The Social Transformation of Self-Injury

Patricia A. Adler
University of Colorado Boulder, USA

Peter Adler
University of Denver, USA

DOI: https://doi.org/10.18778/1733-8077.18.4.04

Keywords:
Deviance; Medical; Self-Injury; Ethnography; Cyber-Ethnography

Abstract: This research offers a description and analysis of the relatively hidden practice of self-injury: cutting, burning, branding, and bone breaking. Drawing on over 150 in-depth interviews and tens of thousands of website postings, e-mail communications, and Internet groups, we challenge the psycho-medical depiction of this phenomenon and discuss ways that the contemporary sociological practice of self-injury has evolved to challenge images of the population, etiology, practice, and social meanings associated with this behavior. We conclude by suggesting that self-injury, for some, is in the process of undergoing a moral passage from the realm of medicalized to voluntarily chosen deviant behavior in which participants' actions may be understood with a greater understanding of the sociological factors that contribute to the prevalence of these actions.

Patricia A. Adler (Ph.D., University of California, San Diego, 1984) is a Professor Emeritus of Sociology at the University of Colorado-Boulder. Her myriad research interests span social psychology, deviant behavior, sociology of drugs, sociology of children, sociology of sports, and the sociology of work and leisure. Along with Peter Adler, her most recent work is *The Tender Cut* (New York University Press, 2011). Together, they were the co-recipients of the 2010 George Herbert Mead Lifetime Achievement Award from the Society for the Study of Symbolic Interaction. Their edited text-reader, *Constructions of Deviance*, is now in its eighth edition.

email address: adler@colorado.edu

Peter Adler (Ph.D., University of California, San Diego, 1980) is a Professor Emeritus of Sociology and Criminology at the University of Denver. His work is informed by a symbolic interactionist perspective and ethnographic methods. Together with Patti, he edited the *Journal of Contemporary Ethnography* for eight years and wrote several books, including *Membership Roles in Field Research* (Sage, 1987), a treatise on ethnographic methods and how researchers locate themselves within their settings; *Backboards & Blackboards* (Columbia University Press, 1991), an insider's account of the subculture of Division I intercollegiate athletes; *Peer Power* (Rutgers University Press, 1998), research on the culture of preadolescent children, and *Paradise Laborers* (Cornell University Press, 2004), a study of hotel workers in Hawaii.

email address: socyprof@hotmail.com

Along a subterranean topic, the deliberate, non-suicidal destruction of one's body tissue emerged from obscurity in the 1990s and began to spread dramatically. Self-injury has gone by several names, though self-harm and self-mutilation have been the other most common appellations.[1] While any language may suggest an implied judgment about the behavior, and self-injury certainly invokes a more favorable connotation than self-mutilation, we employ this term since it was used by our respondents most frequently.[2] Although a range of behaviors may be considered self-injurious, including eating disorders, excessive laxative use, and extreme body modification, among others, we focus here on those specific behaviors that have been identified by the psychiatric and medical communities as falling into this specific syndrome: self-cutting, burning, branding, scratching, picking at skin or re-opening wounds, biting, head-banging, hair-pulling (trichotillomania), hitting (with a hammer or other object), and bone-breaking.[3]

Evidence of intentional self-mutilation traces back to Greek and biblical times (Favazza 1998), although throughout most of history there has been little awareness of the phenomenon; participants acted in a social vacuum. Somewhere in the late 1990s, public knowledge of self-injury began to rise, with depictions of it appearing in books, films, television shows, magazines, newspapers, and other media.[4] Several celebrities came out and admitted their self-injury,[5] and discussions of it flourished among teenagers. This burgeoning awareness, although limited in scope, spread rapidly through certain segments of society—adolescents, young adults, educators, doctors, psychologists, and social workers—leading Favazza (1998) to suggest that it had "come of age." Greater public knowledge affected how self-injurers thought about themselves and were regarded by others. Early in the 2000s, Internet websites focused on self-injury began to appear, complete with public chat rooms and newsgroups where people could interact, anonymously, but with great intimacy. In this paper, we describe how the behavior, attitudes toward, and social meanings of self-injury have changed.

[1] Terms that have been used include self-harm or deliberate self-harm syndrome (Pattison and Kahan 1983; Aldridge and Rossiter 1984; Grantz, Conrad, and Roemer 2002), self-mutilation (Waisman 1965; Favazza and Conterio 1988; Favazza 1996; 1998; Strong 1998; Ross and Heath 2002; Nock and Prinstein 2004; 2005), self-destruction (van der Kolk, Perry, and Herman 1991), self-cutting (Suyemoto and MacDonald 1995), self-injurious behavior (Shearer 1994; Herpertz 1995; Bowen and John 2001), self-wounding (Brooksbank 1985; Tantam and Whittaker 1992; Sharkey 2003), and self-injury (Solomon and Farrand 1996; Hodgson 2004).

[2] Radical feminists politically reject all terms for this behavior except self-mutilation because they believe other terms hide the violence and oppression directed against women (and those men) victimized by the hetero-patriarchal society. They use self-mutilation (and self-mutilation by proxy) to describe not only the behaviors described in this paper but also tattooing, piercing, cosmetic surgery, transsexual surgery, punk music, dieting, and high-heel shoes (Burstow 1992; Jeffreys 2000).

[3] While people may do a variety of almost unimaginable things to themselves, such as self-amputating, drilling holes into their skulls, intentionally making themselves ill (Munchausen Syndrome), and piercing, tattooing, or decorating their bodies in extremely radical ways, these behaviors fall outside of those clinically associated with the specific syndrome known best at the turn of the twenty-first century as self-injury. We, therefore, restrict our focus to these practices not arbitrarily, but because they have been traditionally associated together in the medical literature and because they are performed by a consistent group of people. In other words, people who intentionally make themselves ill or who cut off their limbs are not the same people who cut or burn themselves, and people who undergo "body modification" to get tattooed or scarified come from a dramatically different etiology than people who self-injure, although members of both groups may carve words or designs into themselves. These are different phenomena practiced by different people.

[4] Some popular treatments that came to public attention leading up to or around this time included films such as "Girl Interrupted," "Nightmare on Elm Street III," and "Secretary," television shows with episodes on cutting such as "ER," documentary treatments on The Learning Channel, popular songs such as "Hurt" by Nine Inch Nails, "Crawling" by Linkin Park, "Back to the Coast" by Nikki Sudden, "Last Resort" by Papa Roach, and personal revelations from Richey Edwards, the guitarist and songwriter for Manic Street Preachers. See also Egan (1997).

[5] Some of these included people such as Johnny Depp, Drew Barrymore, Angelina Jolie, Christina Ricci, Fiona Apple, Richey Edwards, Courtney Love, Marilyn Manson, Shirley Manson, Elizabeth Wurtzel, and Princess Diana.

The literature on self-injury largely comes from a psychiatric or medical perspective and is often treatment-oriented in its focus (Brickman 2004; Cresswell 2005; Schoppmann et al. 2007; Gunnarsson and Lönnberg 2022). Systematic or rigorous studies of self-injury from a sociological perspective were rare up through the early 2010s (see: Hodgson 2004). Since many of these studies were conducted on individuals with a history of psychiatric treatment (Grantz, Conrad, and Roemer 2002), little had been known empirically about self-injury among people who are not clinical inpatients (Suyemoto 1998). Yet, most self-injurers never seek the help of mental health professionals (Conterio and Lader 1998), and a larger percentage of the incidences of self-injury never come to medical attention. The behavior is generally carried out secretively, as wounds may be superficial and easily self-treated (Gardner and Chowdry 1985). Many self-injurers are functional and thus remain hidden within society. We fill this void by shedding new light on populations about which little has been previously written: longer-term chronic users, youthful participants who have remained outside of treatment, and people who feel positive about their self-injury. This article draws from our major work on self-injury (Adler and Adler 2011), the first comprehensive ethnographic study on this hidden population.

Subsequent literature has built on our research. McShane (2012) drew on a qualitative sample of 25 in-depth interviews to write about how people who self-injure are affected by suffering, ritual, and stigma. Steggals (2015) used a cultural perspective to analyze self-injury as more of a practice than an illness and as a powerful cultural idiom of personal distress and social estrangement. Chandler (2012; 2016) applied a corporeal lens to argue that understanding self-injury requires engaging with widely circulating narratives about the nature of bodies to see how they are separate from, yet containers of, emotion and how self-injury constitutes a form of emotion work, helping people to both contain and elicit emotions. McDermott and Roen (2016) used a combination of face-to-face interviews and online research to prioritize the perspectives and experiences of queer young people, offering a critical perspective on the role of norms—namely, developmental norms, gender and sexuality norms, and neoliberal norms—in the production of self-harming and suicidal youth. Brossard's (2014; 2018) in-depth interviews with 70 self-injurers challenges the idea that self-injury is a matter of disturbed individuals resorting to hurting themselves due to psychological weaknesses and difficulties. Rather, in the face of the daily tumultuousness of peoples' social lives, individuals use self-injury to attain a sense of control and maintain order—to calm down, or to avoid "going haywire" or "breaking everything." His interactionist model delicately illustrates both the succession of activities leading to acts of self-injury and the trajectory that people follow over the evolving course of their self-injuring careers. Inckle (2010) offered a sociologically informed resource for people who hurt themselves and those who live and work with them. She then (Inckle 2017) applied a feminist analysis drawing on user/survivor perspectives to frame self-injury within societal contexts, highlighting the power of marking one's body to express extreme emotional turmoil. Alongside these titles stand the works of social and medical historians. Millard (2013) charted the rise and fall of various self-harming behavior in twentieth-century Britain, linking self-injury to the huge changes that occurred in mental and physical healthcare, social work, and the wider political environment. Chaney (2017) traced the history of self-harm from the 1860s to the present,

showing just how deeply entrenched this practice is in human culture.

Historically, self-injury has followed the broader moral passage of mental illness: viewed theologically as sinful and evil during the Middle Ages (Bissland and Munger 1985), self-injury was recast in contemporary times, falling under the rubric of the disease model (Conrad and Schneider 1992). We examine the psycho-medical portrayal of self-injury here and debunk it from a sociological perspective. Our analysis casts self-injury as a complex process of symbolic interaction rather than as a medical problem, with broader implications for its changed social definition from a psychological form of mental illness to a sociological form of deviance.

We begin by discussing the literature on self-injury and its grounding in the psycho-medical field. We then outline the nature and sources of our data. We examine the changing demographics of the self-injury population, the ways people learn to self-injure, the factors affecting how they do it, and the ways people embrace it as they collectively forge an online subculture. We conclude by discussing issues involving the meanings of self-injury in people's lives and the implications of these meanings for the social definitions and stigma surrounding this behavior.

Psycho-Medical View of Self-Injury

Self-injury has traditionally been discussed within the parameters of the psychological and treatment professions. The canonical bible of the psychiatric field, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM: American Psychiatric Association 2000), initially listed self-injury not as a disorder unto itself, but rather as a symptom of several other disorders, most notably those having to do with impulse control. It was lodged primarily within the "dramatic-emotional" dimension, and associated as an occasional side-effect of borderline personality disorder (BPD: inappropriate anger and impulsive self-harming behavior, see: Schaffer, Carroll, and Abramowitz 1982), antisocial personality disorder (the tendency to be aggressive, to have reckless disregard for personal safety, see: Virkkunen 1976), histrionic personality disorder (a pervasive pattern of excessive emotionality and attention-seeking behavior often enacted through physical appearance, see: Pfohl 1991), post-traumatic stress disorder (sometimes due to rape or war, see: Greenspan and Samuel 1989; Pitman 1990), various dissociative disorders (including multiple-personality disorder, see: Miller and Bashkin 1974; Coons and Milstein 1990), eating disorders (Favazza, DeRosear, and Conterio 1989), and a range of other conditions such as kleptomania, Addison's disease, depersonalization, substance abuse, alcohol dependence, and various depressive disorders (Bowen and John 2001).[6] However, the issue finally attained international significance, and was included in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (2013:803) as a self-contained category of disorder, rather than as a symptom attached to other disorders.

Effects

Self-injury was considered for many years a suicidal attempt, with users pathologized and regarded

[6] Some believe that self-injury should be clinically classified as a separate impulse-control disorder (Pattison and Kahan 1983). They argued that it should be defined as characterized by severe, uncontrollable impulses, major self-mutilation, onset in late adolescence, a low level of lethality, and repetitive episodes over the years, making it a continuing disorder rather than a dramatic point in life. Favazza (1998) proposed that it be classified and recognized in the DSM as the deliberate self-harm or repetitive self-mutilation [DSM/RSM] syndrome, and in this call, he was joined, thus far unsuccessfully, by others (Alderman 1997).

as weak. Most observers today, however, recognize it as a means by which participants seek a temporary form of relief and view self-injurers as capable or resilient (Favazza 1989; 1998; Favazza and Rosenthal 1993). Although it can be morbid and often maladaptive, our subjects overwhelmingly agree that it represents an attempt at self-help. They claim that their behaviors provide immediate, but short-term release from anxiety, depersonalization, racing thoughts, and rapidly fluctuating emotions. Self-injury, for some, can lead to the diminishing of tension, cessation of depersonalization (grounding), euphoria, improved sexual feelings, diminution of anger, the satisfaction of self-punishment urges, security, uniqueness, manipulation of others, and relief from feelings of depression, loneliness, loss, and alienation. It provides a sense of control, reconfirms the presence of one's body, dulls feelings, and converts unbearable emotional pain into manageable physical pain (Callahan 1996). As such, it represents an emotion regulation strategy (Linehan 1993; van der Kolk 1996) and a grounding technique to end dissociative episodes (Greenspan and Samuel 1989; Pitman 1990; Kennerley 1996). These effects usually (but not always) last the remainder of the day, with individuals experiencing relief ranging from only a few hours to several days or even weeks. Several told us that they continued to derive benefits after they self-injured by looking at or picking at the scabs for as long as these remain.

Methods and History

The nascent idea for this research began in 1982 when a student of Peter's spoke to him about her cutting. Over time, we continued to meet people who cut themselves, which eventually expanded to include burners, branders, and bone-breakers. Becoming curious about the nature of this behavior and its spread, in 1999, we began the process of applying for IRB clearance to research the topic. It took two years to obtain that permission, and there were extensive precautions and safeguards, updated yearly, that we had to follow in gathering data from this vulnerable population.[7]

This analysis draws on 135 in-depth, life history interviews conducted in person and on the telephone, which constituted the largest sample of qualitative interviews with non-institutionalized self-injurers ever gathered. Participants ranged in age from 16 to their mid-fifties, with many more women than men (85% women and 15% men), nearly all Caucasian. Due to the extremely sensitive nature of this topic and the gendered nature of participants, Patti took the lead role in gathering data. In searching for subjects, we began with a convenience sample of individuals who heard, on one of our campuses, through radio interviews, or through the grapevine that we wanted to talk with people who self-injured. We required those who were interested to contact us via email, preview the consent form on our website, and ask for an appointment. These interviews were

[7] We could not interview any people with whom we currently had a subordinate/superordinate relationship (current students) or minors who could not obtain parental consent. This excluded people under the age of 18 who had not revealed their self-injury to their parents, which our interviews with older people revealed to be well over two-thirds of the youthful population. We obtained proof of age from all subjects and both parents' and/or legal guardians' signatures for minors. We gave out a list of referrals to therapists who specialized in treating self-injurers to everyone. When we were doing face-to-face interviews only, these were concentrated in the greater Denver SMSA. As we branched out to telephone interviews, we expanded our therapeutic referral list to include individuals and treatment centers throughout the United States and posted it on our website. We ended up interviewing only two people under the age of 18 (with minor assent and parental consent forms), but over time our IRB requirements for interviewing youth became increasingly difficult to fulfill. We ceased accepting minors into our pool when we were told that our consent form wording must indicate that if parents were aware of their child's self-injuring and did not report that, we had to report them to the authorities.

conducted in our campus offices or at private places chosen by our subjects. Much to our surprise, dozens of volunteers stepped forward to be included in the study.

In addition, beginning in 2001-02, we began to explore the websites and public postings of self-injurers. We joined several Internet self-injury groups as overt researchers and became active participants in group discussions. Because of the intimate nature of virtual communication (King 1996; Mann and Stewart 2000; Chen, Hall, and Johns 2003), we formed several deep and enduring relationships with people in different friendship circles that lasted over the years, discussing with people the features of their ordinary lives, and rallying around them during their many crises. We worked, with others, on the difficulties of supporting people who were disembodied and distant. Together with them, we learned to discern the seriousness of people's suicidal threats, their claims of abstinence, their presentation of different personas under different pseudonyms in different groups, and the consequences of flame wars. We networked through bulletin boards, MySpace, and the hundreds of self-injury-related Web Usenet support groups.

We collected and analyzed 30,000 to 40,000 Internet communiqués and emails, including those posted publicly and those written to and by us. For this endeavor, we primarily used our Internet connections, like other cyber-researchers (King 1996; Waskul and Douglass 1996; Mann and Stewart 2000; Chen, Hall, and Johns 2003; Waskul 2003; 2004), as a means of recruiting subjects. The telephone interviews we obtained through these channels ranged in location all over the United States, Canada, and Great Britain. Of the 80 interviews we completed, 37 were with people who used the Internet in connection with their self-injury.

These interviews were unusually emotional and intense, lasting anywhere from one to four hours. Although some people were initially concerned about being judged by an outsider, the topic's intimate nature and our value-neutral stance led to the establishment of deep rapport rather quickly.[8] People began by telling the story of how they grew up, what their family lives were like, and how they discovered self-injury. Since much writing has associated self-injury with some past trauma, we were especially careful when probing about such events. Most people discussed their past verbal, physical, or sexual abuse, some traced their current emotional distress/pain to the relatively common traumas of adolescence, such as peer rejection or parental/sibling favoritism, but others insisted that their childhoods had been basically happy.[9] Over a dozen of these people have remained in contact with us, continuing to share their evolving ideas and life experiences. We have counseled these individuals on their educations, romantic involvements, parental relations, job searches, and traumatic experiences.

Following this natural history approach, the interviews then moved to specific concepts that evolved inductively over the course of the project (Becker and Geer 1960). At the end of the interview, Patti asked each subject what made them volunteer to come forward. Nearly everyone said the same thing: they wanted others who self-injured to know that they were neither alone nor crazy, and they thought that, by sharing their experiences with us, we would

[8] One person sent a thank-you note after the interview saying that although she had not known what to expect, she was deeply gratified to be able to talk to someone interested in, while knowledgeable and non-judgmental about, the subject.

[9] Although most people appeared to be very candid during their interviews, likely, some may not have confided completely about previous traumatic experiences.

write something that would shed light about self-injury for others.

Epistemologically, these conversations, relationships, and interviews are grounded in the value neutrality of the interpretive, Weberian tradition of the Chicago School. Rather than remaining strictly detached from our subjects, we became involved in their lives, helping them and giving voice to their experiences and beliefs, considered by some postmodern ethnographers and liberal feminists a form of advocacy. Yet, radical feminists view self-injury as violence against women and regard people who speak about it non-judgmentally (even in giving voice to others) as supporting the hegemonic order of patriarchal oppression (Jeffreys 2000). To the extent that we present our subjects' perspectives, our value neutrality is seen, then, as a moral relativism that ignores the inherently oppressive nature of self-mutilation. On the contrary, we maintain that we are giving power to people who have been mostly unheard and misunderstood.

Social Characteristics of Self-Injury

The self-injurers we observed differed markedly from the descriptions in the psycho-medical model. Not only were they more diverse in their composition and character, but their thoughts and actions varied as well.

Types of Self-Injuries

The psychological view of self-injurers is circumscribed, consisting primarily of the population seeking treatment. Clinicians and scholars suggest that this behavior starts in early adolescence, with most practitioners desisting after adolescence (Favazza and Conterio 1988; Favazza 1989; Suyemoto and MacDonald 1995; Kiselica and Zila 2001; Hodgson 2004).[10] Girls are generally considered more frequent participants than boys (Favazza 1998; Kiselica and Zila 2001; Ross and Heath 2002).[11] Like eating disorders, self-injury is seen as located primarily among an educated, middle- or upper-class population (Kiselica and Zila 2001) that is disproportionately Caucasian (Ross and Heath 2002).

Prevalence estimates have been hard to formulate, with data based on inpatient psychiatric wards and emergency room admissions. The numbers of self-injurers have been approximated as ranging from 10 to 20% of all psychiatric inpatients, with 40 to 60% in the more concentrated adolescent population.[12] Emergency room data are more confusing to isolate, since most self-inflicted injuries consist of suicide attempts.[13] Psychologists then attempted

[10] Favazza (1998) alone has suggested that it may persist for a decade or two (typically no more than 10-15 years), with periods of waxing and waning occurring intermittently.

[11] Some have noted as high a figure in their samples as 82% women (Hodgson 2004). At the same time, others have asserted that male participants are more plentiful or equal in numbers to women (Suyemoto and MacDonald 1995; Grantz, Conrad, and Roemer 2002; Tyler et al. 2003).

[12] In 1988, Favazza and Conterio found that seven to ten percent of the psychiatric inpatients they observed engaged in self-injury, while ten years later, Briere and Gil (1998) found an inpatient rate of 21 percent. Among adolescent psychiatric inpatients, this rate has been higher. Darche (1990) suggested that this more focused population was self-injuring at a rate of 40 percent, while DiClemente, Ponton, and Hartley (1991) guessed that it could be as high as 61 percent.

[13] The number of self-inflicted injuries appearing in official ER statistics is difficult to gauge because self-injury is clumped together with self-poisoning, the latter usually a genuine suicide attempt (Hawton and Catalan 1987; Sharkey 2003). Compounding this is the problem that some people do both (Hawton et al. 1997), as well as the larger issue that most episodes of self-injury go undetected, with practitioners ending up in neither psychiatric wards nor hospitals (Pembroke 2000). Setting aside these gigantic problems, studies of hospital admission in the UK estimated a substantial increase in rates and repetitions of self-injury in both genders during an 11-year study in the 1980s and '90s (62.1% increase in men and 42.2% increase in women), with estimates rising to the level of 400 per 100,000 admits per year by the late 1990s (Hawton, Fagg, and Simkin 1996; NHS

to extrapolate from these data to the prevalence of self-injury in the general population, offering guesses of between one and four percent of the at-large population, with up to 20% of the adolescent subgroup.[14] Unfortunately we lack broad-scale epidemiological data from sociological surveys to help refine these assessments.[15]

Structurally Disadvantaged Populations

More recent studies and our data have found the widespread practice of self-injury in broader populations. Self-injury has become much more common among those who suffer and lack control over themselves, such as homeless street youth (Ayerst 1999). Tyler and colleagues (2003) suggested that self-injury has increased in prevalence among this population due to their childhood family abuse, their participation in deviant subsistence strategies, their street experiences, and their frequency of victimization. They proposed that these youth use self-injury to regulate the overwhelming emotions they experience due to their stressful life events, with some using it to becalm themselves, others turning to it for self-punishment, and others desiring the infliction of pain. In their sample, they found that 69% of the people they encountered had done it at least once, with no significant differences noted between men and women. Of their population, only 12% had ever received medical attention.

Self-injury also appears to be growing rampantly among prisoners, especially juveniles. The practice of self-injury in women's prisons has been discussed since the 1990s (see: Heney 1990; Babiker and Arnold 1997; Fillmore and Dell 2000; HM Prison Service 2001; Borrill et al. 2005; Kilty 2006). Its prevalence has also been noted among juvenile delinquents (see: Penn et al. 2003; Matsumoto et al. 2005). Matsumoto and colleagues (2005) found that in the juvenile detention facility they studied in Japan, 16% of the inmates had cut, and 36% had burned themselves at least once. Most of these studies reject the model of self-injury as solely arising out of mental pathology, arguing instead that it primarily represents a form of coping mechanism, a resistance strategy, or even a cry for help.

Like eating disorders, it has commonly been assumed that self-injury is a practice of white, wealthy girls (Brickman 2004), but as with eating disorders, we are increasingly finding self-injury among boys, men, people of color, and those from lower socio-economic statuses. Hanna (2000) found that while ER hospitalizations for whites were 56 out of every 100,000 admits, blacks were admitted at a rate of 39 per 100,000 people, and people of races other

CRD 1998). By 2005, in an American study, McCraig and Burt estimated that of 438,000 ER admits nationally due to self-inflicted injury, non-poisoning accounted for 119,454 cases.

[14] In 1988, Favazza and Conterio used one county's rates for people displaying "emotionally unstable personality" (similar to BPD) and assumed that 1/8 of all BPDs self-mutilate during a year. This led them to estimate a prevalence of 212 BPD self-mutilators per 100,000 in the general population. To that they added the antisocial personality disorder people, the suicidal gestures and attempts people, the eating disorder people, and all the other disorders, giving them a total estimate that 750 out of 100,000 per year in the general population practiced self-injury. These figures are flawed because no one has an accurate sense of the population to which we can generalize the extent of these mental disorders, making the results difficult to generalize to more normative populations (Ross and Heath 2002). Briere and Gil (1998) ventured an estimate of four percent self-injury in the general adult population, the Priory Group (2005) speculated that 20% of all British adolescents engaged in self-injury, and Laye-Gindhu and Schonert-Reichl (2005) found that 15% of the adolescents they surveyed in a school had self-injured.

[15] Neither of the two major surveys of youth health, the National Longitudinal Survey of Youth (NLSY) nor the National Longitudinal Study of Adolescent Health (Add Health), have questions about self-injury. When queried about the absence of these topics, one member of these epidemiological teams indicated that IRB restrictions prohibited their asking questions about such a sensitive topic in a broad survey instrument (Boardman 2005, personal communication).

than black or white were 73 out of 100,000. Our data supported the spread of self-injury to girls from rough inner-city backgrounds, especially those in the foster care system. Particularly vulnerable are homeless youth, prison populations, and people from the lower strata of society who suffer from structural disadvantages in society.

Alternative Youth Subcultures

We also found a growing number of self-injurers who belonged to alternative youth subcultures. Some reported that they hung out with "the wrong crowd" and acted out or were drawn into countercultural groups. They were nihilists who delighted in showing off by burning or cutting themselves. Natalie, a 22-year-old college student, reflected on her junior high school friends:

> Eighth grade was the point at which I really started getting sociable, identifying with this alternative subculture. It wasn't like I hung out with the freaks and the rejects and, like, the outcasts. I definitely was in the subculture of the stoners and the punks, and we hung out on the bridge, and I started smoking and doing drugs, and, um, at that point, I associated with more people who also hurt themselves.

Others joined similar groups as a mode of teenage rebellion, to shock their parents or town (see: Fox 1987 on punks and Haenfler 2006 on straight-edgers). For example, Maggie, a 25-year-old nurse, secretly self-injured as a youth to rebel against her family's strict Mormon beliefs.

Vanessa, a 20-year-old college student, noted that she was currently part of a group that engaged in both self-injury and decorative body modification. Lauren, a 21-year-old college student, had a circle of lesbian friends that used self-injury in their rituals.[16] Men often self-injured by burning, shocking, or branding themselves as part of male homosocial bonding rituals.[17] Self-injury was also frequently practiced in sexual blood play. Finally, self-injury could be the province of young, trendy youth who did it to be "hip." Cindy, a 19-year-old retail salesperson, recounted how people showed others that they were cool:

> I know there's this one site you can go to, I think it's called blue dragonfly or something like that, where they actually sell self-harm bracelets, and if you have one of these bracelets, you're in the clique or something. You're supposed to wear them on your arms to cover your scars, and the more bracelets you have, the more advanced you are in self-harming. So, I guess it's something people can do to be cool.

Typical Adolescents

Beyond these populations, a larger group consisted of teenagers suffering from adolescent stress. Although the psychological literature suggests that self-injurers come from backgrounds of abuse and neglect, many had unremarkable childhoods. Sally, a 22-year-old college student, asserted that she came from a close and contented family. Tracey, an Englishwoman in her early forties, noted, "I've been self-harming for 12 years. I've got no history of abuse, and my recollections of my childhood are happy, so why do I SI [self-injure]? Who knows?"

Sometimes, small events felt overwhelming to individuals going through the difficulties of adoles-

[16] See: Addington (2004) and Venning (2004) for the use of self-injury in lesbian circles.

[17] See: Bird (1996), Gallmeier (1998), and Raphael (1988) for a greater discussion of male homosocial bonding.

cence. Mandy, a 22-year-old college student, noted: "My stepfather used to make fun of my weight or call me ugly." Another young woman believed that her mother liked her sister better than her, while a teenage boy became depressed when his father remarried, and the new wife brought in a step-brother.

Some self-injurers rooted their unhappiness in peer social situations. Rachel, a 23-year-old college student with an intact, happy family, blamed her friends for driving her to self-injure:

> It happened the first time when my group turned against me for some reason. They alienated me for a week straight, they started rumors about me. I didn't go to any activities that week, and I didn't even go to school. I was so sad, it just started. I was crying and so upset and couldn't stop crying, and I just took a coat hanger, and that's how it started.

Others turned to self-injury because they felt they had no friends, describing themselves as loners. Alice, an attractive 22-year-old college senior, noted:

> I never had very many friends in school, I still don't. I always felt pretty isolated, and I took that to heart, felt that there was something wrong with me, I've always felt like people don't like me, and I don't fit in, and I didn't really know why.

Jennie, a 21-year-old college student, rooted her unhappiness leading to self-injury in a romantic relationship. "I guess I was having a difficult time in general, puberty, school. I had this boyfriend, it wasn't the most healthy relationship, and I wasn't getting along very well with my sister. So, I think I blamed myself for everything, and I guess I took it out on myself."

Romantic traumas, while an occasional cause of girls' self-injury, were a more significant factor cited by boys. Break-ups, fights, or other forms of rejection turned them inward to cut. Others from typical family backgrounds turned to self-injury due to school stress, over-commitment in extracurricular activities, and a driving sense of perfectionism. Sometimes, when people failed to meet up to their or their family's expectations, they punished themselves. Sally, a 21-year-old college student, described her decision to self-injure:

> It was a rough time for me. I got miserable. I just didn't feel like confiding in my parents. They probably would have been a great resource of help, come to think of it, but I was at that age where I wasn't comfortable talking to my parents about that sort of thing, and I felt no one understood. So my friend told me about her newfound technique, and I tried it as something that may unleash some of my stress. And it kind of was, which reinforced it.

Kantrowitz and Springen (2005) have suggested that this generation of adolescents faces unique pressures. They are more likely to be from divorced or unstable families, to abuse substances, to have eating disorders, to struggle with depression, and to commit suicide (Coleman 1987; 2004; Swift 2006). Some youth experiencing all these issues struggle to differentiate themselves from the crowd as having "real" problems. Dialogue from the HBO drama, "Six Feet Under," in 2005, suggests that self-injury may be the currently popular form of expressing "teenage angst":

> **Patient:** Maybe I should see your supervisor [twirling her hair]. I don't know if you're ready for me.
> **Brenda [therapist]:** You might be right. But, um, now that we're here…

P: I'm a very complex person.
B: I'm sure you are.
P: I keep ending up in hospitals.
B: Really, well, tell me about that.
P: Well. A few times for anorexia. Twice for alcohol poisoning. Once I hit an artery. I'm a cutter [smiles]. And I keep pulling my hair out [frowns].
B: So I see.
P: It's all this pressure to be normal [crying]. And I can't. And nobody understands.
B: I think I do.

Many people continued self-injuring, either continuously or intermittently, into adulthood. Contrary to extant knowledge, roughly two-thirds of the "regulars" we encountered on the Internet were over 25, and half over 35. Melissa, a 39-year-old college clerical worker, described the people with whom she interacted on the Web daily:

> They just do it and do it for all these years, and it just becomes a part of their life. For example, a woman on one support group, she's self-harmed for over 20 years, and not a single soul knows about it except the people she writes to on the Internet. She's not in therapy, she doesn't go to a doctor or anything, and she just continues to do it.

Many of our contacts saw self-injury as a "burgeoning epidemic." In 2005, Ross Droft, a suburban high school health teacher, estimated that out of the 3,800 adolescents in his school, 30% cut themselves. Hannah, a 19-year-old college student, discussed the prevalence in her former high school:

> Among teenagers, it's so rampant. I'd run across people that I'd known for years, and I'd see them in the bathroom with their sleeves pulled up so they could wash their hands, and I'd glance over and see a little mark that I could identify as injuring. And I'd be like, "Oh, god damn. Look at that! Another."

Cindy, the 19-year-old salesperson, summed it up by saying, "I think it's a very quiet epidemic. It's very hush-hush."

Long-Term Chronic Users

Beyond these populations is a group of older self-injurers who have been cutting, burning, and picking at scabs for at least a decade. Most of these people started when self-injury was relatively unknown and engaged in the practice surreptitiously. Ranging in age from their late twenties to their forties and early fifties, most of those we located had reached out to join virtual communities. This strongly suggests that many older, long-term participants are still self-injuring in isolation, possibly unaware that there are others like themselves, or that self-injury is even a phenomenon (see: Adler and Adler 2005).

Differentiating people who stay with this behavior from those who relinquish it after a shorter period is difficult. They may appear, to others, to be no different from any other people. Danielle, a 35-year-old housewife and mother of three, commented on this in an email communication:

> I think a lot of people think of SI as gothic or depressed kids who will go murder people, that we're that kind of group, and it's not for people, like me, who are educated or otherwise look normal, but they don't know.

Most people described themselves as similar to Danielle, but t others were not as functional. Mary, a 42-year-old former university administrator, married with two children, had succumbed to severe

depression and had not left her bedroom for two years. Linda, a divorced 40-year-old former medical transcriptionist, had to quit her job and was now living on supplemental security and Medicaid. Others were similarly afflicted, not able to work and struggling with maintaining face-to-face relationships.

The reasons they gave for their self-injury varied as well. Some interviewees had a history of physical or sexual abuse, either in their childhood or early adulthood. Danielle, the 35-year-old housewife, had been repeatedly incested by her brother during adolescence. She remarked, "I know, in my experience, most of the cutters I've talked to are survivors of some type of abuse as a child." Linda, the 40-year-old former medical transcriptionist, married a man who ended up verbally and sexually abusing her.

Yet, others have no apparent severe problems. Amy, a 28-year-old bookkeeper for a private, non-profit foundation, came from a more sanguine background. "I think that I grew up pretty privileged. I never was abused in any way. I really can't, I think I had a pretty happy childhood for the most part. So I can't, most of my memories of my childhood I guess are fond memories." She differentiated herself from the self-injurers who had both "teen angst" and "serious mental problems," saying that she could not relate to either group. Trying to explain what prompted her to self-injure, she reflected:

> I think that it's just, I like the way I feel when I do it. I like having it, just being able to think that I can cut later helps me, sort of, deal in the moment with things that might be stressful. I honestly can't understand why people wouldn't cut themselves.

Lisa, a 31-year-old librarian, expressed her frustration in trying to typologize older self-injurers:

> Everything I've seen, I find inadequate. I read, or I talk to people, or I see stuff online where people say, "Oh, everyone who cuts themselves was abused as a child," or, "Everyone who cuts themselves would be a coke addict." Or, there are all kinds of connections, but I don't think that they're as clear as people say. Because I find that people are always trying to attribute it to one thing, and it doesn't seem that clear-cut to me.

Yet, all the self-injurers we encountered were troubled in some way. Some were repressed; some were depressed; some used it as a coping strategy. Denise, a 31-year-old salesclerk from Scotland, discussed her self-injury as "often ritualized, more severe, sometimes a part of daily life. I understood what motivated it, what benefits it brought, as well as the costs. I don't think of it as deviant, but as a coping mechanism [that's] gone wrong."

Many long-term self-injurers had been steadily engaged in this practice for 20 years or more. Others oscillated in and out of the behavior. Danielle quit for four years when she was pregnant and her children were young, but returned to it before the birth of her third child. Johann, a 38-year-old German man, had periods when he mostly abstained, although he reported that it was back to "often" again. He used alcohol or self-injury to "distract" himself from his problems, often when he got depressed. Danielle's greatest fear was that her daughter would learn about her self-injury and model the behavior.

Most people who had self-injured for a long period had no intention of ever stopping. Danielle thought that she was a bad person and would always deserve to hurt herself. Denise saw it as a lifelong tool for managing her depression. Amy expressed her attitude this way:

> I think I'll probably always do it. I don't feel it's really a non-issue for me. I don't ever think about stopping. It's not something that I want to stop, but it's not something that I feel like I need to stop. So, it's just kind of what I do.

Yet, a few people had abated their usage after many years, either through therapy or with the help of online peer support and education. Younger, short-term injurers were more apt to mature out, but those who made it a significant part of their lives had a harder time relinquishing it. Many of these people remained in online communities, helping others, as a way of maintaining their abstinence (see: Brown's 1991 similar discussion of professional ex's).

Learning to Self-Injure

In contrast to the psycho-medical literature's focus on *why* individuals self-injure, a sociological perspective addresses the influence of social structure, culture, and interaction on *how* people engage with it. A variety of social factors have influenced the way people initially came to learn about self-injury.

The nature of individuals' initial onset may significantly be connected to when they began the behavior. People who engaged in self-injury before 1996, about the time when it emerged more publicly, discovered this behavior on their own.[18] Alice, the 22-year-old college senior, reflected on her initiation to cutting:

> **Answer:** And I don't really know why I started to do it. For some reason, it just was something that I think I just did almost accidentally for the very first time I did it, I was probably 12 or 13 [note: 1992], and for some odd reason got some sense of relief out of it.
> **Question:** How, accidentally, did you happen to do it?
> **A:** I think I was just messing around with a sharp knife and just happened to inflict it, maybe just even out of curiosity, on one of my own fingers. For some reason, I don't know what it was, maybe the adrenaline you get out of it, if you're feeling down, it provides a sense of relief for you or something.

Many of these early people, like Alice, cut themselves while shaving, got frustrated and punched walls or trees, or fell and injured themselves, only to find that they liked the effect. Unaware that others self-injured, they learned it on their own and regarded it as their private, special way of making themselves feel better.[19]

Beginning in the mid-'90s, people often heard about self-injury before they tried it. Megan, a 19-year-old college student, recounted how she learned about it through the media:

> **A:** I was, like, 11, I was in sixth grade, and I was reading one of those stupid magazines that, you know, all of the little girls want to read because they think it'll make them seem older, you know? I think it was YM or something, and there was an article about a girl basically talking about her cutting and why she did it and what it was like, and the aftermath.
> **Q:** So that's nine years ago, so that's '96. What did you think of that?
> **A:** Well, I don't know. The way she described it, it was like a way to deal with her mental anguish and these incredible emotions she was experiencing, and she felt a lot of self-loathing. So when I read that, I kind of

[18] This is a common characteristic of loners who lack a deviant subculture, see: Adler and Adler (2005).

[19] In response to being asked during the interview about the first time she ever heard of self-injury, one student replied, "Just when you mentioned it in class."

> associated with her. I was like, "Well, hey, I feel that way too." And kind of her description of the relief she felt after cutting herself kind of made me wonder how I would feel if I did that.
>
> **Q:** So how soon was it after you saw this magazine article that you tried it?
>
> **A:** Probably like the next day.

Joanna, a 19-year-old college student, noted that she heard about it in health class. One day, her teacher taught a segment on it, saying that it was "about stress and emotional problems and how people take out their problems." Believing that she suffered from stress, she thought about trying it. Some, attracted by the allure and intrigue of non-conformity, may be drawn into deviance despite potential, recognizable drawbacks.[20]

By the late 1990s, people were more likely to have heard about self-injury from friends or acquaintances (Brossard 2014). Hannah, the 19-year-old college student, learned about it from a "cool guy." In eighth grade, she was in a "pretty cool teen club" and a boy showed her his scars. Prompted by her response, he told her how he got them, and she was impressed. Trying it for the first time that night, she liked the results. In school the next day, he treated her as cool. He told her more about his scars and how to manage them. This became a special bond between them.

Although it was less common for people to cut together, the social contagion effect became more pronounced over time as groups of high school students self-injured and identified themselves through it (see: Coleman 1987 on clustering and 2004 on copycatting). Amber, a 20-year-old college student, talked about how people she knew in high school self-injured because their friends were doing it:

> But, I think my friend Julie got into a whole cutting thing because of Caitlin and I. She was the last of our little group that got into it. Just because we talked about it and she was going through some rough times, and then she turned towards it as well. I think this is going back to my ex-boyfriend who said, "I just want to define myself in some way," because everyone else was doing it. I think it gives you a sense of belonging to do something other people are doing. So you're in a group or something like that.

From their friends, people learned not only about how to do it but how to interpret it (Becker 1953). Joanna, who heard about it in health class, then learned more from talking to others. Over lunch, a friend casually mentioned that she wanted to cut herself right then. When Joanna asked her why she did it, the girl talked about how it made her feel and said it was "just such a relief." Joanna, excited by this revelation, realized that her cutting produced an adrenaline rush that took away her frustration and replaced it with the sensation she was seeking. "That rush was probably the best part of the whole thing. And I didn't realize that until I talked to them."

By 2000, with the Internet emerging as more prominent, people began looking for information there. Websites sprung up that offered personal testimonials and medical facts about self-injury. Amber, the 20-year-old college student, noted, "I didn't understand it, so I just Googled it and just read all I could on it to try and understand it." Even though she found the descriptions graphic and disgusting, she was curious, so she cut herself on her ankle. From there, she slowly began to self-injure regularly.

[20] See, for example, Biernacki (1988), Faupel (1991), and Jacobs (1999) on drugs, Spradley (1970) and Wiseman (1970) on heavy drinking, and Lesieur (1977) on gambling.

People who came to self-injury because they were curious or they wanted to belong were much less likely to exhibit the impulse-disorder symptoms and pathological family backgrounds described in the psycho-medical literature. They learned that self-injury existed, how to do it, and how to perceive and interpret the effects, and they formed identities and social groups around it.

Engaging in Self-Injury

People who liked self-injury practiced the behavior in varying ways. Psychologists believe that self-injury is most likely to occur because people cannot control their impulses, are histrionic, seek attention, need to alleviate frustration, and act in the here-and-now (Gunnarsson and Lönnberg 2022). We, too, found many who did it impulsively, ducking into school restrooms to cut in toilet stalls, self-injuring when they were drunk and depressed, or doing it whenever the mood struck them.

However, we also found people who self-injured in an ***intentional, planned, and deferred*** manner. Rather than being totally at the whim of their impulses, they debated, evaluated, and assessed the decision to self-injure, both in the initial phases of their involvement and in later returns to the behavior. This type of instrumentalism often drives people in purposive actions toward pursuing interests, objectives, and conveniences (Prus and Grills 2003).[21] We noted several ways that people self-injured in this more sociological form.

Many people who followed the instrumental mode ***delayed*** their self-injury until they were ready to do it. People picked a convenient time because they could hide it better or they would enjoy it more.[22] Some waited until they could get away from parents, until summer was over and they could wear long-sleeved shirts, or until they felt they deserved it. Matt, a 20-year-old college student, postponed his self-injury while he let the desire build up. After waiting, he moved to self-injury without any trigger. Rather than seeking a release, he did it because it felt good. He described his thinking:

> **A:** So this was a rational decision to me. I'd think about it and I'd always remember how good it felt to do it, so I'd keep doing it. I guess it's kind of the same way that I would do just about anything else. Delayed gratification, I guess.
>
> **Q:** So you never sat down and weighed the pros and cons?
>
> **A:** Well, a little bit. I'd know that I had to do certain things, like I'd have to make sure I was always wearing long sleeves or that I'd put something over it when I was asleep to make sure it didn't open up again and have, like, blood all over my sheets and stuff, because that would be bad.
>
> **Q:** So that would be on the cons side?
>
> **A:** Yeah, but, generally, I weighed the cons. The cons were pretty easy to get over, but then I guess the cons began to outweigh the pros when I started losing some of my best friends…So I was like, I have to stop, as much as I want to do it, I shouldn't. And so I made a conscious decision to stop for a while. The pros weren't good enough to outweigh those cons.

[21] Whether the practice of self-injury occurs because of an impulsive urge or as the result of a conscious decision is a source of serious debate on self-injury websites. Many condemn people who do *not* do it out of impulse, arguing that the behavior is so bad that anyone who can resist the overwhelming urge to do it—should. On the other side are those who defend their behavior as rational and reject the irresistible impulse model. They advocate and defend the instrumental model.

[22] Prus and Grills (2003) have discussed people's hesitations to pursue lines of action due to general cautions, earlier personal experiences, and concerns about the viewpoints and reactions of others.

Like Matt, some people ***weighed the benefits*** of self-injury against the personal, physical, and social costs.[23] When they felt bad, they knew it would make them feel better. Others, thinking that this was an unhealthy way to deal with their emotions, brushed away their desires and resisted the urge. As they became unhappy, they re-evaluated their decision, finally deciding that the pros outweighed the cons.[24] Megan, a 19-year-old college student, discussed the thinking that took place before her episodes of self-injury:

> I thought about it ahead of time. It was kind of like, "Wow, I really feel like crap, what will make me feel better?" And then it was like, "Well, I suppose I could cut myself, that made me feel better last time." Then I'd be like, "No, that's not a very good idea. That's not a healthy way to deal with your emotions." Then I'd brush those thoughts out of my mind. And then something else would happen, and I'd be like, "Well, all right, that's it. I can't deal with this anymore." I sat down and thought about if I wanted to do it or not and the pros and cons, and what the consequences would be.

After giving up self-injury during his senior year of high school, Matt made a conscious decision to re-engage. For him, the return to self-injury was not prompted by any specific event, but because he missed it. "I think I wanted to have that feeling again, that release that I could only get from doing that, that calming sensation. And I'm not sure if there was anything really all that upsetting going on at that time." At the time of our interview, Matt was still self-injuring.

Like Matt, Liz, a 25-year-old animal trainer who engaged in self-injury, thought ahead about her self-injury. She talked about her philosophy of ***planning***:

> **A:** I don't like being impulsive. I like making decisions, choosing how I'm going to live, how I'm going to do everything. It gives me a sense of control.
> **Q:** How would you plan it? How far in advance would you start thinking about it?
> **A:** Anything from a few hours to a few days. Depending on how long I can hold it off for.
> **Q:** So then do you think like, "Thursday would be a good night for it," or how does that work?
> **A:** Kind of, yeah. It sounds really weird just talking about it. Like I'll know what days I have to work with certain people, and I'll know that ahead of time and be like, "Well, OK, I know I'm going to be really stressed here, I might as well start thinking about it because I'm going to want to do it anyway."

So, unlike Matt, who deferred his gratification indefinitely, Liz oriented herself to specific days that would be good.

Another way of practicing self-injury non-impulsively was to do it ***routinely***. Hannah, a sophomore in college, established a ritual for herself shortly after she began to self-injure. Nightly, she read for a while, injured, and then went to bed. The evenings were her time to reflect on upsetting things from the day, but this eventually became so routine that she self-injured every night, regardless of her feelings. Some described the release they got from self-injury as a sleep aid.

Finally, others made ***bargains*** with themselves about how and when they would self-injure. Lindsay, a 32-year-old nurse's aide, described her thinking process:

[23] Akers (1985) has suggested that in learning deviant behavior, people are influenced by "differential reinforcement," weighing the balance of rewards and punishments attached to different behaviors.

[24] Becoming disinvolved and then reinvolved, or oscillating in and out of their activities is a common pattern in the practice of deviance (Adler and Adler 1983; Pryor 1996; Prus and Grills 2003).

> **A:** Like I'll sometimes think, "OK, well, I can't cut now, so I'll promise to cut on a certain date." Even if I don't feel like it anymore, I've made myself that promise, and to be able to trust myself, then I have to keep it…
> **Q:** Is it more or less satisfying when you do it that way?
> **A:** Then it's more like it's something that has to be done, and you do it because it has to be done. It's not something that you really look forward to, it's more like a chore, but you have to do it. And I've often done it sort of in rituals, too, where I've done it for so many different reasons and everything that, I don't know, it's just different all the time.

All these modes of self-injury eschewed the impulsive need to fulfill immediate urges and represented forms of conscious thought, decision-making, and planning. They show individuals' rationality, agency, and control over their behavior rather than pathological powerlessness.

Embracing Self-Injury

Many participants regarded their self-injury negatively and were often torn between their desire to do it and their feelings condemning it (see: Adler and Adler 2005). This is particularly the case for people enmeshed in the psycho-medical treatment community, who embrace the individual pathology model, which results in individuals blaming themselves for "their inability to cope" with their suffering (Bareiss 2014:281). Some of the self-injury support groups on the Web had rules prohibiting people from speaking positively about the behavior. Those that fostered or "triggered" the behavior with photographs, suggestions for how to do it, or reinforcement were often forced to close. Yet, a percentage of the self-injuring population remained positively committed.

The first group took a ***passively positive*** position on their self-injury. Sue, a 28-year-old elementary school teacher, managed a neutral stance on her self-injury by never thinking about it. Marnie, a 51-year-old bank teller, eschewed thoughts about her self-injury as well. When asked about her future relationship with it, she stated that she focused her thoughts, instead, on the present. It just was not a part of her thinking process. Those who did think about it sometimes had thoughts of remorse or regret, but when they needed it, they were grateful it was there. They let nothing stand between them and the relief they wanted, and as long as they felt they needed it, they were committed to doing it, no matter what the consequences.

A larger (although still small) group expressed steady ***actively positive*** attitudes about self-injury. They took the "pros" that they weighed in their decision-making and forged them together into a more unified philosophy. These people represented an informal Pro-SI movement, similar to one fashioned for the Pro-Suicide and the Pro-Ana (anorexia) / Pro-Mia (bulimia) movements (see: Force 2005; Vannini, McMahon, and McCright 2005). Pro-ED movements view eating disorders as a lifestyle choice and not a medical or deviant issue. They have many web postings and sites that offer tips on how to avoid eating and hide eating disorders from friends and family, how to calculate Body Mass Index (BMI) and Basal Metabolic Rate (BMR), "thinspiration" pictures, reverse triggers, recipes, fasting suggestions, poetry, photographs of extremely thin models and actresses, and support for resisting recovery.[25]

[25] Anorectics and bulimics use these message boards, chat rooms, and communities (such as http://ana.makeupyourmind.nu/, http://thinvision.conforums.com/, www.plagueangel.net/grotto, Shrine to ANA, Tricks of the Trade, Thinspiration, and others) to share diet tips and poetry, as well as to "vent" about their problems, related to their eating disorder or not. Close

The existence of a Pro-SI movement is still somewhat controversial. Eva, a 30-year-old cashier, disputed the existence of a Pro-SI movement. Although she acknowledged that people openly expressed support to others who did it, she distinguished between people who were "not willing to recover just yet" and more outright encouraged by the behavior. Some suggested that people hid their Pro-SI orientation because they found expressing these views unacceptable.

People espousing a loosely Pro-SI orientation began by accepting it as a ***lifestyle choice***. Vanessa, the 20-year-old college student, expressed this philosophy:

> It was on the *Today Show* or something, and they were doing this "seven-part series," which is so beating a dead horse on self-injury, and they bring all these teenagers that are like, "I had a problem." And they're bringing all these psychiatrists and they're like, "These kids, they need help. It's a mental disorder." I was like, "That is *so* not it." It's just, it's a personal way of expressing emotion. It is a lifestyle choice; it's just the way you choose to express your emotions. I mean, everybody has to have an outlet. You can go and do martial arts as your expression, or you can do art, or you can cut yourself. If some people view it as a problem, if a cutter views it as a problem, then yes, they should get help because if they view it as a problem, then it is a problem. I never saw it as a problem. I just saw it as the way that I chose to do it.

Bonnie, a 28-year-old shoe salesperson, compared self-injury to other ***coping mechanisms***. "Some people drink, some people do drugs, some people kill people," she asserted. She regarded life as difficult, although manageable. Her way of dealing with issues was to self-injure, and she decided that she might as well take a positive attitude about it. Her perspective was, "It's not a, 'Oh my god, I just cut myself, I feel like shit,' kind of thing. It's a, 'Oh, hey, this kind of stuff is going on in my life. How else can I deal with it?'" For Bonnie, self-injury represented an effective coping tool. "Yeah, I think it's effective. I mean I'm not dead yet." Bonnie rationalized that people who injured themselves were better than those who injured others.

Part of the Pro-SI attitude involved ***rejecting the stigma***. Lance, a 28-year-old furniture salesman, explained how people could flip the stigma away from themselves and onto others. "Everybody knows that there's a lot of really bad stigma, but a lot of our views are that once you get past that, they're just getting after you or being upset because they don't understand what's going on. It could be a lot worse. So it's *their* problem, not *your* problem." By putting the problem onto others, he distanced himself from the stigma.

People were aided in their Pro-SI attitude by the ***community*** of people they encountered on the Internet. Cindy, the 19-year-old retail salesperson, noted that from going online, she found others doing the same things. That convinced her that she was not so abnormal and made her feel better. At Pro-SI sites on the Internet, people also found tips for improving their behavior. Cindy mentioned, for example, that she learned how to make a cleaner cut, so she healed with less scarring. Bonnie learned to view her self-injury as better than hurting others, and hence as a strength.

friendships sometimes develop between the people on a message board, who sometimes exchange phone numbers or even meet in person. What is most disturbing about these sites to outsiders, however, may be the vast archives of "trigger" pictures they contain.

People espousing a loosely Pro-SI orientation also took a ***long-term*** orientation to the practice. Amy, a 42-year-old receptionist, asserted her intention to continue self-injuring forever. "Probably the only thing that will get me to change is if I die, that would be it." Others noted that they could sustain it over a lifetime because they were not doing it to kill themselves, they were just doing it.

When people conquered the stigma and shame of their behavior, they became less fearful of showing their scars. Lindsay, the nurse's aide, expressed the view, "Well, don't be ashamed to show your scars, and people all just have to accept it, and you go out there, you know, stuff like that." People who flaunt disreputable identities, what Goffman (1963) refers to as "minstrelization," may engage in these displays as expressions of freedom or defiance (see: Sanders 1989 on tattoos and Wolf 1991 on outlaw bikers).

A final component associated with a Pro-SI orientation was its ***progression***, the tendency for people to "notch up" their behavior, although this escalation may have preceded their more positive attitude. Many of these long-term self-injurers came to accept a level of bodily damage that might alarm non-participants. Amy, the 42-year-old receptionist, noted that she visited hospital emergency rooms often:

> I think I was going for stitches 3-5 times a week… I circulated between the emergency room and some walk-in clinics, and I would do different parts of my body so that it wouldn't look like I had so many stitches at one time.

Many Pro-SI people were older and had a wider range of experience with harming themselves and its consequences. As a result, they learned to manage their self-injury by developing pseudo-medical skills. Liz, the animal trainer, learned how to take care of herself:

> **Q:** And have you ever cut so much or so deep that it wouldn't stop bleeding?
> **A:** Yes. I've gone to the ER a couple of times for that, and, luckily, my boyfriend knew how to stitch, so I went to him a lot, too.
> **Q:** What'd he stitch you with?
> **A:** Just the same stuff that they do in the ER. You can get it pretty easily in Kentucky because of all the horses. We'd stitch up our own horses when something would happen. So we learned to stitch each other up.

Lindsay, the nurse's aide, explained that she also learned to manage more serious injuries without medical intervention by tolerating a higher level of bodily damage. For her, just needing one layer of stitches became a relatively minor injury:

> I won't go to the hospital if I just need a few stitches. If I'm cutting a whole bunch of times, I won't go to the hospital until I need between 45 and 50, unless it's life-threatening or unless it's really going to complicate my life later on.

People such as this often developed other adaptive techniques, moving their self-injury around to different body parts, and avoiding re-cutting or burning in the same area. As Mary, a 38-year-old salesperson said, "Okay, an episode on the leg now, the next episode, better go to the stomach."

Embracing self-injury through the formation of a Pro-SI movement was impeded by the censorship of Internet sites that avoided condemning the behavior. Many people spoke about the high turnover

of such groups, message boards, and chat rooms where they have congregated. Liz, the animal trainer, offered her guess as to why these tended to disappear so quickly:

> **A:** I think it has to do with the negativity surrounding it. Like with Pro-Ana stuff, they just take it off. Their web servers do, and I think they're probably doing the same thing with that…
> **Q:** How do *you* find new sites?
> **A:** Usually, one of the people from the sites before tells me, "Oh, hey, look there's one over here." And you're like, "OK, I'm coming." Or the email group I'm on will mention one.

Pro-SI attitudes only coalesced into a loosely forming movement with the greater communication between self-injurers facilitated by the Internet. These value orientations and behaviors stood in stark contrast to the impulsive and pathological psycho-medical model of self-injury.

Conclusion

Although public awareness of self-injury is still far from universal, it has grown significantly. With this has come a dramatic shift in our understanding of the nature and social meanings attached to this behavior. For many years, the topic of self-injury was an arena dominated exclusively by psychological perceptions and explanations, but in the late 1990s and early 2000s, this behavior changed and expanded in ways that thrust it increasingly into the sociological realm. In this paper, we have discussed four ways that self-injury has become more of a sociological phenomenon.

First, our data show that self-injurers are more diverse than traditionally depicted in the psycho-medical literature. Although the types of individuals who pass through psychiatric institutions comprise a portion of this population, they are augmented by a much larger group that has never been clinically treated or hospitalized. These non-institutionalized self-injurers, lacking the postulated psychological syndromes, have always existed, but have been notably growing in numbers since the 1990s. Traditional inpatient populations have been supplemented by three groups: the poor, weak, and powerless, who have high prevalence rates because they are structurally disadvantaged; older, long-term self-injurers who have emerged from their isolated pockets, finding each other on Internet chat rooms, websites, and newsgroups; and mildly disturbed, alienated, or typically angst-ridden teenagers and young adults.

Second, individuals have begun to "discover" self-injury in new ways, moving beyond the self-invention of the behavior so common before the 1990s. Psychologists consider self-injury a practice that emerges spontaneously in troubled individuals, yet we note the more widespread social learning of self-injury that has been transmitted through the media, health education, and peer group interaction. The psycho-medical disease model, postulated as universal, overlooks the way self-injurers use their customary and ordinary sociological decision-making processes. Self-injury incorporates individuals' social perceptions, interpretations, anticipations, and evaluations to plan and project lines of action. As Sutherland (1939) noted in differential association theory, the way people learn deviant behavior and the general needs and values that drive it are expressions of the same processes as all other learning, needs, and values. Like the artificial tanning discussed by Vannini and McCright (2004), self-injury represents, in part, a com-

plex social process of symbolic interaction rather than purely a medical problem.

Third, the way people engage in their self-injury transcends the psychological model. Not merely pathologically impulse-driven, contemporary self-injurers carefully think about, consider, defer, and plan their behavior (Brossard 2014; 2018). In his study of gamblers, Rosecrance (1985a) noted that the prevailing illness model portrays gambling as pathological, with habitual gamblers driven by compulsion, and unable to control their behavior. Gambling stands in the DSM III as an impulse disorder. Yet, virtually all investigations of gambling groups in natural settings have found little evidence of either compulsive or pathological behavior (Scott 1968; Oldman 1978; Hayano 1982; Rosecrance 1985b;). Like gambling, individuals describe their self-injury as intentional and instrumental, guided by the social meanings they attach to the behavior. They learn through subcultural and interactional venues to recognize and interpret self-injury as an acceptable, albeit deviant, way of dealing with anger, confusion, and frustration. Many self-injurers would like to quit, but those who still practice it recognize its benefits as a coping mechanism and a means of self-expression.

Fourth, we see the beginnings of a subculture coalesced around the acceptance of self-injury as a voluntary choice and lifestyle. Unlike individuals enmeshed in the psycho-medical world who tend to accept their identity as powerless and shameful, those who participate in cyber communities are more likely to feel empowered, in control, and able to assert their collective definitions of their behavior. Participants report that it forms, at least for some time, a component of their self-identity and a way of collectively communicating with and relating to others. People engage in the form of tertiary deviance (Kitsuse 1980), justifying and embracing their self-injury. Although the psycho-medical model individualizes the problem and deflects responsibility away from society, such as McCrea (1983) found with menopause and Beresford (2016; 2020) found with autism, our research, grounded in the perceptions and interpretations of participants, also highlights the role of interactional, cultural, and structural forces and their contributions to the social transformation of this behavior.

The social meanings and social processes associated with self-injury in the twenty-first century carry implications for somewhat of a moral passage constructing broader cultural definitions of this behavior, shifting it increasingly from the realm of mental illness to deviance. People who self-injure may be thought of by the public as emotionally troubled, and as individuals who engage in a non-normative and still stigmatized form of coping, but they are no longer exclusively viewed as suicidal or severely mentally ill. Although sociologists have more often documented the shift towards increasingly medicalized views of phenomena (Zola 1972; Conrad 1992; 2000; Conrad and Schneider 1992; Williams and Calnan 1996), the populations and behaviors discussed here invoke a demedicalized interpretation. Self-injury, thus, joins homosexuality (Fleishman 1983; Bullough 1993), gambling, eating disorders (Way 1995), and drug use (Elliott, Huizinga, and Ageton 1985; Marcos, Bahr, and Johnson 1986) as a behavior increasingly defined as characterized by voluntary choice (Redley 2003).

Mental illness moved from being seen in the Middle Ages as sinful to a medicalized definition

in the twentieth century, diminishing its stigma. Self-injury's movement in the twenty-first century from under the medicalized rubric of mental illness to the voluntary choice of deviance has further destigmatized it for some, particularly those in the helping communities. To be seen as ill is to be derogated; to be seen as self-healing is normal.

Some have questioned the notion that self-injurers have the free will necessary to enact voluntary choice (Burstow 1992; Jeffreys 1997). They regard people "damaged" by traumatic events as psychologically unaware of the forces unconsciously driving their behavior (Liebling, Chipchase, and Velangi 1997). Radical feminists, in particular, regard people's claims that their self-injury is voluntarily chosen as a form of false consciousness, conditioned upon them as victims of the patriarchal establishment. They would, thus, dispute the claims made by our participants as false constructions of a liberalistic/radical individualistic/libertarian perspective that fetishizes choice, since they are blind to the structural forces that impinge on and condition them (Strong 1998; Jeffreys 2000). We see this position as denying the ascription of agency to politically incorrect behavior.

Although the moral passage of self-injury has been slight rather than dramatic, we have seen two types of shifts: in its participants and its symbolic meaning. Writing about "tinydopers," we (see: Adler and Adler 1978) posited how marijuana smoking might shed its deviant connotation as it was transmitted between different populations; it moved from stigmatized outgroups to ingroup deviants, *avantgarde* ingroup members, normal ingroup members, and finally to children. Second, any progression from group to group is accompanied by comparable shifts in the connotations associated with a behavior, as Matthews and Wacker (2002) noted in discussing the moral passage of new practices from initially being defined as deviant to becoming eventually more centrist. They outlined a pathway wherein new ideas move from the fringe to the edge, to the realm of the cool, into the "next big thing," and finally to social convention. Self-injury's passage has traversed both of these tracks (although far from all the way), spreading demographically from the mentally ill ingroup deviants to a wide range of non-extraordinary adolescents, nearly a sacred group. At the same time, its social meaning has symbolically migrated from the fringe to the edge, but is not acceptable to the mainstream. These changing social definitions have potentially profound implications for the lives of self-injurers. Mitigation of their social stigma has diminished self-injurers' rejection, isolation, and alienation. The trend toward demedicalization may help free them from being technical objects of the psycho-medical establishment and from its institutional control (Gusfield 1985). The changing social meanings of self-injury are carving out a space in society where participants may assert their understanding that self-injury is the product of their active choice and free will; that, if it is not normalized, it is at least becoming more widely known and less stigmatized; and that, if not common, it is at least a persistent uncommon behavior.

Acknowledgments

Large portions of this paper were previously published in: Adler, Patricia A. and Peter Adler. 2007. "The Demedicalization of Self-Injury: From Psychopathology to Sociological Deviance." *Journal of Contemporary Ethnography* 36(5):537-570.

References

Addington, Deborah. 2004. "Playing with Fire." Pp. 136-139 in *On Our Backs: Guide to Lesbian Sex*, edited by D. Cage. Los Angeles: Alyson.

Adler, Patricia A. and Peter Adler. 1978. "Tinydopers: A Case Study of Deviant Socialization." *Symbolic Interaction* 1:90-105.

Adler, Patricia A. and Peter Adler. 1983. "Shifts and Oscillations in Deviant Careers: The Case of Upper-Level Drug Dealers and Smugglers." *Social Problems* 31:195-207.

Adler, Patricia A. and Peter Adler. 2005. "Self-Injurers as Loners: The Social Organization of Solitary Deviance." *Deviant Behavior* 26:345-378.

Adler, Patricia A. and Peter Adler. 2011. *The Tender Cut: Inside the Hidden World of Self-Injury*. New York: New York University Press.

Akers, Ronald L. 1985. *Deviant Behavior: A Social Learning Approach*. Belmont, CA: Wadsworth.

Alderman, Tracy. 1997. *The Scarred Soul: Understanding and Ending Self-Inflicted Violence*. Oakland, CA: New Harbinger.

Aldridge, David and Jacqueline Rossiter. 1984. "A Strategic Assessment of Deliberate Self-Harm." *Journal of Family Therapy* 6:113-129.

American Psychiatric Association. 2000. *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. Washington, DC: American Psychiatric Association.

American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. Washington, DC: American Psychiatric Association.

Ayerst, Sandra L. 1999. "Depression and Stress in Street Youth." *Adolescence* 34:567-575.

Babiker, Gloria and Lois Arnold. 1997. *The Language of Injury: Comprehending Self-Mutilation*. Leicester: British Psychological Society.

Bareiss, Warren. 2014. "'Mauled by a Bear': Narrative Analysis of Self-Injury among Adolescents in US News, 2007–2012." *Health* 18(3):279-301.

Becker, Howard S. 1953. "Becoming a Marijuana User." *American Journal of Sociology* 59:235-242.

Becker, Howard S. and Blanche Geer. 1960. "Participant Observation: The Analysis of Qualitative Field Data." Pp. 267-289 in *Human Organization Research: Field Relations and Techniques*, edited by R. Adams and J. Priess. Homewood, IL: Dorsey.

Beresford, Peter. 2016. "From Psycho-Politics to Mad Studies: Learning from the Legacy of Peter Sedgwick." *Critical and Radical Social Work* 4:343-355.

Beresford, Peter. 2020. "'Mad,' Mad Studies and Advancing Inclusive Resistance." *Disability and Society* 35:1337-1342.

Biernacki, Patrick. 1988. *Pathways from Heroin Addiction*. Philadelphia: Temple University Press.

Bird, Sharon R. 1996. "Welcome to the Men's Club: Homosociality and the Maintenance of Hegemonic Masculinity." *Gender & Society* 10:120-132.

Bissland, James H. and Richard Munger. 1985. "Implications of Changing Attitudes toward Mental Illness." *Journal of Social Psychology* 125:515-517.

Borrill, Jo et al. 2005. "Learning from 'Near Misses': Interviews with Women Who Survived an Incident of Severe Self-Harm in Prison." *Howard Journal of Criminal Justice* 44:57-69.

Bowen, Arabella C. L. and Alexandra M. H. John. 2001. "Gender Differences in Presentation and Conceptualization of Adolescent Self-Injurious Behaviour: Implications for Therapeutic Practice." *Counselling Psychology Quarterly* 14:357-379.

Brickman, Barbara J. 2004. "'Delicate' Cutters: Gendered Self-Mutilation and Attractive Flesh in Medical Discourse." *Body and Society* 10:87-111.

Briere, John and Eliana Gil. 1998. "Self-Mutilation in Clinical and General Population Samples: Prevalence, Correlates, and Functions." *American Journal of Orthopsychiatry* 68:609-620.

Brooksbank, Donald J. 1985. "Suicide and Parasuicide in Childhood and Early Adolescence." *British Journal of Psychiatry* 146:459-463.

Brossard, Baptiste. 2014. "Fighting with Oneself to Maintain the Interaction Order: A Sociological Approach to Self-Injury Daily Process." *Symbolic Interaction* 37:558-575.

Brossard, Baptiste. 2018. *Why Do We Hurt Ourselves? Understanding Self-Harm in Social Life*. Bloomington, IL: University of Indiana Press.

Brown, J. David. 1991. "Preprofessional Socialization and Identity Transformation." *Journal of Contemporary Ethnography* 20:157-178.

Bullough, Bonnie. 1993. "The Causes of Homosexuality: A Scientific Update." *Free Inquiry in Creative Sociology* 13:40-47.

Burstow, Bonnie. 1992. *Radical Feminist Theory*. Newbury Park, CA: Sage.

Callahan, John. 1996. "A Specific Therapeutic Approach to Suicide Risk in Borderline Clients." *Clinical Social Work Journal* 24:443-459.

Chandler, Amy. 2012. "Self-Injury as Embodied Emotion Work: Managing Rationality, Emotions and Bodies." *Sociology* 46(3):442-457.

Chandler, Amy. 2016. *Self-Injury, Medicine and Society: Authentic Bodies*. Basingstoke: Palgrave Macmillan.

Chaney, Sarah. 2017. *Psyche on the Skin: A History of Self-Harm*. London: Reaktion Books.

Chen, Shing-Ling, G. Jon Hall, and Mark D. Johns, eds. 2003. *Online Social Research: Methods, Issues, and Ethics*. New York: Peter Lang.

Coleman, Loren. 1987. *Suicide Clusters*. New York: Faber and Faber.

Coleman, Loren. 2004. *The Copycat Effect*. New York: Paraview.

Conrad, Peter. 1992. "Medicalization and Social Control." *Annual Review of Sociology* 18:209-232.

Conrad, Peter. 2000. "Medicalization, Genetics, and Human Problems." Pp. 322-333 in *The Handbook of Medical Sociology*, 5th ed., edited by C. Bird, P. Conrad, and A. Fremont. Upper Saddle River, NJ: Prentice Hall.

Conrad, Peter and Joseph W. Schneider. 1992. *Deviance and Medicalization: From Badness to Sickness*. Philadelphia: Temple University Press.

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

Coons, Philip M. and Victor Milstein. 1990. "Self-Mutilation Associated with Dissociative Disorders." *Dissociation* 3:81-87.

Cresswell, Mark. 2005. "Self-Harm 'Survivors' and Psychiatry in England, 1988-1996." *Social Theory & Health* 3:259-285.

Darche, Mary A. 1990. "A Contribution to the Understanding of Self-Mutilating and Non-Self-Mutilating Adolescent Inpatient Females." *Psychiatric Hospital* 21:31-35.

DiClemente, Ralph J., Lynn E. Ponton, and Dianna Hartley. 1991. "Prevalence and Correlates of Cutting Behavior: Risk for HIV Transmission." *Journal of the American Academy of Child and Adolescent Psychiatry* 30:735-739.

Egan, Jennifer. 1997. "The Thin Red Line." *New York Times Magazine*, July 27, 21-35, 34, 40, 43-44, 48.

Elliott, Delbert S., David Huizinga, and Suzanne S. Ageton. 1985. *Explaining Delinquency and Drug Use*. Beverly Hills, CA: Sage.

Faupel, Charles E. 1991. *Shooting Dope*. Gainesville, FL: University of Florida Press.

Favazza, Armando R. 1989. "Why Patients Mutilate Themselves." *Hospital and Community Psychiatry* 40:137-145.

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

Favazza, Armando R. 1998. "The Coming of Age of Self-Mutilation." *The Journal of Nervous and Mental Disease* 186:259-268.

Favazza, Armando R. and Karen Conterio. 1988. "The Plight of Chronic Self-Mutilators." *Community Mental Health Journal* 24:22-30.

Favazza, Armando R. and Richard J. Rosenthal. 1993. "Diagnostic Issues in Self-Mutilation." *Hospital and Community Psychiatry* 44:134-141.

Favazza, Armando R., Lori DeRosear, and Karen Conterio. 1989. "Self-Mutilation and Eating Disorders." *Suicide and Life-Threatening Behavior* 19:352-361.

Fillmore, Catherine and Colleen Anne Dell. 2000. *Prairie Women, Violence, and Self-Harm*. Winnipeg: Elizabeth Fry Society of Manitoba.

Fleishman, Ellen Gerschitz. 1983. "Sex-Role Acquisition, Parental Behavior, and Sexual Orientation: Some Tentative Hypotheses." *Sex Roles* 9:1051-1059.

Force, William Ryan. 2005. "There Are No Victims Here: Determination versus Disorder in Proanorexia." Paper presented at the Couch-Stone Symposium of the Society for the Study for Symbolic Interaction, Boulder, CO, February.

Fox, Kathryn J. 1987. "Real Punks and Pretenders: The Social Organization of a Counterculture." *Journal of Contemporary Ethnography* 16:344-370.

Gallmeier, Charles P. 1998. "In the Company of Men: Homosocial Bonding and the Symbolic Objectification of Women." Paper presented at the annual meeting of the North Central Sociological Association, Cleveland, OH, April.

Gardner, David L. and Rex W. Chowdry. 1985. "Suicidal and Parasuicidal Behaviour in Borderline Personality Disorders." *Psychiatric Clinics in North America* 8:389-403.

Goffman, Erving. 1963. *Stigma: Notes on the Management of Spoiled Identity*. Upper Saddle River, NJ: Prentice Hall.

Grantz, Kim L., Sheree Dukes Conrad, and Lizabeth Roemer. 2002. "Risk Factors for Deliberate Self-Harm among College Students." *American Journal of Orthopsychiatry* 72:128-140.

Greenspan, Gail C. and Steven E. Samuel. 1989. "Self-Cutting after Rape." *American Journal of Psychiatry* 146:789-790.

Gunnarsson, Nina V. and Mikaela Lönnberg. 2022. "The 'Good' and the 'Bad' Subject Position in Self-Injury Autobiographies." *Qualitative Social Work* 21(5). doi: https://doi.org/10.1177/14733250211043933.

Gusfield, Joseph R. 1985. "Foreword." Pp. v-x in *Deviance and Medicalization: From Badness to Sickness*, edited by P. Conrad and J. W. Schneider. Columbus, OH: Merrill.

Haenfler, Ross. 2006. *Straight Edge: Hardcore Punk, Clean-Living Youth, and Social Change*. New Brunswick, NJ: Rutgers University Press.

Hanna, Refaat. 2000. *Suicide Associated Deaths and Hospitalization: Virginia 2000*. Richmond: Virginia Department of Health, Center for Injury and Violence Prevention.

Hawton, Keith and Jose Catalan. 1987. *Attempted Suicide: A Practical Guide to Its Nature and Management*. Oxford: Oxford University Press.

Hawton, Keith, Joan Fagg, and Sue Simkin. 1996. "Deliberate Self-Poisoning and Self-Injury in Children and Adolescents under 16 Years of Age in Oxford, 1976-1993." *British Journal of Psychiatry* 169:202-208.

Hawton, Keith et al. 1997. "Trends in Deliberate Self-Harm in Oxford 1985-1995." *British Journal of Psychiatry* 171:556-560.

Hayano, David M. 1982. *Poker Faces: The Life and Work of Professional Card Players*. Berkeley, CA: University of California Press.

Heney, Jan. 1990. *Report on Self-Injurious Behaviour in the Kingston Prison for Women*. Ottawa: Correctional Service of Canada.

Herpertz, S. 1995. "Self-Injurious Behavior: Psychopathological and Nosological Characteristics in Subtypes of Self-Injurers." *Acta Psychiatric Scandinavica* 91:57-68.

HM Prison Service. 2001. *Prevention of Suicide and Self-Harm in the Prison Service: An Internal Review*. London: HM Prison Service.

Hodgson, Sarah. 2004. "Cutting through the Silence: A Sociological Construction of Self-Injury." *Sociological Inquiry* 74:162-179.

Inckle, Kay. 2010. *Flesh Wounds? New Ways of Understanding Self-Injury*. Herefordshire: PCCS Books.

Inckle, Kay. 2017. *Safe with Self-Injury: A Practical Guide to Understanding, Responding and Harm-Reduction*. Herefordshire: PCCS Books.

Jacobs, Bruce A. 1999. *Dealing Crack*. Boston, MA: Northeastern University Press.

Jeffreys, Sheila. 1997. *The Idea of Prostitution*. Melbourne: Spinifex.

Jeffreys, Sheila. 2000. "'Body Art' and Social Status: Cutting, Tattooing, and Piercing from a Feminist Perspective." *Feminism & Psychology* 10:409-429.

Kantrowitz, Barbara and Karen Springen. 2005. "A Teen Health Gap." *Newsweek*, December 12, 62-65.

Kennerley, Helen. 1996. "Cognitive Therapy of Dissociative Symptoms Associated with Trauma." *British Journal of Clinical Psychology* 35:325-340.

Kilty, Jennifer M. 2006. "Under the Barred Umbrella: Is There Room for a Women-Centered Self-Injury Policy in Canadian Corrections?" *Criminology & Public Policy* 5:161-182.

King, Storm A. 1996. "Researching Internet Communities: Proposed Ethical Guidelines for the Reporting of Results." *The Information Society* 12:119-127.

Kiselica, Mark S. and Laurie Zila. 2001. "Understanding and Counseling Self-Mutilation in Female Adolescents and Young Adults." *Journal of Counseling and Development* 79:46-52.

Kitsuse, John. 1980. "Coming Out All Over: Deviants and the Politics of Social Problems." *Social Problems* 28:1-13.

Laye-Gindhu, Aviva and Kimberly A. Schonert-Reichl. 2005. "Non-Suicidal Self-Harm among Community Adolescents: Understanding the 'Whats' and 'Whys' of Self-Harm." *Journal of Youth Adolescence* 34:447-457.

Lesieur, Henry R. 1977. *The Chase: The Career of the Professional Gambler*. New York: Anchor.

Liebling, Helen, Hazel Chipchase, and Rebecca Velangi. 1997. "Why Do Women Harm Themselves? Surviving Special Hospitals." *Feminism & Psychology* 7:427-437.

Linehan, Marsha M. 1993. *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York: Guilford.

Mann, Chris and Fiona Stewart. 2000. *Internet Communication and Qualitative Research: A Handbook for Researching Online*. Thousand Oaks, CA: Sage.

Marcos, Anastasios C., Stephen J. Bahr, and Richard E. Johnson. 1986. "Test of a Bonding/Association Theory of Adolescent Drug Use." *Social Forces* 65:135-169.

Matsumoto, Toshihiko et al. 2005. "Self-Burning versus Self-Cutting: Patterns and Implications of Self-Mutilation: A Preliminary Study of Differences between Self-Cutting and Self-Burning in a Japanese Juvenile Detention Center." *Psychiatry and Clinical Neurosciences* 59:62-69.

Matthews, Ryan and Watts Wacker. 2002. *The Deviant's Advantage: How Fringe Ideas Create Mass Markets*. New York: Random House.

McCraig, Linda and Catharine Burt. 2005. *National Hospital Ambulatory Medical Care Survey: 2003 Emergency Department Summary. Advance Data from Vital and Health Statistics* (No. 358). Huntsville, MD: National Center for Health Statistics.

McCrea, Frances B. 1983. "The Politics of Menopause: The 'Discovery' of a Deficiency Disease." *Social Problems* 31:111-123.

McDermott, Elizabeth and Katrina Roen. 2016. *Queer Youth, Suicide and Self-Harm: Troubled Subjects, Troubling Norms*. Basingstoke: Palgrave Macmillan.

McShane, Theresa. 2012. *Blades, Blood and Bandages: The Experiences of People Who Self-Injure*. Basingstoke: Palgrave Macmillan.

Millard, Chris. 2013. *A History of Self-Harm in Britain: A Genealogy of Cutting and Overdosing*. London: Palgrave Macmillan.

Miller, Frank and Edmund A. Bashkin. 1974. "Depersonalization and Self-Mutilation." *Psychoanalysis Quarterly* 43:638-649.

NHS Centre for Reviews and Dissemination. 1998. "Deliberate Self-Harm." *Effective Health Care* 4:1-12.

Nock, Matthew K. and Mitchell J. Prinstein. 2004. "A Functional Approach to the Assessment of Self-Mutilative Behavior." *Journal of Counseling and Clinical Psychology* 72:885-890.

Nock, Matthew K. and Mitchell J. Prinstein. 2005. "Contextual Features and Behavioral Functions of Self-Mutilation among Adolescents." *Journal of Abnormal Psychology* 114:140-146.

Oldman, David. 1978. "Compulsive Gamblers." *Sociological Review* 26:349-370.

Pattison, E. Mansell and Joel Kahan. 1983. "The Deliberate Self-Harm Syndrome." *American Journal of Psychiatry* 140:867-872.

Pembroke, Louise. 2000. "Damage Limitation." *Nursing Times* 96(34):34-35.

Penn, Joseph V. et al. 2003. "Suicide Attempts and Self-Mutilative Behavior in a Juvenile Correctional Facility." *Journal of the American Academy of Child and Adolescent Psychiatry* 4:762-769.

Pfohl, Bruce. 1991. "Histrionic Personality Disorder." *Journal of Personality Disorders* 5:150-165.

Pitman, Roger K. 1990. "Self-Mutilation in Combat Related Post-Traumatic Stress Disorder." *American Journal of Psychiatry* 147:123-124.

Priory Group. 2005. *Adolescent Angst*. Surrey: Priory Group.

Prus, Robert and Scott Grills. 2003. *The Deviant Mystique*. New York: Praeger.

Pryor, Douglas. 1996. *Unspeakable Acts: Why Men Sexually Abuse Children*. New York: New York University Press.

Raphael, Ray. 1988. *The Men from the Boys: Rites of Passage in Male America*. Lincoln, NE: University of Nebraska Press.

Redley, Marcus. 2003. "Towards a New Perspective on Deliberate Self-Harm in an Area of Multiple Deprivation." *Sociology of Health & Illness* 25:348-373.

Rosecrance, John. 1985a. "Compulsive Gambling and the Medicalization of Deviance." *Social Problems* 32:275-284.

Rosecrance, John. 1985b. *The Degenerates of Lake Tahoe: A Study of Persistence in the Social World of Horse Race Gambling*. New York: Peter Lang.

Ross, Shana and Nancy Heath. 2002. "A Study of the Frequency of Self-Mutilation in a Community Sample of Adolescents." *Journal of Youth and Adolescence* 31:67-77.

Sanders, Clinton. 1989. *Customizing the Body: The Art and Culture of Tattooing*. Philadelphia: Temple University Press.

Schaffer, C. B., J. Carroll, and S. I. Abramowitz. 1982. "Self-Mutilation and the Borderline Personality." *Journal of Nervous Mental Disorders* 170:468-473.

Schoppmann, Susanne et al. 2007. "'Then I Just Showed Her My Arms...' Bodily Sensations in Moments of Alienation Related to Self-Injurious Behaviour. A Hermeneutic Phenomenological Study." *Journal of Psychiatric and Mental Health Nursing* 14(6):587-597.

Scott, Marvin B. 1968. *The Racing Game*. Hawthorne, NY: Aldine.

Sharkey, Valerie. 2003. "Self-Wounding: A Literature Review." *Mental Health Practice* 6:35-37.

Shearer, Steven L. 1994. "Phenomenology of Self-Injury among Inpatient Women with Borderline Personality Disorder." *Journal of Nervous Mental Disorders* 182:524-526.

Solomon, Yvette and Julie Farrand. 1996. "Why Don't You Do It Properly? Young Women Who Self-Injure." *Journal of Adolescence* 19:111-119.

Spradley, James P. 1970. *You Owe Yourself a Drunk*. Boston: Little, Brown.

Steggals, Peter. 2015. *Making Sense of Self-Harm: The Cultural Meaning and Social Context of Nonsuicidal Self-Injury*. Basingstoke: Palgrave.

Strong, Marilee. 1998. *A Bright Red Scream: Self-Mutilation and the Language of Pain*. New York: Penguin Putnam.

Sutherland, Edwin H. 1939. *Principles of Criminology*, 3rd ed. Philadelphia: Lippincott.

Suyemoto, Karen L. 1998. "The Functions of Self-Mutilation." *Clinical Psychology Review* 18:531-554.

Suyemoto, Karen L. and Marian L. MacDonald. 1995. "Self-Cutting in Female Adolescents." *Psychotherapy* 32:162-171.

Swift, E. M. 2006. "What Went Wrong in Winthrop?" *Sports Illustrated*, January 09, 60-65.

Tantam, Digby and James K. Whittaker. 1992. "Personality Disorder and Self-Wounding." *British Journal of Psychiatry* 161:451-464.

Tyler, Kimberly A. et al. 2003. "Self-Mutilation and Homeless Youth: The Role of Family Abuse, Street Experiences, and Mental Disorders." *Journal of Research on Adolescence* 13:457-474.

van der Kolk, Bessel A. 1996. "The Complexity of Adaptation to Trauma: Self-Regulation, Stimulus Discrimination, and Characterological Development." Pp. 182-213 in *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*, edited by B. A. van der Kolk, A. C. McFarlane, and L. Weisaeth. New York: Guilford.

van der Kolk, Bessel A., J. Christopher Perry, and Judith Lewis Herman. 1991. "Childhood Origins of Self-Destructive Behavior." *American Journal of Psychiatry* 148:1665-1671.

Vannini, Phillip and Aaron M. McCright. 2004. "To Die For: The Semiotic Seductive Power of the Tanned Body." *Symbolic Interaction* 27:309-332.

Vannini, Phillip, Martha McMahon, and Aaron McCright. 2005. "Not a Pretty Site: Gendered Bodies, Endangered Selves, and Eating (Dis)Orders." Paper presented at the Couch-Stone Symposium of the Society for the Study for Symbolic Interaction, Boulder, CO, February.

Venning, Rachel. 2004. "The Art of Cutting." Pp. 133-135 in *On Our Backs: Guide to Lesbian Sex*, edited by D. Cage. Los Angeles: Alyson.

Virkkunen, M. 1976. "Self-Mutilation in Antisocial Personality Disorder." *Acta Psychiatric Scandinavica* 54:347-352.

Waisman, Morris. 1965. "Pickers, Pluckers and Impostors: A Panorama of Cutaneous Self-Mutilation." *Postgraduate Medicine* 38(6):620-630.

Waskul, Dennis D. 2003. *Self-Games and Body-Play: Personhood in Online Chat and Cybersex*. New York: Peter Lang.

Waskul, Dennis D., ed. 2004. *Net.seXXX: Readings on Sex, Pornography, and the Internet*. New York: Peter Lang.

Waskul, Dennis D. and Mark Douglass. 1996. "Considering the Electronic Participant: Some Polemical Observations on the Ethics of On-Line Research." *The Information Society* 12:129-139.

Way, Karen. 1995. "Never Too Rich . . . Or Too Thin: The Role of Stigma in the Social Construction of Anorexia Nervosa." Pp. 91-114 in *Eating Agendas: Food and Nutrition as Social Problems*, edited by D. Maurer and J. Sobal. Hawthorne, NY: Aldine.

Williams, Simon J. and Michael Calnan. 1996. "The 'Limits' of Medicalization: Modern Medicine and the Lay Populace in 'Late Modernity.'" *Social Science & Medicine* 42:1609-1620.

Wiseman, Jacqueline P. 1970. *Stations of the Lost*. Upper Saddle River, NJ: Prentice Hall.

Wolf, Daniel. 1991. *The Rebels: A Brotherhood of Outlaw Bikers*. Toronto: University of Toronto Press.

Zola, Irving Kenneth. 1972. "Medicine as an Institution of Social Control." *Sociological Review* 20:487-504.

Citation

Adler, Patricia A. and Peter Adler. 2022. "The Social Transformation of Self-Injury." *Qualitative Sociology Review* 18(4):64-91. Retrieved Month, Year (http://www.qualitativesociologyreview.org/ENG/archive_eng.php). DOI: https://doi.org/10.18778/1733-8077.18.4.04