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# **Individuals and their Confidants' Viewpoints on Self-harm: A Qualitative Analysis**

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## Introduction

Attempts to understand self-injuring (SI) behaviors have been ongoing since the 1930s (Hoyt, 2003). Sadly, reports indicated that SI behaviors continue to rise (Gratz, 2006, Gratz, Conrad, & Roemer, 2002; Huband & Tantam, 2004). Most researchers agree that SI is “the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent, but resulting in injury severe enough for tissue damage to occur” (Gratz, Conrad, and Roemer, 2002, p. 128). Tissue damage for sexual pleasure, body decoration, or spiritual purposes are not considered as SI (Martinson, 2001). Common forms of SI behaviors include cutting, burning, head banging, and so forth.

The paradoxical practice of self-harm to relieve tension or maintain a sense of control over life’s circumstances is complicated. Hyman (1999) believed that the causes for much of this self-destructive behavior might stem from difficult experiences in childhood. Infants who have been cuddled and individuals having consistent adult support in the early years of life seemed more competent in regulating their emotions and responses to stresses. McAndrew and Warne (2005) found that self-blame is a common factor among those who self-injure when their loved ones failed to live up to expectations. Gratz, Conrad, and Roemer (2002) discovered that women with a history of self-harming behaviors tended to remember their past distresses in more negative ways—“retrospective bias.” This was in contrast to those who did not have a history of self-harm and who were more likely to minimize, even forget, their negative childhood experiences.

Weber (2002) noted that women who self-injured did so, in part, to keep themselves from harming others: instead of hurting others, they hurt themselves (p. 121). Women who might feel isolated or powerless in directing their anger and frustration toward their offenders injure themselves as means to vent (McAndrew & Warne, 2005). Negative body regards (e.g., poor self-body image) could amplify emotional distresses and enhance the likelihood for individuals to self-harm (Muehlenkamp, Swanson, & Brausch, 2005). Once women were involved in cutting behaviors, they exhibited subsequent intense yearning to continue (Huband & Tantum, 2004).

Those who self-injured often rationalized their actions as necessary, even normal, ways for expressing their emotions. Indeed, Gratz (2006) hypothesized that those who have engaged in self-harm acts might be incapable of or disallowed to verbalize their own emotions. Hyman (1999) observed that the rituals involved in, for example, cutting—seeing blood issuing out of the flesh and even in the cleaning of the instruments used—have provided certain emotional and psychological release, and momentary gratification. A woman could “with each cut, [find that] her faith in herself is renewed” (Rao, 2006, p. 52). Sadly, Hyman concluded that the primary reasons why many would even stop have

been the negative reactions and public condemnations against those who self-injure.

In order to gain more personal insights from those who had once engaged in self-injuring behaviors, we used a documentary on self-injury to precipitate focus-group discussions, we interviewed female students who had self-injured and those whom they identified as empathetic friends in their lives.

## Methods

Four students who had previously engaged in SI behaviors (Group A) and three of their identified confidants with no such prior behaviors (Group B) separately watched a twenty-five-minute long documentary titled *Skin Deep: Understanding Self-injury*. One additional confidant was not able to participate in the study. Their ages ranged from 18 to 23. At the conclusion of the film, participants in their respective groups reconvened for discussions. To facilitate the sessions, open-ended, semi-structured questions were posited to both groups. On occasion, spontaneous interactions among the participants provided more in-depth descriptions. Two audio recorders and a video camera were used to record all conversations and interactions. These recordings were transcribed, coded, and content analyzed for themes and insights. For ease of association while reading this paper, participants in Group A are given fictitious names starting with the letter A and, likewise, Group B with the letter B.

## Results

Individuals in Group A explained that, for them, the onset of self-harm had not been as immediate or impulsive as the documentary had portrayed. Instead of a specific current event triggering a SI act, it usually took place when “you’re by yourself and you just start thinking back on things.” They agreed that there really was “nothing that triggered” their impulse to self-injure. Allison summarized the view of the group when she said, “a lot of times it’s just...being alone for hours...with your thoughts.... It is a response to something specific but not like necessarily that just happened.... It could be something that happened...a long time ago and you’re just thinking about it.”

It was difficult for all to articulate the compounding circumstances encompassing SI acts. Confidants (Group B) agreed that facts about SI, like those presented in the documentary, “covered a lot of general aspects” and though it “did a good job of at least addressing emotionality...it was not as in depth as it could have been.” Those in Group A also concurred that while the film had addressed the emotions associated with SI, it was somewhat superficial. They agreed with Abigail, who stated: “you can’t [completely] understand it yourself.” While self-injury was “a way of dealing with your feelings in a [physical] way,” or substituting the “physical for the emotional,” they also felt that more deep-seeded reasons must be present. Amanda contemplated: “I feel the pain inside but I don’t really know what it’s about or...what it means.” Allison offered this evaluation that the physical effects of self-harm “wakes you up emotionally and...there was proof that I

was stressed.” For her, self-harm was

A conscious decision that I would want to express with [actions] that I didn’t know how to express [with words].... It was more like my language.... I didn’t really know like how to construct it into sentences.... It like became a way of knowing or understanding.

Participants in Group A described vacillating between keeping secret what they had done and revealing the visual marks of their pain. They spoke of using their wounds as cries for help or as means of scaring people off. On one level, they kept the wounds and scars hidden because they were “embarrassing” and “awkward.” Amanda lamented: “We’re supposed to be the good girls... passive and docile...have everything altogether and do all these things.” Self-harm was seen as a way to handle problems “without people knowing or seeing them” or their emotions. On another level, confiding in others could bring about a different set of challenges: the burdens that accompany an acquiring of a “babysitter.” That is, once the scars were known, they became benchmarks for accountability.

For both groups, the healing process and the resultant scars were two important features to the self-injuring experience. For Amanda, physical scars served as a reality check: “you don’t believe that you’ve reached your limit of what you can stand on your own and so you have proof that you’re not capable of carrying it.” Ominously, the healing process had been used as a negative gauge of wellbeing. Allison recounted, “I would get frustrated when I would start healing... because it was like well I’m not healing like [the wound] is healing. And then that would make we want to [cut] more.” As they continued, they resonated with the familiar effects that the more they “take it out on” themselves, the more comfortable they became with self-injuring. They identified with Allison, who said, “It’s like I don’t want to be healed, like I don’t want to change this.... You’re just like really hiding it.... I want to stay in this.” Self-harming for them was an intensely personal act; it was their most powerful form of emotional expression.

As a confidant, Becca noted the significance of the scars: “In my experience [with my friend], cutting has...been about the wound...the fact that the marks are there.” Others in Group B testified to seeing these mindsets in their friends. They have observed their friends as feeling ashamed of their behaviors and wounds for fear of looking like “a freak.” On the other hand, they believed that their friends have used their wounds as a “badge of honor” and have made their acts known to others to be seen as being different and creating an identity for themselves. Bethany summed up the concerns and frustrations of the confidants: “you start to find your identity in the actions or the disorder” and “get so caught up in that, like that they forget that that’s not their identity.”

Where treatment was concerned, both groups saw the value of professional counseling. Amanda said that her counselor was “really insightful, she knows a lot about this without having gone through it [herself].” The confidants also affirmed the necessities of

professional counseling, but spoke more about the importance of a strong “social support system of people who are holding you accountable” and maintaining a “recovery mindset” because SI “is more of a here-and-now kind of thing.” Conversely, while Group A appreciated their friendship, they generally agreed that their friends “wouldn’t understand” and self-harming individuals could become too dependent on the attention given by their friends. Emphasizing the great value of professional counsel, Abigail said, “Whereas the therapist would like, know where to set the boundary...so you learn for yourself how to handle things without needing to like talk to a friend or rely on someone else to fix you.”

To differentiate further, participants in Group B mentioned having “no idea what to do,” “don’t know exactly how to handle it,” and wanting often to tell their friends to “just stop.” Members in Group A, however, readily admitted to the addictive nature of SI. As Aimee described, “it’s almost like an obsessive thought over and over again and you can’t get rid of it.” Amanda elaborated the complexities to healing: “after you address the maladaptive way of dealing with your feelings, you still have the addiction to conquer.” Collectively, they accosted “that a lot of people don’t understand” and do not “realize like how hard it is to stop.”

Participants in Group B expressed their personal confidence in understanding their respective friends and, therefore, the potential for people to understand individuals who self-injure. Brie supposed that someone could “understand the addiction [or] steps of recovery” from different issues he or she has experienced. Becca said, “I think you can get closer and closer to understanding the more you spend time with them, and you learn to think how they think (kind of), and you can almost predict like what they would do in certain situations or whatever.” Individuals in Group A, however, were convinced that not even their closest confidants could understand them fully because there are “always underlying issues” and “there are so many different factors.” All in all, members in Group A agreed with Amanda when she said, “I don’t even understand it really, so I can’t imagine someone else understanding why I do it.”

## **Discussion**

For individuals in this study who had engaged in self-harm, their descriptions were consistent with findings that indicated SI acts as forms of coping mechanisms (e.g., McAndrew & Warne, 2005; & Weber, 2002). They did not act impulsively subsequent to any specific and immediate antecedent event or stressor; SI acts were done after premeditating over previously experienced troubling issues or scenarios. These individuals agreed that their actions were meant to make tangible their elusive emotional weariness and to visualize their sufferings in their scars. Once their sense of suffering is manifested, they see their troubles as being valid and much more than a figment of their imaginations. Nurturing their wounds to healing became a form of self-nurturance: that is, as their wounds could heal, so could they. However, should emotional healing not

coincide with physical ones, the discrepancy could jeopardize progress.

Two even more detrimental effects were evident among the students who took part in this study. The first is as, for example, Hubbard and Tantum (2004) indicated, the addictive nature to self-harming acts. Should individuals experience relief through this form of coping strategy, it stands to reason that they would continue to self-injure and even seek to maximize their “effectiveness.” When no healthier forms of coping strategies seem viable or powerful enough, individuals can be conditioned to associate self-harming acts as a source of comfort or, worse, a triumphing over life’s adversities. Indeed, all individuals in this study had alluded to that “badge of honor” mentality.

When what is otherwise objectionable ends up being accepted, there is what Van der Kolk, Perry, and Herman (1991) described as a dissociation from the self-destructive behavior: Individuals could be psychologically removed from the disgust of the cutting act and associate it instead as being something necessary or positive. This sense of valuing is tied to the second detrimental effect: a personal identity that is partly defined by the SI behaviors. This phenomenon has also been suggested by, for example, Gratz (2006) and Rao (2006). For individuals in this study, some indications that SI behaviors have become indelible to individuality or personal identity included (a) it is a language form to express emotions, (b) a communication tool controlling relationship dynamics such as “help me” or “stay away,” (c) treating the scars as marks of their life and experiences (like soldiers who speak of their war stories through the scars on their bodies), and (d) a gauging of one’s own sense of well-being and self-care as exercised through the healing of self-induced injuries.

While appreciating their friends’ empathy and willing support, students described their confidants to suppose greater knowledge in the matter than they actually possessed. Unlike the sentiments of the confidants, individuals in this study attributed their cessation of SI behaviors to the unambiguous work of professional counselors. They emphasized that professional counseling must be promoted as the best route to recovery. Amanda best conveyed this conviction:

“In like outpatient therapy...you’re working through it, but you’re forced to take responsibility...working through the feelings with my therapist, but at the same time I’m still going to be in charge....’ You have the confidence.... You have to start using like your voice and your mind to explain how you are feeling instead of acting out. Otherwise it’s just like there’s no way outside of it”

### **Limitations and Future Study**

The number of participants was small and lacked diversity. While the socioeconomic representatives from these students were more diverse, their racial and ethnic backgrounds were not: All were White female students. While a high proportion of

individuals who self-harmed were believed to be females (e.g., Claes, Vandereycken, & Vertommen, 2007; & Herpertz, 1995), at least one study has indicated little difference between the genders who had self-harmed (Croyle and Waltz, 2007). Also, this study did not delve into the present coping strategies used by students who had once self-harmed. Brown, Williams, and Collins (2007) reported that individuals experienced greater levels of negative emotions such as hostility, guilt, or sadness even though they had ceased their self-harming behaviors. Future studies should consider the motivations to remain free from self-injuring behaviors.

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