Forum
Shame, Guilt and Identity: An Essay

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ABSTRACT: This essay explores the differences between a practice called body modification and the behaviour known as self-injury (or self-harm, self-inflicted injury, self-mutilation, etc.), in which individuals purposefully harm themselves to get relief from strong emotion or in an attempt to gain control over themselves or their emotions. Although some consider both self-injury and body modification to be synonymous, I argue that self-injury is more like an addiction to many sufferers, making it like a mental illness or a disease. I use a narrative interview with a friend called ‘Eva’ to illustrate these differences from a self-harmer’s point of view, and hope to show that while body modifiers are often proud of their transformations and view the process as a rite, self-harmers, in contrast, are often secretive and ashamed of their behaviour or addiction.

KEYWORDS: self-harm, addiction, body modification, pain and dissociation, shame, guilt, mental illness, self-injurious behaviour, perceptions of deviance

In the early 1990s, American news stories about the nation’s ‘newest epidemic’ began appearing: young people, especially teenage girls, were using razors, cigarettes, or other items to cut, burn and ravage their skin. To the surprise of the public, these ‘cutters’ were not attempting suicide or trying to gain attention; in fact, they were cutting to get relief. Recently, the UK’s Mental Health Foundation, in cooperation with the Camelot Foundation, began the first UK inquiry into self-harm—and found the UK has the highest incidence of self-harm in Europe (Wrottesley 2006). Some argue that it’s all part of a larger trend called ‘body modification’. Conversely, body modification is seen (by the community who follows it) as a ritual event, a rite of passage, a sexual passion, or simply teenage rebellion. On the other hand, a ‘cutter’ (self-harmer, self-mutilator, self-injurer) uses pain to control emotion or as punishment for a perceived wrong. Speaking with Eva, someone who identifies as a cutter, I hope to clarify why Eva’s case is divergent from the modern primitive trend towards body modification.

Norman Denzin defines a self-story as a ‘story of self in relation to an event’ (1989: 48), indicating the separation of the self and the occurrence of an event. Eva sees her illness as separate from her: ‘Suddenly I see outside myself, and what I’ve been doing, and I can’t understand it. . . . then I face the rest of the day knowing that someone did this to me, but it was me all the time’. Despite several sessions with various mental health professionals over the years, Eva has yet to be given a solid diagnosis.

The phenomenon of self-injury used to be linked, in the minds of mental health professionals, with suicide attempts and a past history of childhood abuse (Favazza 1996: 266; Williams 1997: 99). This is not the case with Eva, however. She describes her childhood...
as average, and began cutting around age eleven, to ‘be cool’ (it had become a kind of fad), but quickly discovered other ‘benefits’ of cutting:

I’d get scared, and I discovered that cutting distracted me, made me not scared. If I got angry, I could cut and the anger would just... bleed out, so to speak. But the best part was when I hurt, and that age, you hurt a lot for the dumbest reasons, but I could control the hurt, make myself not cry by biting my hand really hard or scraping my skin against something sharp. Then I started carrying around razor blades, hidden in pockets. You probably can’t do that now—the school would think you’re a terrorist!

Her attempt at humour regarding the subject seems to hide a nervous energy. I ask her if it is like a coping mechanism for stress and strong emotion, and she agrees. In college, she found the constant battle of her emotions exhausting. ‘I would cut to numb myself, just to get some peace. It was heaven then, like I could lock myself in a quiet room in my head for just a little while’. She mentions that this quiet room of hers was difficult to access, and she could only get there by cutting. She implies that the severing of her skin created a doorway for her bad feelings to escape. She hid the scars, thinking it was a ‘disgusting weakness, a terrible shame’. Small things stressed her, like her drum playing in a local pipe band. To keep her emotions at bay, she would cut several times a day. Once, she mentions, she made over a thousand cuts on her ankle. Counting them ‘distracted me from the horrible things I was doing to myself, but they had to be done’. The next day, at a parade competition, her shoe rubbed against her cut ankle and made her feel better: ‘my price had been paid; I was free from feeling guilt [for playing badly]’. In a way, it was as if the constant pain of the rubbing shoes distracted her mind from feeling the emotional pain of her (supposed) inadequacy at music.

Richard Lazarus, who writes on stress and emotion, says the ‘provocation of guilt [comes about by] having transgressed a moral imperative... either imagined or in reality. Guilt motivates a desire to atone, and even to be punished...’ (1999: 237). Lazarus also writes that guilt and shame are quite close to each other, but ‘shame motivates an effort to hide one’s failing, or to cope by externalising the blame’ (1999: 237). In this case, Eva’s guilt is assuaged by the ‘punishment’ of the razor, but the remedy feels shameful. She says of this: ‘Guilt is one of the hardest feelings to reconcile; it’s just so hard to live with. Punishment [made] me think that I had paid a price, or had made it up to someone in some karmic way somehow’. Living in San Francisco and having many friends in the body modification community (and even participating myself, through my nose piercing), I cannot say I have ever met someone who has modified their body (after abuse of some sort), or euphoria.

During this period, her parents found out, and Eva was made to see one of many therapists. Her mother, under direction from a therapist, started checking Eva every morning and night for new cuts. This only made Eva feel self-conscious and degraded, compounding the shame she felt. The therapist also recommended that every time a new cut was found, Eva should be taken to the accident-and-emergency as a sort of punishment. This developed in Eva a deep sense of distrust in the medical profession, not only because her therapist had treated her thus far with so little compassion and respect, but also because in hospital she was met with disapproving looks, snide comments and downright hostility. ‘That certainly didn’t help things’, she adds. Radley verifies this tendency of hostility toward what are regarded as ‘bad’ patients: “bad” patients are
people who are held responsible for their predicament, in that they could have brought it about knowingly’ (1994: 104). In the case of someone who cuts, it is usually obvious (the cuts tend to be methodical, and previous scars are a give-away). Favazza backs this up, saying that the ‘brutish treatment’ received in hospital emergency rooms only keeps self-harmers away, and perpetuates their feelings of isolation and freakishness (1996: 289). Perhaps this is because self-mutilation, in most Western cultures, is largely misunderstood and therefore uncomfortable for ill-trained professionals. On the other hand, piercings that develop infections are typically met with a slight rebuke from doctors and nurses, and the elements of shame and disgust are absent.

Margot Lyon, in *Health and the Sociology of Emotions*, writes of negative emotion and its implications that ‘what is seen as having to be controlled is emotion, and more importantly, the locus of control is seen to be the self. . . . Emotion—the “wrong” kind of it as variously defined as that is—is labelled as potentially pathological’ (cited in James and Gabe 1996: 65). This statement implies that many people equate negative emotion as being unacceptable, or socially deviant, and this bears with it the connotation that if the self cannot be controlled (to society’s standard), then it must be pathological. Williams also mentions negative emotion being socially controlled, demonstrated in a parent scolding a child for crying in public (1997: 99). In fact, Eva brings up this need for control herself, like those with eating disorders who attempt to control their lives with food: ‘It took a long time to realize that perhaps my issue was really with control. I liked making good things happen for people . . . but I couldn’t control the bad things. I would feel god-awfully guilty; it would . . . immobilize me to recall the things I had thought of [about people].’

As mentioned earlier, Eva has a tendency to separate herself from her actions (this illness is an illness; it is not *her*), and she internalises this method of coping as a kind of entity itself. This is almost akin to Jennifer Radden’s premise of a ‘disunited self’ (1996: 37), in which one dissociates from one’s actions or another facet of one’s personality. She uses the more extreme example of dissociative identity disorder, but other literature notes dissociation around the act of self-harming (Williams 1997: 99; Favazza 1996: 148). It is important to point out that dissociation is often felt negatively by patients, whereas the out-of-body feeling Fakir Musafar (see note 1) describes during a ritual of ‘body play’ is always euphoric and positive (Favazza 1996: 148; Musafar in Favazza 1996: 327). In cultures in which body modification is socially sanctioned, self-harm is often associated with a trance-like state, and it begets awareness of oneself and one’s god(s).4

It is through Eva’s physicality that she has access to her emotions and inner self, and although this vaguely relates to the shamanistic ideas of trance, for Eva it represents an ‘otherness’, as if her body and mind are separate:

I remember waking up, the bathroom covered in blood, cleaning it up, going to bed. I woke up with my arm against my chest; my arm, the unscarred one, holding the other one close to my heart. I thought, before I even woke up really, that my arms and body were rebelling against my head. I recalled a thing I heard about in anatomy class: muscle memory. Perform something a number of times and eventually your muscles remember it, like playing a song on the piano and then playing it with your eyes closed. Your muscles remember. Like the time I dumped a pot of boiling water over my hand. The next time I stood there with a pot of boiling water, my left hand shook as if it were protesting. I felt sorry for it. But dumped the water anyway. It wasn’t me who felt the pain, but my poor muscles. They remembered.
This separation or disunity in Eva might be a reason that she doesn’t identify herself by her illness. In her book, Marilee Strong writes that people who cut ‘develop a fixed identity around cutting’, and ‘they come to believe that they are their symptoms’ (1998: 27). And as Blaxter points out, ‘people have to inhabit their bodies, and their physical identity is part of themselves. . . . They have a need to account for this identity. This body is their inheritance, it is the result of the events of their life, and it is their constraint’ (cited in Radley 1994: 112). With an illness so inextricably linked with one’s physicality, it is easy to see why many self-harmers have difficulty distinguishing themselves from their affliction. However, Eva strongly insists that this illness does not define her; it is merely a coping mechanism. How one views one’s body (and its wounds) might be one of the principle differences between self-mutilation and body modification, as Eva continues to show:

Sometimes I regret them [the scars], sometimes I feel sorry for whoever I was when I did them [but] they are angry enough for me. Most have turned white with time, anyway, have given up the rage, have lost their angry, ugly colour; . . . they have receded into the background, joined the ranks of the other scars. I don’t feel sentimental over them the way some cutters do, and I don’t think they represent anything but my own stupidity.

Psychologist Scott Lines writes: ‘[t]he skin becomes a battlefield as a demonstration of internal chaos. The place where the self meets the world is a canvas or tabula rasa on which is displayed exactly how bad one feels’ (cited in Strong 1998: 29). This illustrates that these physical displays of ravaged skin serve to make tangible the suffering (and healing) that has gone on inside. In body modification, there is perhaps the same intent (to ‘show the world’), but it is seen as if something has been conquered, and pride goes with that. In Eva’s case (and most other cutters’), there’s only shame and guilt.

By committing these acts of violence against her own body, she then feels guilty, which by her own earlier admission spurs on more feelings of violence. It comes across as a vicious cycle that one has to break, and it smacks loudly of addictive behaviour. She explains this: ‘I don’t feel anything when I cut anymore . . . no emotion. Not even a regretful “oh shit”. So . . . it’s a . . . practice in repetition . . . because I don’t know any better, or because I just formed a really bad habit and now it’s an addiction. Once you see blood, you have a hard time going back to the old way of doing things’. According to a study of self-mutilation carried out by Favazza and Conterio in 1988 in the US, seventy-one percent of the self-abusers they interviewed saw their behaviour as an addiction, which insinuates the deviant actions of mental illness.

When asked whether or not she will ever stop cutting, she answers, ‘yeah, I do. I think sometimes I regret them [the scars], sometimes I feel sorry for whoever I was when I did them [but] they are angry enough for me. Most have turned white with time, anyway, have given up the rage, have lost their angry, ugly colour; . . . they have receded into the background, joined the ranks of the other scars. I don’t feel sentimental over them the way some cutters do, and I don’t think they represent anything but my own stupidity.'
mal and it does have to stop. Someone might get hurt! [She looks surprised, then laughs.] Sorry.’ Again, her wit saves her from becoming too serious, and by lightening the mood she forces the conversation to seem safer, more controllable.

The issue of—or more precisely, the wish for—control is one that has come up often, directly or indirectly, in my informal discussions with self-harmers, and Eva’s nervous narrative hints at an effort on her part to construct a sort of control around how her illness and behaviour are viewed by others. She doesn’t want to be told not to cut, but she doesn’t want to ‘get away with it’, either. She feels a more genuine understanding of the behaviour by mental health professionals would be encouraging, and perhaps better solutions could be reached between doctor and patient concerning treatment. Indeed, even the health profession in the UK appears to have recognised this to some degree. In February of 2006, The Sunday Times revealed that hospital nurses are proposing to give determined self-harmers clean blades (much in the same way drug addicts are given clean needles to lower infection and disease); nurses also want to distribute first aid packets with sterile dressings to patients, along with advice on safer places on the body to cut. Surveys indicate that around 170,000 patients a year are admitted for self-inflicted injuries, and many suspect the numbers are higher due to unreported cases (Templeton 2006). The proposal, to be debated at the Royal College of Nursing Congress in April, has already sparked controversy among self-harmers and friends of self-harmers. Some feel it is feeding an addiction and making the behaviour seem acceptable psychologically; others believe it might work like reverse psychology and force self-harmers to find safer ways of venting emotion, or at least consider safer options.

Fakir Musafar, often called the father of the modern primitive movement, agrees with Favazza in his book that self-harm is ‘not purely biological, or psychological, or socially determined act but rather involves a combination of these factors as they operate within the web of culture’ (cited in Favazza, 1996: 325). Although Musafar takes the stance that body modification, scarification and cutting are practiced widely in numerous cultures and believes that looking at the ‘whole web’ might make the picture ‘snap into focus’ (Musafar in Favazza, 1996: 325), cases like Eva’s are markedly different because of the emotions attached. In fact, this is even beginning to be recognised in the public sphere. On 12 March 2006, C4 aired Artshock: The Human Canvas, which depicted various body modifiers practicing their art. Lynda Gilby’s (2006) TV Preview issued a warning to potential watchers regarding the graphic images, and while she clearly felt the participants’ behaviour distasteful, she writes that when compared to the desperate self-harming of prison inmates, The Human Canvas comes across as a glorification of self-harm and ‘a very sick joke indeed’. Although her comments reveal that she isn’t aware of the increase in self-mutilation, she undoubtedly sees a distinction between those who practice it as an art and those who are seeking peace within. It is in this same vein that Eva’s behaviour becomes deviant and denotes an illness or addiction. Perhaps Eva herself can explain: ‘Do I think [cutting is] a good thing? Hell, no! It’s controlled my life … [grins] Getting my lip pierced, on the other hand, was fun. And my tattoo… it was a commemoration for graduating college. I was proud of that’.

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Notes

1. This is a term Fakir Musafar, a renowned body-play artist in San Francisco, coined in 1978 in an attempt to place these self-inflicted acts in a wider cultural perspective. He feels ‘self-mutilation’ implies a negative and prejudicial outlook. This, again, is an example of the difference between body modification, which is chosen by someone for a rite or ritual (and displays it), and self-mutilation, which causes shame to those who do it (and hide it).

2. This is a clear example of Denzin’s description of autobiographical ‘truths, in which fact and fiction melt in the mind of the narrator and consequently become subjective (Denzin, 23–4). There is no proof that she was performed poorly, and many of her friends remember her as playing quite well.

3. Although Lyon is writing in the context of the liberal use of Prozac in Western medicine, it can be argued that Eva is using self-harm in much the same way, making the comment relevant.

4. Favazza, in Bodies Under Siege, documents this again and again in the first half of his book, and cites among others certain African groups, Australian Aborigines and groups in Papua New Guinea.

5. The notion that self-mutilating behaviour can be addictive has been proven through scientific means and body responses. Neurotransmitters called enkephalins (an opium-like substance) suppress pain and regulate emotion, which then give a pleasurable feeling to self-mutilators and create addictive behaviour. Self-mutilators can even experience withdrawal symptoms (Favazza, 262).

6. Armando Favazza is a professor of psychiatry at University of Missouri, Columbia, and a leading expert on self-mutilation. Karen Conterio is a co-founder of SAFE (Self-Abuse Finally Ends). This was the largest study to date (in 1998) carried out on self-injury; it sampled 240 chronic self-mutilators.

References