THE QUEER EXPERIENCE OF SELF INJURY: A PHENOMENOLOGICAL APPROACH TO CUTTING

A Thesis submitted to the faculty of
San Francisco State University
In partial fulfillment of
the requirements for
the Degree

Master of Arts

In

Human Sexuality Studies

by

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San Francisco, California

May 2017

CERTIFICATION OF APPROVAL

I certify that I have read The Queer Experience of Self Injury: A Phenomenological Approach to Cutting by Calli Lynn Johnson, and that in my opinion this work meets the criteria for approving a thesis submitted in partial fulfillment of the requirement for the degree Master of Arts in Human Sexuality Studies at San Francisco State University.

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THE QUEER EXPERIENCE OF SELF INJURY: A PHENOMENOLOGICAL APPROACH TO CUTTING

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2017

What is the experience of queer individuals that practice self-injury? What are the meanings that can be made from their practices? A descriptive phenomenological method was used to interview seven individuals between 18 and 28 years old who identified as a gender or sexual minority. The interviews were conducted over email and designed to elicit a descriptive narrative of the last or most memorable time participants had practiced self-injury—specifically had cut themselves. The narratives were then analyzed using descriptive phenomenological methodologies to produce an essential experience of the erotic experience of cutting. Key findings include: integration and connection of the participant's self when cutting; the ways subject and object blurred for participants; tools of harm, including their meanings and relationships with participants; and the way cutting was erotic for participants. The research suggests that queer identity influences their relationship to their self, their body and cutting by creating a queerer personhood.

I certify that the Abstract is a correct representation of the content of this thesis.

Chair, Thesis Committee

5/17/17
Date

ACKNOWLEDGEMENTS

I'd like to acknowledge Dr. Colleen Hoff and Dr. Jessica Fields for their support and advisement on this project. Your willingness to go on the intellectual adventure of phenomenology and self-injury with me and support in the risks I've taken has been invaluable to my intellectual growth and development as a professional. I'd also like to acknowledge Dr. Frederick J. Wertz for all the guidance and mentoring in phenomenology he provided which has been priceless to the progress on this thesis and my intellectual growth. I'd like to thank Nicki for all the words she gave me and for being on the other end of the phone while I talked things out with myself. I'd like to thank my parents for all the forms of support they have provided, even if you don't quite get it you let me figure it out. And lastly, I'd like to acknowledge Zoo for everything.

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This thesis explores the experiences of individuals who identify as a gender or/and sexual minority and who participate in self-injury, specifically cutting. What is their experience with cutting? What are the meanings to be made from how they experience their gender and sexual minority identity and their self-injury? Is there a pattern to how individuals position how they describe their queer identities within how they talk about their cutting?

This thesis came from the lack of discussion of sexuality in a review of self-injury literature. Much of the literature shows that youth who are not heterosexual and not cisgender are at a higher risk for self-injurious behaviors as well as suicidality, but those quantitative studies only propose possible explanations for increased risk. Possible reasons for increased risk seem to fall in line with the minority stress model, but there is a lot to be desired. There is little qualitative research about self-injury, and even less involving gender and sexual minorities that practice self-injury.

Other topics of sexuality are discussed in self-injury literature as well. Multiple partners and high-risk sex and histories of childhood or adolescent sexual abuse or assault are often risk factors for self-injury. However, much of the literature has focused on youth self-injury, and it can be quite difficult to discuss young people and sexual behaviors. The lack of discussion of adult self-injury and sexuality is necessary to explore, sexuality as an identity and as a behavior and how sexuality interacts with other behaviors and identities of the adult self-injurer.

Due to the qualitative nature of this study and phenomenological method of this study, there were no hypotheses. Phenomenology as a method and philosophy guided this study due to the non-judgmental and non-pathologizing nature of its approach to science as well as the deeply empirical method of going "back to the thing itself" that descriptive phenomenology has organized itself around.

A note about terminology used in the text that follows is important to understanding this work. In this thesis, the term “erotic” will be used to describe a sexual desire or excitement, although sexual may be considered a misnomer as there is not traditionally preconceived sex in this text. Erotic is meant to encompass a wide range feelings, sensations, desires and thoughts that may coincide with sexual arousal, although it may not lead to sex. The use of the term queer is both an identity category and a descriptor. Queer is used as an identity category as an umbrella term to encompass a diverse range of non-heterosexual and non-cis-gender identities. Queer as a descriptor is meant to mean a strange sense of “other” or a sense of unique difference from the normative sense of something that would not be called queer. At times the term queer may be used ambiguously and in those instances, it is meant to be ambiguous, as there is a lack of clarity as to what is queer due to the rather subjective nature of the term.

Literature Review

Self-Injury

Self-injury has been called many things as a phenomenon, such as self-mutilation, self-inflicted violence, wrist cutting syndrome, nonsuicidal self-injury, and self-harm. The terminology around the same behavior has changed over time due to pathologization and evolution of the behavior and its classifications. The most common terms in literature today are self-injury or nonsuicidal self-injury (NSSI), and most individuals who practice the behaviors use the terms self-harm or cutting. "Nonsuicidal self-injury (NSSI) is the direct, deliberate destruction of one's own body tissue in the absence of suicidal intent. NSSI is direct in that the ultimate outcome of the self-injury occurs without intervening steps" (Nock, 2009, p. 9).

Self-injury is not a suicide attempt; however, it can often co-occur with suicidality. This relationship is tricky, however, because most often those who are suicidal and practice self-injury are classified as attempting suicide; however, self-injury can be a way for people to ease suicidal urges. There are three different types of NSSI in developmentally normal individuals. Compulsive self-injury is a mild ritualistic behavior, such as hair pulling or head banging. Episodic wounding is done every so often with no clear differentiation of severity. Repetitive NSSI is done more frequently, such as multiple times per week, and the individual practicing the behavior likely feels that NSSI is central to their identity (Nock, 2009). For accuracy among clinicians, distinguishing

severity is important. Mild NSSI has a low frequency and low severity of injuries. Moderate NSSI may have injuries that require medical attention but could be episodic or repetitive in frequency. Severe NSSI occurs with high frequency and severe injury that will have scarring or disfigurement (Nock, 2009).

NSSI is a taboo topic, and this silence masks a frequency some may find surprising: "… estimates of the rate of NSSI: Approximately 7.7% of preadolescents, 13.9% to 21.4% of adolescents and young adults and 4% of adults report a lifetime history of NSSI" (Nock, 2009, p. 15). In individuals who identify as a gender or sexual minority, the odds of engaging in NSSI are about three times higher than for those who do not identify as some sort of gender or sexual minority (Batejan, Jarvi, & Swenson, 2015). "In addition to general risk associated with LGBQ identity, the results… show that bisexual individuals are at higher risk for engaging in NSSI compared to heterosexual, gay, lesbian, and questioning other individuals" (Batejan, Jarvi, & Swenson, 2015, p. 144).

The question remains, why do lesbian, gay, bisexual, transgender or queer (LGBTQ) individuals harm themselves? Why does anyone who practices NSSI do so? Favazza offers one answer:

> The short answer to the question "why do patients deliberately harm themselves?" is that it counterintuitively provides temporary relief from distressing situations and from a host of painful symptoms, such as anxiety, depersonalization, and desperation. The long answer is that it also touches on the profound human experiences of salvation, healing and orderliness. Self-injury is a morbid form of self-help (2011, "Preface," para. 19).

There is a four-function model engineered by Nock (2009) that has become the most widely accepted model of why the behavior continues. These functions are positive or negative reinforcement, either the provision of sensation or stimulation, providing help-seeking behaviors, an escape from social interactions or a removal of negative affect or thoughts (Nock, 2009). How individuals harm themselves can be either direct or indirect. Direct self-harm is NSSI behaviors, whereas indirect self-harm is behaviors such as eating disorders, where the harm is not immediate (Walsh, 2006). "…The most common methods of self-injury reported consist of the following: cutting, scratching, and carving, excoriation of the wounds, self-hitting, self-burning, head banging, self-inflicted tattoos.." (Walsh, 2006, p. 10). Individuals report that the most common location for NSSI has been the wrists and arms, hence the previous name of NSSI as "wrist-cutting syndrome." However, almost no place on the body is not subject to NSSI. Dr. Walsh, one of the earliest scholars in the field of self-injury and a clinician who has been treating NSSI, has made a note about the location of self-injury in his 2006 book: "In my experience, injury to any one of four areas of the body is cause for special concern. These are face, eyes, breasts (in females) and genitals (in either gender)" (p. 89). Particularly relevant to the experiences discussed in the manuscript are his thoughts on self-injury on breasts or genitals.

> Nonetheless, the symbolic meaning of breast or genital self-harm, and the level of distress it implies is cause for special alarm. Breasts and genitals are sensitive regions with nerve endings that are very responsive to stimulation and pain. To

> deliberately harm these areas, the person has to have somehow "turned off" the normal physiological pain responses (Walsh, 2006, p. 89).

Self-injury is not in the Diagnostic and Statistical Manual 5th Edition (DSM) as a disorder, only symptoms of other disorders. NSSI commonly occurs with anxiety, depression and eating disorders. "It may be described clinically in terms of impulsivity and issues of control over one's body" (Favazza, 2011, "Part One," para. 3). Often individuals with NSSI are diagnosed as having borderline personality disorder. However, there has been a recent push by some scholars (Nock, 2009) for a self-injury diagnosis on its own.

In treating NSSI, there are therapeutic options as well as medication. Cognitive Behavioral Therapy (CBT), as well as Dialectal Behavior Therapy (DBT), are the therapeutic techniques used. Medication for self-injury is not often prescribed for outpatient individuals because it does not stop the person from having the urge to harm themselves; it only prevents the endorphin release or the physiological sense of "getting high" that occurs for some that practice self-injury (Nock, 2009). The most popular types of therapy, cognitive-behavioral or dialectal-behavioral, both involve shaping behavior, but use different ways of doing some. Sometimes, elements of DBT and CBT are combined because they can be complementary.

> In assessing and treating clients who exhibit nonsuicidal self-injury, cognitive therapists pay special attention to the maladaptive beliefs that underlie the clients' problematic behaviors. These beliefs shed light on the idiosyncratic logic that clients use in choosing to engage in behavior that appears to the outside observer to be incomprehensibly self-defeating. Cognitive therapists do not adopt the

> conceptual viewpoint that clients who self-harm are expressing an inherent "need to suffer" or masochism. Instead, NSSI is conceptualized as a faulty coping mechanism—an attempt at self-help gone awry, maintained by a variety of internal and environmental consequences that reinforce the behavior (Nock, 2009, p. 201).

In DBT, behavior is the primary concern. DBT therapists often use reinforcement, conditioning or shaping techniques to help eliminate undesired behaviors. As Nock explains,

> Individual DBT therapy is organized around a hierarchy of target goals that aim to eliminate (a) NSSI and suicidal behaviors; (b) therapy interfering behaviors such as nonattendance or not doing homework; and (c) factors leading to decreased quality of life, including homelessness and drug dependence (2009, p. 231).

Therapists do not have to specialize in CBT or DBT to use elements of either technique, however some therapists only use DBT to treat self-injury, which may not be the most effective treatment and can be limiting when a therapist is rigid in their methods.

Phenomenology

Phenomenology is both a philosophy to guide an investigator's mindset as well as a theory to guide their work. It is a non-traditional theory due to the focus on lived experience that comes from taking a phenomenological attitude (F.J. Wertz, personal communication, 2017), and the steps that are used to analyze lived experiences using the theory will not produce hypotheses or generalizable results. In fact, it often does not include other methods beyond the phenomenological attitude.

> The phenomenological attitude is reflective. It selectively turns from the existence of objects to the processes and meanings through which they are subjectively given. This attitudinal focus is called a "reduction," the field of investigation is

> not narrowed but rather is opened up and expanded to encompass all the complexities and intricacies of psychological life that come into view (Wertz et. al. 2011, p. 125).

Descriptive phenomenology originated with Edmund Husserl, who was one of the first to develop a set of methods that could be deemed scientifically appropriate for studying conscious experiences. The difficulty at the time was to overcome the natural science approach or objectivism (Wertz et al., 2011). "Husserl expressed the fundamental orientation of phenomenology in his inspired call 'zu den sachen selbst' (to the things themselves), meaning that knowledge must be grounded in contact with unique characteristics of its subject matter" (Wertz et al., 2011, p. 53). Husserl made intentionality or the way that consciousness relates to objects, the foundation of his methodology to studying experience as a reorientation to a human science approach (F.J. Wertz, personal communication, 2016). The distinguishing factor of phenomenology involved two epochés (or "abstentions"). The epoché of the natural sciences requires bracketing natural scientific knowledge such as theories, hypotheses or prior research on the topic. This allows the researcher to reflect and analyze the phenomena at hand without their reflections being colored by prior knowledge. The second epoché, of the natural attitude, is sometimes called the phenomenological reduction. It pushes the researcher to consider how the phenomenon presents itself. It also means that the psychologist following the epoché of the natural attitude does not take a position on the

existence of experiences or objects within the experience from participants (Wertz et al., 2011).

"Phenomenological reflection, called 'intentional analysis,' shows that human experience is embodied, practical, emotional, spatial, social, linguistic, and temporal" (Wertz et al., 2011, p. 126). Intentional analysis is about describing the "how" and the "what" of the experience of the phenomena and is a procedure to investigate how the experience occurs for people (Wertz et al., 2011). Consciousness is transcendental in the way that it is of something beyond just consciousness, for example, one is conscious of reading this paper, as well as the environment that the reading takes place—consciousness is not just awareness of awareness. The psychological experience of intentionality, or the way consciousness is related to a person's lifeworld, whether it be just their experiences or shared with other individual's consciousness, creates a meaningfully way of experiencing phenomena.

Following intentional analysis is eidetic analysis, which explicates what is essential to an experience of a phenomenon. Eidetic analysis is used to summarize what is key to an experience of a phenomenon. It uses imaginative variation to see what can be changed in the experience and to the extent it would modify the phenomenon. In eidetic reduction, each experience of the phenomenon is generalized together (Wertz et al., 2011). All phenomenological methods involve eidetic analysis, however, how it is used can vary based on preference and style. A method of data analysis known as a Colaizzi-

Style Method involves six steps: "reading the descriptions, extracting 'significant statements' formulating meanings, organizing expressed meanings into clusters of themes, exhaustively describing the investigated phenomenon, and validating the exhaustive description by each respondent" (Vagle, 2014, p. 103). This method has strongly influenced the data analysis method on this project.

Vagle (2014) has brought up the difficult in understanding intentionality as a method of analysis because of its misnomer and the tendency of phenomenologists to turn their study toward the purpose of an individual instead of how the relationships that individual has influenced how meanings arise. Due to this, Vagle (2014) has introduced a "post-intentional phenomenology" influenced by two points of post-phenomenology that has been proposed by the phenomenologist Don Ihde. The first point has been to move from Husserlian phenomenology to look at Merleau-Ponty's thoughts on the body. The second is that it cannot be transcendental or be presupposed and established a priori, it is existential, or beyond scientific knowledge and objective values while focusing on reality, and how we access our world and other people in it (Vagle, 2014). Vagle (2014) further champions Ihde: "Rather, he suggests that the body in the Merleau-Pontean sense need not be fully dissolved in the social, but that an embodied intentionality exists in which the body is lived through and is permeated by the social" (p. 113).

Another move to post-phenomenology from intentionality has occurred in following the process of intentionality.

> So, when I "post" intentionality I am saying that intentionalities cannot be traced. One cannot start with the stable subject and try to follow that subjects intending toward and with the world. That very subject is both constructed and constructing, not dissolved. She is both agent and acted upon: what is available for that subject is both a manifestation of the social and is made possible by that subject's intending. (Vagle, 2014, p. 113).

Post intentional phenomenology also discards the elements of invariance and structure in the focus of analysis in the phenomenon, only focusing on variants (Vagle, 2014).

Post-intentional phenomenology is seen in Ahmed's (2006) work about sexual orientation. Ahmed takes a much more embodied approach to looking at the phenomenon as a way of existing in the world instead of a category. The focus is on the body in her text, and she uses it as a way of relating to the world (Vagle, 2014). The embodiment has strongly influenced the following work in the way that the body is a way of looking at its lived experience of self-injury and how the phenomenon causes the body to relate in different ways to different things both organic and inorganic. Furthermore, this work has used a post-intentional phenomenological philosophy because "the goal is to see what the phenomenon might become" (Vagle, 2014, p. 119) instead of what the phenomenon is in essential structure.

Genealogy

Moustakas (1994) was the first phenomenology text used to guide methodology and design of this study. Moustakas (1994) uses transcendental phenomenology. Initially, the chosen methodology would be a modified version of the Moustakas-modified Stevick-Colaizzi-Keen method. However, with reading Giorgi et al. (1985) work, it was

decided not to confine the analysis to just one phenomenology. From there, reading about Vagle's (2014) post-intentional phenomenology, it was decided to include some post-intentional phenomenology as well as other elements of phenomenology discussed in the text. From Vagle's (2014) work, reading Ahmed's (2006) *Queer Phenomenology* helped to clarify the attention directed to subject and object. R.D. Laing's (1952) work helped provide a major example of how to study the self and to ensure the self in self-injury was addressed with his phenomenological study of schizophrenia. While Laing's (1952) work differed based on the questions he was asking to understand the experience of schizophrenia, the model of the self as a fluid and abstract concept helped to open the door to questioning the self in this work in a way that has not been previously modeled in self-injury research. The core guiding influence for the phenomenology used in this study was Dr. Frederick Wertz, who's book (2011) and mentorship helped to develop an increased understanding the methodology although it belongs to no particular school of phenomenology.

Method

Procedure

The screening survey link to the Qualtrics designed survey was posted on one self-injury website forum and posted on the project Tumblr, a blogging website. The project Tumblr posted the survey in a variety of different forms, such as a link post, a

text-post, and a photo-post. The posts were tagged with multiple descriptors to have the posts spread across Tumblr for the highest number of views, and potential participants gathered. After few participants had responded to the request for participation, a revision was submitted to allow a wider posting on multiple social media sites, as well as on a Listserv.

An initial interview guide was developed and used. However, after several completed interviews, the data was found to be lacking in detail and depth; many participants were dropping out due to the intensive nature of the initial design. The revised guide used fewer questions, although the questions, in essence, asked the same things as the first guide and had a broader, more ambiguous scope after considerable thought of what the desired answers would achieve from the questions. The revised guide required less participant effort, with only two instances of answering questions instead of the multiple times required by the first guide. Five completed interviews used the method below.

The participant was first contacted using their e-mail address collected from the screening survey. With the initial contact email, the participant received the informed consent form to review along with the interview guide and a list of resources and directions on how to return the electronically signed consent form. The participants who returned the signed consent form were then sent the interview guide again along with the mental health resource list with instructions to answer the provided questions with as

much detail as possible. Those who returned the signed informed consent were entered into the first round of gift card drawings. They received two reminders, 72 hours apart, if their answers were not returned promptly. If there was no response after seven days, it was assumed they had decided to discontinue their participation. They were not contacted any further.

Once the initial answers to the interview guide were returned, the answers were read multiple times to ensure the responses were understood. Any questions from the data probing to elicit further detail were noted and compiled into a second email to follow up with the participant. The participant was then sent those questions with the resource list, a roster of the days on which the reminders would be sent, and an explanation that once they completed the follow-up interview guide, they would have completed the interview process and thanked for their time. They were also told they would then be entered into the drawing for the second set of gift cards to an online retailer. Seven participants completed the study, two from the first interview guide, and five from the revised interview guide.

Analytic Process

Completed interview transcripts were compiled on a word processing document. The transcript was then de-identified, and the participant was assigned a number and letter identification for data organization. The transcript was formatted for analysis and

printed. The chosen method of analysis was a blend of the phenomenological methods I discussed above.

The transcript was first to read multiple times without any notes made on the transcript. The multiple readings of the transcript were the "immersion" step, allowing the researcher to absorb the data without any previous knowledge coloring analysis. When immersed in the data, any thoughts or questions or references to relevant literature or other participant data were written in a notebook with the line number of the interview that caused the researcher to think of those specific things. The researcher was considered immersed when they did not write any notes when reading through the transcript.

The researcher then read the transcript for themes and noted them on the transcript with highlighters and markers with a color key on a separate sheet of paper. Coding data involved the marking of the transcripts. The researcher read for larger themes that informed the interview guide, as well as participant-specific emergent themes. During coding, the researcher also marked sections of data that were not thematic but were instead puzzling due to the complexity in statements that felt imperative but not transparently meaningful.

After the transcript had been coded based on themes, the coded sections of text were compiled. The sections that were coded based on the multiple themes apparent in the text were placed under every separate theme as well as compiled together for more in-depth analysis. These coded sections were read for meanings. This was considered the

"meaning-making" or "analysis" step of data analysis. The coded text under each theme was reviewed for clear, inherent, and hidden meanings. These possible meanings were written down, as were the relationships each section of the text had with the others within the theme. Meanings were next compiled under each theme. These were read to see if the theme made sense and seemed complete. Any thoughts or questions that were prompted by these readings were noted, and those themes were considered incomplete. The multi-themed sections of text were teased apart to see how they interacted with one another. The sections were also analyzed holistically. Multi-themed sections were considered for apparent and inherent meanings, noting all ideas and questions. All the themes were read again with the multi-themed sections in mind to see if any questions or ideas could be answered with the addition of the multi-themed sections. If anything was considered unclear, the data was then imaginatively variated, in other words, the researcher considered whether, if one element of the theme was taken away or something was added, would it change how the theme was understood? If a clear answer came from imaginatively variating the meanings, the data was understood.

The next step after "meaning-making" was considered the "essential experience" of the data analysis. The thematically organized data was read multiple times to try and separate the textual and structural experiences. The textual experiences were considered the physical sensations or experiences, or the external events noted in the data. The structural experiences were considered the internal experiences, such as the thoughts,

feelings, personal value judgment statements, or anything that could not be physically seen by an observer. The experience of cutting was then written from the data as a textual experience. The experience of cutting was written as the structural experience after the textual experience. These descriptions of the participant's experiences were then combined to create an essential experience. Ensuring that the essential experience was true of the participant's interview transcript, the supporting statements from the interview were embedded into the essential experience using the participant's words.

Each participant's interview transcript was subjected to the above analysis. All the participants' essential experiences were then read together to see the overlap and differentiation between participants. The essential core experience that was present for all seven participants was considered the essential basic experience. Then, the different elements not present in all of the participants' individual experiences were re-considered. The transcripts were re-read to see if the element was present in other's transcripts and had been missed, or if it was entirely unique to just one participant. After the different elements had been considered and added to the essential core experience, the essential experience was revised for clarity. When it became apparent that the way participants wrote of cutting seemed erotic, the essential experience became much clearer.

After analyzing the participants' data, it was decided that Participant 6 or F would be removed from the data set due to lack of necessary detail needed for phenomenological analysis. The narrative was considered incomplete due to the use of

the first interview guide used which did not elicit the necessary detailed information in either interview. Participant 2 or B used the first interview guide as well; however, the data was deemed rich enough to use.

Results—Essential Experience

It will start out with something that does not feel quite right, a queerness, just a background disturbance that grows, or it is triggered spontaneously. A gut-wrenching day, being screamed at or told they are a disappointment. Alternatively, it is a sense that they have made a mistake, they could have done better. That they are not enough, they will never be enough, whatever enough is. Alternatively, it becomes a desire to escape, to leave the negative feelings of helplessness, worthlessness, shame, fear, anger behind. Even going in, deciding to do it, it is known as a temporary fix, something they would prefer not to do but are not aware of a better option. Sometimes they want to destroy, make a mark, feel the sting. Sometimes those thoughts come one right after another. They decide on a queer act of self-care the moment they feel the trigger burrow under their skin. They define self-care as cutting, getting rid of feelings, thoughts, and desires that will not leave them.

However, the moment the urge is triggered, there is an anticipation—both physical and mental. The body relaxes but also feels drawn taut. There is the relief that their body just knows, expects. The mind knows it just has to make it to the evening, just

before bed, when it can leave the horrible set of feelings, thoughts, and misery even for a moment. Sometimes favorite places on the body tingle with anticipation, arms, thighs. There is a fixation on location, particular attention to the place to be shredded, it is treated well before being abused. The arousal begins when the urge is triggered. It grows until it can be acted on, typically at night and always when they are alone. The arousal thrums through the body—need to get it out, get a release, to feel better, even if better is bloody.

Going through the ritual is like a queer foreplay, increasing the arousal of the much-anticipated event as the urge grows far too overwhelming to resist, despite the desire to resist, not to destroy flesh, draw blood. There is a war, knowing there will be regret, even if it is only about aesthetics, but the regret is never enough to prevent it in the end. The ritual of gathering tools and picking a location bleeds from foreplay to intercourse. The specificity of the tool is not where emphasis, value or importance lies. It has its value because of the possibilities it provides, the pleasure. That is where the tool gains its sentimental value in the possibility, but it can always be replaced. The blade penetrates the skin, and it hurts most of the time. The pain is worth the pleasure it brings, the quieting of the mind, the knowledge that it will always make them feel better. The repeated injury, either carefully measured or rashly wrought, it does not matter. The sting might not even come until the next assault on the abused skin, but it will always come.

When the subject and object join, they meld and transcend beyond clear distinction. Is the skin the subject, the person, or is the tool just an extension of the

subject to cause pointed harm? The object becomes the skin, the place where destruction occurs, but it is not them, but it is. They are both and neither. Their self cannot be so easily assigned. The intercourse reaches a climax once there has been enough blood, enough wounds. Enough always changes, it is never quantifiable until it becomes too much. There are just seconds between the bliss of enough and too much, overwhelmed senses and stimulation. Finding enough instead of too much takes practice and instinct and depends on how they feel before they can cut and how long the arousal has lasted before they can act. There is a sense of peace and satisfaction, feeling sated after.

Floating on an endorphin cloud the mind is slowing, silent and peaceful. They do not clean up. They care more for the object, the tool of pleasure, release, and pain, than for their wounds. They have to care for the tool, it is or has become an extension of their self, the extension that is hard and sharp and cutting that does not experience the pain they feel, it can only cause pain. However, sometimes there is a demand to clean the wounds, prevent the mess, and the task is done with annoyance. Clean up the blood, the evidence that they have engaged in a taboo perverse pleasure. They feel nothing emotionally but feel the pain, the sting, the burn. Sometimes it leads to rest, other times the urge returns and the cycle will begin again, multiple times a night until they must sleep and end the intercourse not because of satiation but because of outside forces. Sometimes they are insatiable, the desire is under their skin, and they have to cut multiple times a day just to get it out and achieve the painful silence.

They feel the most love for their bodies when they are rending those bodies at the seams. They have favorite shoulders or ankles; they love their scars as proof of survival, a calendar of life events and as secrets. Though they take pleasure in keeping to themselves, they will show the scars off, daring someone to say anything. They care for their bodies by hurting themselves, the rare time they feel integrated with their body. They find the contradiction pleasurable, a challenge to test tolerance and a way of escaping and feeling good. They do not feel good about cutting; they know it is taboo. However, the relief from the overwhelming stress of being queer in a world that stigmatizes and has helped them to internalize their phobias cutting is a momentary break from everything. Cutting is a perverse pleasure they can control. Cutting is all theirs. They can control cutting in a way they have hardly felt before, and the power bleeds into other parts of their life that are theirs alone. Food intake, emotional reactions, and how they present themselves to the world—they can lose control of all of this and more and still have the cutting. Despite how others have hurt them in the past, they are still the captain of their ship, and they still do the most harm to themselves. It is theirs exclusively.

They do not want to say they are unhappy they are queer, but they all had to go through a path of acceptance of themselves that straight individuals never have to take. They have to hide their differences, one more secret on top of a pile. They are afraid to be queer, unprepared for a life they never thought would be theirs. The violence toward

other queer people and that their families speak of makes them stay silent. They do not have the support that is often taken for granted, the accepting friends "don't care" which is the double-edged sword of not making a big deal of their identity, but also not taking them seriously. They are both delegitimized and questioned about why they would choose to be so different. They feel that they know if they came out to their parents they would lose their love, and that sense of knowledge makes them question the love they have under false pretenses. Desperate for love in most cases, they would rather sacrifice whatever they had to have their family. They show themselves love in a most violent way by cutting regardless of how others show them love. Sometimes they have told their parents and have been met with the "hate the sin, love the sinner" mentality that offers no support, and yet they are told they are still loved.

Analysis and Discussion

In this section, the discussion of the essential experience, or the results of the interviews, is analyzed. The essential experience generated five sites of analysis: integration and connection, subject and object blurring, the tool of harm, cutting as erotic and grounding the erotics of pain and pleasure. Integration and connection discusses the way cutting and participants queer identities acted as bridges of connection between mind and body and the physical act of cutting aided in integrating the very divided self that participants existed as when they were not cutting. Subject and object blurring is a rather

abstract discussion in the cutting space, the way that subject-hood and object-hood are blurred, confused and not easily assigned. The abstractness of subject-hood and object-hood is the most philosophical discussion of this section because it cannot be grounded due to the existential exchange that continuously occurs when participants are cutting. The tool of harm focuses on the way inorganic tools become integrated into the personhood of the participant that cuts, creating a queerer personhood based on the perception of whom these participants see themselves as. Cutting as erotic is an attempt to show the way that the act of self-injury is an erotic, physical act in a queer embodiment of sexuality. Grounding the erotics of pain and pleasure is a potential neurobiological and neurochemical explanation of how cutting is not only perceptually erotic for individuals but is physically like sexual arousal and the queer roles that pain and pleasure play in that arousal. The medicalizing language used in grounding eroticism may be perceived as pathologizing, however, the fact that there is a plethora of evidence of the biological functioning to support the immaterial feelings and perceptions of eroticism furthers the argument of normalization and non-pathological acts of cutting. The sense of the inexplicable creates a sense of mystery that leads to fear and pathologization which is the opposite of this argument.

Integration and Connection

Participants had much dislike for their bodies, whether it be about their perception of their size or disliked the scars from previous self-injury on their bodies. Some disliked

how their bodies are read as a specific gender in the world, or how they inhabited their body, disliking feminine curves when desiring to be gender ambiguous. They also disliked the panic attacks they experience and physiological urges to cut themselves.

These disclosures about their dislike of their bodies had occurred before they started sharing the specific narrative of how they cut themselves, or during the narrative of the act. However, when they were talking about cutting themselves, their dislike of their body turned into a sort of affection. They had favorite shoulders to cut on, or they liked that the fat on their thighs allowed them to cut deeper or with less pain. They liked the scars they had previously claimed to disliked because cutting into preexisting scars hurt more but made them feel better. This affection toward their bodies only lasted as long as they felt relief from their self-injury—from the period of arousal until they were sated. The affection abruptly ended when they felt shame, or disappointment, or anger in themselves for giving in to the urge to cut themselves, for destroying their flesh, creating more scars, for bleeding as much as they were or for not achieving "enough," whatever the ambiguous "enough" meant for them. Even in their cutting of their body, it does not necessarily seem as if it is their body, the pain, and blood; the act seems both alien and their own. This duality raises the question of their alienation from cutting, as well as their connection to it. Does it come from the messages of how self-injury is taboo and wrong? The shame they receive from the people in their lives and media and the alienation comes from a sense of duty to try to internalize those messages, or is it something else?

Participants' lack of connection to their body, their dislike and even distancing of their mental or internal self from their body except when they were cutting seems ironic. While most of the self-injury literature poses some possible explanations for self-injury as a source of sensation seeking, participants appear to move beyond looking for sensation from their body and instead look to inhabit their body in a visceral way that they struggle to achieve at other times. This inhabiting of their body seems like a way for participants to claim ownership of the sensations and feelings they have for a period when they are alone and thus to feel ownership of their body. The alienation they feel when not cutting seems connected to feeling as if others have more control over their selves and bodies than they do—whether it be parents, romantic or sexual partners, or professional mental health staff.

Furthermore, those who continue to cut themselves after being forbidden to, or who go into treatment, seem to be exerting more ownership and possession in a way that they cannot verbally do against those who have taken some of their autonomy. One participant remarked about harm reduction practices suggested by his therapist. Even when this participant seeks to gain connection and possession of his body by cutting, the therapist has entered into the possessive space of the participant. His self-injury is no longer his own if he follows the practices the therapist suggests, which leaves him unsatisfied and exacerbates his cycle of harm.

These individuals feel they lack privacy or ownership of possessions, even their bodies at times when they are triggered to feel an urge or compulsion to cut that seems "other" to them. Some of them describe not wanting to cut but nonetheless doing it out of a sense of duty or habit. There is almost a war over their bodies, a struggle to take control not only from the people in their life who deny their autonomy but also from urges that seem alien to them. The battleground of the war is their flesh, and they only get a sense of winning the war when they destroy it.

The lack of connection, or possession, of their body, signals how "othering" works in their self-injury. Most participants felt their queer identity, whatever it is, was not a part of them—as if they could project their queerness away from themselves and then possess it only at the appropriate time. For participants, their queer identity is a source of trauma. Unlike a trauma like a natural disaster that may occur once and the survivor can work toward healing themselves with the knowledge they are unlikely to experience the same natural disaster, these queer participants are often re-traumatized each time they possess their queer identity because of the time when they "other" the identity. They are experiencing the natural disaster of their identity over and over and each time get caught up in the negative feelings their identity generates when influenced by less accepting family, friends and society. Also unlike a natural disaster, participants have felt they should have some sort of control or choice in the matter due to the popularized but false narrative that queer people have made the decision to be queer. This

myth of choice undermines many participants desperate exercise of control that often influences their cutting as well. The believed myth of control makes participants feel even more helpless, adding on a further sense of trauma and a need to "other" the part of themselves that heightens their stress and negative feelings of self.

The "othering" is not to say they do not want to be queer, they all embrace their identity. The embracing of their identity came after a period in which they denied their queerness, or struggled to understand it, or did not accept queerness as an accurate description of who they were. Some had a short period of that fight; others have never moved past struggling with their identity into accepting it. One participant spoke of feeling as if she was not prepared to be a lesbian, her life had always been about how to get a man and have children and when she turned out to be a lesbian, she felt very unprepared. There is almost a personal sense of betrayal to themselves for being queer because they will have to live a life that most feel to be much harder than a straight, normative life. This sense of betrayal may help to understand how exactly individuals "other" their queerness from themselves.

This "othering" of their queer identity seems to be an extension of how they cast their body as "other" or otherwise disconnect from their body. It seems a protective way for them to survive their war in that they do not let many things come to their very core, what makes them theirs, to protect whatever fragile thing that is. If they can "other" their body, they cannot be hurt worse than what they do to themselves. It makes them more

protected, feel less affected when they have health care providers invalidate their identities, telling them they just have not had sex with the right man yet and they cannot be asexual. It makes their "othering" of their identity seem like something they are willing to sacrifice—and sometimes do sacrifice—to make their lives easier.

These participants seem to need to find a way to integrate themselves fully, both mind and body. They get brief glimpses of that integration when they cut, and achieve such a sense of relief, but it always fades. Perhaps their cutting continues because of the reward of feeling the relief, the pleasure of being whole when they are cutting. However, unable to establish the permanent integration, they repeatedly pursue the brief periods when it does occur and the blissful relief, or silence or calmness that follows.

Subject and Object Blurring

In her post-intentional phenomenological approach to sexual orientation, Ahmed interrogates the roles of subject, object and orientation (2006). Ahmed (2006) considers what orientation is, as an identity and a direction, who and what joins the subject in various orientations towards other objects and the principle that if someone is oriented to something, they are also oriented away from something. The role of subject and object comes up when considering orientation towards an object or subject that should be where it is, and what the "should" or "supposed to" reinforces the heteronormative discourse of "naturalness." In the heteronormative discourse of what a subject it, inorganic objects incorporated in to subject-hood definitely do not fit the traditional understanding of what

is subject. Furthermore, to other organic material such as flesh and element of identity such as queerness, points to a queerer existence of orientation and personhood.

In this project, Ahmed's discussion sparked an interrogation of how participants seem to blur the boundaries of subject and object once their complicated relationships to their bodies and identities were understood due to their lack of integration and connection participants experienced. The subject of this discussion is the person, including their body and mind, and the object is the tool used for self-injury, whether it be a pocket knife, scalpel, carpet knife, tweezers or broken glass. One might assume, first, a linear relationship between object acting on the subject and, second, that the people or objects inhabiting these roles would not change. However, based on the division participants have felt from their bodies and identities, and the attachment to tools of harm, and injuries they create or the scars that come from the wounds, it appears that the assumed linear traditional relationship is very blurred and queerer. It questions what a queer self-injurer sees as their personhood, their core being.

The subject is assumed to be a person, their body, their skin, their thoughts, feelings, the perception of sensations, and it is subsumed under the title "person." Everything above would be typical of someone who does not self-injure or who does not see their queer identity as something that can be separated from them or lacks embodiment. This criteria excludes the participant group of this study.

The object, on the other hand, is recognized as a tool. It is not characteristically human. It does not have feelings or signs of life. It is an experience of "other" and in the most literal sense, an object that could be anything that is not part of a human.

One participant describes their favored tool for cutting—a pocket knife—as a safety blanket. They feel panic when they do not have it with them, and they carry it with them nearly everywhere. Like others, they describe the tool of harm as a friend or a romantic partner, someone or something that is always there for them, a constant in their ever-shifting lifeworld. They use the tool to cut, an extension of themselves to cause harm on their selected body part. They do not see the body part as them until they are drawing blood, and the sense of connection with their body fades when they have to clean up the mess and apply bandages. They offer care and affection to the tool—not the bloody body surface that has to be sliced open. In this situation, the skin of the participant, the body, seems completely alien and "other." It is the object they use to gain pleasure, peace, cause pain. The tool is them; it is an extension of their subject, their focus is the tool doing careful (or not so careful) damage to the object. Their mind is silent; they do not feel anything or think anything when they are cutting. They become nothing due to the absence of thoughts, feelings, everything that made them who they are when they are not cutting, and they become the tool, the subject. This exchange of subject-hood and object-hood seems natural, not forced, it just is.

Many participants spoke of their scars as both objects, "othered" parts of them, but also integral parts—what makes them who they are, the subject as they exist in the world. The scars are an organic object on their subject, but it is also the subject placed on an object they do not care for or wish they could change. These scars hold meaning for participants, and they are a calendar or journal of significant moments of their lives, worn on their skin. Some participants hold these scars as special and do not want to do further damage to them because they like how they look, others like to re-open the scar tissue because it is a more intense sensation, or they have run out of space elsewhere. The scars are the clearest example of boundary-blurring between subject and object that can be presented. How can the scar be an object when it holds so much meaning? How can the person be the subject when they have no attachment to the body beyond the organic object's placement?

This alienation of subject and object seems possible only because of the way participants lacked an integration of their self and their body and characteristics they ascribed to themselves. The blurring of these lines occurs when participants cut themselves or reflect on their instances of cutting and provide narratives of these events. The participants do not seem to inhabit the same core self as they move through the world due to their way of "othering" their queer identity, self-injury, their body, thoughts, or feelings. By taking inanimate objects and making them integral to their well-being, they either push the definition of the subject or, more likely, reassign what it is to be subject

and object. In that gesture, they open up the possibility of a queerer existence of personhood.

The Tool of Harm

The tool that participants use to cut themselves is unique due to the way that it becomes theirs. All participants wrote about a journey of discovery of which tools and methods of self-injury satisfied them, or "worked for them" the best. All of the participants landed on cutting as their method of choice. Some participants wrote of using any sharp object available when the urge hit them to get off; others wrote of having a favored tool, or a favored type of tool. This range of tool choice might suggest that the tool choice does not matter. In reality, though the specific tool does not matter, the chosen tool has a high value. Indeed, a participant's tool is an extension of their self, used to injure at times of great need. The tool itself is not important. Instead, it is the ability that the tool provides that gives the tool value. The tool, the injury, the sensations, all must align for the self-injury session to be satisfying enough to make the participant feel sated.

One participant wrote that when the urge hit, they used anything remotely sharp to injure themselves, to sate the urge immediately. Pen caps, a mechanical pencil, broken glass, and razor blades or tweezers were all used opportunistically. Some participants wrote of spending much time identifying and storing materials to cut themselves even

when they did not have an urge—through their forethought acknowledging what seemed inevitable: that they would want to cut sometime soon.

This dedication of time and care into tools is contradictory in the way it is not reciprocated to take care of the wounds after the injury. Some use specific tools because they are trying to take a harm reduction approach suggested by their mental health professional, although it is not exactly what they want. Others began using a specific type of tool and continued to use the same tool because it always worked for them and they never had to change. The tool does not matter so much for sentimental value: no participants wrote about using a specific singular tool because of what it meant them. The only participants who wrote about using the same tool over and over did not mean that it had to be the same knife, it just had to be a pocket knife or a carpet knife. The lack of sentimental value in object choice is an interesting comparison to the care shown for the tool after use. Participants wipe the blade clean, sanitize it, put it away to make sure it is available the next time they have an urge. They do not do the same thing for their bodies. Because they do not care for their bodies in the same way, it further lends itself to the belief that the tool is perceived as part of their person, the core of who they are, more so than their body is. Participants do not care for their body, do not see it as them so much as something they cannot escape because they see their body full of flaws and limited in control. They even fault their bodies for making a mess by bleeding after they cut and they neglect it because their body is beyond their control. The tool used to cut however,

they wield with complete control, and its use brings painful pleasure and is something they have decided on and gained autonomy from. Tool integration into the body when there is so much "othering" and division with everything else in their lives is interesting.

Cutting as Erotic

Participants write of cutting as an encounter that is almost sexual, as though cutting is a partner to take to bed. However, the term sexual encounter has a sense of lacking due to the expectations that come with the term "sexual encounter" which is subjective based on the person who is reading this and their expectation of what sex means. If cutting is phrased as an erotic experience, it seems perverse, and it is not intended to assume that cutting is a fetish connected to masochism for these participants. It is not the same as the experience of sex with a partner: in the erotic experience of cutting they are having sex with their self or the "other" part of them; they are having sex with their body, but they are also the one in complete control. Due to their "othering" of parts of their self, it is as if they are having intercourse with their integrated self when they cut and acting on their self as a whole. With a partner, participants lack complete control, and they are not whole in the same way.

When thinking of self-injury, the act itself is a sort of self-eroticism that is usually not considered due to the violent nature of cutting oneself. Participants will strip down to expose their vulnerable flesh, either naked or partially clothed to give them the best access. They will caress the area they wish to cut, stroking the skin, pinching, scratching,

gazing at it in a loving manner, with compassion and reverence that it is their body, their skin, they have possession and control of it. They will pick up their tool, pinching it between their fingers or holding it as if it were a pen or pencil to write their desire on their skin. They will use their tool and apply exquisite pressure, stimulating all the nerve endings in their skin, so they have a sense of burning as if there is a trail of fiery pleasure in the wake of their tool. This penetration, initially shallow and testing, is thrust deeper as the desire increases. The first application of pressure, the first slice, may even bring about a sigh or whine. They will thrust the tool against their skin, into their skin, until they fall over the edge where the pain of stimulation becomes pleasurable, or perhaps the stimulation is pleasurable and reaches a point of pain. There is an eroticism of cutting open their skin, of seeing their blood, causing their pain and pleasure, the sensations they produce from peeling their skin apart in search of the ultimate relief; relief from the built-up tension they hold in their mind and bodies.

Reading the act of cutting as though it were an act of intercourse is further queered when blood could be considered ejaculate or what is colloquially referred to as "cum." The imagery of a cut, a slit in the skin, oozing blood and open for anyone to see inside the body is reminiscent of a vagina during arousal and intercourse. The labia like the skin and the cum like the blood, at first not rampantly present but as arousal and stimulation increases, the flow of blood becomes more present as does cum. This imagery is of a more peaceful, heterosexual variety, but can be taken further if one reads fevered,

uncontrolled cutting as forceful, penetrative sex without preparation or arousal in which blood would be present in the intercourse because of injury. The reading of cutting as intercourse is ambiguous regarding gender and orientation and is up to the reader's imagination to assign gender and orientation to the actors. This ambiguity can further be queered when technologies or inorganic materials are incorporated into the body as the tool of cutting has been and becomes an extension of the person to harm themselves. The reading of blood and fluids as a point of queer eroticism destabilizes notions of what is sex and what is the injury.

The four-stage model of female sexual arousal researched by Masters and Johnson (LeVay & Valente, 2006, pp. 81-82) is extremely similar to how participants experience the cycle of cutting, and the stages are present in the narratives of how they describe their most memorable or last incidence of cutting. In the excitement phase when participants begin to feel arousal in the original model, participants also feel arousal such as a tingling under the skin in their preferred areas of cutting, or a sense of relief knowing that they will eventually cut because they are aroused. In the plateau phase, high arousal is maintained for a period, either a few minutes or hours in the sexual sense. In the self-injury sense, participants also have a plateau phase where they experience a strong desire to cut and may go through a ritual of preparing to cut. This plateau phase may last days for them based on their perception of being able to cut, or to their conflicting desire to cut and their resistance to act on their desire. The orgasm phase in the original model is

described as climatic sexual pleasure and release, which could also describe the orgasm phase of cutting. One participant described it as "a flower of relief blooming under [his] skin" when he finally cut himself. Another participant wrote, "It is the best thing in the world while you are doing it, it solves everything, and you wonder why you would ever stop when it feels so good and brings such a sense of relief." When in the resolution phase for both cutting and sex, arousal and excitement subsides. It is described by participants in a variety of ways. "My head is blissfully silent" or "I feel so relaxed, normally I have insomnia, but after I cut, I can finally sleep."

Grounding the Erotics of Pain and Pleasure

How can participants feel pleasure when they also feel pain as they cut themselves? It is a unique mix of perception and hypothesized neurobiology, which initially may not feel particularly queer until it is understood that participants choose to cut to experience a queer sort of eroticism. They have found a way to "hack" their brain to experience pleasure from something that is undeniably painful as well and get the benefit of feeling better when they could attempt more normative practices like their non-cutting peers. All participants stated they felt pain when they cut. They were not dissociated from their bodies; it was, in fact, one of the only times they felt connected to their bodies. They wrote of desiring the pain, desiring the way the cutting would make them feel better, the desire to stop cutting but feeling unable to. Participants seem to gain

pleasure from not only the change in affect that cutting provides but also the physiological responses that may be occurring.

Van Der Kolk (2014) in his experience with combat veterans saw that participants in group therapy had the most animation recounting their traumatic experiences in war and wondered why men often thrived on recounting those experiences but felt numbness or emptiness when not experiencing the horror or grief of the trauma. He worked to understand what made people attracted to things and activities that motivated and made them feel alive and found that people can adjust to all sorts of stimuli, even if they are not immediately pleasurable; terrifying or painful events gradually become enjoyable and pleasurable once the brain alters the chemistry in reaction to these events. "Fear and aversion, in some perverse way, can be transformed into pleasure" (Van Der Kolk, 2014, p. 32). In an experiment Van Der Kolk (2014) conducted on pain tolerance based on traumatic stimuli, he found that "exposure to stress may provide a similar relief from anxiety" (p. 33) based on the change in neurochemistry that has previously occurred when exposed to unpleasant or traumatic events.

Individuals who self-injure alter their neurochemical activity in, among others, endogenous opioids; this is due to the way opioid antagonists, which block the release or actions of opioids on receptors, have had some success in eliminating the self-injurious behavior. The way that participants report changes of pain sensitivity when they are injuring as well as the way that altered endogenous opioid levels have been found in

individuals who practice self-injury adds further support to this theory. It is also suspected that altered transmission of serotonin plays some role in self-injury due to the inward and outward aggressive behaviors that are particularly impulsive, as well as the hypothesis that serotonin is involved in the perception of pain (Nock, 2009, pp.100-107).

It has been thought that using a pharmacological treatment such as an opioid antagonist could reduce or eliminate self-injury due to removing the pain-eliminating physiological response. Opioid antagonists such as naloxone or naltrexone have been experimented with as an effective treatment, but the results have not been widely successful. Naltrexone has been shown to reduce self-injury in some participants that lead to evidence of endogenous opioid activation in self-injury, however, in other cases, self-injury increased (Nock, 2009). Because of the implication of endogenous opioids in self-injury, the hypothalamic-pituitary-adrenal axis (HPA) is also connected to self-injury. Early traumatic experiences have been linked to altered functioning of the HPA and stress responses which are related to some risk factors of self-injury. In the model proposed by Sher and Stanley (Nock, 2009) individuals who self-injure are hypothesized to have much lower levels of endogenous opioids and that by practicing self-injury they are trying to reach a homeostatic balance. Individuals expose themselves to painful stimuli such as cutting or extremely stressful conditions to naturally increase levels of endogenous opioids to create a stress-induced analgesia effect (Nock, 2009, pp. 100-107).

In the brain, the pain and pleasure mechanisms are located in the same areas. When individuals feel the pain, their body produces endogenous opioids the counteract pain as well as releasing other neurotransmitters such as dopamine and serotonin. At the time of orgasm, the body also releases dopamine, serotonin, and oxytocin along some of the same pathways. It has been found that endogenous opioid antagonists enhance male orgasm satisfaction and intensity, shorten refractory period and increase number of orgasms (Sathe, Komisaruk, Ladas, & Godbole, 2001). It is believed to work by blocking the opioid response to pain, which would physiologically block pleasurable feelings. An endogenous opioid release would, in turn, mean that individuals bodies interpret masturbation as painful, even though it is perceived as pleasurable.

Could the same function allow individuals to perceive self-injury as pleasurable even when they recognize the experience of pain when cutting? "The subjective utility — or 'meaning' — of pain or pleasure for the individual is determined by sensory, homeostatic, cultural and other factors that, when combined, bias the hedonic experience of pain or pleasure" (Leknes & Tracey, 2008, p. 314). The meaning may in fact also account for the relatively low rates of success of pharmacological treatment using endogenous opioid antagonists to extinguish the cutting behavior, because those it does not work on may not be looking for the pleasurable high that injury would naturally cause, but the pain that is created instead. Perception is just as important as the actual sensation.

> As stated at the beginning, closely related to the subjective interpretation of a sensory stimulus is the concept of meaning. Meaning allows for many alternative paths to well-being. Consideration of this factor might help to explain the abundance of paradoxical aversive or life-threatening human behaviours found across society that are considered 'pleasurable'. Even suffering can be rewarding if it has meaning to the sufferer. Continued study of the commonalities and differences between pain and pleasure is therefore necessary if we are to advance our understanding of human suffering and well-being (Leknes & Tracey, 2008, p. 318).

The perception of pain does not compare to the pleasure of the alleviation of the adverse effect or the mental pleasure. The pain and pleasure coexist, and that is why the two drugs do not consistently work. The way that the drugs work on orgasm and pleasure is evidence of the effect or possible effect on cutting. People may be looking for the pain, and by removing endogenous opioids, it could potentially reinforce the behavior because it is considered satisfying and the same effect on brain systems may occur after cutting as takes place in orgasm.

By acknowledging the neurobiological possibilities of the same functions activating and the role that perception plays as well, it is not a far cry to consider the way a cutting episode could be similar to sex or masturbation for individuals. "Recent studies have reported an average age of onset [of self-injury] between 12 and 14 years" (Nock, 2009, p. 40) and "[b]y age 15, almost 100% of boys and 25% of girls have masturbated to the point of orgasm" (Viglianco-VanPelt, and Boyse, 2009). Developmental milestones are supported by some individuals stating that the discovery of masturbation replaced self-injury for a period. At the same time that individuals are experiencing puberty, the

onset of self-injury is also occurring. It is reasonable to assume that if individuals find masturbation as an adequate replacement to alter affect, the inverse could be true in that self-injury becomes more satisfactory in altering affect but still provides the physiological experience of masturbation, a sense of "a flower of relief blooming under the skin."

The pleasure may also help to explain why even when individuals have the desire to stop cutting, they do not or are only able to for short periods. If cutters experience their events of cutting similar to the way that they would experience masturbation or orgasm, why would they want to stop if they know it will feel so good?

> Orgasm is the subjective experience of intense pleasure and release at sexual climax. It is usually felt as a brief sequence of spasms in the genital area, although the sensation often radiates out to involve other parts of the body. Respiration rate, heart rate and blood pressure all reach peak levels during orgasm. Muscle spasms may occur anywhere in the body. There is often a sense of loss of control, and the person may groan or shout involuntarily. Orgasm is usually felt as a relief of sexual tension, followed by calm (LeVay & Valente, 2006, p. 78).

The hedonic principle of most individuals would find it outrageous to ask people to stop masturbating or having sex. It seems an apt metaphor for queer individuals who are often given messages to cease to be queer due to a lack of acceptance. They can go short periods of suppressing something as integral as their sexual or gender identity or cutting practice, regardless of their mixed feelings about it, they always come back it to what they wish they could stop being or doing.

These participants have had to forge their path to an identity they did not want and have struggled to accept and embrace, and the queerness they inhibit seems to filter into the experience of self-injury. Perhaps by reconceiving the perception of self-injury as having more meaning as erotic, pleasurable and painful, embedded in desire and instinct and neurobiological functions, the focus can be less on how bad self-injury is for people who do it, but instead how to find other more pleasurable ways of achieving the same state. In a phrase, harm reduction, even if there is a queerer way of reducing harm, queerer meaning more different and unique to meet the person trying to reduce harm on their queer self. It is also essential that perceptions be queered or changed to look outside the societally assigned normative perceptions, as well as the relative meanings of harm, pleasure, pain and desire.

Conclusion

Writing about self-injury is a difficult topic, and it is particularly taboo if it does not push the individual to seek treatment to end the behavior. To go a step further and write about self-injury as an eroticized event, similar to sex or masturbation, and pay particular attention to desire and pleasure in the narratives the participants have shared very uncomfortable. This project has been continually challenging due to the nature of phenomenological work. By immersing oneself in the data, it became personal. The participants lived experiences became the experiences of the author because in the

immersion the author worked very hard to try to understand the experience as if it was their own. The author would find themselves using terminology that participants used that was typically foreign to how they wrote and spoke, and in dreams or nightmares some of the narratives of participants merged with the authors own experiences. The author would feel distressed, and the participants would linger in their mind long after their specific experience was analyzed. Some narratives triggered anger at the pain and injustice the participants faced, and some triggered disgust so intense periods away from work lasted weeks at a time. There was also a fear of the work this thesis accomplishes would not be enough, but also there was a struggle to define what enough would be and how to judge how this work would measure up to it.

The original plan to create an essential experience of queer individual's self-injury was different, but it was not particularly risky. However, like self-injury, the risk got higher as the project continued, the push to grasp at an intuition that there was something more that could be achieved, that the original plan was not enough, grew. Just like post-intentional phenomenology, it is a way of discovering what it may hold, not a strategy for confirming preconceived notions.

After reading Fields' (2016) article about looking at desire and pleasure, the entire project seemed to change. Fields (2016) focused on the "felt experiences of intimacy" (p. 32) with incarcerated women in a participatory action research study and examined her reactions to several interactions with women she interviewed and "…[she] focus[ed] on

[her] own erotic experiences: met and unmet, palpable, straining, and enlivening desires…" (p. 32). The author asked their self where the desire and eroticism were in this work, both theirs and their participants. The author worked to identify the points where the complex feelings that encompass desire and eroticism wove together from the participant's standpoint as well as the authors and where those feels diverged and why.

The long-lingering thought about the similarities of self-injury as a physiologic response if charted, and how sex or masturbation would have a similar diagram, could no longer be denied. While it is fair to say that physiological arousal could have the same chart beyond just sex or cutting, these two seemingly opposite behaviors became less of opposing behaviors and created more thought-provoking "what-ifs" that pushed the project into a more uncomfortable territory. The discomfort was due to the lack of knowing about similar projects that have been done. There was nothing to guide this work once the decision was made to explore the erotics of self-injury as a phenomenological experience but not as kinky sexuality. The lack of other literature modeling the possibility of this project has made this feel particularly fragile and riddled with doubts about what was right, good, or acceptable.

There has been work about people who participate in S/M (sadism/masochism) culture and also self-injure, but for this project, the desire was not to look at self-injury as a fetish or kinky behavior, just something queerer than the original literature has proposed as a symptom of mental disorder. Therein lies the question as to why this is

valuable work. The literature has been clear that self-injurious behavior is tough to end, whether it be considered an addiction or just an undesirable behavior. Some treatments work, but stating there have to be treatments for self-injury pathologizes the behavior.

This work holds value because it takes a step toward looking at self-injury as something that is not pathological. It has pushed to look at cutting as a behavior and what kind of perspectives that can be taken to see that it is not inherently wrong. It is a push to look at self-injury as something beyond the binary of good/bad, healthy/pathological. It is an attempt to queer perspectives of queer individuals to experience their cutting as something queerer than just drawing blood to shift affective states. Self-injury is a way to change affective states, which has been well-established in the literature. The lingering question as to why it is so hard to stop cutting even when the desire to stop is clearly there, and participants try again and again and fail, leads one to wonder if there is more to self-injury that is beyond the classical psychopathology literature. By considering cutting as an eroticized event, it opens the door to looking at self-injury as having more meaning than was previously established.

What is meaning? Significance? Importance? A communication method? Self-injury was previously established as a symptom of a disorder, lacking meaning beyond a signifier of something "other," something disturbed. By considering cutting as erotic, it gains importance as a mode of being for people that cut. They are communicating with themselves a set of complex desires and feelings they do not have the language for, or

deny themselves any other expression of or are denied by others. Cutting as erotic can change meaning based on the desires the person has when they cut and reflects the fluidity of queer life.

What is so intriguing about this work is not the way people harm or the stressors throughout the day. There are well-established findings that support the fact that gender and sexual minorities have increased life stressors and poor mental health outcomes. Working on the idea that trauma leads to cutting, these participants have experienced many traumas, but their queer identities are often not thought to be traumatic when they are. When participants recognize they are queer, the identification of being "other" and "non-normative" alone could be more traumatic than many realize due to how society treats gender and sexual minorities at large. The knowledge of difference, potential fear of violence, the need to hide a core aspect of their identity continues to feel traumatic even after they have reached a sort of peace with their queerness because it is something they cannot discard from their selves or change. They cannot be any less queer or have stop same-gender attraction in the way other traumatic experiences can be integrated and healed. What is intriguing is that by looking at the way that self-injury is almost an eroticized experience, it is possible to see the difficulty individuals have in stopping self-injury. Looking at cutting as something that is not aversive and hard for most and instead of looking at it as another way people seek to feel connected with their

bodies, it moves cutting from a problem to something that seems more natural and organic.

These individuals acknowledge it is not socially acceptable, that their cutting behaviors are not acceptable and that they should quit. They recognize that their cutting is also paired with other self-destructive behaviors such as eating disorders and suicidality. However, many fall into the traditional argument about why they should stop if it helps them, know. They know if it stops helping them they will stop. There is the danger in the question of how these individuals may escalate if cutting stops helping them, but that is beyond the scope of this thesis project.

No intervention comes from this work, and that makes this feel fragile and incomplete. Establishing ideas about integration, recognizing queer identities as traumatic and queer personhoods seem to set this work up for a therapeutic intervention which goes more toward pathologizing cutting than just knowing what the experience has been for seven people. The goal of this phenomenological work, to go back to the thing itself, has been achieved. One set of experiences has been presented here, and that must be enough. The enough of this work should be found in the space between not enough and far too much, and there has not been enough practice to find if this has been satisfactory or will satiate the desire to understand to know. There is a perverse pleasure in closing this experience with more questions than answers because it has triggered an arousal to learn

more and see what answers could be found when boundaries are pushed. This project has disregarded conventions of psychological or even phenomenological work.

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Appendix 1

Essential Experiences

Participant B

Almost every day is the same. Wake up late, browse the internet and try not to think negative thoughts. That seems impossible though and almost every night ends the same way. He tries to resist the need to cut himself, to punish himself, to fight against the thought that he deserves pain. He tries to fight against the thoughts that he will never be loved, that he is disgusting, that even though his mother believes his sexuality is a sin, he does not care. He will spend long minutes trying not to cut his left forearm with a scalpel as the negative thoughts grow more intrusive, until he cannot resist any longer. He makes a clean cut on his left forearm, only about an inch long and although it is painful he feels relief. His head has become empty and silent. As the blood wells up, he can manage his thoughts. However, the feeling does not last because then he becomes disappointed in himself that he cut again, and all the negative self-thoughts about being a failure come back. They become overwhelming and he cuts again to manage. He tries to limit how many times he cuts a night, harm reduction as his therapist says, as well as using a scalpel to ensure the wounds are cleaner. "I don't care much about myself," he writes. He only cleans the wounds and puts on bandages to prevent infection. "I only care about the wounds so I don't disappoint the people that care about me so I don't get sick." The way

other people think about him is how he draws his self-worth. "When I don't feel accepted I often feel miserable about myself… I make myself bad in my thoughts."

His identity as a bisexual man means a lot to him because his own self-acceptance was tremulous with his religious upbringing. "My sexual orientation… my family thinks it's a sin and when I came out to my mother she said she would support me, but also that if she goes after the Bible she still thinks it's a sin. So it's difficult for me, on one side I'm happy I can identify as what I am and it gives me a good feeling, on the other side I don't feel accepted, at least not fully." He says the he is not and never was religious; he only did as he was taught. But when he came out to his mother she told him he was a sinner and "since then he doesn't feel accepted anymore."

He lives with his family in a very stressful situation with little privacy, and would like to change that but cannot because he relies on disability support due to his severe depression. He has been hospitalized three times in the last two years and was suicidal but was afraid to die so he did not. He feels more stable now, which means for him, not suicidal, even though he is cutting and recognizes he is afraid he will not be able to stop or he will cut too deep, but despite support for him to quit, he does not know if he wants to stop. He knows he should stop, but it works for him to handle his bad thoughts, like guilt that he is a burden to others even though he knows nobody is a burden, and his lack of relationship is one of the biggest factors of his cutting. "I wanna feel love, I wanna feel what it's like to be loved, I just don't wanna be alone anymore. I never had a long

relationship and I never had sex. This is a huge factor for my self-esteem. I feel not lovable, I feel ugly and disgusting." His tortured relationship with how others view him and his sexuality seems to drive his cutting, but he does not think being bisexual made him cut himself, and he is right, it seems how others reacted made him a cutter.

Participant G

She is proud to be gay. Not a lesbian, because lesbian has negative connotations to her. Gay is also a loaded term, she just prefers to say "my wife." She gets frustrated that she is not often read as gay, and still struggles to navigate who it is safe to come out to and who gets vague, non-specific answers. She wants openness around sexuality because it is annoying and tedious when everyone assumes she is straight, a parallel from her college sports days when she was afraid to be difference lest her teammates aggressively go against her. As she has gotten older she has gotten more confident in her identity as a woman and loves to learn about feminism and women's rights. This education has helped her to feel like attacks on the female gender are personal attacks. The education of women's rights has made her feel hopeful and proud. The comfort in her gender did not come as easily as her sexuality as she had a lot of deep-rooted shame about her identity and attraction to females.

Her self-injury started around age 14 or 15 when she lived in an emotionally repressed community where outward displays of emotion were frowned upon. She remembers someone mentioning self-harm, specifically cutting around that time. When

she first started she used objects she had easy access to, paper clips, scissors. The wounds were light scratches or a little puncture wound, things she could pass off as everyday injuries. When she realized how much relief she felt, "it became a regular thing." Over the ten years she has injured on and off, she has: "cut, burned with a curling iron, burned with objects heated up with a lighter, intentionally take things out of the oven without protection, scratched, dug at [her] skin plucked body hair, neglected self-care including picking scabs, not allowing wounds to heal, biting, pinching [her] skin to leave bruises, punched walls, stabbed self with a knife and many other sharp objects, rubbed skin on carpet to get friction burn, held hand under hot/cold water, hit self with objects to cause pain/bruising, exercised to the point of pain/fatigue/injury." These types of harm were experimented with as she looked for what worked best for her.

When her easy access objects no longer satisfied the urge, no longer caused enough damage or pain she would seek out new objects. She sought out damage and pain initially, due to everyday stressors, bad things happening. If she failed a test or was bad at her parents, or felt out of control, she felt as if there was nothing to do to make herself feel better, the urge to injure arose. Feeling desperate and out of control were her biggest triggers in her earlier days. To satisfy her urge for pain and damage she spent a lot of time sourcing her tools. Testing their ability for harm, and sharpness. She speaks about self-injury like it's her addiction—"sourcing equipment for [her] then daily habit."

She learned how to talk about her addiction by researching ways people harm themselves on the internet. She tried so many ways of injury to realize through "self-exploration" she needed to use cutting as her method of self-destruction. "The blood and the scars and the watching the wounds heal, that was what I needed. I needed to be able to see the damage I have caused myself, I needed to feel them under my clothes as I moved." She found cutting gave her the most long-term pleasure. Injury became less trigger by a desperate mood and more of a daily habit, a ritual, an obsession. She would plan where she would cut herself in class, when she was in the shower she could not leave without cutting because of the pattern it had become even if she did not feel bad. "Maybe there was a sense of comfort in the ritual, maybe just knowing that I always had that was enough to sooth me."

After she discovered the pleasure, the soothing comfort of cutting, her "fascination and influential harming" phase began. She became fascinated with an accidental burn and the scar it left. She also became attracted to copying other people's injuries, she mainly writes of other women's accidental injuries she tries to emulate. This led to her first purposeful burning event; it came after she disclosed to a teacher the sexual abuse from her caregiver's son from ages 7 to 11 and the physical and emotional abuse by a caregiver she used the burn as punishment for opening "[her] big fat mouth" and for "being weak and pathetic and not being able to deal with it" at age 18. She did not plan the burn but it became a test of strength and pain tolerance. The pain, relief, damage

and pleasure were instantaneous. The test of strength is a big element of fearing people would see her as weak, and that is the last thing she wants. She repeatedly burned herself in the same place over several days after her trauma disclosure at 18. Then, a year ago she when discussing the trauma in therapy, the same urge, the most powerful itch, came back. She had seen a coworker with a burn on her harm, the old attraction to copying injuries coming back. Her selection of tools came back, the care and consideration of the object she wanted to use. The first object, heated scissors, did not do enough— enough damage, enough pain, enough of a reminder for her weak and pathetic talking about trauma. Her search for the ambiguous "enough" always occurs when she injures. When the scissors were not enough she pressed her arm into the oven rack, twice. That was enough for her, that time, to use her skin and scars like a calendar of events. The pain and the pleasure of the branding gave way to the thrill of hiding the wounds from her wife and the other people in her life. She "enjoys looking at the scar, [she] [is] proud of that scar, [she] did that, all [her]."

Her scars are something she takes immense pride in. Her wife does not understand how she could self-injure, but when they were dating her wife would kiss her scars. "[she] liked the fact that [her] wife cared and maybe saw [her] pain, a little bit but [she] didn't like her touching them, [she] felt vulnerable and exposed. [She] feel[s] that way about anyone touching them, it is a very personal and private thing. They are [her] battle scars, when people touch them it feels like they take the power and the memory away a

little bit." For her, scars are a huge part of self-injury. She is immensely proud of them but worries how they will impact her future career. Most of her obvious self-injury scars have faded over time but her most prominent scars are the emulated injuries of others that look like accidents. She thinks about getting tattoos to cover the scars a lot.

The last time she cut herself, she had had horrible nightmares of being kidnapped the night before so when she woke up her body was in fight or flight mode all day. She had been feeling really down, emotionally, all week and was fighting against really intense urges to hurt herself. She does not remember being productive at all, all day. She tried playing outside with her dog, that usually made her feel better but it was not enough that day. She decided that in her bath she would shave her legs. When she was shaving, she accidentally nicked her knee. The accident made her think of how easy it is to pass off the nick, so she did it again. She dragged her multi-blade shaving razor over her knee again, digging it in the bony flesh. It stung some, but not enough. There was not enough damage on her knee so she moved to shin, pressing down and hooking the razor in to rip off chunks of skin. She moved to her other knee, wondering what would be enough blood. "There it is again, the constant thought of enough, I wonder what would be enough, how much blood, how much removed skin, how deep, how wide, how long, how much would be enough?" Even though it was stinging intensely, she started on the other knee in search of enough. She pushed the razor into her bond and dug down as she pulled the razor away, chunks of skin in the razor and floating in the bathwater. Suddenly not

enough became too much. The stinging became too much and it looked too painful. She had always picked fleshier parts of her body that were easier to hide. The frantic sense of panic set in when she got out of the bath because the blood and water mixed, streaming everywhere. "That's the thing about blood, its beautiful and powerful but its messy and it stains." She was still in the bathroom trying to use toilet paper to soak up her blood but it was not enough, again.

She waddled to her bedroom to put on black pants to cover the wounds and hide the blood and went into the bathroom to clean up the evidence. She joined her wife on the couch after cleaning and it hurt to sit and walk but the pain had reached the point of being enjoyable. She had the pleasure of her dirty, bloody little secret hiding under her clothes. She had to be careful and was very aware of her legs as not to bleed on anything. While her cuts were healing it hurt to lean on them, but it was a pleasurable reminder, a secret she was sharing with herself. "It felt empowering to have cut [herself], it felt relieving, it was a distraction from the dark thoughts [she] was having."

"For a very long time, she felt a sense of control and power hiding the secret of herself harm behavior, in more recent years she has felt less comfort and empowerment from hiding the secret and more a sense of shame that it is still an issue she is struggling with." That shame came after she cut her knees. She felt sick with build and shame having to hide the cutting from her wife and she felt as if she had let her therapist down. She wanted to call her therapist but did not want to "be that needy and pathetic patient

that couldn't help herself." After talking with her therapist she felt even worse and cut her left forearm with a very very sharp kitchen knife.

For her, cutting seems to be a way to show possession of herself, "that she is still the captain of her ship and she can still hurt herself worse than anyone else." But even in an attempt to possess herself and empower herself, she relies on others, emulating their wounds, relying on hiding from them for the thrill and pleasure it provides her, but others also weaken the value self-injury has for her. She was not ashamed, or guilty, until her wife and therapist entered her mind. The empowerment she felt from her feminist education parallels the empowerment of how to hurt herself came from online.

She tries to stop harming, initially it was unintentional, but now she has been in recovery countless times with success to varying degrees. Ultimately she is ambiguous if she wants to stop, another instance of not knowing hen enough is, but she will know when she finally feelings cutting does not give her pleasure anymore or fulfill her emotional needs or help her any longer.

Participant H

Negative feelings trigger her to cut. A panic attack, or her perception of being mistreated from others. She started cutting when she was young; her once trustworthy best friend spread around her high school that she was a lesbian which led to non-stop taunting and torture from the other kids. She initially used a pen cap to scratch her arm in class. She does not know where the instinct came from, only after she felt immediate

relief. Shortly after, she graduated to using manicure scissors several times a day at the time she considers the worst. Cutting her wrist is the best but now she settles for her ankle because it is almost as good and it is easier to hide. Hiding is important, now and then. When she was young, a student reported her to a teacher and when her parents found out they threatened to punish her for it because they thought she was seeking attention. Now she hides her addiction from her girlfriend because she still cannot talk about cutting or when she is triggered.

Her cutting morphed from the only solution for her anxiety and depression to now feeling like an addiction, a time when she cannot stop the overwhelming urges and she breaks and cuts. The incidents can still be triggered by being treated poorly by others or anxiety or not feeling anything positive, but her sexuality is no longer a central aspect of what makes her cut.

She will often feel triggered, like a growing urge by nothing in particular. It continues, sometimes over several days. Her resolve not to cut weakens; she knows that evening she will cut, and she already begins to feel better. She waits until she is alone and has the TV on in the background. She will use her mini-Swiss army knife, her beloved tool she carried everywhere "like a safety blanket." It is a controlled thing, sometimes it has been frantic but now she prides herself on control, it is vital. She cuts her ankle and immediately feels relaxed, calm, and better. She cannot compare it to anything else although she wishes she could because then she might have something to do other than

cutting. Relapse is so hard for her because she thinks it is the greatest thing while she is cutting her ankle, sometimes to the point that there is no space left un-cut. She always feels pain when she cuts, it hurts, but then she gets the rush that makes the pain worth it.

She has tried to get help multiple times in her life, mostly for anger management because she was so angry. She was angry she was not prepared to be a lesbian, everything was about how to get a man and have kids. Now she is accepted her identity as a lesbian and has pride in it. But the access to mental health always came from a medical doctor's referral. The first time she was told if she talked about hurting herself her parents would be told. The second time she went to her GP after being able to stop cutting for several years only to start again. She was concerned but the GP dismissed her and referred her to a CBT therapist who did not know what he was doing.

Participant I

She started cutting and recognized she was queer at the same time, around 14 or 15. She will describe herself as gay or queer in person, but considers herself close to gay on the Kinsey scale at 5.5. When she talks about her sexuality, she feels proud of her identity but also thinks sometimes she has made it up in her head, made herself up to be special which does not often come out to people as queer, she is too fearful. She feels as if she has always trying to balance being "the creepy gay in the shadows" and fight the predatory lesbian stereotype but she struggles with the way people talking about lesbians

that kills her confidence to confront them as well as her occasional attraction to men. This leaves her feeling bottled up, unable to express herself.

Her inability to emotionally regulate comes from how she grew up around her father and the masculinist tradition of the only acceptable emotion is anger. She fondly remembers imitating him, but recognizes the extent to her imitation limits how she learned how to express and regulate her emotions, which is why she struggles with cutting.

For her, cutting is the answer when she feels strong emotions like anger, jealousy and sadness but does not know what to do with them. The first time she ever cut herself was in high school after she heard she did not get a place in the play. She was so upset, feeling like a failure, sad, angry and disgusted with herself. But she was trapped by not knowing what to do with how she felt, so she gouged a deep wound into her wrist with her mechanical pencil. Like her memory of the event, the scar is still one of her worst to date.

In high school she used dull objects so the scars were not very prominent, and she did not care for the wounds because she did not care about them. However, after high school she started using sharp objects that caused more damage and left much more noticeable scars. She then paid attention to the wounds, putting cream on them to heal them and then massaging the scar to lessen the appearance—she looked up how to care for the wounds online. The severity and frequency of her self-injury fell off during her

senior of high school when she started masturbating. "Masturbation replaced cutting for [her], almost entirely." When she started cutting again after high school it has always been after she has had alcohol to drink.

Her complicated feelings about her identity come out when her relationships with others seem to relate to the others being in relationships and receiving affection when she does not. She has an unrequited love relationship with a girl that has lasted several years, although infrequent due to moving around. She has been physically involved with this girl and had sex with her while the girl has been in a relationship with her boyfriend. She feels as if she was used to have the girl cheat on her boyfriend, but the girl does not believe what they had was real sex. This is yet another invalidation of her identity, just one of a lifelong series of invalidations by herself, others in the queer community and even a high school teacher who wished their gay-straight alliance would have real queer people, not just straight and bisexual girls.

She recognized how the girl affected her and even told the girl she did not like the boyfriend and being around them together and how it has been too hard to be around her, even going so far as to disclose cutting incidents to the girl after they hang out. The girl agreed that space would be a good idea. Just a short span of time later, one night the girl called and asked her to come over and hang out, the boyfriend was in a night class until late. She did not feel comfortable going to the girl's house because then she would have to leave once the boyfriend got home or "face the emotional consequences," the

unrequited love and flaring jealousy that she does not know how to deal with as well as trying to set boundaries and not being respected.

The girl came over to her house, where they drank wine and had fun chatting. The girl broke her wine glass, and they turned to more emotional topics. The girl was upset and she had her join her on the bed so she could put her arm around her. They discussed heavy topics and the girl started crying so she held her in a hug. The girl needed a distraction so they took silly selfies. The girl texted her boyfriend something and expected a quick reply and when she did not get one she got more upset and said "screw it, let's do this" and straddled her and started trying to make out with her. While they were both drunk, she was less drunk and pushed the girl off and went to the bathroom where she decided she wanted revenge on this girl so she put bright red lipstick and drove the girl home, they both were crying tears that turned eventually into sobs. She dropped her off and kissed her goodnight, leave the bright red lipstick mark for the boyfriend to see on the girls face.

When she got home, she was so upset at first she could not even explain what she was feeling. On the second attempt, she described overwhelming anger, guilt and mostly hurt. She was getting ready for bed, changing shirts and saw the broken wine glass. She cut herself on her chest where she felt the emotion was centered to let it out. She always cuts large enough wounds to feel as if she can let the hurt out of them. She cut herself with the wine glass stem, cutting an unintentional pattern that she only made because it

felt right. After seeing the glass to when she cut herself, she said she was not thinking anything, and compares it to the survival instinct when drowning, she is not thinking she is trying not to drown.

She was bleeding a lot from the cuts and felt as if she needed to document the cuts, the pain because later she would not believe that the pain she felt was real and that by taking pictures of it she was validating her pain so she could not be disgusted by it later. She feels that those thoughts were not rational, but as close as she could get to rational at the time.

She deleted the pictures of the wounds, the blood-stained wine glass and the selfies she and the girl took together. She was calmed down enough afterword to clean her wounds and put cream over them and put band aids on them. She was able to fall asleep quickly after the whole ordeal.

She always feels pain when she cuts but it feels relational to how upset she is. She feels a lot of shame being 26 and still cutting herself, which is comparable to how she feels about her identity—being unable to flirt and allow herself to be interested in other girls.

When she cuts, it's not just the physical pain she feels. She feels jittery and thinks that feeling is probably the adrenaline. Emotionally she always feels a toxic mix of being hopeless and anxious, hurt and angry, feeling disgusting and like a failure, fear, shame and despair. And while she is always feeling those negative things, there is a sense of

awareness that always whispers about what she knows what she is doing, but has resigned herself to feeling guilty and ashamed. After self-injury episodes, she is able to sleep, her usual insomnia gone, and has always had to cut herself in high school to be able to sleep.

Participant J

They do not identify as female, even though they are read as such and present as such. They wish they could be androgynous and will away the feminine body shape they have. They do not identify as a guy either, although if they have to be gendered they would prefer to be masculinized. They do not like their breasts, but do not mind their vagina because they know how it works and if they know how it works they have control.

They must be controlled all the time. They spent many years learning how not to cry they do not cry because it was a weakness their pointed out and they never stopped considering showing any emotion as weakness. When they face strong emotions in a conflict, they do not know what to do or what emotion they are supposed to use, so they fall in to a stone-faced parade rest. Control does not just extend to emotion or expression of emotion, it also appears when they have sex. They believe they can control their physiological arousal as a form of consent, and during sex they measure their ability to control themselves by their partners uncontrolled actions. In BDSM scenes, they control their reactions to being a submissive, which inhibits their ability to get to sub-space. They control their pleasure just like their cycle of binge-purge behavior. They restrict and

extremely control their eating in the way they could never control their behavior as a child with ADHD. Their father controlled their life, they knew any privacy was forfeit, anything they had could be taken away. They were desperate to have something they could control, that was theirs.

They started cutting at age 12 with pocket knives they had access to as a member of a youth military group. They graduated to using carpet knives shortly after because the knives were always lying around the house. Carpet knives have been their tool of choice for cutting, but they also burn themselves with cigarettes, use "bad sex" or sex they do not consent to, disordered eating and dressing feminine to harm themselves.

Their lack of control through their youth led to their practice of not allowing themselves to be mad at others. They take on the responsibilities of wrongs, even though it is not their fault. They feel as if they deserve anger and punishment for their perceived failings, even though they never learned how to deal with emotions.

They have a limit of what they can take of what triggers them. While they do not feel too bad about mistakes at work or in the gym, they cannot handle a person they respect talking badly about queer people. They learned early that they cannot trust those they would typically seek out for help from a young age and the pattern just continues. When they were a teen they asked their sensei for help with their self-injury and initially the sensei was tolerant until they went to the sensei with a severe wound. Then the sensei betrayed them, calling their parents and telling them they did not want to see them, to get

out of the gym that was their only safe haven. As an adult, their psychiatrist threatened to withhold ADHD medication if they did not speak to a therapist. Both therapist and psychiatrist dismissed their sexuality and used the common refrain that they had not met or slept with the right man yet because they truly were not asexual, that it is not a legitimate sexuality. Which proved to them they could not trust people they thought they could and need to further control their behavior. They lied to the therapist to quit seeing them but have not stopped cutting.

They had a conflict with their partner and they both split to cool down. They were in their room daydreaming, feeling at fault for the conflict. Their partner tore their door open and leaned on the frame just like their father used to do. They startled and quickly became overwhelmed and isolated themselves in the quiet, dark of their closet to calm down. Once calmed, they apologized to their partner. After they made up, they went to bed in their separate rooms, except they decided to punish themselves for being a horrible partner, even though their partner scolded them and told them they were disappointed in their behavior, not allowing them to get angry because they felt their partner was completely right.

They felt they deserved punishment, they were angry at themselves, not allowing themselves to be angry at anyone else. They could not cut on their favored shoulder because they had a tattoo there, and they had to think about the logistics of hiding the wound as well. They decided to cut on their thigh, closer to their groin than knee. The fat

they hated outside their cutting mood was an asset to them now. It allowed them to cut deeper. When they are in the cutting mood, they fantasize about deep cuts. When they are not, they never want wounds that could need medical attention. It has only occurred by accident three times, and they did not get medical care. Typically they only cut slightly deeper than cat scratches but fat allowed them to go deeper. The softness of the area made the pain a sting, but not an intense, toe-curling, shudder-inducing pain. They cut, and then went over several cuts because they were not deep enough, but the desire to go deeper is a fantasy for them. They wished they had never started cutting on their thigh so they did not know the new dangerous possibilities it held. They cut two sets of horizontal lines but paused, not wanting to do more damage, hoping for their cutting mood to pass. To bide their time, they took a picture of their leg and posted it to an eating disorder forum under the self-injury thread. That helped the time pass and the mood to leave as well, now feeling bored with the injury and not wanting to clean up the mess. They care for their wounds only to avoid mess, they much prefer doing the damage.

They think their self-injury has changed their perception of pain and their interest in knife play in BDSM. They do not fear pain, so they take more risks as the submissive. Their willingness for knife play is very different than when they cut themselves because they have a fear from their partner that does not exist when they cut themselves.

They define self-injury as mental or physical harm they inflict on themselves purposefully. They do not consider how the pain they experience at being feminized by

being called ma'am or being called out as a woman as self-harm, even though they hate being feminized they go to length to perform femininity. Their long hair, dresses and skirts, jewelry, it is all a performance to them, a self-inflicted painful performance. It may also factor in to their inability to see themselves in their minds eye because they think in pictures. Perhaps the most telling of how they feel about their self is how they are foggy or greyed out in their mind. They wish they were normal, but define normal as standard they cannot meet. These standards come from other women and girls, and they see their self as too fat, too tall, too dishonest to be normal.

They do not see their self-injury as a problem. They defend it, stating that if the wounds came from BDSM and were not self-inflicted, no one would say anything. To them, self-injury serves a purpose to relieve stress, to have control, and they will continue to use self-injury until it no longer serves a purpose. Self-injury is only a tool of control for them.

Participant K

She feels that if her family knew she was queer, they would immediately stop loving her. That makes her question their love for her now, but she would rather not come out to them and lose the good relationship she has with them as well as their financial support. She passes as a straight woman because she has been dating the same man for many years and plans to marry him. However, after the Orlando Pulse shooting, she does not let her friends erase her identity or her boyfriend fetishize it. They keep her secret for

her, and if she is ever not with her boyfriend, she would like to exclusively date women and wonders if she repressed her desire for women and wishes she had experimented with them in the past. Her relationship to her sexual identity seems divided, because she will not make it a priority for herself or recognize it as an important part of herself while it causes her a lot of negative feelings around her self-worth. She feels that her sexuality played a role in her cutting, because she believes that she deserved the pain and punishment from her self-injury because she felt her sexuality was negatively tied to her self-worth.

She stopped cutting herself when she was fifteen, with only a few relapses since. She cut herself as a method of choice, but also burned herself, scratched herself until she was bloody and pulled her hair. She typically cut on her thighs and avoided disturbing the burn scars on her wrists which she really liked, and never practiced self-care after she cut herself. She cared more for the razor blade she used by wiping the blood off than for her wounds. Just as she can other her sexuality identity, she seems able to other her body, separate it from her feelings and her self.

The last time she cut herself, she was fifteen. She spent the day in school being blamed for her abusive ex-boyfriend's suicide attempt. She had an event after school so instead of going all the way home she was going to hang out with her friend's house. She considered smoking marijuana with them because she wanted to get the ex-boyfriend off her mind, but they did not end up smoking. Instead, they were goofing around in a

backyard, and then next to a busy road. Just before she was going to tell the three of her friends not to continue what they were doing, a police officer pulled up to give them a warning. That triggered a panic attack for her, and an ambulance and her father was called then. All day she had been feeling lonely and shamed for the ex-boyfriend's suicide attempt and those feelings then turned to humiliation and shame as her father started yelling at her on the way home in front of a family friend.

Once home, she was yelled at by both of her parents for an hour. She was feeling so hopeless, and during the lecturing was pulling her hair but was told to stop. After being told she was grounded, in her room she began to panic again, worried about how she would be cut off from all of her social support as well as the information about her ex, and how unfair it was her parents were doing this to her without even acknowledging that she was going through a difficult time. The loneliness, shame, anger and panic became too much for her. She cut herself ten times along her left arm with a razor blade, starting at the wrist and moving along her arm. After, she showered and while in the shower her mother demanded to see her arms and when she resisted, her mother threatened to pull her out of the shower.

Once the wounds were shown, her mother made her get dressed and show her father, and then her mother cleaned and bandaged the wounds. They told her if she ever cut herself again, they would hospitalize her and then made her sleep with her mother for

the fear she would hurt herself again. She had spent the whole evening crying, until in bed her mother told her to stop.

She wanted the help that being hospitalized would provide, but was afraid that it would make her graduate late or ruin her GPA. She knew her parents would not hospitalize her because a year earlier when they found out she cut herself they sent her to a psychologist. When the psychologist wanted to diagnose her with an anxiety disorder, her parents pulled her out of therapy because they thought she was exaggerating all her symptoms and the therapist, by taking her seriously was reinforcing her. She has seen other counselors once she turned 18, but has been afraid of mentioning her self-injury lest they tell someone she is a danger to herself. She sees herself slipping in self injury recovery, because she gets more intense urges now. She would like to see a therapist and actually bring up her self-injury but never her sexual identity, she does not feel it is important even though it makes her feel that she deserves pain.

Her self-injury seems to come from a lack of personal control and a desire for help she never got. She wanted mental health help, but never got it. The cry for attention her parents assumed was the root of the problem was probably right, but the manipulation of attention she received only made her feel more helpless and hopeless, making her injure more.

Participant L

He identifies as pansexual but his friends do not take him seriously and it makes him question if he will find love anywhere but with a straight cis woman. And although he identifies as male, he also feels androgynous and not too attached to any gender roles. He thinks if he were not physically intimidating he would be subject to more than verbal abuse. He loves the love he has to give, but his identity makes him feel strange and worthless. His friends think he identities as pansexual for attention. They have said they "don't care" what his sexual orientation is, but that is a double-edged sword. They do not make a big deal about his orientation and seem accepting, but at the same time they do not care enough not to invalidate his identity which leads to him invalidating himself.

The invalidation of his sexual orientation is also a pattern around his self-injury. In middle school, his friends reported his cutting, and his teacher called home. His parents sat him down and told him not to cut himself again. But after that they never said another word about it. It was, and still is, upsetting that they were not concerned enough for him. His parents did not take his cutting seriously or worry about getting him psychological help. He did not and does not want help, but the dismissal from his parents sticks with him. That is why he associates mental health help with pain and assumes such care it will not help him. Talking about his self-injury with his friends always feels like an imposition and that he should not say anything so being asked to write about it was beautiful to him, a relief he typically only feels from cutting.

His cutting is an anti-suicide gesture. When he is in the habit of cutting himself, he is always suicidal but would never use cutting as a way to commit suicide. He will use anything to cut himself as long as it is sharp as a way to distract himself from his overwhelming mental state of feeling out of place, strange and worthless. The physical sensation of the pain, and the flower of relief that blooms under his skin when he cuts makes the bad thoughts disappear. After he feels the spread of relief, he is hard-pressed to take care of even the deepest cuts he has made.

He rarely feels truly content anywhere. He does not feel he fits into society. The strangeness, otherness, worthlessness, depression and bad thoughts he cannot even differentiate, just that he is being rolled over by bad thoughts, catch him at his desk at night. He grabs a sharp metal tool used to hang trinkets on a wall it is the closest thing at hand. He starts to drag it all over his arm and hand, not caring the pressure he places on it or the possible depth of the cuts. As the stinging pain helps a sense of relief bloom, he stops after three or so cuts. He feels better, and later in the evening calls to vent to his friend, but does not mention self-injury. He manages to keep that a secret, even though the wounds have not turned into scars yet.

He wants to stop. He would love to never cut again. He does not permanently stop thought, he will take long periods off but he always comes back to it, so it is hard. He will not seek help, he believes he can handle it himself, he cannot stand the thought of paying someone to open up to. It will not kill him, so why worry about it?

Appendix 2

Interview Guide

Thank you for your participation in this study. Understanding the experience and meanings of self-harm among LBGTQIAP+ identified individuals is an important area of study so that services can be made available for those who need them.

How old are you?
How would you like to be addressed?
Where are you from (state or country)?
How would you describe your gender identity?
How would you describe your sexual orientation?
How would you say others read your gender presentation and/or sexuality?
What sort of support do you have in your life for these issues around gender, sexuality and cutting?
How do you feel about your gender identity?
How do you feel about your sexual orientation?
How does the way that other people treat your gender identity affect how you feel about yourself?
How does the way that other people treat your sexual orientation affect how you feel about yourself?
What does self-harm mean to you?
What does self-care mean to you? How important is self-care to you after you harm yourself, such as bandaging the injury or cleaning up?
When did you first harm yourself?
What did you do to harm yourself?
Did how you harmed yourself change over time, and if so, how did it change?
What do you feel like your gender identity and/or sexuality and how you are read by other people had to do with yourself injury?
Please think back to the last time you engaged in an act of cutting, or one of the times you remember in the most detail. Please tell me the story of what happened that day, starting when you woke up, to when you went to bed in the most detail you can provide. Please also include the story of how you cut yourself. I want to know what you were thinking, what you were feeling, and what you were doing, how it felt to injury yourself, what you thought before and after.
Did you have a hard time answering any of these questions or remembering any details?
If you ever sought help for self-harm, when did you do so, what kind of help did you seek, and how was the experience for you?
Was there anything you wrote/said that surprised you?

Is there anything you want to add to that I haven't asked about?
Why did you decide to participate in the study?