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Impassioned communication and virtual support roles of online postings: The case of self-harmers

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lAbstract

Although there is an emerging literature on online users support groups, limited research has focused on the online users support groups concerned with self-harm. The present study reports the findings of inductive content analysis of self-harm online messages from one self-harm online users group. One hundred messages were examined. Categories were determined and inductive analysis revealed online self-harm postings showed two themes. The first theme was "impassioned communication", 76% of the postings had this major theme. There were three sub-themes included in this theme: being a "failure", "people not understanding", and "improvement". The second theme was "virtual support". Although presented as two separate themes "impassioned communication" and "virtual support" are inter-related as some postings suggested the need for support with impassioned communication. These results support the established view that the internet is the place where individuals can access emotional support or social integration, especially helpful for those who are, or feel, marginalised (e.g., those experiencing disenfranchised grief, self-harming). The present study shows the usefulness of utilising online message boards as a research tool for conducting research among populations that are difficult to access.

Key Words

Content analysis, Disenfranchised grief, Impassioned communication, Online messages, Self-harm, Virtual support

Introduction

The practice of self-harm, where people deliberately inflict damage to their bodies by a variety of means, has been reported in the research literature for several decades (Murray, Warm, & Fox, 2005). Self-harm can be defined as "the intentional destruction of body tissue without suicidal intent" (Klonsky, 2007, p. 1039).

It is estimated that more than 140,000 people present to hospital after an episode of self-harm each year in England and Wales (Hawton, Fagg, Simkin, Bale, & Bond, 1997). The Department of Health Social Services and Public Safety in Northern Ireland (2010) identified cutting as the second most common method of self-harming in the Western Health and Social Care Trust catchment area of Northern Ireland, making up 17.2% of all accident and emergency admissions in 2009. Furthermore, it is estimated that the prevalence of self-harm has increased by over 150% over two decades (Favazza, 1998). As early as 1980, Goldney and Bottrill stated that, with the exception of liver disease due to alcohol misuse, self-harm patients cause the most hostility in clinicians. Most people following self-harm, do not go to hospital (Hawton, Rodham, Evans, & Weatherall, 2002), it is suggested this may be because the provisions for such patients is notoriously poor, with little understanding of self-harm being a coping and survival mechanism (Broadhurst & Gill, 2007).

Self-harm is a practice often misunderstood by family, friends and professionals (Simpson, 2006). Self-harm is often a response to interpersonal crises (Hawton & James, 2005) however, some professionals do not see it this way. Doctors and nurses working in accident and emergency departments have sometimes been reported as being unsympathetic towards those who self-harm, perhaps because of their perception that the behaviour is manipulative and attention seeking (e.g., Walsh & Rosen, 1988). These misperceptions, due to inadequate understanding, could mean self-harmers do not seek or receive the support they require.

Negative misperceptions about self-harm may exacerbate feelings of disenfranchised grief, due to lack of social support and care. Disenfranchised grief due to a perceived absence of social support (Doka, 1999) can be exacerbated by feelings such as self-isolation and shame. A link has been demonstrated between self-harm and dissociation (e.g., Low, Jones, MacLeod, Power, & Duggan, 2000; Zlotnick et al., 1996), and people who self-harm and feel distanced, or cut off, may do so due to the internalisation of feelings such as invalidation or isolation (Messer & Fremouw, 2008).

With the increase in the accessibility of the internet via PCs, tablets, and mobile homes, there has been a rise in the availability of social communication and support on websites and websites are becoming a popular source for obtaining health-related information (Griffiths, Tang, Hawking, & Christensen, 2005). Youths who self-harm may engage in more online activity than those who do not self-harm (Ybarra & Mitchell, 2007), because the internet can be used as a means of communication and as a way to receive support, acceptance and validation (Lewis & Baker, 2011; Lewis, Rosenrot, & Messner, 2012; Rodham, Gavin, & Miles, 2007; Whitlock, Eckenrode, & Silverman, 2006). The topic of self-harm is ubiquitous on the internet, with hundreds of online support and discussion groups based around this subject (Murray & Fox, 2006). This allows for a sense of connectivity not previously possible.

While there is an abundance of literature about self-harm which focuses on self-poisoning, research has suggested that other forms of self-harm, such as cutting, are more prevalent, but under-researched due to biased sampling methods (Warm, Murray, & Fox, 2002, 2003). This is likely to be because many self-harm studies use participants from accident and emergency departments. These settings are more likely to have access to life-threatening forms of self-harm, such as self-poisoning, rather than cutting which rarely requires hospitalisation (Hurry, 2000).

The present study uses a broad classification of self-harm methods to classify them as a distinct behaviour because there is no single comprehensive system to categorise self-harm behaviours although there are several specific definitions in existence (Latimer, Meade, & Tennant, 2013). Deliberate self-harm is a sub-type of self-destructive behaviour (Lundh, Karim, & Quilsch, 2007) that causes immediate and intentional body damage (Babiker & Arnold, 1997; Kreitman, 1977). There can be many functions of self-harm such as interpersonal and intrapersonal (Klonsky & Glenn, 2009) and different intentions such as suicidal and non-suicidal (Hawton & James, 2005). The present study focuses on non-suicidal self-injury and online messages regarding it.

The Internet has been shown to be a valuable resource for people seeking support. For example, among samples of, 100 participants receiving treatment for schizophrenia, bipolar disorder, depression and anxiety, more than half (53%, N = 19) of internet users reported going online to look for health information (Borzekowski et al., 2009). An online message board, specialised for males with eating disorders, had 101 messages with themes of men needing emotional support or being willing to provide online support for those who were reluctant to

seek support in the real-world (Doran & Lewis, 2011), and an online message board for people with complex regional pain syndrome had members seeking and providing support because mobility problems can compound segregation (Rodham, McCabe, & Blake, 2009). This is especially the case for those who feel isolated by their condition, such as those who self-harm, because of the anonymous support and information it provides (Warm, Murray, & Fox, 2002; Reinhold, 2003; Whitlock, Powers, & Eckenrode, 2006). Engaging in self-isolation (avoidance of others and not disclosing feelings) can be a coping strategy, and can put people at a higher risk for self-harm behaviour. A meta-analysis of self-harm research found that almost half of participants were socially isolated (Pattison & Kahan, 1983). Adolescents with a history of self-harm are more likely than those without such a history to sanction self-isolation in their rooms (Evans, Hawton, & Rodham, 2005). Other research supports the association between self-harm and isolation (Dennis, Wakefield, Molloy, Andrews & Friedman, 2007; Patterson, 2007). Self-harm and isolation could be associated because segregation increases feelings of loneliness, rumination, depressive symptomology and decreases of social support and self-esteem, which have all been associated with self-harm (e.g., Lundh, Karim, & Quilisch, 2007; Traynor, Gonzalez, & Nolem-Hoeksema, 2003).

A behavioural model of self-harm which is based on the postulation that self-harm is a negatively reinforcing means of lessening undesirable emotional activation is the Experiential Avoidance Model (EAM; Chapman, Gratz, & Brown, 2006). The most commonly noted reason for self-harming is emotion regulation (Brown, Contois, & Linehan, 2002), and when self-harm appears to stabilise emotional crises the behaviour may become addictive. Undesirable emotional states linked with self-harming include ones related to abuse, social isolation, conflict with family or friends and loss (Do & Lee, 2010). Risk factors for self-harm include recent stressful life events such as arguments with people close to you and losses, bereavement, family or relationship break-ups (Asarnow et al., 2008). If losses are not perceived to be socially supported, the absence of social support can lead to disenfranchised grief (Doka, 1999). Research has also supported correlations between self-harm and an increase in the number of physical complaints or illnesses (Herpertz, 1995; Suyemoto, 1998).

When grief is disenfranchised, such as when loss cannot or is not openly expressed (Doka, 1989), self-harm can feel the only release for difficult unexpressed emotions. Self-harm can seem the only way to free oneself from the overwhelming emotions and tension (Bosman & von Meijel, 2008; Huband & Tantam, 2004; Kocaleven et al., 2005) associated with disenfranchised grief.

Self-harm is often a response to interpersonal crises (Hawton & James, 2005), however, some professionals may not see it this way. For example, research has shown that Emergency Department nurses can occasionally not show sympathy (McCann, Clark, McConnachie, & Harvey, 2007), and emergency health staff can be equivocating or negative (Pompili, Girardi, Ruberto, Kotzalidis, & Tatarelli, 2005).

In 2013, 21 million households in the United Kingdom had Internet access, 83%, and 36 million adults accessed the Internet every day, 20 million more than in 2006 (Office for National Statistics, 2013). In recent years there has been a vast increase in discussion groups on the Internet about self-harm and there is academic disagreement about whether participation in them can alleviate or exacerbate self-harming behaviour (Murray & Fox, 2006). If people feel a lack of emotional support and social integration they are likely to face more stressful situations, feel alienated and perceive themselves as lacking control over their lives (Cohen, 1988) which is why Internet support can be useful. Online discussion groups have the potential to be a form of readily accessible emotional support or social integration from the comfort of one's own home at any time of day or night (Huws, Jones, & Ingledew, 2001). There are a range of advantages to using online support groups as a research group including the fact that the anonymity may result in more honesty or the broaching of "taboo" subjects compared to face-to-face contact time (Coulson, 2008). Evidence suggests that young people feel empowered online and are protected by a degree of anonymity, which enables them to talk more freely about sensitive subjects such as sexually transmitted infections, contraception, and pregnancy (Borzekowski & Rickert, 2001), sexuality and health (Suzuki & Calzo, 2004), emotional difficulties (Gould, Munfakh, Lubell, Kleinman, & Parker, 2002), as well as general health (Ybarra & Suman, 2006).

Help-seeking is recognised as a difficult journey for people who self-harm for a variety of reasons. Longden and Proctor (2012) noted that people who self-injure "are ambivalent about help-seeking due to feelings of unworthiness or shame" (p. 20). The shame and guilt involved in hiding self-harming behaviour may exacerbate feelings of grief because these emotions are unexpressed. This grief is disenfranchised because it is not resolved, and seemingly numbed by the physical pain of self-harm. The Internet may have particular relevance for those who self-harm because it provides a low-risk venue for finding similar people who share perceived or real differences and the exchanging of information which is difficult to convey in person or when using a real-life identity (McKenna & Green, 2002). The Internet allows for connectivity on a scale not previously possible between people who self-

harm however it is not known whether these relationships "significantly provide companionship, personal aid, information and a sense of belonging" (Wellman & Frank, 2001, pp. 233-273), or whether they reduce or increase the frequency of self-harming episodes because it has been suggested that the Internet can be a source of "potentially destructive information" (Thompson, 2001, p. 400). Other perceived negative effects of self-harm websites include encouraging or triggering of deliberate self-harm behaviour (Messina & Iwasaki, 2011; Whitlock, Powers, & Eckenrode, 2006) and the normalisation of self-harm behaviours that may prevent website users from seeking professional help they need (Baker & Fortune, 2008; Messina & Iwasaki, 2011). It has also been reported that the support that such websites offer carries a very different model and style of support offered by health care professionals (Messina & Iwasaki, 2011). Therefore, the aim of the present study was to investigate how self-harmers feel and how online message boards can enable the users to communicate or seek help.

Method

Participants

The authors of the first 100 messages from an online message forum dedicated to self-harm were used as participants from an online message forum, with 49 different named participants and 19 anonymous postings all from 2014. 100 messages were chosen because of the in-depth content analysis involved, more would have stretched time constraints and not allowed adequate detailed analysis.

Recruitment and Rationale

An online message forum dedicated to self-harm (https://self-injury.net/blogs) was selected for analysis because of its open accessibility. It was the only site where non-members could access all blogs. Participants can post blogs on this site or write comments on other blogs without the requirement of signing in.

Ethical Considerations

Informed consent can be waived when members' communication takes place in a public place when those participating can expect to be observed (British Psychological Society, 2006; Coulson, Malik, & Po, 2007). This was a publicly accessible group with no sign-in required. Guidelines for internet-mediated research (British Psychological Society, 2017; Childress & Assamen, 1998; Coulson, Malik, & Po, 2007) were observed.

Qualitative Analysis

The first 100 messages were extracted and analysis was undertaken using a content analysis approach (Morse & Field, 2002) to investigate how self-harmers feel and how online message boards can enable the users to communicate or seek help. A selection of verbatim postings are presented within the analysis. Content analysis is a method of analysing written, verbal or visual communication messages (Cole, 1988). It is a systematic and objective means of describing and quantifying phenomena (Downe-Wamboldte, 1992; Krippendorff, 1980; Sandelowski, 1995). The messages were read and re-read and the data coded by identifying continuing themes, concepts or words (Morse & Field, 1995).

Categories were defined from the data in inductive content analysis. Inductive content analysis is used when previous knowledge about the subject is fragmented (Lauri & Kyngäs, 2008). Researchers use inductive content analysis when preconceived ideas and categories are avoided thus allowing new insights to emerge (Kondracki & Wellman, 2002), enabling categories from the data to become apparent.

The structure of analysis was operationalised on the basis of moving from the specific to the general so that instances were read about individually then combined into larger wholes (Chinn & Kramer, 1999).

Quotes from the forum are presented verbatim, including typographical errors.

Results

The content analysis of the 100 postings revealed two main themes. The first theme was labelled as "Impassioned Communication" and had three sub-themes: "Failure", "People not Understanding", and "Recovery/Improvement". The second theme was "Support". Although presented below as two separate themes they are in fact inter-related because some postings suggested they needed support in their impassioned communication.

Theme 1: "Impassioned Communication"

Of the 100 postings, 77 had some emotional content and involved "impassioned communication". In this theme, there were two negative sub-themes of "failure" and "people not understanding". There was also a positive sub-theme of "recovery" and "participants trying to recover". The communication was impassioned through such descriptions as:

"Recently I've discorvered that I'm getting too tired to keep on my mask of happiness at work.. I'm not sure if anyone else feels that way … I'm so tired of acting happy just to make other people not worry" (Respondent 10),

"Today I just can't seem to stop crying. I was suddenly hit with an agonizing longing. A longing so deep that I know it will forever plague me ..." (Respondent 11),

"Today I realized how far I have come in the fact that I actually manged to tell my boyfriend I started cutting again…The last time I was activaly cutting..I couldn't mange to reach out to anyone with words…So instead I cut all up and down my arm..not big cuts mind you, but there was enough of them angry and red that I couldn't hide them…

I couldn't run away after that I couldn't hide it..I had to get help..and my mom is the one who got me that help…

I wanna reach out to her again..but I'm terrifed that she will blame it on my boyfriend..well that and the fact that she'll tell my step dad..and I don't want a lecture…I don't need one..most of the things he tells me is stuff I already know

I thought about telling my best friend..but I don't want my boyfriend to get jealous and feel like I'm seeking emotional support from someone else…

I just have so much repressed anger…like when I told my boyfriend about cutting..he told me he thought I was handling my depression…I need to talk to a perfessional and all the free ones are a bus ride away…since I spend all of my time at work I can't seek the help I need…so I am dealing with my depression..with books and cutting…

Also he blames this website for me cutting..what he doesn't know is I found this heaven after" (Respondent 12),

"Yesterday I had a bad flash back of the times when my mom forgot about me … times when I was left at places and people forgot to pick me up …" (Respondent 14).

Sub-Theme 1a: Failure

Five of the impassioned communication messages expressed the emotion of being a failure, or not efficaciously succeeding in life. For example, respondent 1 in this sub-theme was upset about not having a child:

"… Why can't I just have my beautiful baby? Why? Why must I feel like this? Why won't the tears stop? I just want a child; a baby that I can love and nurture."

There was no direct link between the respondent self-harming and wanting a child because they do not mention self-injuring. Respondent 2 mentioned feeling as though they were a failure and was very direct about it – mentioning the word "failure" three times in their posting and associating it with "hitting rock bottom". Respondent 3, who also directly states feeling a failure, does not mention self-harm openly either but does describe themselves as "sucking at pretty much everything". Respondent 42 describes hating themselves:

> "I feel like a screw up. I've been so depressed and anxious all day. It was supposed to be a good day for my sister, but I couldn't find time to really enjoy it passed all my self-loathing and thoughts of SI. I hate this. Then I feel like I made one of my close friends angry because I can't make it to an event she invited me to. I know she's mad. I've been withdrawn from everyone and she doesn't get it. Why can't I be normal? I hate this. Just a two more days and hopefully it'll get better. I just have to keep it together for that long."

A respondent definitively posted feeling a failure: "That's how my life is. How I feel everyday. Like a failure. Ha. who am I kidding? I am a failure …" (Blog 13). These respondents all seem very despondent and with nothing to look forward to so having a negative psychological well-being.

Sub-Theme 1b: People not Understanding

Four of the impassioned communication postings had the theme of other people not comprehending self-injury or people not understanding how those who had posted feel. Respondent 1 expresses that it is not only non-self-harmers who do not understand but people who do self-harm also "… because everyones reasons are different ." "People not understanding" was posted definitively "I've been put in therapy and I've been told over and over again that it's not the only option but some people don't understand and some people can't just simply tell another that there are other ways." (Blog 15). Respondent 14 mentions people not understanding directly "I've been put in therapy and I've been told over and over again that it's not the only option but some people don't understand and some people can't just simply tell another that there are other ways". The subtheme is also involved in the second theme of needing support. The posters of these messages also seem to have a negative psychological well-being, an inference is being lonely "God … I just want somebody to hold me while I cry and tells me it'll be alright and mean it..." (Blog 15).

Sub-Theme 1c: Recovery/Improvement

This sub-theme was present in six postings, all of them within the emotional expression theme. This subtheme is the title of one posting which may highlight its importance to them "Trying to recover**,** I want to recover from self harm". (Respondent 4). Three of the messages say when they last harmed themselves "December 1, 2013 was the last time I pressed those scissors into my skin" (Respondent 6), "It's been over one month since I last self-harmed. " (Respondent 29), It's been almost a month since the last time I self harmed. Im really proud of myself. It feels like my depression hasn't gotten any better, but I'm fighting one battle at a time. I only ever talk to my one friend about these problems because I only trust her. She gets frustrated with me, which I totally understand, but she gets upset because I get stuck on the

bad things in my life. I don't mean to dwell, but she thinks that I like being upset. I would give anything to go back to being the person I was before I became depressed. I wish she could understand that. Hopefully I'll be able to see a therapist soon and get myself sorted out. I was so frustrated with my friend that I posted on here. Im so glad I found this website. (Respondent 44). One respondent has only just begun her recovery, stating "I am going to try not to cut myself for a few days and see how it goes. I am really afraid right now." (Respondent 4).

Theme 2: Support

Nineteen of the postings contain the theme of support, eight are implicitly requesting help by describing a self-harming episode and ending the message by asking a general "... whats wrong with me?" (Respondent 5), or explicitly by directly saying "help me" (Respondent 48). Three of the support postings are offering help, such as "im always here for you, if you ever want a chat just message me." (Respondent 1). "Don't ever forget that you are stronger than you will ever realize. Smile and show the world that it does not have the power to bring you down" (Respondent 9). A respondent describes wanting to stop, but not knowing how to and feeling alone:

> "I started to cut myself last year and I still don't know why. There isn't a reason to do it. I've never been bullied, in fact, no one talks to me or even notices me and I don't think I mind. I have a really close friend and I'm always myself around her, but I still cut.
>
> My parents are probably the happiest people I know, they love me and want the best for me and I feel like I'm mental. Is this supposed to happen? All the time, I think about killing myself in different ways. I've even thought about school shootings and I'll be the first one to die, purposely running out there and getting myself shot. I even wanted to kill some one there, but I know if I did that, my whole life would be ruined.
>
> I don't know what to do or how I'm supposed to tell someone about this. I just want to stop thinking this way and I want to stop cutting my arms because I like it when it hurts. I want to be happy or normal and realize everything's going to be okay. But at 13 years old, all I'm thinking about is when I'm going to kill myself and leave this terrible world. Please, if anyone will tell me what to do, it's all I'm asking." (Respondent 18).

Discussion

The aim of the present study was to examine how self-harmers feel and how online message boards can enable the users to communicate or seek help. The results show that "Impassioned Communication" was a major theme identified in 77% of the 100 messages analysed. This finding supports the view in the literature that the internet is the place where people can access emotional support or social integration from the comfort of one's own home at any time of day or night (Huws, Jones, & Ingledew, 2001). This was also evident in the theme of "Support".

This study identified two themes, “Impassioned Communication” with sub-themes of “Failure”, “Recovery/improvement” and “People not understanding” and the second theme was “Support”. The support theme has sub-themes of asking for help and offering help, which supports ideas such as the Internet may have particular relevance for those who self-harm because it provides a low-risk venue for finding similar people who share perceived or real differences (McKenna & Green, 2002). The support theme has been found in other studies which have focused on self-harm forums. Self-harmers may view friends and family as not understanding their behaviour or not being able to communicate with them, so self-harm discussion groups are a way to provide communication and support (Murray & Fox, 2006). However, this theme has been found to have negative influences on maintaining self-injurious behaviour because the content of videos showing non-suicidal self-injurious behaviour may maintain such behaviour (Lewis & Baker, 2011; Lewis, Heath, St. Denis, & Noble, 2011; Whitlock, Eckenrode, & Silverman, 2006).

Disenfranchised grief, due to a perceived or actual absence of social support (Doka, 1999) can be exacerbated by feelings such as self-isolation and shame, feelings also associated with self-harm. The grief emotions related to antecedents and consequences of self-harm are shame, loneliness, self-isolation and guilt. These emotions are often only expressed through self-harm, not through an adaptive means. A link has been demonstrated between self-harm and dissociation (e.g., Low, Jones, MacLeod, Power, & Duggan, 2000; Zlotnick et al., 1996), and people who use self-harm and feel isolated, or cut off, may do so due to the internalisation of feelings such as invalidation or isolation (Messer & Fremouw, 2008). Moreover, such internal feelings may be reinforced from outside sources included those that are grounded in social processes (e.g., marginalisation, stigma), institutions (e.g., expectations, norms, social mores), discourses (frameworks of meaning-making, shaping understanding and subsequently shaping behaviour), and structures (e.g., class, gender, race). It is significant that professionals understand disenfranchised, or unexpressed, because grief can affect people in different ways, including relying on self-harm behaviour. The focus of treatment needs to reflect more adaptive ways to cope, such as finding non-harmful ways to express disenfranchised grief.

The present study had a number of limitations. Content analysis is interpretative and interpretation can be personal so there is the possibility that the researchers’ inferences represent personal and theoretical views, rather than the phenomenon of how the self-harmers felt when expressing themselves. Inferences are based on the collection of reliable and valid

data (Weber, 1990) and links have been demonstrated between the results and the data (Polit & Beck, 2004) therefore this limitation has been minimised.

Using inductive content analysis has enabled a greater understanding of internet self-harm social reality, the respondents communicating how they feel has made a reality over the internet. The message data has credibility because it has “adequate representation of the constructions of the social world under study” (Bradley, 1993, p. 440). It also has transferability, the ability to transfer the working hypothesis to another context such as drug addictions. This was ensured by “rich description and reporting of the research process” (Foster, 2004, p. 230). There is a degree of dependability because the Internet allows for the exchanging of information which is difficult to convey in person or when using a real-life identity (McKenna & Green, 2002). The coding is transparent and there is no ambiguity. This present study shows the usefulness of utilising on-line message boards as a research tool for conducting research with people who can be difficult to access.

Acknowledgments

The authors would like to thank the Editors of this journal special issue, Dr Wulf Livingstone and Dr Caroline Hughes.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

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