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“What I Had to Do to Survive”

Self-Injurers’ Bodily Emotion Work

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I can picture myself perfectly sitting at my desk in my bedroom with the glass in my hand. I didn’t even know it was called self-injuring. I just knew it made me feel better. It made me feel happy for some strange reason. The anticipation as I held the glass over my skin was so exciting that it was almost unbearable. Then before I knew it there was a fresh scratch. And I was delighted when I saw the blood appear.

Our bodies may be the material that enables symbolic interaction (Mead 1934) and the experience of emotionality (Cooley 1902). But as Kate, a twenty-one-year-old self-injurer, suggests in the preceding quotation, we can also strategically employ them to suppress and evoke feelings.¹ In this chapter, we examine how self-injurers suppress distress and evoke authenticity and self-efficacy. As one interviewee put it, “This is what I had to do to survive in my eyes.” We also show how self-injurers’ emotional troubles derived largely from the precariousness of their everyday lives and how self-injury often unintentionally nourished the very emotional dilemmas they were trying to escape. In other words, rather than resisting or trying to change the social conditions causing them trouble, they blamed themselves and took it out on their bodies, which temporarily made them feel better.

Adler and Adler (2005, 345–46) define self-injury as the “deliberate, non-suicidal destruction of one’s own body tissue,” which can involve a range of behaviors including “self-cutting, burning, branding, scratching, biting, banging, hair-pulling, and bone-breaking.” Psychologists dominate the study of self-injury, and many argue with each other over what alleged mental illness causes people to self-injure (see, e.g., Andover et al. 2005; Lochner et al. 2005). Adler and Adler, however, move research on self-injury beyond the purview of abnormal psychology by examining how self-injurers rationalize and carry out their actions, contributing to sociological theory on, and social-psychological understandings of, deviance. In this chapter we build on their work by showing how self-injurers can deepen our understanding of emotion work.

Hochschild (1979) defines emotion work as the “deliberate act of trying to change in degree or quality an emotion or feeling” (561). She points out that people

do emotion work both to suppress undesired emotions and to evoke desired emotions, and that emotion work may be expressive (controlling outward expression), cognitive (changing the way one thinks about a situation), or bodily (changing an embodied practice). Hochschild names two examples of bodily emotion work: trying to breathe slower or relaxing muscles when trying not to shake. Similarly, Thoits (1989) suggests that people can manipulate bodily experiences to do emotion work, giving the examples of drug and alcohol use, deep breathing, and exercising. While the study of emotion work has flourished over the past thirty years, most research has neglected bodily emotion work and instead focused on how people do expressive or cognitive emotion work.²

Methods

We learned about self-injury by interviewing fifteen current or former self-injurers about their experiences. Interviewees approached us after hearing about the project from mutual friends, flyers posted around campus, announcements on online message boards, and canvassing in college classrooms. Thirteen of the interviewees were women and two were men, and they ranged in age from eighteen to thirty-three. All but two were white, and their educational attainment ranged from less than a high school diploma to a Ph.D.

Interviews lasted between one and four hours. During that time, the interviewees talked about their feelings and experiences with family, school, and work, as well as with self-injury. We assume that interviewees' descriptions and interpretations of their experiences are the closest we can come to accessing the "lived actualities" of their world (Smith 1987, 176). By coding interview transcripts for similarities and differences and brainstorming about the emerging analyses, we determined that framing self-injury as emotion work best encapsulated their experiences.

Self-Injury as Bodily Emotion Work

Although interviewees traveled different pathways to self-injury, most said they did not remember exactly why they first did it. For instance, when Kate was helping her mother pick up the pieces of a broken glass, she pocketed a shard "for no reason" and later used it to scratch her arm. Echoing others, she said it gave her a "rush" and made her "feel better." Only a few interviewees said that they had planned their first self-injury, which they linked to suicide. In the midst of suicidal thoughts, two said they ultimately decided that they did not want to die and turned to self-injury instead. Monica said of the first time she engaged in self-injury, "I thought of it as a rehearsal" for suicide.

Regardless of why they began, interviewees found that self-injury initially alleviated distress, evoked authenticity, and elevated self-efficacy. Self-injury was thus a form of bodily emotion work that made them feel better about themselves. But as they came to depend on cutting, it often backfired and evoked the negative emotions they were trying to escape.

Alleviating Distress

Adolescence and young adulthood are rife with physiological transformations (e.g., puberty) and social transitions (e.g., changing schools, shifting orientation from family to peers) that young people often experience as distressful. Distress refers to a mix of feelings, such as anxiety, loneliness, fear, shame, and anger (see Mirowsky and Ross 1995). Like the self-injurers Adler and Adler (2005, 352) interviewed, our interviewees cited the “mundane [problems] of ordinary adolescent life” as causing such distress. These problems included teasing and bullying at school, academic pressures, arguments with family and friends, and body image issues.

Others’ policing of their non-ideal bodies, along with their own interpretations, evoked undesired emotions. Lauren recalled, “At primary school I was picked on and called a pig and never really had any friends.” Dawn said, “I used to wear *really* big clothes. I felt like I needed to cover myself. I didn’t like my body.” Kate revealed that since she was “old enough to be body conscious,” she has not liked her “chubby” body. Emily, in contrast, had “hang-ups” about her “skinny” body since high school when she was called names such as “skeleton,” “ugly,” and “freak.”

Most interviewees also attributed their distress to familial disagreements or academic pressures. Amanda, a new college student, explained:

The big thing for me was always my grades, which—partly because I’m always busy—are usually less than perfect, especially in high school. They just weren’t straight A’s. And that was a problem for [my mother]. And, so it was kind of, nothing was ever good enough. And then she’d take it to that means *she* wasn’t good enough. And I’d internalize that: “I can’t even make my mother feel like she’s doing a good job as a mother.”

Amanda thus viewed her distress as rooted in her failure to live up to her own and her parents’ expectations for her to be a good student and daughter. Overall, interviewees’ distress did not appear to stem from psychological dysfunction. Instead it appeared to derive in large part from their everyday lives and the larger culture. Some were teased [Note: ‘distress’ seems implied] because their bodies did not live up to impossible-to-reach gendered cultural ideals. Some were distressed by their inability to live up to high standards for academic achievement.

Like yoga or tai-chi practitioners (see Szabo et al. 1998), self-injurers used the body as a tool to alleviate distress and evoke tranquility. Gwen said, “I guess I just felt like there was just so much—there was just so much inside of me and I felt like I could not express it. . . . But [self-injury] was kind of like letting it out.” After injuring themselves, interviewees were no longer overwhelmed with distress and could relax. Describing their cutting, Kate said, “[It was] the only way to clear my head and let me get some sleep,” and Christine said, “It’s what put me to sleep at night.” Pam said she would “sometimes get kind of sleepy” after cutting herself.

Self-injurers’ evocation of physical pain helped suppress their emotional pain, at least temporarily. Kate described the physical pain of cutting as inducing a trancelike state: “Before [cutting] there are all these thoughts about what a bad person I am. I feel angry, sad, stressed, upset and a thousand other things all at once. Then when I’m cutting . . . I feel almost nothing but the pain. It sends me into a sort of trance

that lasts a few minutes. Then afterwards I feel peaceful." Amanda explained that self-injury could mitigate distress because the experience of physical pain demanded the self's attention: "[Cutting] is a complete distraction from anything else going on in your brain. Because physically your body is going to go to what it feels is most pressing . . . so then all the other problems really just feel insignificant for a while."

Interviewees also described the sight of blood on the skin as coinciding with a sense of release. For Pam, the "beading up" of blood was a "cue that that was enough." Amanda recalled that a "cleansing moment of clarity" would come to her "right after it started bleeding." And, like Pam, a scratch or cut would not "count" unless it bled. Like most interviewees, Pam and Amanda defined such do-it-yourself bloodletting as a kind of climax.

Interviewees said they often focused their attention on the physical bleeding, which further enabled them to temporarily escape their emotional pain. As Emily explained:

The blood always [provided] a certain comfort . . . I would focus on it and watch it. It took my mind away from the world for a while. Seeing the blood would be like reality coming back for a while, and I would often cry [then] remain totally silent, numbed and still. I can't remember ever thinking about what had made me cut after I had done so, it seemed further away somehow. I'd be there, bleeding, and that would be it.

For Emily, focusing on the blood during self-injury alleviated distress and released tension. Some respondents, like Christine, shifted their cognitive focus from their emotions to their bleeding bodies: "Well—I just, I felt calm watching it. Like, watching it coagulate, watching it dry, it was just very calming to watch it. And it always made me think it was very beautiful, in some odd sense." Like some people's experience of other forms of art, their bodywork engulfed self-injurers' attention and made the turmoil of everyday life seem of a different world.

Overall, interviewees revealed that family life, academic pressures, and peer judgment caused emotional difficulties. But they sought personal rather than collective solutions to their troubles. Interviewees grew up in a culture that emphasizes individualistic and therapeutic understandings and solutions to social problems (Bellah et al. 1985). In addition to creating conditions for distress, such ideology shaped how they experienced self-injury. Many of the interviewees came to define their self-injury as cathartic, which suggests they used a cultural discourse of emotions to make sense of their experiences.

Evoking Authenticity

Our culture increasingly valorizes feeling "real" and "genuine." As Vannini (2006, 237) points out, "When individuals feel congruent with their values, goals, emotions, and meanings, they experience a positive emotion (authenticity)." People often label such feelings as evidence that they are being their "true selves." Adolescents and young adults often question whether their attitudes, personalities, and feelings are authentic and search for their so-called true selves.

Our interviewees described feeling “fake,” “numb,” “removed,” or “unreal.” Others felt their lives were “surreal” or just not “real enough,” or they said that “consciousness is just a dream.” They said that such feelings were especially sharp when they began self-injuring. At the time of her first self-injury at age thirteen, Pam remembered feeling alone and unreal at home as well as at school.

I felt, like, not really real. I just felt so fake. Nobody really knew me. Even my own parents didn't know me. . . . It was around the time of my birthday and my parents gave me a bunch of gifts that, like, anybody who knew me would not have given me. . . . So I felt kind of like ghostlike and kind of unreal. And I was just really upset and I just wanted to do something that would change it.

Echoing others, Pam further explained that self-injury made her feel “much more in the world” and not “in the middle of a dead zone anymore.” Cutting herself thus helped her feel like an authentically embodied subject rather than others' wrongly defined object.

While most respondents' feelings of inauthenticity emerged when others failed to affirm their emotions or identities, a traumatic event sometimes played a role. For Gwen that event was finding her boyfriend's body hanging lifeless from a noose. She said:

I learned not to show emotion, . . . I kind of trained my mind—like, if anything started creeping up in my mind, just don't feel it, you know? So it kind of affected the cutting in the sense that when I felt like I *didn't* feel, or like nothing's really real, and I just kind of feel like I'm out of myself just, like, watching everything happen, then I want to bring myself to some place physical.

In response to her boyfriend's suicide, Gwen began to deal with her shock and grief by training herself to keep her emotions at bay. But distancing herself from the emotional experience led to a feeling of inauthenticity similar to, though far more intense than, what flight attendants often experience (Hochschild 1983). By creating self-inflicted physical wounds, Gwen, like other interviewees, felt as though she was healing other-inflicted emotional wounds.

Seeing and feeling themselves bleed, bruise, or scar made interviewees' pain more tangible and “real.” Amanda said, “There was something about the blood. Like, it was, I was always just like, ‘Hey, wow, that's really beautiful.’ And I could see it. And it was like I could see into my self sort of. I could see, like, seeing it physically made me feel more real emotionally.” Focusing on the blood and feelings of physical pain thus helped self-injurers evoke feelings of authenticity and alleviate distress.

Self-injurers often interpreted the scars left behind as bodily mementos of their emotional troubles. They saw such scars, which they usually hid from others, as a reminder of their true selves and the authenticity of their (perceived) damaged souls. Andrew compared his scarring to the story about “a guy who puts a notch on the bedpost for every woman he's slept with. The marks on myself [are] a way to visualize my frustration.” Isabel preferred a different metaphor, referring to her scars as “maps to the places I have been.” Monica's scars geographically represented a past abortion: “I now cut my stomach; right above where my pubic hair begins, [which] sort of fits

the whole imagery of the abortion. I often feel like stabbing myself in my womb, as if to recall what happened. I like to see my scars there. [They are] a real sign that something terrible happened right there." As Monica explained later in the interview, the "scars show that my pain is *that* real and *that* bad." For Monica and others, the physical markings and scars of self-injury proved the authenticity of their emotional pain. Touching and examining the scars were like opening the lock to one's diary to review one's biography and authenticate the self.

While the larger culture markets feeling authentic to young people, the institutions in which they must spend their time—such as school and family—often constrain freedom of expression. In addition, interviewees often did not feel comfortable expressing the emotions they were feeling to others and others often did not validate who they believed themselves to be. As a result, they felt particularly inauthentic. As a form of bodily emotion work, however, self-injury helped interviewees feel more genuine and real.

Elevating Self-Efficacy

Gecas (1989) defines self-efficacy as feeling effective, competent, and in control of one's situation. Adolescents and young adults are usually embedded in institutions that constrain freedom and autonomy, and they generally lack resources that can be cashed in for efficacious feelings (Lewis, Ross, and Mirowsky 1999). Our interviewees revealed that peer relations, educational experiences, and family dynamics all contributed to their feeling powerless.

Becky talked at length about the lack of control she felt as a child and adolescent. When her family moved, she said, she was "at the bottom of the social ladder" at her new school and was constantly teased by her peers, who played tricks on her and called her names like "weirdo." Becky said she felt "hopeless, like nothing would ever get better." Echoing Becky and other interviewees, Christine also said she felt her life was especially "out of control," adding "[when] my stepmom and I got into an argument, or I found out that she was doing something behind my back. Or, at school, if someone said something about me and I found out about it later. Or if I didn't do well on a test or I didn't get something in on time." While interviewees clearly recognized that family disagreements, peer group dynamics, and educational evaluations and requirements had something to do with their lack of control over their lives, they drew on a therapeutic discourse to blame themselves. After Becky talked about being stigmatized at school, for example, she said, "I was angry at myself because I couldn't change my position." Others labeled feeling disempowered as evidence they were a "control freak," "immature," or "a high-anxiety person." Framing their lack of self-efficacy in individualist terms led them to search for personal solutions.

While they felt they had little objective control over their public lives, backstage they could temporarily reclaim authority over their corporeal selves in ways that felt empowering. For example, Becky, who felt "angry" and "hopeless" about her family and school life, said, "I couldn't punch my mom or the people teasing me, so I just, I did it to myself. . . . [Self-injury] really was a feeling of relief. Like, I could actually do something. Like I had power over something. Like, I could control something—which I really couldn't do when I was a teenager." Becky saw that she lacked control

over her life, but self-injury allowed her to “do something” about it and elevated feelings of self-efficacy.

Interviewees most commonly revealed that two particular aspects of self-injury fostered a sense of control: carefully wielding their tools to control the severity of the injuries and the intensity of the pain. As Andrew put it, “I had all the control over it when I cut myself. It was my choice completely. How deep to cut, how long . . . It was something I had so much control over. I could control the pain. There was nothing else that I felt like I could control.” Rachel similarly discussed controlling the pain and the severity of the injury—whether through the depth of the cut, the pressure of the blade, or the duration of the injury: “It makes me feel like I’m in control of the pain. Because usually when I’m doing it, I feel pain in some way—like emotional pain, I’m upset about something and it’s painful. But when I’m doing it, I can control how much it hurts and how long it hurts.” Rachel therefore viewed the physical pain of self-injury as easier to control than her emotional pain. Controlling the physical pain during self-injury made respondents feel more in control of their emotional pain and, by extension, their lives in general.

Self-injury also boosted self-efficacy in part because it involved negotiating the boundary between a nonfatal and a fatal injury. Interviewees often said they carefully chose how to cut to avoid serious injury. For example, in describing one episode of self-injury, Amanda recalled, “I actually cut my wrist that time. But I did it horizontally and I knew there was no way that thing was going to cut deep enough.” In addition to their strategic choice of method, some interviewees discussed choosing locations to minimize severity. Even when they were feeling particularly out of control, interviewees usually directed their blades to geographically safe zones. Heather explained:

I was about fifteen. I was fighting with my family and I couldn’t stop crying, I wanted to break stuff and I felt guilty about what I had done—stolen money from them—so I got a knife and cut my arm. But I cut the front of my arm, that’s where I’ve always done it. Never the back, I was afraid of hitting an important vein or something, so I never did it to kill myself, only because I was too overwhelmed.

Safely navigating the body through a dangerous mission evoked feelings of empowerment.

As young people, the interviewees were constrained by institutional regulations and family authority structures and also were targeted by peers and other adults. At an age when they were supposed to be on the road to independence, they had little control over their lives and they blamed themselves for it. And while self-injury may appear to be an extreme form of emotion work, pragmatically speaking, it worked—at least temporarily.

Emotional Blowback

Strategies of emotion management, even if they appear to be “successful,” can often have unintended consequences (Hochschild 1983). The primary unintended consequences of interviewees’ bodily emotion work included decreasing emotional returns

as well as increasing feelings of distress, inauthenticity, powerlessness, and shame. In other words, self-injury created a kind of "emotional blowback."

While self-injury could release distress, evoke feelings of authenticity, and foster self-efficacy, interviewees found that it was only temporarily effective. After her first cut, for example, Emily said, "I felt relief but it was very temporary." Dawn said that although self-injury allowed her to "forget about what my problem was [for] a while, something else would build up and upset me. So it . . . obviously wasn't a permanent solution." Similarly, Becky said that self-injury helped "get rid of my anger for while, until something else pissed me off."

Interviewees kept returning to self-injury, however, because they believed it was more effective than other methods. As Pam put it, "Anything I did just for the sole reason to get that effect, that relief, would fail. And because nothing is as good as cutting myself, I'd end up right back in the same situation." Echoing others, Amanda said, "I don't know if there's anything else that gives the same rush, the same control, the same feeling of power."

As interviewees continued using self-injury to cope with their emotions, however, they had decreasing emotional returns. To compensate, they increased the frequency and intensity of the bodily emotion work. After Pam first began cutting herself, she "found that the next time, a similar level of injury—like one little cut that bleeds—wasn't sufficient to get the same sort of result." Similarly, Dawn said, "When I first started doing it, I was probably doing it maybe once a week. And then it slowly got more and more until I was doing it every day. I got to the point where I think that I needed to do it to get through the day." Because cathartic experiences were more difficult to produce, many increased the frequency and severity of their self-injuries, even if only to survive another day.

As interviewees increasingly turned to and intensified their preferred method of bodily emotion work, they also increased the chances that others would find out about their self-injuries. People questioned and confronted them about their self-injury (especially if they noticed scars or bandages), evoking distress and, when they lied about it, inauthenticity. Echoing other self-injurers, Gwen indicated that when people inquired about her injuries, she knew they could "tell that [she was] just trying to make something up." Christine said her step mom "came running upstairs and basically attacked me, [yelling] 'Pull up your sleeves!'"

As interviewees increased their dependence on and the severity of self-injury to evoke desired feelings, they also increased the chances that something would go wrong. After Andrew "bought new razor blades," he said, "I didn't understand how sharp they were [and] I was frustrated about school and I broke down to the muscle." Like Andrew, Emily recalled trouble controlling the bleeding and sought parental help.

I cut my leg maybe about four or five times, and it would *not* stop bleeding. It was just bleeding and bleeding. And I didn't know what to do. I actually told my mom—and that was after she had already known about it. I didn't even want to talk to her about it, because I was trying to stop it and I couldn't . . . I was doing it because I wanted to be in control, and . . . I was really out of control of the situation [and] it really scared me.

After Gwen's self-described "worst cut," she said, "I don't really remember much directly after I did this, because I was in shock and I was losing a lot of blood." She was discovered by her boyfriend, who took her to the hospital. She received twenty staples to close up the wound. "I got back to my apartment and I was like, holy shit! Blood everywhere!" she recalled.

Most interviewees recalled crossing the threshold into danger at least once. When they did, they lost control not only of their bleeding but also of a sense of control over their lives, unraveling feelings of self-efficacy while evoking distress. And when others found out about their bodily emotion work, they also felt ashamed.

As their self-injury became more frequent and severe, and as others became more suspicious of it, problems in interviewees' lives only increased. When asked if she saw her self-injuring as a problem, Pam, who required medical treatment for some of her self-inflicted wounds, said, "I see it as a problem because of the consequences that I suffered from doing it. . . . It's a problem that makes you lose your job, makes you not be able to pay your bills, alienates you from your family because they're afraid that you're going to die."

Discussion

We have sought to better understand the experiences of those who injure themselves and explored how people use the body to shape their feelings. Although Hochschild's (1979) original theorizing on emotion included the notion of bodily emotion work, there has been little subsequent research or conceptual clarification. Whereas Hochschild (1979) discusses bodily emotion work as changing preexisting physical symptoms of undesired feelings to manage emotions (e.g., through deep breathing), we show how self-injurers create physical symptoms to manage emotions. While self-injury may seem extreme, bodily emotion work is quite common. Yoga and other forms of exercise, sexual activity with or without partners, as well as simple laughter can similarly change our feelings.

As young people, interviewees had little power over their lives. They were often the target of harassment, they were socially isolated, and they lacked economic and social resources that might have offered some emotional protection. As a result, they often felt overwhelmed with feelings of distress, inauthenticity, and powerlessness. To make sense of these feelings, they used an individualistic discourse and defined their feelings, rather than their social causes, as the problem and therefore sought personal solutions. They discovered that one strategy of bodily emotion work—self-injury—was particularly effective, enabling them to alleviate distress, evoke authenticity, and elevate self-efficacy. While this bodily emotion work induced immediate relief, its temporary nature led interviewees to increasingly rely on self-injury to manage emotions. As a result, however, they re-created the same emotional experiences and interpersonal tensions from which they were trying to escape.

How might one stop self-injury? According to S.A.F.E. (Self-Abuse Finally Ends) Alternatives, a leading self-injury treatment center, effective methods of treating self-injury include interpersonal therapy, voluntary institutionalization, a contractual agreement to stop self-injuring, and the development of alternative emotion work techniques (such as exercising or putting one's hand in a bowl of ice).³ While we agree

that it is important for self-injurers (and everyone) to find healthful ways to deal with their emotions, we fear that isolating, institutionalizing, and stigmatizing self-injurers as mentally ill likely increases their feelings of disempowerment, distress, and inauthenticity—feelings that could further drive self-injury underground.

Our interviewees who stopped injuring themselves believed that understanding and dealing with the social causes of their emotions was important. As Becky explained, “You’re hurting yourself, for no really good reason. It makes you feel better, but unless you get rid of stuff that’s making you feel crappy in the first place, it’s not going to go away. Deal with that, and you won’t want to mess yourself up anymore.” By changing her social life and altering her reflexive sense of self, Pam, said she stopped self-injuring in her late twenties.

I think that there was a time, rather suddenly, where I figured a lot of things out. I figured a lot of why I was feeling that way to start with and how much it mattered to put a lot of things in perspective, from an adult perspective that didn’t [create] a helpless, like, “I can’t change this” feeling. And then I also met a lot of nice people in my life. I got a job and I kept it. And I met cool people. And I think that there are ways to feel a lot more real by just living your life [and] by being connected to other people.

Becky and Pam, echoing others, make several important points about quitting. It is important to come to an understanding of their emotional difficulties (“I figured out why I was feeling that way”), to address the source of those feelings (“Unless you get rid of the stuff that’s making you feel crappy in the first place, it’s not going away”), and to engage the social world and other people in ways that promote desired feelings (“[You can] feel more real by just living your life [and] connecting”). Quitting self-injuring, it seems, thus requires exploring the connections between emotions and social life, as well as developing a network of supportive others.

NOTES

1. All names are pseudonyms to protect interviewees’ anonymity.
2. For example, while the review of emotions research in sociology in Turner and Stets 2006 mentions that emotion work may involve physical work, the authors do not cite any research that has investigated it.
3. “Safe Intensive,” S.A.F.E. Alternatives: Self Abuse Finally Ends, www.selfinjury.com/treatments/intensive/, accessed January 15, 2011.

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LIVING RESISTANCE

Intersex?

Not My Problem

Esther Morris Leidolf

My life changed completely when I was thirteen and was sent home from camp with abdominal pain. A pelvic exam revealed an imperforate hymen prohibiting the flow of menstrual fluid. I had surgery—my first of many—to open my hymen so I could menstruate. During the surgery, they found vaginal agenesis with a slight vaginal “dimple,” and no detectable uterus. I had secondary sex characteristics; body hair and breasts, so they guessed I had ovaries . . . somewhere.

I was diagnosed with “congenital absence of vagina” and labeled with “sexual dysfunction.” The doctors talked to my parents about vaginal reconstruction so I could have a “normal” sex life. I was suddenly and shamefully different. I went from selling Girl Scout cookies to correcting my *sexual dysfunction* in one afternoon. My abdominal pain was overlooked and the focus became creating my vagina ASAP. Yet all I cared about was the loss of fertility and my dream of having children.

I spent the next few years going to (male) specialists who ordered tests to confirm my gender; and curious doctors and their interns who probed me with multiple instruments in multiple holes at multiple times. My chromosomes were counted and discussed in front of me as if I were not there: “Got to run that test again just to make sure.” They spoke about me but never to me. They examined my breasts, labia, clitoris, and vaginal dimple with blind eyes.

My doctors subscribed to a narrow version of “normal” and I wasn’t it. Never once was I asked what I wanted, what I felt. I was too young to know I had rights—to ask questions or slow the process down. I had major doubts about what was happening, but I was not yet capable of asking the fundamental question: Whose struggle is this? Mine or my doctors? Frightened in a cloth hospital gown, I did what I was told, which ended my relationship with my body. Like an android on an assembly line, I felt my body was less and less my own. There was so much focus on the woman I should be that I lost all knowledge of the girl that I was.

Once I was officially determined female, my reconstruction was arranged. In 1972 I had my second and third surgeries. I was fifteen and a half. That summer I took a “trip” for three weeks to avoid explaining why I had to go to the hospital. I spent my recovery in the maternity ward. For seventeen days it just was me and my mom, and a lovely nurse named Donna, who protected me from night-shift professionals trying to satisfy their curiosity as I slept.

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Esther Leidolf, the thirteen-year-old
I was not allowed to be. (Photograph
courtesy of author's family collection.)

Two weeks later I had the mold and stitches removed—my third surgery. My introduction to vaginal penetration was postoperative therapy to keep my vagina functional (read: big enough for a penis). I was told to insert a vaginal dilator every night to stretch the scar tissue, but nobody told me how.

The problem was solved, for everyone but me.

Their “surgical success” left me with unanswered questions: Why was my gender challenged in the first place and then confirmed as though it were something I didn’t already know? Why was my body taken away and rearranged like a sexual action figure by men with knives? The pressing need to feminize my body actually neutered my soul; all the fuss just reinforced my despair. Inside this anomaly, I felt terribly wrong because I didn’t really care that I was born without a vagina.

My anger resurfaced when I started having sex. After all that trouble I discovered that a penis would respond to anything. I felt abused in the most intangible way . . . like a victim of arrogance and assumption . . . an instant survivor. My doctors said I would never meet another woman like me, so I alienated myself from peers; and No! I don’t have a tampon! Like the hunchback in the bell tower, I found a place to hide when normality failed me. Denying my depression, I began to understand that normal was merely a concept for people who couldn’t cope with physical diversity. Even my “corrective” vaginal surgeries will never change the fact that I was born with vaginal agenesis.

When I was a teenager, the meaning of my vagina was so ingrained I didn't think to question the assumption that I should get one. I was told that my skin-graft vagina would make me a normal woman. In 2000 my sister sent me an article and I learned about Mayer-Rokitansky-Kuster-Hauser syndrome (MRKH) for the very first time. I got my medical records from each of my doctors and there it was: Mayer-Rokitansky-Kuster-Hauser syndrome. In over thirty years of medical visits, none of my doctors mentioned the actual diagnosis, or the other symptoms of my syndrome. Apparently, vaginal dysfunction was all my condition meant to them, and all they thought I needed to know.

Guided by a possible diagnosis, I researched MRKH and discovered many associated symptoms. The connection to my disabilities left me numb. If only I had known . . . Reading about MRKH made it painfully clear that my experience was not simply about one "abnormal" body. Nonconsensual cosmetic surgeries are so much broader than unusual medical conditions and people we think we will never know. This is about the power society has to force us to be other than we were born to be. Women are bombarded with artificially enhanced caricatures of the female body and encouraged to aspire to them. According to the American Society of Aesthetic Plastic Surgery, breast implants for teenage women eighteen and younger has risen nearly 500 percent from 1997 to 2007. Why?

I want people to understand that the concept of *normal* that we aim for is imaginary. People don't fail to meet the definition of "normal" gender, but the definitions fail to meet the people. Emotional and sexual counseling would have enabled me to decide whether and when I wanted surgery. But being born without a vagina was not my problem. Having to get one, without my consent, that was the real problem.

Visit www.MRKH.org or www.IntersexCollective.org.

LIVING RESISTANCE

Doula-Assisted Childbirth

Helping Her Birth Her Way

Angela Horn

Birth in the United States is a medical event. But it hasn't always been that way.

At the turn of the twentieth century, only a small percentage of women gave birth in hospitals. Today, nearly all women birth in the hospital and, while there, they are unlikely to experience a natural birth (Rooks 1997). For instance, over 75 percent of women in the United States give birth with epidural medication (Declercq et al. 2006), one in four labors is induced (Zhang, Joseph, and Kramer 2010), and one in three women has her baby by cesarean surgery (Menacker and Hamilton 2010)—one of the most commonly performed surgeries on women. This means that all but a very few women begin motherhood with stitches, postbirth pain, and in many cases disorientation and anxiety stemming from their overmedicated births. The standard medicalized birth does not bode well for babies either. Despite advanced technologies and the exorbitant funds pumped into maternal healthcare, the United States ranks a dismal forty-fifth in infant mortality (CIA 2010). This means that for every one thousand babies born, six will die in the first year (MacDorman and Matthews 2008).

I am a doula, a woman who provides expectant families with educational and informational support and aids in the relief of labor discomfort, typically through massage and labor-facilitating positions. The most challenging clients I work with are those who birth simply and naturally, that is, in contrast to accepted medical norms. After all, allowing labor to start naturally and eschewing pain medication are now considered “alternative” practices. And birthing at home or in freestanding birth centers is uncommon.

In my work, women tell me about their experiences with (what is now considered) conventional obstetrics. Often providers are supportive of a woman's choices to birth her way, but near her due date, things begin to shift. Doctors often withdraw support for the mother's wish to wait for labor to begin spontaneously once the due date passes. Even though the best evidence shows that the normal length of pregnancy in a first-time mother is forty-one weeks plus one day (Mittendorf et al. 1990), many providers induce labor at forty weeks if the woman has not begun labor. What's the problem with that? Well, induction is not risk-free: induced labors often require the use of medication to stimulate contractions or soften the cervix, and the resulting contractions are often longer and more painful and more often end in cesarean surgery—a major operation that itself increases the risk to mother and baby.

Provider disapproval surfaces at other times, too. When it is suspected that a woman is carrying a “large baby,” induction or elective cesarean or both often fol-

lows. Ultrasound, however, is not an accurate way to predict fetal size; sonographers and physicians I have worked with indicate that estimations can be off by up to two pounds! Yet, in the final weeks of pregnancy, many providers suggest an ultrasound to check the baby's position and size.

In my practice, I witness countless situations in which women, desiring to birth as naturally as possible, encounter resistance from their care provider and sometimes even family and friends. Women are repeatedly reminded of potential health risks, reinforcing fears (often unfounded) about complications and undermining confidence. In some ways, anxieties are not unexpected. Birthing in a hospital, flat on the back (supine), with fetal monitoring and epidural anesthesia to numb the body from just under the breasts down is practically the only birth we hear about in America. But there are other birth stories and there can be more.

As a certified doula, my role is to help women who want a different birthing experience to actually have one. But it is also my responsibility to preserve a woman's faith and trust in her care provider. This means I must walk a very fine line. When a woman is being pressured into an intervention she may not need, I have to squelch my desire to scream, "You are being lied to! You are being duped!" Instead, I provide her with evidence-based information, help her formulate questions, and if she wants, role-play ways she can advocate for herself.

I recently worked with two clients who were being pressured into scheduled cesarean births because their providers suspected large babies. In both cases I educated the women and their partners about current practice guidelines that advise against induction of labor or cesarean for a suspected large baby, reliable rates of complications from a large baby, and how to prevent those complications—many of which are, ironically, the consequence of common obstetrical practices. For instance, birthing in the supine position contributes to malpositioning of the baby and narrowing of the mother's pelvis. In contrast, birthing in a squatting position can increase the pelvic opening by up to 28 percent (Blackburn 2007), allowing optimal dimensions for the passage of large babies. In other words, when a big baby is suspected, women should be encouraged to get up and squat, not lie down on an operating table.

One of these couples felt that they could not live with themselves if they attempted a vaginal birth and their baby was injured, even though the statistical incidence of shoulder dystocia is less than 2 percent (Gherman and Gonik 2008). The other couple's strong faith allowed them to take the small risk. With the first couple, I reflected back to the mother her views of the risks, letting her know that I understood her dilemma and that I supported her decision. With the second, we focused a lot on the couple's strong faith. I reminded her of her belief that God created her body in his image, perfectly designed to birth the baby. We also talked about her providers in this perfect design and that they come not from a place of trust but rather, a place of fear—fear of complications that can lead to injury to mother or baby, situations in which they are often blamed and sued. In the end, one woman chose a cesarean; the other chose to let labor begin on its own and had a vaginal birth. The eventual outcome was two happy couples and the births of two large, healthy babies. And while their births differed dramatically, both mothers claimed ownership over the way they brought their children into the world.

The twenty-first-century birthing scene is not friendly to providers, mothers, or babies. In this current medical climate with the threat of litigation hanging over care

providers' heads, physicians and midwives tend to "over treat." They are sued over the cesareans that they do not perform, not the ones they do. Sadly, the threat of a lawsuit over an injured baby trumps evidence-based birth practices and takes labor out of the hands of expectant women.

When parents want something different for their families, they are faced with fear mongering. Some women are accused of intent to harm or kill their baby, simply because they question convention and trust that a low-tech birth can be a safe birth, even a safer birth.

My work enters here, where women want and deserve an empowering birthing experience that affirms women's potential to birth her way with the support of those she trusts, beginning her life as a mother feeling confident and supported. But I am a big believer that we cannot actually empower another; rather, we strive to foster the self-reflection and self-advocacy necessary for individuals to empower themselves. My mission, then, is to supply the education, information, and nonjudgmental support that helps expectant families discover their voices and find their power.

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