

Living with a Thousand Cuts: Self-Cutting, Agency, and Mental Illness among Adolescents

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Abstract The phenomenon of self-cutting has attracted increasing attention in scholarly and popular venues. Most of the literature is written from clinical, historical, or psychometric standpoints, and what has been missing is an ethnographic understanding of self-cutting as a lived experience. The present discussion begins to fill this gap drawing on data from our project on adolescent psychiatric inpatients in the American Southwest, during which we followed these youths and their families for between one and two years as they moved from the hospital back to their homes or to other treatment facilities. Of the 47 young people (22 females and 25 males) who participated in this project, 27 or 57% had cut themselves at some point. Focusing on illustrations from case studies that highlight their cutting experience, we examine self-cutting as the cultural and experiential locus of a crisis of agency in the relation between body and world and thus as the enactment of a fundamental human process in the context of individual experience. [adolescents, self-cutting, agency, psychiatric care]

Self-cutting can be understood clinically as a symptomatic behavior, on the one hand, and as a bodily practice embedded in a cultural imaginary and identity on the other. It is present in a variety of ways including the 1993 memoir of Susanna Kaysen “Girl, Interrupted” (with its 1999 film adaptation), the 1995 acknowledgment by Princess Diana that she identified herself as a “cutter,” and the 2011 video “F**kin’ Perfect” by the pop music performer Pink. The Internet has become a massively popular resource for cutters to share information (Hodgson 2004; Ryan et al. 2008), and one study identified more than 400 message boards about cutting generated via five search engines (Whitlock, Powers, and Eckenrode 2006). Youths may identify with “Emo” or “Goth” culture which lionize depression and cultivate self-cutting as a cultural practice (Young et al. 2014; Zdanow and Wright 2012). Popular concern about perceived dangers of self-cutting has at times been heightened to the point that one cultural historian suggested that “Cutting has become a new moral panic about the dangers confronting today’s youth” (Gilman 2012, 1008).

Anthropology has not been disposed toward addressing cutting as a problematic cultural or clinical phenomenon given the disciplinary propensity to understand body mutilation and modification in terms of rituals and cultural practices. This is perhaps because ritual meaning is not so dependent on distinguishing whether harm is inflicted by others or by oneself or on differentiating cultural practice from psychopathology. These distinctions are clear in one

of the rare instances in which an anthropologist has addressed the issue of self-injury, here in the context of commenting on an article relating it to borderline personality disorder:

[T]he concept of self-injury . . . is problematic in the discipline of anthropology given the significance historically accorded to cultural relativism. Correspondingly, body “modification” is not “self-injury” as long as it is socially normative, for example, a facet of an initiation ordeal or body ornamentation (e.g., circumcision, scarification, piercing). Among the rare examples of acts that seem readily identifiable as “self-injury” are New Guinea practices of cutting off a finger to demonstrate mourning and Baatombu (Western African) male finger amputation to show grief and anger over a wife’s infidelity. Both are, however, considered culturally legitimate and not indicative of pathology. (Sargent 2003, 26)

One other anthropological observation has been provided by Lester, who notes that current explanations of self-harm can be grouped into four categories: communicating emotional pain, emotional or physiological self-regulation, interpersonal strategy, and cultural trend. She notes that these categories share the idea that self-harm manifests individual pathology or dysfunction, with the cultural assumption of the individual as a rational actor. In contrast, an anthropological perspective emphasizes the “cultural actor who embodies and responds to cultural systems of meaning to internal psychological or physiological states” (2012, 727). Emphasizing the powerful symbolic significance and long cross-cultural record of self-harm and blood shedding as ritual and even therapeutic practices, she suggests that contemporary cutting may be seen as privatized and decontextualized social rituals affecting transformation parallel to collective initiation rituals that operate in a cycle of self-harm and repair, especially in the case of adolescent girls struggling with the aftermath of sexual abuse and/or with contradictory gender messages (Lester 2012). Sociocultural characteristics of a typical “self-cutter” emerged in the 1960s as Euro-American, attractive, intelligent, and possibly sexually adventurous teenage girls, that Brickman (2004) claimed was partially taken up in medical discourse in a manner that “pathologizes the female body, relying on the notion of ‘femininity as a disease’” (Brickman 2004). Gilman took exception to assumptions of pathology with the provocative claim that “self-cutting is a reasonable response to an irrational world” (2012, 1013).

From a clinical vantage point, self-cutting is often viewed as a type of injury or harm to the self. The historical backdrop to this development can be traced to Menninger’s (1938) attention to self-mutilation as distinguished from suicidality. The distinction between “delicate” and “coarse” self-cutting was made by Pao (1969), with Weissman (1975) focusing on wrist-cutting syndrome and Pattison and Kahan (1983) proposing the existence of a deliberate self-harm syndrome. Favazza ([1987] 1996, 1998) provided cases of extreme and highly unusual forms of self-mutilation in excruciating detail, with an attempt to classify types based on severity. With the provisional emergence of nonsuicidal self-injury disorder (NSSID) criteria in the fifth version of the Statistical and Diagnostic Manual of Mental Disorders DSM-V (APA 2013),¹ the distinction between self-harm as within a normative or pathological range remains equivocal. This is illustrative of the manner in which conceptualizations of self-cutting continue to be embedded in a complex cultural history of changes in the incidence, popular awareness, and social conditions in which such phenomena occur.

Bodily Experience, Struggle, and Existential Precarity

While it is possible to find clinical, psychometric, survey, and historical approaches to the phenomenon of self-cutting, we lack an ethnographic account with a substantive locus in the interactions of individuals, grounded in the specificity of bodily experience (Csordas 2002) and the immediacy of struggle in the face of existential precarity (Jenkins 2015). In this article, we take a step toward such an account with a discussion situated at the intersection of two anthropological concerns. First is the ethnographic understanding of experiential specificity through anthropological adaptation of phenomenological method (Csordas 2002; Desjarlais and Throop, 2011; Jackson, 1996; Katz and Csordas, 2003; Ram and Houston 2015). Drawing on this approach, we understand *experience* as meaningful sensory perception in temporal context and within particular cultural, social, and interpersonal settings and *subjectivity* as the more or less enduring structure of experience. With respect to mental illness, this approach invites anthropological recognition of *struggle* as a fundamental human process that comes to light in the context of lived experience (Jenkins 2015, 15). Second is the ongoing anthropological concern with adolescence as a stage in the life course at which identity is consolidated and people approach full cultural membership (Csordas 2009; Levine 2007; Lowe 2003; Schlegel 1995; Suarez-Orozco and Suarez-Orozco 1995) but which is also fraught with challenges to well-being that anthropology can contribute to understanding in a way relevant to mental health policy and practice (Burton 1997; Dole and Csordas 2003; Jenkins and Haas 2016; Korbin and Anderson-Fye 2011a, 2011b; Lester 2011). The contemporary anthropological approach to childhood is strongly influenced by child standpoint theory that aims at an account of society from where children are socially positioned and in which they are not passive social “others” but agentic participants in social life, hence co-constructors of social knowledge and by extension of knowledge generated by research² (Alanen 2005; Fattore, Mason, and Watson 2016; Hunner-Kreisel and Kuhn 2010; James 2007; Mayall 2002; Wells 2015). In particular, anthropologists have taken up the idea that “children have agency and manifest social competency” (Panter-Brick 2002, 156; see also Bluebond-Langner and Korbin 2007, 243).

Guided by these concerns, we will focus specifically on self-cutting among a group of adolescents who have been psychiatric inpatients; by attending to experience and subjectivity articulated in the youth’s own voices, we will come to understand self-cutting as a crisis of agency enacted on the terrain of their own bodies. There is scant literature on how young people conceive and understand mental health (Armstrong, Hill, and Secker 2000), let alone experiential accounts of adolescent mental illness from the standpoint of the child (Hejtmanek 2016). In addressing the experience of cutting among a clinically defined and diagnosed group of youth, our stance is not to fall prey to accepting a false dichotomy between ethnographic and clinical sensibilities; that a young person is following a regimen of psychotropic medication is as much an ethnographic as a clinical fact, and that a young person lives in a fragmented family environment may have clinical as well as ethnographic implications. Self-cutting can be understood as a troubling symptomatic behavior or as a creative struggle for agency and may exhibit elements of both pathological obsession and

ritual transformation, but in either case it is an enactment of a vexed relation between body and world.

Southwest Youth and the Experience of Psychiatric Treatment (SWYEPT)

This discussion is based on SWYEPT, our study of youth in New Mexico who were inpatients in the state's flagship Children's Psychiatric Hospital at the University of New Mexico (Csordas 2013, 2015; Jenkins 2014). New Mexico is a state whose total population according to the 2010 United States Census was 2,059,179. In 2010, according to the US Census Bureau's categories, by race the largest population proportions were designated "white" (68.4%) and American Indian/Alaska Native (9.4%), with 23 federally recognized Indian tribes in the state comprising various groups of Pueblos, Navajos, and Apaches; other racial categories were minimally represented. By ethnicity, Hispanics or Latinos accounted for the largest single block (46.3%), while among non-Latinos the largest blocks identified themselves as generically white (40.5%) or American Indian (8.5%). New Mexico is one of the poorest states in the nation. According to the US Statistical Abstract, as of 2008 the median household income was \$43, 508 or 44th among the 50 states, and the proportion of persons living below the poverty level was 17.1% or 5th in rank among the states. New Mexico ranks as one of two states within the United States hardest hit by child poverty, with the rate of 30% in New Mexico (Macartney 2011, 6). Relatedly, home foreclosures have also been inordinately high. Along with poverty comes a serious drug problem, with parts of the state severely afflicted by heroin and methamphetamine use, and the presence of violent gangs, with one antigang website listing 178 in the Albuquerque area.

The SWYEPT study examines cultural meaning, social interaction, and individual experience among adolescent patients and their families, with the long-term goal of producing knowledge of broad use to those concerned with the treatment of adolescents suffering from mental illness in the context of significant cultural differences. The aspects of this knowledge include: (1) types of problem, illness, or psychiatric disorder experienced by afflicted adolescents; (2) trajectories of adolescent patients from the community into treatment and back into the community; (3) patient experience of therapeutic process and family response to that process; (4) alternative and complementary resources brought into play by families on behalf of patients; (5) difference between the experience of afflicted adolescents and that of counterparts who have not been diagnosed or treated for emotional disturbance. Notably for present purposes, ours was not explicitly a study of self-cutting or self-harm, but cutting emerged within the ethnographic interviews as a theme deserving of the particular attention we devote to it here.

We recruited participants for the study with the assistance of three clinicians at Children's Psychiatric Hospital (CPH) who referred to us patients aged 12–18 they judged as not so severely cognitively disabled or developmentally impaired as to be unable to participate in interviews and not so emotionally fragile or clinically vulnerable that their participation would be unduly stressful. We obtained informed consent from youth and their parent or primary guardian based on these referrals, recognizing the ethical responsibility of

respecting the vulnerabilities of individual patients and the need for continued rapport in the relationship between therapists and families, as well as the importance of our respect as researchers for the clinical expertise of the referring therapists. All participants entered the project as inpatients at CPH. Assisted by a team of graduate student ethnographers and clinically trained diagnostic interviewers, we conducted ethnographic interviews covering life history and experience with illness and treatment with the young people and their primary parent/guardian three times at approximately six months' intervals.³ During this period, we also conducted the child version of the Structured Clinical Interview for DSM-IV (KID-SCID), a clinician-administered research diagnostic interview (Hein et al. 1998; Spitzer et al. 1992), the Adolescent Health Survey (Resnick, Blum, and Harris 1989), and the Youth Self Report and Child Behavior Check List (Achenbach 1991) for children and their parent/guardian respectively. Although initial interviews occasionally took place in the hospital, it was rare for a participant still to be there at the time of the second and third ethnographic interviews. Yet it was not always the case that they were at home, since it was not uncommon for them to be placed instead at another treatment facility of in-treatment foster care. This often led us far afield from the hospital in Albuquerque, such that our ethnography ranged across the entire state of New Mexico and occasionally beyond.

In this respect, our work was not strictly speaking a clinical ethnography in the sense of ethnography primarily situated in a clinical context that focuses on the institutional cultural milieu and interactions among patients and staff (Csordas 2017; Estroff 1981; Hejtmanek 2014, 2016; Jenkins 2015; Lester 2007, 2009). Our focus was instead on the experience and subjectivity of the troubled youth along their trajectory back to their families, back again to the hospital, to other institutions, or to treatment foster care. Whenever possible we conducted interviews in participants' homes both for their convenience and so that interviewers could conduct ethnographic observation of the domestic environment and neighborhood setting. Our primary ethnographic locus was thus the family rather than either the clinic or the community, following the methodological premise that families are the principal formative intersubjective locus for adolescents and for the mentally ill, no less for mentally ill adolescents (Jenkins 2015; Korbin 2013). Given these caveats, our work could be described as clinical ethnography in a different sense, insofar as it synthesizes clinical and ethnographic sensibilities and approaches (Herdt 1999). This means not only a balanced attention to diagnostic profile and life experience, but recognition that narrative data generated by diagnostic and ethnographic interviews can be complementary by identifying different kinds of experientially relevant events and themes (Csordas et al. 2010).

The participants constituted an ethnically diverse group including New Mexican Hispanics and Latinos of Mexican descent, Anglo-Americans, and Native Americans. While an ethnically diverse group of youths whose economic and residential conditions vary, the life situations of most are shaped by features of structural violence (Farmer 2004). Of the 47 adolescents (22 girls and 25 boys) who participated in the research, 57% (17 girls and 10 boys) reported having cut or harmed themselves at some time, comparable to 61% among adolescents hospitalized for psychiatric problems in a previous study by DiClemente, Ponton, and Harley (1991) in another North American location. This rate can be understood

against the background of a reported rate of 1–4% of self-injurious behavior in the general population (Alderman 1998; Klonsky, Oltmanns, and Turkheimer 2003), while the rate among adolescents has been placed by various researchers as ranging between 1 and 39% (Nock and Prinstein 2005; Ross and Heath 2002; Suyemoto 1998). Let us now take a closer look at cutting among several of these young people in order to get a sense of how they talk about it and what it means to them, its place in the overall configuration of their experience, and the similarities and differences among them that might allow us to characterize cutting as a crisis of agency.

Profiles in Cutting

SWYEPT participants represent a wide range of diagnostic profiles from a clinical standpoint and a diversity of life experiences from an ethnographic standpoint (see Jenkins 2014 for a comprehensive summary), but our purpose here is to present a series of vignettes that summarize the range of experiences and utterances centered around the phenomenon of cutting. Lacking space to present full case studies, we briefly examine how they describe their own cutting behavior and what that behavior means in the context of their troubled lives and in the constitution of their subjectivity. We have selected these instances and interview excerpts based on the young person's relative ability and/or willingness to elaborate on how cutting has been a part of their lives. Each profile includes the biographical and ethnographic context of the young person's experience, their diagnostic and functional status, medication history, their own (and occasionally their parent/guardian's) experiential commentary, and a brief interpretative commentary.

We first met Maria, a Hispanic 17-year-old female, when she was living in a ranch style home in a lower-income neighborhood that was bustling with the activities of her extended family and infant son. During the course of the study, she later lived in an apartment with her son, boyfriend and mother, moving again two years later into a very small apartment with her toddler. Maria was the youngest of three daughters to a single mother with multiple boyfriends and father figures. She bore the physical and emotional marks of a major arm injury in midchildhood from a car accident in which her extremely drunk mother was driving, as well as enduring severe and catastrophic stressors related to abuse, neglect, and sustained psychosocial instability in her early life. While Maria is close to her older sisters, they were not a significant source of personal or financial support and held an antipsychiatric opinion about how Maria did not need medication. She relayed that she had to “grow up fast” (by age four) since her mother had severe problems with alcohol. Indeed, her mother's alcohol abuse severely affected their relationship. Maria was sexually assaulted at the age of 11 by her mother's ex-boyfriend, which disturbed her greatly; she marks this as a time of pain and confusion. She grew up believing her adoptive father was her biological father, but when Maria was 15, her father went to fight in Iraq. While in Iraq, he wrote her two letters saying that she was not his biological daughter, and he was getting remarried and could not support her financially or otherwise. She said she was devastated by this, by the fact that he would “cut me out of his life.” Maria responded by cutting on herself. In this instance, we have a patent metaphoric and literal alignment of psycholinguistic and palpable

bodily expression. These events have created major emotional and psychiatric challenges for Maria. When Maria began the study, she had been admitted for a suicide attempt and ongoing postpartum depression. Prior to being admitted, she had an eating disorder, along with self-harming and abusing cannabis for two years. Her SCID diagnosis shows mood disorder due to a general medical condition, postpartum major depressive disorder, brief psychotic disorder related to postpartum depression, separation anxiety disorder, PTSD, alcohol abuse, cannabis dependence, and an eating disorder. Her narrative of cutting centers on her reaction to rejection by her stepfather:

One time I tried to call his wife's phone, and I said, "can I talk to my dad," and she said "yeah," and she left me on hold for, like, five minutes, and she came back and said he wasn't there. And so, that, like after that, I just freaked out. Like, I started crying hysterically and that's when I was, like, "just forget it." Like, I started cutting, do something to take the pain away, because I was so hurt I just felt like he didn't love me, like, I just felt, like, abandoned. And, I, I thought maybe if I started cutting that he would see that I'm hurting and he would come back and he would care, he would see that things aren't okay. And, I mean, he didn't. He never—I still haven't talked to him. And that—and then, the other reason was because I've been overweight my whole life and I started starving myself, I lost about thirty pounds and I was happy with myself, I got attention from guys, I was just . . . it worked for me. I mean, it was a bad way, but it worked, and, and, um, I would starve myself and if I did eat, I would throw it up and, yeah . . . [I was feeling] pretty hopeless. Every day I was always worried about eating something or getting caught cutting, or just always worried, trying to hide everything, trying to keep everything to myself. I mean, it did get hard, 'cause I knew I wouldn't be able to keep it a secret forever. And I just felt pretty hopeless. [Then] my mom caught me cutting and my auntie, like, was wondering how I lost so much weight. I mean, she like started investigating and she, she caught me throwing up and after that things just went downhill from there. My mom called my counselor at school, and my counselor called CPS (Child Protective Services). CPS said that I needed to go to the emergency room and in the emergency room, they did an assessment and I was put in [another hospital]. I learned a lot more from there. I remember this girl told me "You are cutting yourself the wrong way; you are supposed to cut down." Like, wow, I learned that there.

For Maria, cutting was an intended if fraught means of communication in the face of the emotional pain of abandonment. This was not the first time she cut; her practice began at age 11 following the sexual assault by her mother's boyfriend. In the narrative excerpt above, her motivation was explicit and her logic clear when her father proved unresponsive to her telephone call.

In semiotic terms, cutting was a concrete bodily hurt that stood as a sign, the object of which was her emotional hurt, and the interpretant of which was her need for emotional connection. Along with bulimia that resulted in weight loss and "attention from guys," it formed a complex related to self-esteem and the need for intimacy from males in the context of a close but troubled relationship with a mother marked by alcoholism. Though cutting proved ineffective in communicating with her stepfather, it was apparently effective in a negative sense by addressing her emotional pain. In this sense for Maria cutting was an

agentive practice and bodily technique operating in tandem with bulimia—one technique to take away pain and the other to gain attention—against the background of multiple interpersonal traumas. Finally, she was able to evaluate bulimia as something that worked, but in a bad way. Secrecy and isolation are themes for her even though her mother and aunt discovered her actions and initiated a trajectory of consultation with a school counselor leading to hospitalization; in fact, Maria had already spoken to the counselor before this event without telling her mother. It was her mother's contact, however, that led the counselor to suggest treatment. Maria insisted that she had not cut herself since leaving the hospital.

Dana was a 12-and-1/2-year-old Hispanic and African American girl who lived in a small town south of Albuquerque with her adoptive parents, younger brother, maternal uncle, and the uncle's fiancé. Dana was adopted with her brother Jordan (four years her junior) at the age of five. She had five younger siblings (with different fathers) with whom she still had contact. Dana and Jordan were originally placed with a family in Las Cruces, but they were sent to their current home because that family only wanted Jordan. Their adoptive parents suspected a history of sexual abuse because Dana would "play with herself" when she first arrived. Dana was diagnosed with ADHD at the age of five. She reported having depressive feelings since the first or second grade, even having suicidal ideation in the third grade. She was placed in Treatment Foster Care (TFC) in a nearby town for one-and-a-half years, from the third through fifth grades when she threatened to kill herself. When she was eight years old, she threatened her adoptive mother with a knife, which led to TFC for another one-and-a-half years. She narrated that the change was positive for her initially, but that her depressive feelings intensified later on. In February 2008, Dana began being more aggressive to her adoptive parents, cutting herself and writing threatening letters. Her parents decided to send her to a respite for the weekend; in response, Dana threatened to physically hurt her father and was taken to the hospital by the police. After returning home, Dana was better able to control her anger; however, this did not last—she engaged in behavior prohibited by her parents, stole from her school and from her parents, and was eventually suspended. Dana had been receiving psychiatric treatment for several years at the time of her participation in the study, including anger management and medication for ADHD. Her mother viewed much of Dana's aggression as typical adolescent growing pains or in the mother's words "that raging hormone period." Her diagnostic picture from the KID-SCID included ADHD (combined type), oppositional defiant disorder (barely met criteria), and major depressive disorder (single episode). She described her experience of cutting as follows:

In third grade, I threatened to kill myself and I went to a treatment foster home and then I came back in fifth grade and [the cutting] started at the beginning of seventh. I wrote this, like, life threatening note and I told my dad not to read it and then he said he wouldn't and then that day he went in my room and got it and read it and then mom showed it to my counselor, and then my counselor showed my other counselor and she said that I had to come to here [the hospital]. Before that I was, like, threatening to kill myself and I was cutting myself. . . . my mom told the school counselor that I was cutting myself. Like, after Christmas. 'Cause I was angry, frustrated, and, like, sad. Depression.

[Cutting makes me feel] better, mostly when I'm having those feelings. This last past month, it was like mostly every week. [Causes of the cutting are] like . . . depression. And, uh, peer pressure . . . anger.

Prior to her hospitalization Dana had concealed her cutting, and her mother describes the surprise of learning about it:

And then we noticed—my husband noticed—well, she said “mom, my arm hurts.” and I go “what did you do?” and she said, “I cut myself.” And we didn't think nothin' of it. We're like “oh, she was at school, and she scraped it or something.” And then when we went and got her some Neosporin to put on there, and then, one of us seen it and was like “oh, my gosh. This isn't just a scrape. These are cuts.” And [her dad said] “Whoa, that's pretty, pretty intense there.” But she cut herself, like, sixty-three times with, um, I guess it was a razor blade. But it wasn't, like, a deep cut, but it was enough for it to bleed. But she did it by her ankles and stuff. She cut herself . . .

The regularity of Dana's cutting only became evident to her parents as a result of family therapy in the hospital, where according to her mother, “she really started telling us where she hid her razor blades, and I mean they were good hiding places. And why she was doing it and it took her a week or two and then [the therapist] finally cracked her on it.”

Dana gave her account shortly after being admitted to the hospital. She denied having any mental health problems, identifying her main issues as depression and anger and peer pressure. Her comments on cutting are much more in the form of a life-event narrative than an illness narrative. She not only said that cutting makes her feel better in a random or generalized way but explicitly with respect to those negative feelings, and explicitly acknowledging that she likes the pain—though note that the narrative of her hospitalization begins with her complaint to her parents that her arm hurt. With respect to the problem of agency, note her detached observation that “the cutting started” at the beginning of seventh grade in conjunction with the active statement that “I was cutting myself.” She was currently in what was supposed to have been a “stable” family setting for her, and she continued to be in contact with her siblings. Yet her experience and practices belie the stated therapeutic intentions and instead reflect a crisis of agency and identity. Aggression, stealing, and misbehavior against others are closely linked to cutting and suicidality not only as forms of agency but as ways of marking and problematizing the boundary between herself and others. Despite having initially concealed her cutting from her parents, embracing the “Emo” cultural idiom provides a form of identity that incorporates cutting as an explicit practice rather than an anonymous symptom but also and importantly mediates the emotional relation with her mother. In her mother's words:

Well, she says that she's Emo. And I'm like, I'm like, I never heard it. And I go, “what's Emo?” and she goes, “well, it's a person that likes to cut themselves and they feel good about themselves.” And I'm like “What!? How can you feel good about”—I mean, I get a scrape and I'm like, crying bloody murder. And she's like “No, Mama, I like to feel the pain. It feels good.” And I'm like “Dana. How do you know you're Emo?” And I go “I haven't even heard of it.” And she goes, um, um, she goes “well, Mom, it's just like I said, I cut myself, like when you get mad at me and stuff and I don't wanna' take it out

on you”—No, wait, let’s see . . . like I get mad at her, and she doesn’t want to retaliate, so she cuts herself. That’s what she says.

There could not be a clearer articulation of cutting as an intersubjective bodily technique to exercise agency. In this case, inpatient treatment appears to have brought the practice to light and framed it as problematic. When we first met Dana in the hospital she said she hadn’t cut herself in about a month, and at her second interview she recalled that “we weren’t able to cut there and then like if we like wanted to, we could like talk about it instead of cutting and it got me used to just like talking.” She claimed not to have cut herself at all after leaving the hospital and not to be worried about starting again. Her mother, however, reported that “she said she does it every once in a while, but I never see it on her.”

We first met Anna, an Anglo-American girl, two weeks prior to her 13th birthday. Anna’s father was unemployed and so was her mother, and this has left the family in a precarious financial situation. She lived in a home in a modest income subdivision with her mother, father, and two older siblings. Our ethnographic and diagnostic notes describe relationships in the family as “difficult,” “fractured,” “abusive,” and “sometimes supportive.” Her home environment growing up was unstable, and Anna has witnessed and experienced periodic violent episodes. She was born during her mother’s first marriage. Anna was sexually assaulted by one of her stepbrothers, although the extent is unknown due to a contradiction of reports from both Anna and the brother in question; Anna is an admitted compulsive liar, and telling the truth is something she was working on in therapy. Prior to hospitalization, Anna had tried to run away with one of her brothers, who is currently homeless and the only family member he keeps in contact with is Anna. Nevertheless, during her time in psychiatric care, Anna cited her family as the best part of her life and looked forward to returning home and becoming a good role model for her younger siblings. Her KID-SCID diagnosis shows depressive disorder, anxiety disorder, and PTSD. Anna herself reported that she had depression and anger problems. She described her cutting as follows:

So, after about five times of running away, I started cutting at my house, I don’t even know why I started cutting, but I knew that I couldn’t get a hold of drugs so I just started cutting my wrist with my razor blade and within a week, my mom caught me because she is very observant. I haven’t been cutting for that long, but I still want to cut and I still like to cut. I mean, when you take drugs, you feel that “*Aaabb*” feeling and when you cut, after you cut, you feel that “*Aaabb*” feeling. You just relax, like, “*Uffff*.” When you take drugs, you take pot, you get all relaxed and I don’t know, you think, like, if someone told you a knock-knock joke, it would be so funny when you are high. You just start laughing for no reason and you just be laughing and laughing and it’s like so much fun to be high. You have this, like, smile ear to ear and you hallucinate, like your mouth can be like touching the ceiling or something and it’s, like, funny. It’s funny because it is really happening, but it is not really happening. In your eyes it’s happening, but in real life it’s not. And, like, if someone were to tell you a joke, it would just be, like, so funny. And everything is, like, so happy. Like, you are all chill and everyone is happy. I mean, it’s nice to be high. And me, when I cut, I like to cut, not for the pain, but just to see, like, the blood. I like to see blood now. And I would cut, I would just give myself like little tiny razor cuts really fast so it wouldn’t hurt real bad, but I would like to squeeze

the blood and scratch the scabs and just have them there and, like, but my mom caught me within a week.

Anna appears to describe her first cutting as spontaneous and without motivation, but she says she began at a time that coincided with not being able to get drugs and explicitly links her experience of cutting to the experience of being high. Her bodily orientation is toward the pleasure of the high, seeing the blood, and scratching the scabs and away from the pain caused by the lacerations. Arguably, Anna's fascination with her oozing blood and the scabs that form on her skin are more reminiscent of the heightened perceptual features of cannabis intoxication than of a morbid self-destructiveness. For her, marijuana smoking and cutting clearly share a common effect. She makes it clear that "I still want to cut and I still like to cut." With respect to family intersubjectivity, as the youngest sibling in an unstable family environment, it might be assumed that she did not receive a great deal of adult attention, but Anna appears genuinely impressed and supported by the fact that her "very observant" mother discovered her cutting within a week of her starting it. Her agentive engagement with cutting appears to be structured along an axis between the desire for self-stimulation and the recognition of her cutting as problematic and something she was "caught" doing.

As a contrast to Anna, let us turn to the situation of Sarah, a 15-year-old Anglo-Hispanic girl who was raised by her mother, maternal grandparents, and later stepfather from the age of around eight. At the time of her interviews, she lived with her maternal grandparents, a pleasant older couple who seemed quite concerned for their granddaughter and unsure of how to help her. Sarah faced problems with her family, primary support group, social environment, and education, although from all accounts, she had received much care and attention over the course of her childhood. She saw her siblings every day during an afterschool period and also spent some weekends with her parents, but there was also tension in this relationship, as she and mother apparently fought often—Sarah ran away from her parents' home four times. Since around the age of 10, she experienced fits of rage, intense tantrums, and mood swings. She first had treatment around the age of seven for ADHD, receiving outpatient therapy irregularly as a child. She was hospitalized twice before recruitment into the SWYEPT project, and both times the admitting incident was a suicide attempt. Neither Sarah nor her grandmother identified early/middle childhood familial instability or trauma as contributing to her problems, but they pointed to traumatic peer rejection as exacerbating and precipitating her illness. Sarah initially explained her problem as "congenital bipolar" and later described how the bipolar manifested over the course of childhood as "neediness" that remained an issue for her. Sarah referred to social-skills deficiencies—not being able to get along with peers and maintain friendships—as motivating her self-harm. Her diagnostic picture from the KID-SCID included bipolar I disorder (current episode: major depressive), and moderate generalized anxiety disorder. She had many symptoms for binge eating disorder (likely due to medication) but did not meet the diagnostic criteria. Her narrative of cutting is as follows:

I was just so lonely and so reclusive and so just, suicidal almost again. But I wasn't really that bad—I wasn't like planning on hurting myself that bad, but I cut myself superficial scars on my arm. Just to make those superficial marks, because I was mad. I was just

angry, I was just very unsettled all the time. Very irritable, and would like throw things, and hit things, and. I hit people and stuff and it was just not good. I tried it out because I just thought, I was mad, I just wanna like watch blood—it didn't help. It didn't. I thought about it—all it did was make me more angry. 'Cause when I saw those scars, and I still do, it makes me upset. It makes me never want to do things again. Because I just didn't really feel any better. It doesn't help. I don't know how people get almost like this high on themselves from doing it. Like it makes it go away for a second, the pain. I don't think it does that for me at all. . . . I had a friend when I was in middle school who would cut herself, like badly, when she was sad. She'd get tons of bracelets and just cover her arm—it was like thick, awful, wounds but she felt so—I saw her doing it one time in the bathroom, it was just like, the way she got like instantly calm, I thought, maybe it would work for me when I really am pissed. And just like a way to hurt yourself without really hurting yourself, I thought. But it didn't help. I don't know, I never wanted to cut myself before, but I was just mad, and I just thought about it, you know.

Our data do not allow us to determine the relative contributions to her distress of a family environment from which Sarah ran away four times and the intensity of stressful peer relations. Notable in her narrative, however, is her articulation of a degree of experiential specificity in which she distinguishes the self-harm of cutting from suicidality and explicitly identifies it as a way to hurt yourself without really hurting yourself. She places her experiment with cutting in the context of highly irritable behavior and makes an explicit link between affect and embodiment: “I was mad; I just wanna like watch blood.” She clearly acknowledged having observed the technique used by a friend and the awareness of a relief “almost like this high” that it affords some people. Although like Anna in the preceding vignette she wanted to see blood, in distinct contrast Sarah knew precisely why she cut herself but definitively concluded that she felt no such relief and that cutting did not help at all. Sarah's agentive engagement with cutting is doubly evident in her decision to try it and in her recognition that the experiment was a failure for her, only making her angrier in a way that endures along with her scars. In her case there is no indication of habit or compulsion and no indication that cutting was anything other than a one-time experience.

Quincy was a lively Anglo-American 12-year-old, living in his family's well-kept ranch home on a quiet street in a middle-class area. Quincy lives with his biological mother, adoptive father, and younger sister. At the time of the study, his biological father was not involved in his life. However, prior to the study Quincy had spent school breaks and part of a summer with his biological father. His mother believed that during this time Quincy was physically and sexually abused and that his father possibly took Quincy with him during drug deals. Quincy and his mother have not heard from his father for several years. As he grew older, Quincy's anger, impulsivity, and aggression grew as well. When he was first admitted to psychiatric care, Quincy identified himself as angry, depressed, and as a cutter. When we met Quincy, he had been admitted to the hospital after an incident in which he used a razor blade at school to cut himself. Quincy was diagnosed with ADHD at two-and-a-half years old, and experienced cutting, depression, and suicidal thoughts since the age of 12. His KID-SCID diagnosis shows bipolar disorder, cyclothymia, history of major depression, ADHD, and oppositional defiant disorder, and his parents added in that Quincy also had learning disabilities. Additionally, Quincy has psychological stressors caused by early psychosocial

instability and abandonment related to his father's absence, but overall, he appeared to have a fairly stable and supportive secure life. Quincy described his experience:

I would just like cut myself at school and stuff like that. I'm a cutter. [I started] last school year [in sixth grade]. Um, lots of other kids started doing and so I started doing it. I'm a follower. But not—I was a follower then, but not really now. It's different now. I've learned my lesson. Plus it hurts (*small laugh*) . . . [I would cut] in my room being depressed. In my closet, with the door shut. In the dark. That's pretty much it . . . [I brought razor blades to school] in my backpack. I cut myself with one. And then, I resold the razor blade to a kid, and he cut himself real badly.

Comparable to the vignette of Dana presented above, his mother offered one of the more clear-cut narratives of learning about her son's behavior:

When he first started cutting, we didn't know for a long time. Until I figured, you know what? Why is he wearing jeans in the summertime? It's so stinkin' hot out. He said, "Well, all skaters wear jeans," you know? Protects their legs and stuff, so I let it—yeah, that makes sense, right? Until one day I walked in on him and he had just his shorts on. After he got out of the shower, his legs were a mess. He, he cut here . . . and he had carved his name in his legs. He had "Quincy" here. And he was bloody and scarred. And we knew that he had started cutting on his arms, too.

A particular modulation of agency and identity is highlighted by Quincy's comments that he had been a "follower" and a "cutter." In this sense, it is significant that he cut not because it hurt but despite the hurt it caused. Yet Quincy was one of the more creative cutters with respect to using a variety of implements to harm himself. Respective to cutting in the intersubjective milieu, while on the one hand he concealed his cutting by doing it hidden in his closet and wearing long sleeved shirts and pants, on the other hand he brought it into his social environment in the incident of selling a razor blade at school and another incident in which he attempted to trade for a knife in the family's church parking lot one Sunday. He had periods in which he did not cut, but for him episodes could be severe enough to lead directly to hospitalization, and in one case according to his mother "he got down really low and wanted to go back to the hospital and so he just grabbed some knives and was just hacking at his arms." This is quite distinct from cutting as a neurobiological coping mechanism to diminish emotional pain and instead marks an instance of a somatic communication technique with awareness that self-harm automatically brings hospitalization.

Ben was a 15-year-old Anglo-American male who lived with his adoptive mother, step-father, stepsister, and several pets including five dogs, four cats, and two guinea pigs. Previously, Ben lived with his biological mother until he was nine, and his life had been unstable with bouts of homelessness and coping with his mother's mental illnesses, which evidently was a type of schizophrenia. After the age of nine, he was entered into the state and foster-care system. He was placed with an aunt and uncle who were planning to adopt him, but they were physically abusive. Subsequently, he was placed in another foster home. His sister was then planning to adopt Ben, but she disappeared to Mexico. When he was 12, Ben was adopted by

his current family. During the study, Ben learned that his stepfather, a war veteran, did not want to see him again. The stepfather had PTSD, depression, and was threatening towards Ben. The employment status of Ben's various guardians has been unstable, and there is often financial strain on the household. Ben reported his religion as Satanist but that he was not allowed to practice his religion at home. Things were hardly better at school. In the tenth grade, Ben was in a Christian school and had recently been reclassified to the ninth grade. He enjoyed drawing, writing, reading, and hanging out with his stepsister and family. He first began receiving mental health services when he was 12 years old while in a foster home. Ben was admitted to the study during his second psychiatric hospitalization, with his first hospitalization having occurred earlier in the same year. His current admission was for depression and cutting behaviors. His KID-SCID diagnostic picture shows panic disorder without agoraphobia, alcohol and heroin abuse, and cannabis and cocaine dependence. His own report and his clinical diagnosis also include depression, and the clinical diagnosis also added possible PTSD.

I think I started cutting from depression, like, probably late seventh grade or early eighth grade. I like pain, so it sounds like bragging (*laughs slightly*). I don't want to brag about that, but it was a stress reliever for me. Like, my friends would try to get me to stop doing it, but I just kept on saying "No" and I kept on doing it. [The relief would last] probably like a week or a week and a half [and I wouldn't do it again] at least until it heals . . . if I am in a room by myself and I am doing my schoolwork or something I just think about, like, bad stuff, like ways to kill myself or when is the next time that I am going to cut or something like that. I haven't really tried [to stop those thoughts] so I don't know if I can . . . I like piercings and tattoos and stuff. I, like a stick went through my lip and I put a piece of paperclip in there so it could stay open and then I pierced my ear with a safety pin and I was trying to tattoo a pentagram right there (*gestures*) and then I just peeled it off because I was gonna get in a lot of trouble with my mom. Because I'm really leaning towards being a Satanist.

Ben is another youth with a precarious and unstable familial, residential, and economic situation who explicitly links his cutting with depression. It is not surprising that the incident that brought him to the hospital where we met him was "trying to scratch through my skin to get to the vein, like cut it or something. I took a knife and I tried to slit my wrist because of my dad not wanting to be a part of my life, because I split with him and, just, like everything that's happened in the past it's like catching up to me." Unlike Quincy, he explicitly claims to like the pain of cutting, as well as experiencing it as a form of "stress relief." The fact that friends at school try to talk him out of cutting indicates that he does little to conceal it and may well advertise it as a provocation in his conservative Christian school, though his mother reported having asked to see his arm because at home she observed he was often wearing long-sleeved shirts and walking about with his arms folded. There is also a compulsive and habitual element in Ben's cutting, evident in his solitary ruminations about suicide and cutting, and this corresponds with a strong cigarette habit. His mother suggested that "[cutting] was probably a pretty good stress reliever for a while, but, at some point it just becomes habit." The compulsive element is likely related to the fact that for Ben cutting, piercing, and tattooing are related to the idiom of Satanism, which contrary to the idiom of Emo in the case of Dana described earlier, has a religious and ritualistic rather than a

primarily experiential cast. Elsewhere in his interview Ben indicated that the stress relief of cutting was also associated with watching the blood, but contrary to Anna's description of watching her bleeding with the eyes of a stoner, the idiom of Satanism provides the affordance of a more morbid connotation for bleeding.

Modes/Moments of Agency in the Relationship of Body and World

We have presented and analyzed these vignettes with an emphasis on experiential specificity and on the importance of youth's own voices under conditions of structural violence. Having examined the cutting experience of six among the 27 youths who narrated cutting and/or self-harm, it is evident that each has a highly distinctive profile while often invoking common themes of family relations⁴ and bodily experience, and we shall elaborate shortly a characteristic problematic of agency. Are these youths typical in any way, and if so typical of what? The challenges faced by many adolescents, certainly in the "Land of Enchantment" that is New Mexico's self-description, are recognizable among these young people often in amplified form and complicated by additional factors that amount to extraordinary conditions both personal and structural (Jenkins 2015). Their situations are often vulnerable and precarious, but there are various forms of vulnerability and precarity. They are, for example, not children who live "in the streets" like homeless children without families (Panter-Brick 2002) but children who are "in the system" with a trajectory back and forth from home to various settings of institutional care.

These institutions vary along the axis of emphasizing what Hejtmanek (2016) has characterized as psychiatric custody and therapeutic process, terms that bear overtones of the carceral and the caring respectively. Indeed, conditions in some of the facilities where we interviewed study participants were sufficiently oppressive to count as just as much a form of structural violence as conditions of poverty, gender violence, and gang activity. Yet the larger scale politics of health care created another form of structural violence in the form of severe contraction of services under the regime of "managed care" that was ongoing throughout the duration of our project. Payment for both residential treatment and day treatment was approved with decreasing frequency, and the average length of covered stay decreased drastically. From the standpoint of CPH clinicians, this meant that patients were often being discharged to disorganized family environments which did not provide sufficient opportunity for their condition to stabilize or to less intensive levels of care for which they were not prepared (see also Kano, Willging, and Rylko-Bauer 2009; Watson et al. 2011; Willging, Waitzkin, and Lamphere 2009; Willging and Semansky 2010). Yet whether the experience leans toward the carceral or the caring depends not only on the character of the institution but on the different pathways into the hospital including through the police, the courts, physicians, families, and in some instances, volunteering. Once in the system, all are exposed to and inculcated with discourses of diagnosis, coping skills, and medication.⁵ Finally, although cutting is prominent among these youths who have been psychiatric inpatients, on the one hand not all of them are cutters and on the other not all cutters come to be psychiatric patients.

What is critical in making anthropological sense of their experience is that suffering is not a barrier to interpretation and understanding because it partakes of the broader spectrum of human experience. Moreover, while we have a specific existential, ethical, and political concerns for the “extraordinary conditions” of this particular group of adolescent self-cutters who are psychiatric inpatients (Jenkins 2015), their experience enacts and partakes of “fundamental human processes” (Jenkins 2004) and may highlight them in a way from which we can learn as much about the human condition as about a distinct pathological or cultural process. In other words, regardless of how troubled any one of them might be or appear to be, a careful look at their experience reveals the operation of fundamental human processes in a way that allows them to be seen not just as idiosyncratic individuals or representatives of a marginal category of afflicted subjectivity, but as having much in common with those who might more readily be classified as “typical.”⁶

With these considerations in mind, we must outline the range of issues that define the domain of cutting for these youths in treatment as a first step in understanding similarities and differences in their modes of bodily being in the world. Is cutting a learned behavior, and if so can it be called a “technique of the body” in the sense in which Mauss ([1934] 1950) used that term? The answer is yes in situations where it is associated with the cultural complex defined by young people who define themselves as “emo,” “goth,” or “scene.” In this circumstance, the delicate cuts are, as one participant’s mother said, like a “badge of honor.” There is indeed an element of technique evident in one girl’s report that while hospitalized another girl patient told her “you are cutting yourself the wrong way, you are supposed to cut down.” Particularly among SWYEPT participants, this learning could take place among peers in the hospital or residential care facility as well as at school or from siblings at home, and the mother of one of our male participants acknowledged that all three of her sons were “cutters.” Nevertheless, it is possible for cutting to be primarily a self-discovered practice, evident in one girl’s comment that “I was shaving my arm and I accidentally cut myself and I liked the way that it felt and that is when I started cutting. That is when I started purposefully cutting myself on my wrist.” These findings compare with a study of participants in online message boards that indicated a substantial group of cutters who had never heard of the practice before engaging in it, some even reporting they thought they “invented” it, not knowing they would feel better before they cut for the first time even if it was accidental, while a third of respondents had heard of or knew someone who cut before they began; self-learners typically began cutting at age 16 while those who learned from others began at age 14 (Hodgson 2004).

Cutting as an Emo technique is also most often associated with the apparently careful use of a razor blade and fits the model of “delicate cutting,” whereas among SWYEPT participants, there was in addition a range of implements used: fingernails, pencil, knife, toothpick, thumbtack, scissors, paperclip, binder ring, and broken glass. Using such a range of implements is not unique to these youths (Hodgson 2004, 164; Ryan et al. 2008, 240). Also in relation to Emo/Goth culture, cutting stands in relation to tattooing and body-piercing, the principal diacritics being that the latter are typically done by others and not by oneself and that the latter are often for performative display while cutting is typically concealed.

Girls who wear “lots of bracelets” may be both adorning themselves and concealing the scars on their wrists. Placement is stereotypically on arms and legs, wrists and ankles, and one is inclined to interpret as more idiosyncratic instances such as those we recorded of poking under one’s fingernails, cutting one’s thumb, or cutting one’s stomach. Hodgson’s (2004) survey respondents often tried to pass by concealing their scars or created cover stories but sometimes also disclosed their cutting with an excuse for doing something wrong or a justification that it was a way to deal with emotional pain, but these disclosures did not include display as with stylized body modification.

With respect to severity, the continuum between delicate and deep cutting is significant among participants. On the mild end of the continuum, there are reports of scratching without drawing blood. Even dangerously deep cutting may be unintentional and, in the words of one mother, an instance of “going overboard” rather than aimed at serious self-harm or suicide. Likewise, even superficial cuts can be overdone, as in the report by one mother that her daughter had cut herself lightly with 63 times on various parts of her body. A final element of excess is the instance in which a boy carved his name in his leg and another in which a girl carved her boyfriend’s name in her arm. These are perhaps too conveniently expressive of gender stereotypes, specifically of the narcissistic boy and the infatuated girl.

Variation occurs along the temporal dimension as well. Onset of cutting can occur at quite a young age, and its duration varies as well. We have observed participants with only one transient episode of cutting, those in which it is habitual and compulsive and those who have had on-and-off periods of cutting with varying durations. This periodicity may occur either because conditions of stress may wax and wane or because the relieving effect of the cutting endures for a period of time before it in effect needs to be renewed. Episodes of cutting may be situational or habitual. An instance of the former is a girl who, although she had been cutting herself periodically for several years, indicated that a recent episode was in relation to the conjunction of her grandfather dying and her boyfriend breaking up with her. A habitual instance is the boy who used a pencil or a toothpick as his instruments, though according to his mother he scratched but never broke his skin. He said, “Two months ago I started cutting myself. I just couldn’t stop cutting myself. I had the opportunity to do it, I couldn’t help it . . . sometimes it’s just no reason, other times, it’s just because I want to. It’s because I feel like it.” Notably, this boy indicated that the cutting did not make him feel better.

The intentionality of cutting is complex, and as was the case among SWYEPT participants, cutting may be associated with other forms of self-harm such as head-banging, self-choking, bulimia, eraser burns, or drug abuse. The motivations typically reported for cutting in this study were depression, anger, frustration, stress, and tension. The intended results included relief, to feel good, to feel pain, to hurt oneself, and to see the blood. Notably, three of the participants reported that cutting did not make them feel better. With respect to integration of cutting into one’s identity as a mode of self-orientation, it was more common to hear that a young person “started cutting,” “cut myself,” or even “ended up cutting,” but there were instances of girls and a boy who declared either that “I am a cutter” or “I was a cutter.” The only other study of intentionality among adolescent inpatient cutters we have been

able to identify used the self-injury motivation scale II (SIMS-II) developed by Osuch, Noll, and Putnam (1999), which taps factors including affect modulation, desolation, punitive duality, influencing others, magical control, and self-stimulation. The researchers found that the mean number of reasons cited for cutting themselves was 20 out of the 36 listed in the instrument as contributing to these factors and that 56% described their cutting as impulsive while 60% reported feeling emotional relief (particularly from depression) after cutting (Kumar, Pepe, and Steer 2004). Notably, males and females cited comparable reasons for self-injury, with a trend for females to use cutting for controlling negative affects more than males (Kumar, Pepe, and Steer 2004).

Self-cutting is also not invariably linked to suicidality. Among girls who were SWYEPT participants, 18 reported suicidality, and 17 reported cutting; three of the cutters were not suicidal, and four of the suicidal girls were not cutters. Among boys, 14 participants reported suicidality, and 10 reported cutting; three cutters were not suicidal, and seven of the suicidal boys were not cutters. Moreover, cutting was by no means the only or the most common method for suicide attempts by participants. In this respect, we note the study by Gulbas et al. (2015) which expressly focuses on the relation between suicidal behavior and nonsuicidal self-injury (NDDI) among Latina adolescents in the United States. They compared youth who harmed themselves (the majority by cutting), those who attempted suicide, and a smaller group who did both, concluding that

For those girls who used NSSI, cutting provided an avenue to control the chaotic emotions produced by [cultural] fragmentation. When NSSI no longer enabled control, some participants turned to suicide. Among suicide attempters with and without histories of NSSI, their perceived inability to bridge their chaotic and fragmented world led to desires for self-destruction. It might be that intent is ambiguous because adolescents feel uncertain about their place in the world because of the competing and contradictory messages they receive about who they are and who they should be. (2015, 311)

Gulbas and colleagues identify a series of factors relevant to both NSSI and suicide that correspond to features we found among the SWYEPT participants, including family fragmentation, conflict, physical and sexual abuse, and domestic violence. The relationships among these factors are complex and are found cross-culturally, though they tend to be more severe with suicide than with NSSI (Adrian et al. 2011; Andover et al. 2012; Baetens et al. 2011; Muehlenkamp and Gutiérrez 2004; Wong et al. 2007).

Given the multiple challenges faced by our study participants in New Mexico, and the extraordinary conditions (Jenkins 2015) that define the contours of struggle for coherence in their lives, a focus on the specific act of cutting offers a necessarily limited but existentially critical insight into the nature of their experience. Without a doubt this requires attending to the question of children's agency as a capacity with which youth are endowed, as we have invoked by citing childhood studies literature and in our analysis of individual vignettes. Childhood studies scholars embrace a concept of agency as a reaction against models of childhood with more structural and chronological substrates, allowing children to be recognized as meaning makers rather than passive recipients of action (Bluebond-Langner

and Korbin 2007). However, in the present context, we must also see agency as a fundamental human process that is no less fundamental for being challenged by illness (Jenkins 2015). Specifically, self-cutting is a crisis in the agentive relation between adolescent bodies and the surrounding world, or put another way, a crisis of their bodily being in the life-world that they inhabit. In understanding embodiment as an indeterminate methodological field, this relationship between body and world is defined by three modes or moments of agency: the intentionality of our bodies in acting on the world or being-toward-the-world, the reciprocal interplay of body and world embedded in a habitus, and the discursive power of the world upon our bodies to establish expectation and shape subjectivity (Csordas 2011).

To be precise, approaching the interpretation of cutting from the standpoint of agency in these troubled adolescents' body-world relationship has the immediate effect of shifting interpretive attention from the wounded flesh to the relation between the active hand of the cutter and the self-inflicted wound. It is then not just a matter of the pain, the relief, or the blood that originates at the violated boundary between self and world, and the concomitant breach in bodily integrity. In the first mode of agency, regardless of the implement used to cut with, the cutter's hand is an agent of self, and the opening of the wound and flow of blood are an emanation of personhood into the world. Cutting is a form of active being-toward-the-world whether understood as a form of projecting outward or as a kind of leaking (analogous to leeching) and draining into the world. This mode of agency is epitomized in the statements of identity such as "I am a cutter." In the second mode or moment of agency, hand and flesh together instantiate the reciprocal relationship of body and world. The cutting hand interpellates the part of the animal and material world that is one's very own body, and that precise fragment of the world responds with the opening of the flesh (as the parting of lips). In this way cutting highlights the simultaneity of body as both self and other. The flow of blood marking not only the violation of a boundary but the opening between body and world. The reciprocity between body and world is highlighted in the simultaneous infliction of pain and the granting of relief. The cutter's body is also the locus of an anguished subjectivity that elicits the application to itself by an agentive hand ambivalently cruel and kind, of an otherwise inert implement from the material world, whether it is a razor blade or a piece of glass. In the third mode of agency, both hand and flesh are no longer part of an inviolate self but conscripts of the world's oppressive agency, and one's body may as well not be one's own but just a body, any body, "the" body as an object rather than a subject. The cutter's hand is now the hand of the other, the wound is world-inflicted, and structural violence is incorporated at the most intimate bodily level. That is, it is inflicted by an anonymous oppressive world or the world dominated by the cruelty of others, and one's flesh becomes an inert object alienated not only from selfhood but from the trajectory of a possible life, isolated from others and immersed in the immediacy of present pain and unproductive bodily transformation.

We must take care to distinguish what is specific to each young person and what is fundamental to their bodily experience in the account we have just given. Attending to the immediate life worlds of individual youth reminds us that each has a distinct experience of cutting under distinct circumstances. Gender, ethnicity, and socioeconomic status matter

to define these circumstances, while family relations and especially family instability are particularly insistent and frequent themes. Insofar as all the youth we have discussed were psychiatric inpatients, they can be counted among the more extreme instance of adolescent self-cutters, while exhibiting varied diagnostic profiles, levels of functioning, regimes of psychiatric medication, and phases of treatment and recovery. The combination of individual uniqueness and shared extremity across their situations has allowed us to elaborate a multi-layered crisis of agency in the relation between body and world and highlights the existential profundity of cutting as a function of its mute immediacy in practice. The possibility for this kind of embodied existential analysis is that cutting is not an idiosyncratic occurrence but a culturally patterned act. Yet it cannot be accounted for just because other kids do it, and this is why it has been important to examine it in the lives of afflicted adolescents rather than simply as an element in the ethnography of “Emo” culture.

The interpretive point is that the trajectory of our argument from experiential specificity on the individual level to the fundamental human process of agency does not define the ends of a continuum. We must instead understand the extraordinary conditions of suffering as simultaneous with the enactment of fundamental human process, because the relation between body and world is always embedded in a specific instance, and each specific instance points to our shared existential condition of embodiment. Identifying the wounded flesh as locus of agency at the intersection of body and world as we have done brings to the fore a particular configuration of relations between self as active and passive, strategy and symptom, subjectivity and subjectivation. The moment of cutting is a fulcrum or hinge between the self as agent or as patient, with an intended pun on the medical sense of patient. From the standpoint of individual experience, cutting in the first sense is a strategy that is part of the self as agent, while in the second sense it is a symptom that is part of a disease process. As a cultural phenomenon, cutting in the first sense exhibits the body as existential ground of culture and wellspring of agentic subjectivity (where subjectivity is an emergent structure of experience), while in the second sense cutting identifies the body as a site at which cultural practice and structural violence are inscribed and have the effect of subjectivation (where subjectivation is a nearly anonymous discursive outcome). In this respect, the distinction between subjectivation and subjectivity in the cut/cutting body is substantively parallel to the distinction between symptom and strategy in the afflicted person. Perhaps the analysis we have presented suggests that self-cutting may indeed be sufficiently complex to serve as the core of a distinct diagnostic category and too problematic with respect to agency to be defined as a symptom in the ordinary sense. Whether or not this proves to be the case, the existential complexity to which we have pointed is precisely what one would expect by bringing attention to bear on cutting as a crisis of agency with its locus at the intersection of body and world.

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1. Appearing just before the appendix of DSM-V, several conditions are listed as "Conditions for Further Study," including "Nonsuicidal Self-Injury." Based on available empirical studies, self-cutting is among the most common criteria for this condition (Zetterqvist 2015). Currently, a "personal history of self-harm" (V15.59) is listed among the V-codes, which may be a focus of clinical attention; however, nonsuicidal self-injuries are not recognized as autonomous mental illnesses (Caldwell 2013).

2. Problems with the theory include the implication that children are an inherently oppressed or marginalized social group, and that work in this paradigm inadequately accounts for variations among children's experiences and that privileging children's voices can exclude the voices of others who constitute their intersubjective milieu (see Bluebond-Langner and Korbin 2007; James 2007).

3. Ethnographic interviews concentrated on life events, family background, origin, and understanding of the problem/illness, the pathway followed into the treatment situation, expectations of treatment, experience of treatment (including acceptance or resistance, and particularly meaningful or alienating elements), interaction with staff and other patients, medication use, school and peer relations, religious involvement, and expectations for the future. We carried out parallel interviews, most often in the patient's home, to interview the patient's parent, guardian, or primary caretaker, that is, the person with whom the young person had the most face-to-face interaction. These interviews determined household composition and demographics, kin and social networks and resources, religious and ceremonial activities and affiliations, attitudes toward the patient, and understandings of the patient's problems and/or illness.

4. Among participants in the SWYEPT study, some of the Hispanic mother-daughter relations appeared to be characterized by an emotional closeness describable as enmeshment and the role exchange in which daughters became caretakers of or intimate friends with their mothers. This is likely as much cultural as clinical, and Garcia (2010) describes a similar type of mother-daughter relationship to the point in some cases where the intimacies of mutual heroin addiction are passed on and shared. See also Ghandi et al. (2016) on self-injury in relation to adolescents' attachment to their mothers. However, as we have seen, severe difficulties in parent-child relations among SWYEPT participants are by no means limited to Hispanics and by no means limited to relations with mothers.

5. All of the youth whose experience we have described, and indeed all of the SWYEPT participants, have complex medications histories. The experience of psychiatric medication and the discourse surrounding that medication is the subject of a separate forthcoming publication.

6. An anonymous reviewer of this article reported "feeling voyeuristic" reading through the vignettes, but from an ethnographic standpoint that emphasizes experiential specificity and intersubjectivity, voyeurism is in the eye of the beholder. To resist turning away from the pain of these youth is to embrace the ethical responsibility as anthropologists and scholars of listening to children's voices in the immediacy of their life worlds.

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