and civil rights activists, some of whom were also psychiatrists. Critics note, however, that the psychiatric classification of homosexuality as a mental disorder appears to have been replaced with that of 'Gender Identity Dysphoria' which has its own issues in terms of pathologising (or *re*-medicalising) diverse expressions of gender and sexuality (Conrad and Angell 2004).

Unlike homosexuality, self-injury was not included as a specific disorder in the DSM until 2013. Nonetheless, Adler and Adler argue that since the late 1990s self-injury has been 'de-medicalised'—increasingly used by diverse social groups for a range of reasons (Adler and Adler 2007). By way of evidence, they highlight the accounts provided by some of their participants that self-injury was a 'chosen' method of coping with day-to-day strains of daily life; others who suggested self-injury played a role in 'homo-social bonding'; and still others who allegedly self-injured in order to identify with particular subcultural (or indeed mainstream, 'trendy') groups. We addressed this latter claim in Chapter 4, where I argued that evidence for the use of self-injury as a way of identifying with 'trendy' groups was questionable, and appeared to be based mainly on accounts which talked of what 'others' did. Similarly, Adler and Adler's contention that self-injury, especially among young men, was carried out as a form of (non-pathological) 'homo-social bonding' also appeared to be based on the conjecture of others, rather than accounts of young men themselves.

Following the claims made in their 2007 paper in the *Journal of Contemporary Ethnography*, Adler and Adler's 2011 monograph somewhat toned down their de-medicalisation thesis. However, while they presented a slightly more nuanced discussion of the role of medical perspectives, they continued to maintain that self-injury has:

> evolved from being a symptom of mental illness practiced by suicidal individuals to becoming a visible, albeit not accepted, mode of expression for disaffected or disempowered youth and a coping mechanism for adults. (2011: p. 213).

However, there is some evidence that even prior to the 1990s—when self-injury allegedly began to 'spread outwards to non-clinical populations'—*something like* self-injury was practised by those who were not identified as 'mentally ill' or 'suicidal'. Adler and Adler also acknowledge this, but ultimately appear to dismiss these as anomalies. Earlier, in Chapter 2 we discussed the cases of Hebdige's 1970s 'self-lacerating' punks, and de Beauvoir's casual reference to the 'common' practice of self-mutilation in the 1940s. Above, we saw that Sarah Chaney had charted links between the self-mutilation described by nineteenth-century alienists, and that used by Nathaniel Hawthorne to characterise the emotional and moral angst of Arthur Dimmesdale in the *Scarlet Letter*. Another small challenge is offered in other fictional accounts. In *The Clergyman's Daughter*, Orwell writes a main character who regularly sticks herself with pins as a form of religious atonement and self-punishment.

> She made it a rule, whenever she caught herself not attending to her prayers, to prick her arm hard enough to make blood come. It was her chosen form of self-discipline, her guard against irreverence and sacrilegious thoughts. (Orwell 1960 (1935), pp. 12–13)

More recently, but crucially, still prior to Adler and Adler's 1996 watershed, in *Crosses* (1991), Shelly Stoehr wrote of two teenaged protagonists who engaged in a range of self-injurious practices.

These fictional examples, and brief asides in academic works, are not to be taken as an argument that self-injury was as widespread, or had the same meanings, in the 1800s, or the mid-twentieth century as has been in the early twenty-first century. However, these examples do weaken the contention that self-injury was previously the sole preserve of psychiatric patients who were suicidal. If anything, this should underline the precarious nature of making claims about practices that may have been around for some time, but not measured and labelled by the 'human sciences' (Hacking 2006).

Although Adler and Adler acknowledge more of the complexity of medicalisation when writing in 2011, their de-medicalisation thesis nonetheless rests on a problematic analysis of the accounts of people who have self-injured, where accounts of what 'others' do is taken at face value. For

instance, where they claim that men who self-injure often do so as a form of 'homosocial bonding' and others for 'subcultural membership'—these are largely based on second-hand accounts, interviewees talking about what they *do not do*. As we have discussed throughout this book, accounts of self-injury are vulnerable to charges of inauthenticity, and a key way in which authenticity is demonstrated is by castigating the alleged practices of 'others'. Further, Adler and Adler develop a fairly narrow treatment of medicalisation and the subtle, nuanced and far-reaching ways in which medical ways of knowing can come to shape and, perhaps, dominate understandings about bodies and emotions. As such, their analysis does not address the ways in which medical knowledge can emerge in accounts and perhaps practices of self-injury. An example of this is seen where narratives of choice are accompanied by explanations which draw on clinical, biomedical terminology in order to make sense of the efficacy of self-injury. Dean and Jonathan, both writing in 2014, each suggested the positive feelings associated with self-injury were related to 'endorphins', as well as more sensate, corporeal aspects of their practice—blood, scars and cuts.

> *I self-harm because I like to see blood flow from my body, it makes me happy (endorphin release). Also because it helps me get on with things in my life. (Dean, 15, 2014)*

> *It allows me to forget some of my stresses/problems. The endorphins also help and make me feel somewhat excited afterwards, the scars, blood, and cuts are a part of the reason. (Jonathan, 16, 2014)*

Accounts about self-injury combine biomedical terminology with wider cultural meanings in order to provide narratives that 'make sense'. This undermines any notion of self-injury as de-medicalised, since 'medical' ways of knowing continue to suffuse understandings of the practice. Perhaps in part because self-injury inherently involves the body, and because bodies are understood through a biomedical—and potentially increasingly neurochemical—lens; such language is drawn on to illustrate and justify the use of self-injury.

Mental Illness and Self-Injury: 'Real' Self-Injury and the DSM-5

Alongside the challenges discussed above, perhaps the most significant challenge to the view that self-injury is, or is becoming, de-medicalised, is the 2013 inclusion of the *proposed* diagnosis of 'Non-Suicidal Self-Injury' in the APA's DSM-5. This followed many years of concerted efforts by some psychiatrists—and the International Society for the Study of Self-Injury—to have something like NSSI recognised as a psychiatric diagnosis. Jennifer Muehlenkamp, who in 2015 is listed as 'Representative at Large' of the Society, published a paper in 2005 calling for the creation of a diagnosis of Self-Injurious Behaviour (Muehlenkamp 2005). The International Society continues to work towards research which will 'improve the reliability and validity of a NSSI diagnosis'.[2] In the following section, I address some of the contextual factors contributing to the solidification of NSSI as a psychiatric classification. Alongside this, I critically analyse the proposed diagnosis itself. My analysis draws implicitly on the sociology of diagnosis—reflecting the *potential* power of novel ways of naming and categorising human action (Jutel and Nettleton 2011).

Calls for self-injury (or self-mutilation) to be recognised as a distinctive syndrome or psychiatric diagnosis can be traced back at least to the 1950s and 1960s. The group of psychiatrists studied by Millard and Brickman were clearly engaged in setting out the key symptoms of what was named variously as 'wrist-cutting syndrome', 'delicate self-cutting' or 'self-mutilation'. Later, Armando Favazza, often cited as being responsible for the popularisation of self-mutilation in the academic and popular imagination, proposed that repetitive self-mutilation might be understood as an Axis I 'impulse control disorder … not elsewhere classified' (Favazza 1996: p. 253).

Self-injury first, formally, entered the DSM in 1994 as one of a set of nine diagnostic criteria for Borderline Personality Disorder (BPD). The association between BPD and self-injury has been controversial and, for many patients, hugely problematic. BPD itself is a divisive diagnosis, with

[2] http://webcache.googleusercontent.com/search?q=cache:http://itriples.org/self-injury/fast-facts/ Accessed and cached 03/11/15.

numerous studies pointing to its stigmatising nature; the gendered way in which the diagnosis is constructed, and the function of the diagnosis as a 'label' that a (female) patient is difficult and untreatable (Bjorklund 2006; Nadine 1999; Shaw and Proctor 2005). There was growing dissatisfaction with the location of self-injury in the DSM as a diagnostic criterion for BPD alone, with suggestions that this may lead to 'inappropriate' diagnosis of—especially—adolescents who had self-injured (Wilkinson 2013).

Debates about the classification of self-injury as a psychiatric disorder in its own right, or as a symptom of another, have to be understood in the context of broader upheaval within psychiatric theory and practice. From at least the 1960s, psychiatry has been subject to internal and external attacks on its validity, with the process of diagnosis coming under particular scrutiny. Thomas Szasz, himself a psychiatrist, famously argued that 'there is no such thing as mental illness' (Szasz 1960). Szasz' work is especially relevant here, since his argument about the non-existence of mental illness rested on the non-physical, non-verifiable, *subjective* nature of mental illness (as opposed to apparently objective *physical* illness). As we have seen in the preceding chapters, accounts of self-injury often grapple with tensions around the difficulty of 'proving' emotional distress, and the potential role of self-injury in demonstrating distress unequivocally. Szasz was one of several who are now framed as 'anti-psychiatrists' involved in the critique of a range of aspects of psychiatry, from treatment (particularly psychotropic drug treatment) to diagnosis and the 'labelling' of individuals as having psychiatric disorders (Laing 1960; Scheff 1966). The case of homosexuality—noted above—was a particularly stark example of the potential for psychiatry to be a tool through which oppressive social norms could be enacted.

However, despite numerous and continuing challenges, psychiatry has endured, and perhaps even expanded. One of the more recent debates within psychiatry concerned the DSM-5 and the expansive nature of the diagnoses in it (Wykes and Callard 2010). Along with NSSI, which we discuss in detail below, DSM-5 saw the number of diagnoses listed grow: for instance, premenstrual dysphoric disorder and hoarding disorder were added (American Psychiatric Association 2013). This has been a source of significant concern for many, who argue that such expansion reflects an inappropriate attempt to pathologise 'normal' experiences such as

bereavement or toddler tantrums (Pickersgill 2014). Such debates are a fascinating case study for the way in which medical practice and theory attempts to demarcate and negotiate the boundaries between normality and abnormality. Regarding NSSI, such debates raise questions about the implications for those who self-injure if they are to be 're-classified'—no longer 'potential borderlines' or engaging in 'typical teen angst' behaviours; they may now have their own disorder, officially 'abnormal'.

Thus far, responses to the proposed diagnosis have been mixed, and fairly restricted to clinical researchers and practitioners. Two strands emerge out of initial challenges to the construction of NSSI as a separate diagnosis: (a) that self-injury should not constitute a separate disorder, since there is no effective treatment, and those who self-injure are not necessarily 'disordered' and (b) that self-injury *is* related to suicide, and characterising it as 'non-suicidal' could have detrimental effects on suicide prevention initiatives (De Leo 2011). Psychiatrists and psychologists working in the UK have also argued that the diagnosis of NSSI 'could stigmatise large numbers of young people unnecessarily' (Kapur et al. 2013: p. 328). These concerns clearly address the extent to which psychiatric labelling and treatment is seen appropriate in the case of self-injury. Indeed, arguments about stigma are particularly interesting, since self-injury is *already* framed as a stigmatised practice. However, aside from the issue of 'stigma', less has been said about the potential impact of this 'proposed' diagnosis on those who self-injure.

In the following section, I undertake a detailed analysis of the proposed criteria of NSSI which entered DSM-5 as one of several 'conditions for further study'. My aims in doing so are to closely examine the way in which self-injury is constructed through the text of the proposed diagnostic criteria. Through this, I demonstrate the way in which clinical knowledge continues to reproduce self-injury in particular, limited ways. Further, I argue that these constructions do not resonate with the lived experience of those who self-injure—reflecting instead a narrow view of what self-injury is *expected* to be on the basis of prevailing cultural and clinical narratives about the practice.

Making Up the Non-suicidal Self-Injurer

> We think of these kinds of people as definite classes defined by definite properties. As we get to know more about these properties, we will be able to control, help, change, or emulate them better. But it is not quite like that. They are moving targets because our investigations interact with them, and change them. And since they are changed, they are not quite the same kind of people as before. The target has moved. I call this the 'looping effect'. Sometimes, our sciences create kinds of people that in a certain sense did not exist before. I call this 'making up people'. (Hacking 2006: p. 3)

Psychiatric classifications, especially as enshrined in the DSMs are examples *par excellencé* of what Hacking refers to as 'making up people'. Indeed one of Hacking's most evocative illustrations of his theory is that of Multiple Personality Disorders (MPD) (Hacking 1995). Certain types of people, Hacking argues, are 'made up' by the way that they are classified by the 'human sciences' (e.g. psychology, psychiatry, and some social sciences—including sociology). With MPD, for instance, Hacking argues that the classification and popularisation of the disorder offered a new resource through which people could understand themselves, or be understood by others—particularly psychiatrists. Hacking's work gets to the heart of debates about the 'reality' of mental illnesses, though he explicitly sets himself apart from this debate. Rather, he suggests that we can consider how ways of knowing about people and then describing them provide resources through which to articulate personhood.

We might consider, for instance, the way in which those who self-injure are classified as 'deviants' in some US-based sociological work (Adler and Adler 2007; Taylor and Ibañez 2015). Characterising self-injury in this manner is not neutral, benign or merely descriptive, but rather serves to reinforce a view of self-injury as abnormal and 'other'. Indeed, Goffman identified this peculiarity of sociological work on deviance in 1968 (Goffman 1968b).[3] Hacking argues that diagnoses in

[3] Goffman notes in a footnote in the final chapter of Stigma: 'It is remarkable that those who live around the social sciences have so quickly become comfortable in using the term "deviant", as if those to whom the term is applied have enough in common so that significant things can be said

particular may have 'subtle effects on how patients think of themselves, how they feel and how they behave' (Hacking 2013: p. 2). As such, careful examination of the way in which self-injury is named by the medical profession is instructive, not just as a way of exploring medical categorisation, but as a way of reflecting on how names might shape personhood and practices.

As discussed above, people who self-injure had been characterised as potentially or probably 'borderlines' within psychiatry, leading from the close association between BPD and self-injury in the DSM IV. This was not a neutral characterisation: both self-mutilation and the diagnosis of BPD signified 'badness' rather than 'madness' (Markham and Trower 2003; Shaw and Proctor 2005). The 'excessive' stigmatisation of BPD (and with it self-*mutilation*) continues to be noted and critiqued. However, knowledge of self-injury's association with 'deviance' and with 'BPD' was not restricted to professional sociologists or psychiatrists. It leaked out. BPD and self-injury featured in book and film portrayals of madness and adolescence, including Susanna Kaysen's *Girl, Interrupted*. From the late 1990s onwards, such information also circulated on internet forums and information sites. As such, the case of self-injury offers a partial illustration of Hacking's 'looping effects', whereby study and commentary on something that comes to be labelled as a 'disorder' contributes to changes and alterations in the nature of the disorder, and the meanings associated with it. In this case, individuals who self-injured are able to draw on such commentary to develop a view of self-injury as representing psychiatric disorder.

> *[I self-harmed] Because I was living with undiagnosed bipolar and social anxiety disorder. (Jody, 16, 2014)*

> *Behind self-harm usually is a mental illness. Depression and social anxiety in my case. (Leanne, 16, 2014)*

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about them as a whole. Just as there are iatrogenic disorders caused by the work that physicians do (which then gives them more work to do) so there are categories of persons who are created by students of society, and then studied by them' p. 167.

As discussed earlier in this chapter, these types of meanings were not available for people who were injuring themselves earlier on in the twentieth century. However, as knowledge about self-injury proliferates, so too does the association between self-injury and mental illness. The association then emerges in accounts of those who self-injure, and loops back into clinical accounts. Along the way, particular formula stories can be seen to predominate: self-injury as a method of coping with emotional distress, self-injury as emotional expression or release. As we see in the following section, these stories are present in the diagnostic criteria for NSSI and indicate a significant blurring of the lines between lay and professional knowledge. Further, I would suggest that the proposed diagnostic criteria for NSSI may provide additional resources through which those who self-injure can be characterised by themselves and others. As Hacking notes, diagnoses such as those set out in the DSM 'may … have other more subtle effects on how patients think of themselves, how they feel and how they behave' (Hacking 2013: pp. 7–8). No longer 'borderlines', instead, those who self-injure might in future be known as 'non-suicidal self-injurers'.

In the next section, I provide a close reading of the proposed criteria, drawing out the ways in which this reproduces and potentially cements a version of self-injury. I pay special attention to the role of bodies and corporeal practices in the text of the criteria. This embodied focus challenges and exposes a problematic orientation towards the body in the criteria. I demonstrate that the relationships between practices, bodily outcomes and long-term effects, as constructed in the text, imply a disconnect with qualitative accounts of the embodied, lived experience of self-injury.

Practices and Bodies in the DSM-5 Criteria for NSSI

According to the DSM-5, NSSI involves engaging in 'intentional self-inflicted damage to the surface of his or her body of a sort likely to induce bleeding, bruising, or pain' (p. 803). The criteria state that this should have taken place on at least five days, in the last 12 months. At first glance, then, NSSI incorporates a range of practices, focusing on the surface of the body, and reflecting closely the types of self-injury addressed

in this book. However, later, under a heading 'Diagnostic Features', the criteria begins to focus on a particular form—cutting, and indeed, cutting of a particular severity.

> The essential feature of nonsuicidal self-injury is that the individual repeatedly inflicts shallow, yet painful injuries to the surface of his or her body. (p. 804)

While still using the broader term 'injury' the use of a descriptor of 'shallow' causes problems—is it possible to have shallow bruising, or shallow burning? Possible, but perhaps unlikely. Further, at the end of the paragraph it is noted that 'The inflicted wounds can become deeper and more numerous'. The injuries have become wounds now, deeper and hitting (unless it causes a 'deep wound', presumably) falls off the radar.

The focus on cutting is maintained as the criteria moves on to describe a 'typical' act of self-injury (a 'session'):

> A single session of injury might involve a series of superficial, parallel cuts—separated by 1 or 2 centimetres—on a visible or accessible location. The resulting cuts will often bleed and will eventually leave a characteristic pattern of scars. (p. 804)

We now move from cutting, to a very particular form of cutting which results in 'superficial, parallel cuts'. Certainly, such an image of parallel red lines reflects visual imagery published online (Sternudd 2014). However, the language of 'superficiality' is interesting: can *superficial* wounds leave scars? Can wounds which do not *always* bleed leave scars? I am being deliberately pedantic here, because the language gives an impression of precision that belies a failure to engage fully with the embodied experience of self-injury. While I have focused often on the potentially permanent nature of changes to the body enacted by self-injury, such permanent changes are by no means inevitable. If cutting remains 'superficial', if injuries do not often bleed (much) and if one has skin that does not scar easily then it is possible to injure oneself regularly and not 'leave a characteristic pattern of scars'. Furthermore, if the practices of self-injury used tend towards hitting, sticking with pins or

inserting/swallowing objects, then again—this is unlikely to result in a set of scars as described on page 804 of the DSM-5.

As if acknowledging the over-focus on 'superficial cutting', the following paragraph attempts to address a wider range of injuries, including stabbing injuries (mostly to the upper arm, for some reason), burning with cigarettes and—oddly—'rubbing with an eraser'. Although these practices widen out the scope of the diagnosis somewhat, they are still rather specific: stabbing to a particular area of the body, burning *with cigarettes* (rather than flames, hot metal, branding, kettles or scalding with water—all of which have been described in qualitative studies of self-injury), finally burning through rubbing with an eraser is included, which—perhaps more than the others—invokes a particularly youthful image of who the person 'with' NSSI might be.

Curiously, the criteria then moves from 'superficial' injuries to a discussion of 'severe psychopathology', including suicide attempts. As such, a series of 'nonsuicidal' and 'superficial' practices are tied discursively to severe psychopathology:

> Engagement in nonsuicidal self-injury with multiple methods is associated with more severe psychopathology, including engagement in suicide attempts. (p. 804)

This statement authoritatively notes an association between NSSI and severe psychopathology, which includes suicide attempts. At the same time, the criteria notes that most people who do self-injure do not receive clinical attention. This raises questions about how such associations (between NSSI and psychopathology) come to be known. The answer is community studies, carried out almost solely on high school or college populations. Such studies tend to exclude students who do not regularly attend school (or who do not go to college), and they rely—evidently—on self-reporting of self-injury and 'honest engagement' with the study instrument (the questionnaire).

The criteria acknowledge that there are significant gaps in (clinical) knowledge about NSSI: '[t]he great majority of individuals who engage in nonsuicidal self-injury do not seek clinical attention.' Yet the criteria are nonetheless written in a manner which belies this lack of knowledge,

authoritatively proclaiming certain forms of self-injury as 'typical', having a 'characteristic pattern'. Similarly, when addressing the distinctions between BPD and NSSI, the criteria notes:

> there are differences in the involvement of different neurotransmitter systems, but these will not be apparent on clinical examination. (p. 805)

However, while research has found some indication of, for instance, different levels of endogenous ('naturally occurring') opioids between patients formally diagnosed with BPD who self-injure, and those who do not, these are based on extremely small samples and—necessarily—involve individuals who are engaged in clinical treatment (Stanley et al. 2010). The 'majority' who engage in NSSI and are not in psychiatric treatment are generally not included in such studies. Indeed, we know very little about the involvement of neurotransmitters in self-injury among those who are not already in clinical treatment (Kirtley et al. 2015).

The 'non-suicidal self-injurer' who emerges in the diagnostic criteria for NSSI may exhibit 'characteristic scarring', as discussed above. However, under the heading of 'Functional Consequences of Nonsuicidal Self-injury', negative repercussions of self-injury are restricted to potential infection with blood-borne diseases if cutting with 'shared implements' (p. 805). This brief aside is striking for two reasons: firstly, sharing tools for self-cutting may well be something which occurs, but is not mentioned in any of the published qualitative studies with people who self-injure; secondly, the sentence (the *only* sentence) under the heading 'Functional Consequences of Nonsuicidal Self-Injury', effectively erases other 'functional consequences' which *are* reported. This includes scarring which goes beyond the 'characteristic parallel' patterns left by 'superficial' cutting and burning, which can result in loss of sensation; deep cutting which severs tendons leading to loss of function in limbs, especially fingers; infections, which can occur, especially if deeper wounds are not treated carefully—and which may be more likely if individuals are cautious about seeking formal medical help due to previous poor treatment (Pembroke 1998; Spandler and Warner 2007; Warner and Spandler 2011). Finally, NSSI is related to suicide (Kerr et al. 2010), and thus it may be reasonable to suggest

that—although rare—practices labelled as NSSI may result in death. However, in itself this suggestion raises problems with the label of NSSI and indeed the definition of suicide itself. If an act results in suicide—then it automatically becomes 'suicidal'. It is this type of issue which has contributed to concerns among some commentators about the appropriateness of having a diagnosis which focuses on motivation (Arensman and Keeley 2012). As such, the criteria runs counter to some voices within suicide research: from Durkheim onwards, there has been a general dissatisfaction with using motive as a way of distinguishing suicidal acts (Arensman and Keeley 2012; Durkheim 1952).

The complex relationship between NSSI and suicide is addressed in the criteria under the differential diagnosis of Suicidal Behaviour Disorder. Here we see a substantial amount of effort being put into both valorising the distinction between NSSI and suicide, whilst acknowledging the substantial overlaps. The discussion here addresses the issue of 'false intent declaration' and 'reports of convenience' as well as arguing for a clear distinction between the intent involved in suicidal behaviour disorder (intent to die) and that entailed by NSSI (experience of relief). How exactly 'false intent declarations' are ascertained is not made clear. The mention of the apparent existence of such declarations does however serve to cast doubt over the accounts of those who psychiatrists may be considering labelling as having NSSI. Truth or authenticity emerges again then in clinical constructions of what self-injury is. At the same time, the 'intent declarations' of those who harm themselves has a central position in the ability of clinical practitioners to diagnose someone as 'having' NSSI *or* Suicidal Behaviour Disorder. Further, the 'intent declarations' have clearly played a role in the very construction of the diagnosis of NSSI—with the intent of 'relief' (as provided by those who self-injure) becoming an important way in which NSSI is clinically demarcated from suicide. Simultaneously, these declarations are subject to suspicion, not to be fully trusted.

The final section of the entry regarding Suicidal Behaviour Disorder is, frankly, confused. I reproduce it in full here:

> It is reasonable to conclude that nonsuicidal self-injury, while not presenting a high risk for suicide when first manifested, is an especially dangerous form of self-injurious behaviour. This conclusion is also supported by a

> multisite study of depressed adolescents who had previously failed to respond to antidepressant medication, which noted that those with previous nonsuicidal self-injury did not respond to cognitive-behavioural therapy, and by a study that found that nonsuicidal self-injury is a predictor of substance use/misuse. (p. 805)

So, NSSI is an 'especially dangerous form of self-injurious behaviour', but, in comparison to what and with what understanding of 'danger'? The claim follows a discussion of findings that many who self-injure report having suicidal ideation, including during the act of self-injury. Yet, at the same time the criteria argues that those who engage in NSSI do so without an intent to die. As such, NSSI is reframed as non-suicidal but nonetheless especially dangerous—because sometimes it is *potentially* suicidal. Further evidence in support of the claim takes the form of studies which find those who engage in NSSI did not respond to a particular (contentious) form of therapy. Such arguments belie a narrow view on what 'danger' might mean. There are likely to be many groups of people who do not respond to cognitive-behavioural therapy (CBT)—but this may imply that CBT itself is not a universal panacea, rather than people in these groups being especially 'dangerous'.

Addiction to Self-Injury

An important means through which practices and behaviours are subject to biomedical interpretation is where they are reworked as addictions. Fraser, Moore and Keane (2014) have explored this in detail in *Habits: Remaking Addiction*, where they consider the expansion of addiction discourse (and biomedical scrutiny) to incorporate obesity and overeating. Self-injury is also a practice that is *potentially* addictive (Victor et al. 2012), a theme which was strongly endorsed in my 2014 study. In this section, I consider some significant contrasts between treatment of addiction to self-injury in the DSM-5, and the way in which the notion of addiction was responded to by younger participants contributing to the 2014 study.

In the DSM-5, addiction is addressed uncertainly and briefly. Indeed, while the DSM-5 as a whole is characterised as expanding the concept of addiction, the proposed criteria for NSSI stops short of claiming the

practice as definitively addictive. This is a curious move, since there is clinical research which argues that self-injury *is* addictive (Nixon et al. 2002; Victor et al. 2012). Certainly, the evidence for this appears no more conclusive than evidence for the 'involvement of different neurotransmitter systems' which, as we saw above, was presented more authoritatively:

> [w]hen the behaviour occurs frequently, it might be associated with a sense of urgency and craving, the resultant behavioural pattern *resembling* an addiction. (emphasis added DSM-5, p. 804)

The language used here is significant, and reflects the contentious nature of an understanding of self-injury *as* addictive. Addiction in the DSM-5 is applied more widely than previously, with gambling and internet use formally proposed as either certainly (gambling) or potentially (internet use) addictive (Fraser et al. 2014). As Fraser et al. note, in order to frame practices that do not involve ingesting substances as addictive, the notion of addiction itself has to be altered. In this case, the brain disease model of addiction and neuro-scientific ways of knowing have had a profound impact on the way in which the DSM-5 was able to characterise addiction. Addiction has evolved from being understood as a quality of particular substances (alcohol, opiates) to describing corporeal, neurological processes. The addictive 'substance' becomes endogenous-endorphins, dopamine- and as such may be generated by ingestion of a substance *or* via bodily practices, such as overeating, sex—or self-injury.

Neuroscience, brain disease and older notions of dependence jostle alongside one another in the accounts of those who self-injure. In particular, younger participants who contributed to the 2014 research frequently drew on the language of addiction to legitimate and justify their practice of self-injury. Endorphins, dopamine and 'the rush' each featured, but so too did broader talk about becoming *dependent* on self-injury because it successfully addressed negative mood states.

> *Self-harm becomes habitual as a way of dealing with stress, and it works. If whatever is driving the self-harm does not get addressed, the behaviour becomes a 'go to' solution when you are feeling wrong. (Ruth, 2014)*

Ruth addresses habit here, suggesting that if a practice—self-injury—is experienced as effective, then it will be repeated. Addiction might be more usually thought of as a stigmatising label to avoid. However, the accounts of those taking part in the 2014 survey almost all emphasised the addictive nature of self-injury, and many declared their own practice as shaped in part by addiction, dependence, craving or habit. These accounts drew explicitly on cultural discourse of addiction and drug use:

> *Quitting is intensely difficult. You come to rely on it as your only coping mechanism. You lose your ability to deal with situations healthily. If something bad happens, you fixate on a blade like a junkie would a fix. (India, 15, 2014)*

Some emphasised the physical nature of their dependence, for instance, Trixie wrote '*I physically ache to cut sometimes*', while Mara suggested that '*it is known that some people feel withdrawal symptoms if they don't self-harm, much like an addiction*'. Supporting arguments about the increased prominence of neurochemical models of addiction, several participants drew authoritatively on 'endorphins' or 'dopamine' to explain the addictive nature of self-injury:

> *It causes increased dopamine levels which is addictive. It offers instant relief It's an escape that works. (Nina, 16, 2014)*

> *It creates a rush of endorphins the brain remembers. (Emily, 23, 2014)*

In the DSM-5 criteria, self-injury is said to appear 'addiction-like'—the text stops short of confirming self-injury as definitively addictive. There is a tension then, between and within the accounts of those who self-injure, and clinical narratives. While the DSM-5 significantly expanded the scope of addiction to incorporate non-substance-related activities, self-injury itself was not included in this, nor explicitly framed as addictive. At the same time, among younger people who are engaged in self-injury, addiction appears to play an important role in how they articulate, and account for, their practice. Addiction emerges as both a psychological issue—it works, and is a successful response to 'stress'; and a biological, neurochemical matter—it works, and is addictive because of 'endorphins' or 'dopamine'.

Habit has been proposed as a potentially less stigmatising way of framing addiction (Fraser et al. 2014). However, Nancy Potter (2011) has argued in relation to self-injury that the notion of habit is a poor replacement for addiction. Ultimately, she argues that both concepts might represent 'Master Narratives' which limit the possibilities for understanding self-injury in diverse ways. While I agree to some extent with Potter's assessment of the implications of habit and addiction for those who self-injure, I would suggest that she misses some of the reasons that these types of account might appear attractive. In particular, I would argue that the accounts provided by young people in 2014 draw on addiction as a way of *authenticating* self-injury. Rather than simply deflecting blame, using the language of addiction and dependence allows self-injury to emerge as a *legitimised*, physical, pathological behaviour.

> *The endorphins also help and make me feel somewhat excited afterwards […] The endorphins and stress relieving feeling following the harming can lead to habit and it can lead to addiction. (Jonathan, 16, 2014)*

Framing self-injury as addictive might offer a counter-claim to charges of attention-seeking, 'copying' or manipulation. This is indicated in Lee's exasperated response to a question about addiction and self-injury. He argued it *was* addictive, explaining *'Why would I WANT to do it otherwise?'*. Instead of situating self-injury as an artful, wilful practice, addiction offers an alternative reading, drawing on notions of compulsion. This parallels the attractive nature of neurochemical models of addiction, which have been heralded as offering a less stigmatising way of approaching and treating 'addicted' persons. By locating pathology in biology and neurochemistry, such models are said to absolve patients of responsibility, guilt and blame for their actions (Buchman et al. 2011). However, concerns have been raised—including in relation to self-injury—about the dubious benefits of applying discourses of addiction to a wide array of practices (Fraser et al. 2014). Further, the neurochemical model of addiction has also been criticised for potentially cementing—rather than dismantling—stigmatising responses to addiction (Meurk et al. 2013).

With regard to self-injury, the use of addiction and being 'out of control' sits particularly uneasily, since being '*in* control' is also employed in

narratives that seek to explain the practice, sometimes simultaneously. For instance, Mia, writing in 2014 suggested self-harm was addictive *because* '*you feel in control and it makes you forget the emotional pain for a while*'. Other participants wrote of self-injury becoming out of control as a result of addiction:

> *Self-harm can very easily spiral out of control because it is addictive and there are constant urges to cut deeper and every time you survive a cut the next will be worse. (Nick, 17, 2014)*

Accounts of self-injury which drew on the notion of addiction did so in complex, sometimes contradictory ways. While in some senses this might be read as reflecting 'inaccurate' knowledge among youthful respondents, it can also be seen as an understandable use of a concept which is clinically and culturally uncertain.

Narratives of addiction provide another layer of complexity to debates about the medicalisation of self-injury. Addiction discourse offers another set of 'professional' resources through which self-injury can be legitimised. Additionally, addiction provides a way of trying to articulate the complex way in which control, or lack of control features in the practice of self-injury. Addiction discourse is used increasingly widely, by both professional and lay people, as a way of making sense of a 'lack of control' as well as trying to understand how bodies, and selves, can become compelled to act in ways that are objectively harmful (Reith 2004). Addiction for the young people who took part in the survey was frequently framed in neurobiological, bio-technical terms. While some referred to habit, and the idea that 'anything that makes you feel better, you'll do again'; many drew on the language of neuroscience to underline the seriousness, and tangibility of their experiences of addiction to self-injury.

Self-Injury, Biomedicine and the Boundaries of Authenticity

This chapter has examined in some detail debates and contradictions regarding the medicalisation of self-injury, and the extent to which self-injury is or is not, should or should not, be a target of medical

intervention and control. Starting with Adler and Adler's suggestion that self-injury was becoming de-medicalised, I argued that this interpretation of the 'spread' of self-injury requires further consideration. Far from being increasingly irrelevant to understanding self-injury, I have demonstrated that medicine in general and psychiatry in particular continues to play a significant role in shaping the meanings that self-injury has. This occurs in a number of ways.

Firstly, we see that clinical research plays a vital part in measuring self-injury, and through this, demarcating what is and is not classed as self-injury and constructing *who* self-injures through a focus on particular populations. This plays out in different ways according to the type of definition used, and as we saw, there are important differences in how self-injury is named. The construction of NSSI—formalised in the DSM-5, and increasingly used by researchers based in the USA provides a stark example of this. Such research continues to focus on the same groups of patients: female, young, clinically treated (Klonsky et al. 2015), further fixing an image of the 'typical self-injurer' (Favazza and Conterio 1989). However, the role of clinical knowledge in shaping the meanings associated with self-injury has not been well incorporated into existing sociological studies. It remains to be seen how the increasing use of NSSI might shape lay understandings and experiences, but attention to the power of definitions, names, *diagnoses* should be paid in any future sociological work in this area (Jutel and Nettleton 2011).

Secondly, the language of biomedicine plays an important role in shaping discourse about and explanations for self-injury. This is especially apparent in the way that the language of addiction is used to make sense of self-injury. The case of addiction offers an important qualification to the way in which the role of medical knowledge in shaping self-injury might be characterised. This is not a straightforward example of medical knowledge dominating 'lay' understandings. Indeed, we see that clinical literature regarding addiction in general, and in relation to self-injury in particular, is ambiguous, reflecting wider disagreements about the nature of addiction, its relationship to biology and its 'authenticity' as a 'mental disorder' (Fraser et al. 2014). Despite this, for many who self-injure, the language of biomedical addiction clearly offers an appealing and understandable way of articulating the practice.

The response to the proposed diagnosis of NSSI reflects ongoing fissures within and without psychiatry regarding the appropriate response to self-inflicted damage amid uncertainties about the relative roles of agency, illness and will power (Pearce and Pickard 2010). These arguments are not new: Durkheim's *Suicide* contained a lengthy discussion of the relationship between mental illness and suicide (ultimately arguing the two were not automatically related), while Chaney's work traces long-standing debates among psychiatrists about the meaning of self-injury and its relationship to mental disorder. In Chapter 6, I will address these issues in more detail, focusing in finally on the role of authenticity in shaping meanings, experiences and clinical responses to self-injury.

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6

Authentic Bodies, Authentic Selves

The Relevance and Importance of Authenticity

A concern with authenticity has been presented throughout this book. Authenticity is a concept which is both difficult to grasp, and of central importance to questions of ontology and epistemology: of the way in which we can articulate and identify what is 'real', and what is 'not' (Vannini and Williams 2009). Alessandro Ferrara (1998) has argued that the concept of authenticity is vital in navigating threats to the notion of 'validity' posed by postmodernism and the 'Linguistic Turn'. With regard to my analysis of self-injury, threats to validity, truth claims and the role of narrative have also been foregrounded. In this final chapter, I will address some of the different ways in which the concept of authenticity *works through* self-injury. Broadly, I consider authenticity in three, inter-related, ways (I draw here on Vannini and Williams 2009). Firstly, authenticity can be understood as a normative, evaluative concept. Disregarding whether or not one is or is not 'authentic'—judgements about authenticity have normative power, to be inauthentic is clearly marked (in most analyses) as bad and wrong (e.g. Hochschild 2003b). Secondly, we can examine authenticity as a socially constructed concept—one that can be employed

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artfully, manufactured, or less pointedly, should be understood as emerging out of social meanings and interactions. Finally, authenticity can be studied phenomenologically—to what extent do people *feel* authentic, how do they attempt to *live* authentically? Each of these approaches to authenticity has some traction in analysing self-injury, and considering the role of medicine, bodies, embodiment and society. However, I will argue that a narrative approach to the uses of authenticity is of particular importance.

In this chapter I pick up, and run with, some of the numerous threads of authenticity that were initiated in earlier chapters. These threads include the anxieties around 'copying' raised in Chapter 2. Anna's narrative, which differentiated between those who 'copied' and those who did not—her disbelief that those 'copying' could go through with self-injury, it must hurt. The role of bodily sensation (pain, lack of pain) provided a way through which Anna could articulate the (in)authenticity of some 'others' who self-injured. Unease about copying was reflected also in those accounts which emphasised 'self-learning', and struggled with the notion that the 'idea' to injure might have come from others—friends, or subcultural celebrities. This unease and ambivalence is not well addressed in existing (clinically oriented, quantitative) work which has identified and attempted to explain links between subcultural identities and self-injury (Young et al. 2014). Importantly, as we saw in Chapter 4, despite—or perhaps because of—the apparent 'spread' of self-injury to wider groups of people, disparaging views about copying, and self-injuring for 'fashion' appear to have endured. A closer examination of the role of authenticity in shaping these accounts may help to illuminate and contextualise this issue.

Another thread—again tied to the body—concerns those accounts which spoke of self-injury as being a way of authenticating or 'proving' the existence of 'real pain', 'real feelings': *this* is how bad I feel, and you can *see* how bad I feel. Chapter 3 showed how this related to emotions being framed as 'inside', less visible and less tangible than 'outside' (physical) pain. The visibility of self-injury, especially in the form of cuts or burns, emerged as harder to dismiss and easier to tend to. At the same time, perversely, self-injuries can be interpreted by others as 'fakes'—not 'real' self-injury. These narratives rest on particular understandings of

bodies, emotions, truth and authenticity. In Chapter 4, I suggested that the importance of visibility could be tied to broader biomedical discourse about truth, scientific measurement and the privileging of sight over other senses (Brighenti 2007). This privileging can be associated with an ongoing disparity in funding for medical research and care, where there is an overt focus on 'physical' rather than 'mental' health (Millard and Wessley 2014). Medicine has a significant role to play in authenticating self-injury and in shaping how particular forms of self-injury come to be accepted as evidence of 'real' distress.

The authenticity of self-injury has long been contested within psychiatry. In Chapter 5 we examined relevant scholarship from the history of psychiatry, which demonstrates the long-standing nature of attempts to define and demarcate self-injury, and establish or deny links with psychiatric disorder, and suicide (Chaney 2011; Gilman 2013). More recently, psychiatric efforts to define self-injury have crystallised in the criteria for Non-Suicidal Self-Injury (NSSI), set out as a disorder for 'further study' in the American Psychiatric Association's Diagnostic and Statistical Manuals (DSM, American Psychiatric Association 2013). My analysis of the proposed diagnostic criteria for NSSI highlighted the potential power of psychiatry to further shape understandings of *what self-injury is*, and the contentious nature of attempts to recognise self-injury as a 'legitimised' form of psychiatric disorder. However, alongside internal psychiatric debates about the nosology of self-injury, sociologists Adler and Adler have argued that self-injury is becoming de-medicalised. In contrast, I have suggested that even where self-injury might be 'chosen' and practised entirely away from the medical gaze, how it is understood is nevertheless shaped by biomedical discourse about bodies, emotions, neurochemistry and hormones. I have argued that biomedical language is employed both to make sense of self-injury, and as a way of authenticating the practice.

My analysis of authenticity in this chapter foregrounds its use in narratives about self-injury. Reflecting the approach taken throughout the book, I am concerned with the phenomenological experience of practising self-injury, of being someone who has self-injured, but I do not pretend to be able to access such experiences (Atkinson 2009). Rather, I analyse the way in which phenomenological, embodied experience is

articulated via narratives and explanations, justifications and excuses for the practice of self-injury (Scott and Lyman 1968).

Self-Injury as Authentic Practice: Or Practice of Authenticity?

> It seems to be the lack of […] embodied self-consciousness, that characterises the experience of the participants in this study. It was in this sense that they felt unreal, not like themselves, dead, fragmented. They cut to demonstrate that they were real. They believed (reflexively) that they were real, but they also needed to know (tacitly, directly, prereflexively) that they were. (Horne and Csipke 2009: p. 663)

Horne and Csipke's analysis of the accounts of people who had self-injured argued that feelings of unreality (deadness, fragmentation, dissociation) were central to understanding the functions and meaning of the practice. A similar motif emerged in accounts across the 2007 and 2014 studies. For instance, Belinda and Francis suggested they self-injured in order to feel *something* more concrete or real. Alluding to several key themes in this book, Keely, writing in 2014 suggested she self-injured in order to '*cope with overwhelming emotions, to feel real again, to see blood*'. Certainly, hurting oneself to feel 'real', to feel something more concrete, perhaps more authentic, appears to be an established method of accounting for self-injury. In this section, I further interrogate the meanings of this type of narrative and the ways in which it relates to cultural understandings of bodies and medicine.

Self-Injury as a Practice of Authenticity

Like Horne and Csipke's respondents, several participants in both studies have addressed the idea that self-injury can act as a way of centring or grounding the self. For Belinda, the physical, tangible practice of self-injury was contrasted with more confusing, ephemeral feelings:

> *I think, it's always been, just to feel something else. Just to … or feel something, em, … concrete. That meant something. You know like, my arm is bleeding, it hurts, that-that is a solid, feeling. It's, there's—there's no confusion about it […] I, need to feel something, just for a little bit, not always, just for a little bit, something that I know is real and it's there and its concrete and its, this is, this, and that's that, and its real and it's just, sort of more black and white. (Belinda, 21, 2007, original emphasis)*

A key question here is why the practice of self-injury is framed as working in such situations. What is it about the act of cutting, burning or hitting one's body that leads to a satisfactory resolution: the end of dissociation, a more comfortable 'concrete' feeling? Why might physical, visible wounds be tied to a more authentic, integrated self?

I would suggest that the reason these accounts make sense—and are so often taken at face value by others—is because they build upon pre-existing, deep-rooted, dualistic view of bodies and emotions, of feeling and visibility. Veena Das (1996) addresses this, when she writes of the difficulty—perhaps impossibility—of having pain recognised by another. Pain—particularly *emotional* distress—is understood as interior, invisible, individual. Leading from this, 'emotional' distress is vulnerable to charges of inauthenticity because it cannot be seen, and because communications of distress can be ignored or invalidated. In contrast, Sara Ahmed writes of the *social* nature of pain—of the need for acknowledgement from others:

> … [it is] because no-one can know what it feels like to have my pain that I want loved others to acknowledge how I feel. The solitariness of pain is intimately tied up with its implication in relationship to others. (2014: p. 29)

In accounts provided by those who self-injure, we see attempts (often foiled) to communicate pain—both verbally and *physically*. Distress can be uncertain, and in the accounts of several participants, this uncertainty related to self-assessments as well as the assessments of others. Harriet, for instance, spoke of the difficulty she faced in having her distress recognised, because she 'looked fine', and—crucially—had not injured herself:

> *… sometimes it feels like, … you want, you go down and try and speak to somebody but it's like—but* ***you've not done anything so, they think, 'oh you're fine'*** *like, it's like sometimes like, well, if I do something then maybe people'll realise then that I'm hurting, inside […] and then they're like—'but why didn't you come to us before you did it?' It's like, well I tried to! But you wouldn't help me! […] so it's like, quite difficult, to know what to do. (Harriet, 26, 2007, emphasis added)*

Belinda's account provides a further illustration of the difficulty participants said they faced when trying to have their distress recognised. Belinda's confusion about how she felt, the overwhelming nature of her interior 'mind'—which she described as busy, traffic-filled, noisy and unstoppable—was tied discursively to earlier experiences where her distress was invalidated, ignored.

> *originally it was just a lot of hurt and confusion, and just I didn't know what to do with it, and, I wanted people to sort of, I don't know, I didn't know whether I wanted them to know or just to understand or just, I think know, because they didn't know, even when I told them they still didn't know. Em, and I just wanted people to say, [to] see that, yeah you know, you missed her, she wasn't alright. (Belinda, 21, 2007, original emphasis)*

Belinda associated her practice of self-injury with her failed attempts to get 'attention' from those around her about the abuse and distress she was suffering in her mid-teens. As such, her narrative speaks to a need to have distress validated, authenticated—recognised. She spoke of trying to tell people, which did not work; she then said she cut herself and did not hide this, because she hoped people would *'see … you missed her, she wasn't alright'*. In her narrative, she suggests that this did not work either. Belinda went on to describe her recent self-injury as related to confusion and the need for something concrete. At the time of her interview, Belinda framed her practice of self-injury as now private, not meant for others, just for herself: *'I just don't want people to see, I just, it's a me thing […] it's just a re—release, just to, distract, to feel something different.'*

Belinda and Harriet's accounts highlight the inherently social, and precarious, nature of authenticity. How possible is it to authentically

recognise one's own distress if it is ignored, invalidated, by others? Each account also points to the importance of embodiment, and of visibility, in understanding how self-injury might be used—with differing levels of success—to authenticate experiences of distress. Belinda describes initially using self-injury to attempt to demonstrate her distress *to others*. When this also failed to garner any acceptable response, she continued to injure herself, but in a more 'private' manner—using the practice to intervene in her overwhelming emotional states *for herself*. In each case, the injuries are framed by Belinda as representing more concrete representations of otherwise interior, confusing and inaccessible emotional states. For Harriet, this played out slightly differently: she suggested that *others* could not recognise her distress *unless* she had injured herself.

Clinical perspectives on Belinda's account might focus on her 'failure' to regulate her emotions in a 'non-pathological' manner, or they might highlight the 'dysfunctional' nature of her family relationships. Unsympathetic readings of Harriet's narrative would likely label her 'attention-seeking'. A critical, sociological reading, in contrast, points to the socially constructed nature of the self-injured bodies that these women refer to. This is a body which is understood as having an interior which can be 'worked on' from the outside, as a way of both communicating and authenticating feelings of distress. Further, rather than framing Harriet, Belinda, or their families, as 'dysfunctional' we might consider the wider emotional cultures that these accounts—and those of others who self-injure—allude to. In particular, I refer to the tendency *in general* for negative emotions to be dismissed and minimised in social life. This was briefly addressed in Deborah Lupton's work on lay accounts of emotions, when she noted that her participants emphasised the importance of both control and release with regard to emotional health. However, an important proviso related to releasing 'negative' emotions, especially anger. Participants across both studies have emphasised the importance of 'releasing' strong, negative feelings—such as anger—in private, *away from others*. This is evident in narratives which address the importance of not 'bothering' others, and of fearing the impact of negative emotions being directed anywhere but 'the self'.

> *People [say] like – 'no but you've gotta tell us when your angry' and I'm like 'ooo, I can't do it!' cos like, [it's] just too hard for me to … to like say it […] And, it's like I think I'm scared of people's reactions about saying, like I'm like angry with you about that. (Harriet, 26, 2007)*

Returning to Horne and Csipke's analysis, I want to suggest that accounts of the phenomenology of self-injury—its function in 'manipulating body-based experience' (2009: p. 663)—need to be understood in light of available cultural scripts about bodies, emotions and social life. Narratives which address the role of self-injury in reintegrating the self, generating concrete feelings in the face of overwhelming, internal, emotions, can be read as justifications (Scott and Lyman 1968). Those who provide such narratives accept responsibility, but reframe self-injury as an understandable (justifiable) practice. However, such accounting only makes sense in the light of a range of cultural assumptions: that strong, negative emotions are unacceptable in many/most social situations; that emotions themselves are intangible, hard to grasp; and that we can work on our bodies in order to enact emotional changes.

Self-Injury and the Authenticity of Emotion

The idea that self-injury 'transforms' emotional pain into physical pain is increasingly wide-spread, and accepted. As discussed in Chapter 3, I would suggest that a more critical examination of this method of accounting for self-injury is necessary. Rather than taking for granted the emotional pain—physical pain transformation, we might ask why it is that physical pain is privileged; why individuals who self-injure (and those who do not) might struggle to express, or communicate strong negative emotions. Further, we should question more widely *where* strong, negative emotions might originate—and turn towards social and cultural explanations, rather than focusing in on individual, or familial factors alone.

Accounts which centre on the role of self-injury in transforming emotional pain into physical pain rest on an understanding of emotions as *potentially* inauthentic. This contrasts with visible, physical wounds which are more difficult to dismiss by the individual who is self-injuring; or

others who may come to see the wounds or marks. As such, the narrative of emotional–physical transformation points to the socially constructed nature of authenticity. That 'real pain' is subject to question, that self-injury is *simultaneously* a way of demonstrating 'pain' and *also* potentially inauthentic. Authenticity and self-injury are ambivalent.

At the same time, the emotional–physical transformation narrative cannot be disentangled from a dualistic understanding of the body: as separate from, but nevertheless a container for emotions. Physical pain is privileged—it provides a visible marker, and a tangible wound which can be nurtured and cared for, in a way that emotional pain cannot. However, the ability of physical pain to somehow transform emotional pain, remove distress and release anger implicates an irrevocably integrated emotional, corporeal self.

In Chapter 4, I argued that the focus on visibility becomes more understandable in light of the way in which medical knowledge and medical practice also privilege visibility over patient reported symptoms (Mol 2003). The use of neuro-narratives—emphasising the role of endorphins, serotonin or dopamine—provides a further illustration of the importance of visibility and biomedicine in shaping the meanings of self-injury, and attempts to authenticate the practice. Similarly, the accounts from younger people writing in 2014 indicated that addiction discourse is becoming more accepted—at least among some. The authority lent to these types of account belies the lack of clarity found in research which has attempted to identify neurological processes in the bodies of those who self-injure (Kirtley et al. 2015). What this does provide evidence of, I would suggest, is a potential challenge to more complex, social and cultural explanations for self-injury.

The very preponderance of accounts which advocate addiction as an explanation for self-injury, or emphasise the importance of internal, biological processes, can itself be seen as a social phenomenon. Such explanations provide concrete accounts of self-injury, which avoid the messiness of social life, side-step uncomfortable, negative connotations associated with attention-seeking, affirm seriousness in the face of those who suggest self-injury is a 'fad' or a manifestation of 'teen angst' (Adler and Adler 2011). This analysis sits easily with broader accounts of the 'turn' towards neurology in order to explain diverse aspects of human life and

social practice (Buchman et al. 2013; Rose 2003; Rose and Abi-Rached 2013). I would add to this that for self-injury, the use of the language of biomedicine, of neurology, offers an important means through which individuals can authenticate the practice of self-injury. As such, this is an important—though highly contestable—resource for both those who self-injure, and clinical practitioners and researchers engaged in the study or care of self-injury.

The Authentic 'Self-Injurer'

In contrast with accounts which speak of authenticity as a driver in, or outcome of, self-injury, in Chapters 2 and 4 we addressed accounts which used the concept of authenticity in a more normative manner. Those who self-injured in certain ways were marked as inauthentic, and these narratives could be seen as serving to distinguish between types of 'self-injurer'. A particularly reviled figure was the 'attention-seeking self-injurer', but also problematised were those seen as 'copying' self-injury. In many cases, those who were framed as self-injuring inauthentically were 'others'.

> *Absolutely not. Although there are a few vile people who harm for attention, most of self-harmers really do have problems. (Gita, 14, 2014)*

> *… there are a lot of fake self-harmers who make tiny cuts for attention. (Leanne, 16, 2014)*

My analysis of these accounts argues that such narratives are produced as a way of working through the meanings of self-injury, and in doing so generating a coherent, and legitimate self for the teller. Self-injury is—we are told—a stigmatised practice, one that is associated with mental disorder, insanity, youth and immaturity. This incorporates an association with 'attention-seeking' and 'copying': playground jibes. In this context, narratives which construct 'others' who self-injure in problematic ways serves to distinguish between different types of self-injuring person, while seeking to assure the listener that the teller is 'not like that'.

Such narratives generate an account of what 'authentic' self-injury looks like, and the types of person who engage in the practice (see also Johansson 2011). Self-injuring 'for attention' rather than 'in private' is one clear distinction, alluded to strongly by Gita and Leanne, above. However, accounts often troubled the attempt to separate out 'attention-seeking' and 'privacy'. Participants in the 2007 research, who were afforded more space and time to discuss their experiences, frequently talked of fluid and varying approaches to privacy with regard to their self-injury. Only one participant—Justin—suggested that 'no-one' knew about his self-injury. Others spoke of injuries coming to be seen by others, or being known about by 'only a few'.

The shorter accounts provided in the 2014 study overwhelmingly focused on secrecy and the 'hidden' nature of self-injury for the participant. Such accounts reflect prevailing public discourse about the 'hidden' nature of self-injury. For instance, Adler and Adler's *The Tender Cut* has the subtitle: *Inside the **Hidden** World of Self-Injury*. Advice to parents or teachers frequently emphasises the 'hidden nature' of self-injury, providing 'warning signs' to look out for, such as long sleeves or moodiness (Smith 2012). However, I would suggest that it is important to question the reification of 'hidden' self-injury. Even among participants in 2014, there were occasional hints that the practice was not entirely hidden all of the time:

> *I self-harm and only one person knows. It's not to get attention, it's a way to cope when there isn't another way. (Leon, 15, 2014)*

> *Nobody besides my therapist knows about my cuts. Well, that and a psych forum I visit. (Nickie, 16, 2014)*

Further, in 2007, participants such as Belinda, Anna and Rease described self-injury that was not *necessarily* hidden, but was nonetheless *ignored*. As such, even where participants emphasised secrecy and the hidden nature of self-injury, there *were* exceptions. In Chapter 4, I suggested that the emphasis on 'privacy' in many of the accounts provided in 2014, and in other research, represent 'formula stories' (Loseke 2001): acceptable, culturally available ways of narrating the experience of self-injury. Scratch

the surface, and the idea of 'private' self-injury becomes contested: private to who, secret from who?

I would suggest that the continued valorisation of privacy and secrecy maintains a cultural account where self-injury is viewed as private, secret, *and therefore* visible self-injury is subject to negative readings: 'manipulation', 'attention-seeking'—'inauthentic'. This contradictory and perverse framing of self-injury was first problematised by Crouch and Wright (2004) over ten years ago. However, if anything, the emphasis on self-injury as hidden seems to have become more entrenched. At the same time—and entirely anecdotally—evidence of self-injury has become more visible. One only has to pay a little attention—especially during warm weather—and the traces of self-injury can be seen on many arms. Indeed, if we accept the narrative about the 'epidemic' levels of self-injury, and the DSM-5's characterisation of self-injury as leaving 'characteristic scars', then we can only expect to see such evidence more and more often. It is important that future research and theorisation about self-injury consider the impact of these theories on individuals living with visibly self-injured bodies (Chandler 2014).

Authentic Self-Hood, Self-Injury and Late Modernity

> The psychological foundation, upon which the metropolitan individuality is erected, is the intensification of emotional life due to the swift and continuous shift of external and internal stimuli. (Simmel 2010: p. 103)

Authenticity appears to have become an increasingly pressing concern over the course of the twentieth century, and remains so in the early part of the twenty-first. This is reflected in unease about the *loss* of authenticity—for both individuals and groups; disquiet about the mass manufactured, artificial nature of cultural production (Vannini and Williams 2009). Some have argued that anxiety about identifying one's 'true self' has emerged alongside an increasing fetishisation of the individual, such that the search for, or articulation of, the 'true self' has become an all-consuming project (Erickson 1995: p. 122).

While attempting to *be* authentic, to nurture and pursue one's 'true self' may be increasingly important, the prospect of living authentically is perhaps more out of reach than ever. At the turn of the twentieth century, Simmel bemoaned the mental effects of living in the fast-moving, brutalising metropolises of the turn of the last century. He can hardly have predicted the rise of McDonaldisation—the simulation and simulacra of postmodern, 'media saturated' world where nothing is solid, least of all 'real' (Baudrillard 1998; Ritzer 1996). Taking authenticity for granted as a concept, we might accept that it is indeed more difficult to live authentically. In theory at least, the opportunities and options we have for self-development are multiple and varied (Giddens 1991), but also of uncertain provenance, frequently manufactured, fake, copied (Meštrović 1997). Again, in this respect self-injury reflects this ambivalence, simultaneously more 'real' and tangible, and yet open to (disparaging) charges of copying and 'fashion'. Injuries can represent both sincerity and artifice; they can be read as both a sign of deep inner pain, or as evidence of superficial teen angst, a passing 'fad'.

Bodies have been argued by some to be the last vestige of solidity in a late/postmodern, uncertain and ever-changing world (Ferreira 2014; Shilling 2003). Simultaneously, bodies are apparently more mutable and flexible than ever before and, indeed, this flexibility offers a further way in which bodies can become a way of expressing authentic selfhood (Featherstone 2000; Sweetman 2000). We can choose from a wide array of diets, moving in and out of 'fashion'. Low-carb, gluten-free, low-calorie, high-fat, low-fat diets each promise to shape our bodies outside and in, to enhance fitness and decrease our risk of cancer and heart disease (Bordo 1993). A rapidly expanding industry has grown up around fitness—offering more ways in which bodies can be moulded to suit: toned, slim, muscular, big, small, hard (Underwood 2013). For those with access to ever-greater material resources, cosmetic surgery can provide still further alterations to bodies—addressing less flexible areas: breast size, nose shape, wrinkles, as well as offering 'easy' ways to thinner, firmer bodies via liposuction and body contouring (Gimlin 2006).

Practices of self-injury share significant similarities, but also important differences, with other cultural practices which impact on the look and feel of bodily surfaces. Debra Gimlin (2006) argued that accounts

of cosmetic surgery were frequently oriented towards feeling 'normal', and removing sources of social dys-appearance: where bodies came painfully to the foreground because of the perceived negative responses of others towards particular body parts (noses, breasts, fat). Similarly, some accounts of self-injury address the role of feeling 'normal'—establishing emotional equilibrium. The focus with self-injury is a feeling self (rather than a visible self) that is perceived as 'abnormal' or 'inappropriate'. Self-injury is then narrated as an (effective) method of working on the body to address feelings experienced as 'excessive', 'confusing' or 'inappropriate'.

Self-injury differs from practices such as cosmetic surgery and (most) tattooing and piercing, in that it is practised by the self, rather carried out by an 'other'. In this sense, we might understand the use of self-injury as more comparable to two other forms of, seemingly disparate, body work: exercise, and the ingestion of psychotropic medication. Psychotropic medication is routinely used in order to regulate moods, or alter emotions via interactions with 'brain chemistry' (Lyon 1996; Stepnisky 2007). Similarly, exercise is increasingly framed as a method of working on the body in order to release 'endorphins', to maintain positive moods, alongside the 'physical' benefits of fitness (Fullagar 2009). There are striking similarities here, with narratives about psychotropic drug use, exercise *and* self-injury drawing on widely circulating neuro-discourse (Rose and Abi-Rached 2013).

However, with regard to authenticity, there are interesting divergences. Psychotropic drug use generates anxieties among users about the effects of ingested substances on their 'real self'. Qualitative accounts of those using psychotropic drugs reflect ambivalence regarding the questionable benefits of having moods regulated by 'external' means, which are taken into the body (Fullagar 2009). Anthropologist Emily Martin (2006) has reflected eloquently on this issue, questioning the ambivalent nature of psychotropic drug use in contemporary American society. Martin draws on a quote from a psychiatrist, asking what kind of person we might be if we can only 'cope' through a 'chemical':

> 'What kind of a person would we be when … the only way we can cope with situations is through a chemical?' I will also place his answer—'Then we're not really much of a person'. (Martin 2006: p. 273)

Similarly, Simone Fullagar (2009), and Jeffrey Stepnisky (2007), have each reported the ways in which psychotropic drug use *and* experiences of depression are narrated as potentially unsettling to the notion of a 'real self'. Is the 'real self' revealed, or obscured, by depression, by use of psychotropic drugs?

With self-injury, the question of authenticity is different. As we have seen throughout the preceding chapters, self-injury is said to be used in order to 'feel' authentic; to 'prove' the existence of distress that is otherwise subject to question. At the same time, self-injury itself can be charged as inauthentic: copied, carried out for inauthentic reasons—attention-seeking, manipulation. These narratives emerge both in the accounts of those who self-injure, and in the formalised language of the DSM-5 criteria for NSSI. The 'real self' in narratives about self-injury (and perhaps with exercise) appears to be less under threat than in the accounts of depression and drug use analysed by Stepnisky and Fullagar. It is possible that the discursive and sensate relationship between bodily practices (e.g. cutting, or running) and associated 'releases' (e.g. of endorphins, or adrenaline) is less troubling because it is more self-directed. Psychotropic drugs are generally, though not always, 'prescribed' by another person. Further, the use of psychotropic drugs involves ingesting an exogenous substance. In contrast, exercise and self-injury are characterised as stimulating the 'release' of endogenous substances—by necessity already a part of the body/self.

Medicine and the Self-Injuring 'Other': An Ending

> We have the feeling that there is some fixed, super thing about mental illness, a reality that divides the real illnesses from the fakes. I believe that our conceptions of real illnesses are of necessity being … renegotiated at present. (Hacking 1998: p. 95)

At the beginning of this book, I set out to develop an analysis of self-injury that was grounded in, but critical of, personal accounts. I sought to treat the accounts with respect, but also to avoid taking them for granted,

at face value. At the same time, I said I wanted to avoid 'othering' those who self-injure. This is a difficult position to maintain: in critiquing, we often necessarily have to objectify, create distance, look at things from a different angle. In part, I hope to have reigned in the 'othering' by reflecting on the implications of my analyses for my own practices of self-injury, for my own experiences of living in and with, a self-injured body. At the same time, I am wary—as I have noted previously—of assuming that my experiences are in some way comparable to those of the diverse group of people whose stories of self-injury form the core of this book. Ultimately, what this book offers is a necessarily partial account, but one that I hope offers a useful contribution to debates and discussion about self-injury.

Biomedical interpretations of self-injury have been emphasised throughout the preceding chapters. Rather than arguing that self-injury has become de-medicalised (Adler and Adler 2007), I have suggested that self-injury is irrevocably shaped by medical knowledge, and medical practice. Such shaping is not one-way, nor is it monolithic. Rather, we can identify interactions between clinical accounts of self-injury and the narratives of those who self-injure; each of which draw on biomedical and, more often, neurochemical perspectives on the body/self. Narratives about self-injury incorporate medicine in subtle and not-so-subtle ways. Neurochemical explanations which speak to the 'release' of endorphins, or the role of 'pain relieving brain chemicals', employ medical discourse in order to generate meaningful accounts of self-injury. Accounts of self-injury which speak of the 'transformation' of emotional pain into physical pain are drawing on a range of cultural narratives that are heavily influenced by 'medical' knowledge. These are not separate (Lupton 2012). Medicine separates 'mental' and 'physical' health, and privileges the latter. This both reifies and relies upon a parallel privileging of 'sight' (visibility), and 'touch' (tangibility) over and above less 'concrete' markers of distress/illness/injury. Such dualisms provide resources for individuals generating narratives about their practice of self-injury; just as these very narratives challenge the purity of dualistic oppositions between mind and body, self and society, emotionality and physicality.

Throughout the years, I have spent living with, and studying, self-injury I have been constantly haunted by the sense that we must be finished now. Surely, there is no room for *yet another* study about self-injury,

another exposé about a celebrity who has cut themselves, another set of guidelines on how health services should respond to self-harm, another sensational newspaper report about 'epidemic' rates of self-injury among young people. The rate at which these additional pieces of knowledge are produced shows no signs of slowing down, however, and by writing this book, I am of course further contributing to this. I remain convinced, though, of the urgent need for sensible, critical, sociological work on self-injury. The practices of self-injury, the people who self-injure, and the medical technologies and systems around them, continue to evolve. There is a grave need for sociological contributions to these ongoing debates and discussions. My own work, and that of other sociologists (Adler and Adler 2011; McShane 2012; Steggals 2015), has clearly demonstrated the multiple and complex ways in which society shapes the experiences and meanings associated with self-injury. It is vital that this voice is not lost, and that alternative readings of self-injury can be explored, critiqued, and offered. Better this, than a more dystopian future where self-injury is reduced to a (neuro)biological process, where the narratives of those who self-injure are ignored and where individuals who experiment with the surfaces of their bodies are too readily pathologised, subject to treatments which may run the risk of brutalising the diverse, socially mediated practices that make up self-injury.

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Appendix

List of participants across both studies

Pseudonym	Data from (year)	Age	Location	Gender	Type of data
Aaliyah	2014	14	USA	Female	Survey
Aaron	2014	17	UK	Male	Interview
AJ	2014	14	None given	Male	Survey
Alice	2014	14	None given	Female	Survey
Ami	2014	16	USA	Gender fluid	Survey
Andy	2014	16	None given	Male	Survey
Angelo	2014	16	USA	Male	Survey
Anna	2007	33	UK	Female	Interview x2
Beatrix	2014	15	None given	Female	Survey
Becky	2014	16	USA	Female	Survey
Belinda	2007	21	UK	Female	Interview x2
Benjamin	2014	17	UK	Male	Phone interview
Brandon	2014	15	USA	Male	Survey
Cally	2014	17	USA	Female	Survey
Cara	2014	14	UK	Female	Email interview
Chelsea	2014	17	UK	Female	Survey
Chloe	2014	16	USA	Female	Survey
Cody	2014	16	UK	Male	Survey
Craig	2007	28	UK	Male	Interview x2
Darcy	2014	14	None given	Female	Survey
David	2014	16	None given	Male	Survey

(*continued*)

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(continued)

Pseudonym	Data from (year)	Age	Location	Gender	Type of data
Dean	2014	15	None given	Male	Survey
Dinah	2007	32	US	Female	Interview x2
Donna	2014	17	UK	Female	Survey
Ellen	2014	18	USA	Female	Survey
Emily	2014	23	USA	Female	Survey
Emma	2007	37	UK	Female	Interview x2
Evan	2014	14	None given	Male	Survey
Eve	2014	21	USA	Female	Survey
Finn	2014	16	None given	Male	Survey
Fiona	2014	16	None given	Female	Survey
Frances	2014	13	UK	Female	Survey
Francis	2007	24	UK	Male	Interview x2
Frank	2014	17	None given	Male	Survey
Gavin	2014	17	None given	Male	Survey
Gita	2014	14	None given	Female	Survey
Greta	2014	13	None given	Female	Survey
Harriet	2007	26	UK	Female	Interview x2
Hayley	2014	18	UK	Female	Survey
Heidi	2014	16	None given	Female	Survey
Helen	2014	16	UK	Female	Survey
Hermione	2014	15	None given	Female	Survey
India	2014	15	USA	Female	Survey
Iona	2014	15	UK	Female	Survey
Jamelia	2014	15	USA	Female	Survey
Jane	2014	15	USA	Female	Survey
Jay	2014	16	UK	Female	Survey and Email interview
Joanne	2014	14	None given	Female	Survey
Jody	2014	16	UK	None given	Survey
Jonathan	2014	16	None given	Male	Survey
Justin	2007	28	UK	Male	Interview x2
Katie	2014	15	UK	Female	Email interview
Keely	2014	26	None given	Female	Survey
Kelly	2014	14	None given	Other	Survey
Kevin	2014	15	None given	Male	Survey
Lacey	2014	17	USA	Female	Survey
Laura	2014	16	None given	Female	Survey
Leanne	2014	16	None given	Female	Survey
Lee	2014	16	Elsewhere in world	Other	Survey

(*continued*)

(continued)

Pseudonym	Data from (year)	Age	Location	Gender	Type of data
Leon	2014	15	None given	Male	Survey
Linda	2014	27	Elsewhere in world	Female	Survey
Lisa	2014	16	None given	Female	Survey
Lorna	2014	16	USA	Female	Survey
Lou	2014	13	None given	Other	Survey
Louise	2014	15	None given	Female	Survey
Mara	2014	15	None given	Female	Survey
Marissa	2014	16	USA	Female	Survey
Mark	2007	33	UK	Male	Interview x2
Matt	2014	16	UK	Male	Survey
Mia	2014	14	UK	Female	Survey
Michelle	2014	15	None given	Female	Survey
Milly	2007	28	UK	Female	Interview x2
Molly	2014	15	None given	Female	Survey
Nick	2014	17	UK	Male	Survey
Nickie	2014	16	UK	Female	Survey
Nina	2014	16	UK	Female	Survey
Olivia	2014	16	None given	Female	Survey
Omar	2014	15	None given	Male	Survey
Oona	2014	16	None given	Female	Survey
Paul	2014	15	None given	Male	Survey
Paula	2014	16	UK	Female	Survey
Polly	2014	16	USA	Female	Survey
Rachel	2014	16	UK	Female	Survey
Rease	2007	28	UK	Female	Interview x2
Richard	2014	16	UK	Male	Survey
Rob	2014	15	UK	Male	Survey
Robert	2007	33	UK	Male	Interview x2
Ruth	2014	None given	None given	Female	Survey
Ryan	2014	16	UK	Male	Survey
Sarah	2014	15	None given	Female	Survey
Sidney	2014	15	USA	Trans	Survey
Susie	2014	23	USA	Female	Survey
Tala	2014	15	UK	Female	Survey
Tam	2014	14	Elsewhere in world	Trans	Survey
Tim	2014	14	UK	Male	Survey
Trixie	2014	21	USA	Female	Survey
Uma	2014	15	UK	Female	Survey

(*continued*)

(continued)

Pseudonym	Data from (year)	Age	Location	Gender	Type of data
Ursula	2014	15	None given	Female	Survey
Vince	2014	16	UK	Male	Survey
Vivien	2014	16	None given	Female	Survey
Yolande	2014	14	USA	Female	Survey
Zara	2014	14	UK	Female	Survey
Zoe	2014	16	None given	Female	Survey

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Note: Page numbers with "n" denote notes

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