

Qualitative Health Research

<http://qhr.sagepub.com>

From Feeling Too Little and Too Much, to Feeling More and Less? A Nonparadoxical Theory of the Functions of Self-Harm

Outi Horne and Emese Csipke
Qual Health Res 2009; 19; 655
DOI: 10.1177/1049732309334249

The online version of this article can be found at:
<http://qhr.sagepub.com/cgi/content/abstract/19/5/655>

Published by:



<http://www.sagepublications.com>

Additional services and information for *Qualitative Health Research* can be found at:

Email Alerts: <http://qhr.sagepub.com/cgi/alerts>

Subscriptions: <http://qhr.sagepub.com/subscriptions>

Reprints: <http://www.sagepub.com/journalsReprints.nav>

Permissions: <http://www.sagepub.com/journalsPermissions.nav>

Citations <http://qhr.sagepub.com/cgi/content/refs/19/5/655>

From Feeling Too Little and Too Much, to Feeling More and Less? A Nonparadoxical Theory of the Functions of Self-Harm

Outi Horne

SANE (UK), London, United Kingdom

Emese Csipke

Kings College, London, United Kingdom

It is widely agreed that one of the functions of self-harm by cutting or burning the body is to regulate emotion. There is an apparent paradox in the emotion-regulative function of self-harm: some people are using self-harm to both increase and decrease affect. The aim of this study, which followed the principles of the grounded theory approach, was to generate a paradox-free theory of the functions of self-harm that is of immediate relevance to the participants themselves, who are often confused about the behavior and the experiences preceding it. We found that “feeling too little” and “feeling too much” share characteristics in three categories of experience: emotional awareness, sense of self/reality, and body-based experience. We explain the functions of self-harm in terms of body-based experience: Self-harm resolves a state of psychosomatic suspension and increases the extent to which the body is involved in the experience of emotion.

Keywords: *behavior; embodiment/bodily experiences; emotion work; mental health and illness; self; self-harm*

Defined as self-administered, nonaccidental injury to one's own body without suicidal intent, self-harm is found in both clinical and nonclinical populations (Gratz, Conrad, & Roemer, 2002), and is reportedly increasing among adolescents and young adults (Fortune & Hawton, 2005). There are many reasons individuals engage in self-harm. There is agreement that it is a method of releasing, expressing, or regulating distress, blocking memories/flashbacks, and/or managing “dissociation” (e.g., Briere & Gil, 1998; Gratz, 2003; Linehan, 1993). Elements of self-punishment and expressions of self-loathing (Zila & Kiselica, 2001), as well as a number of symbolic meanings such as communicating or recording inner pain through damaging the body, have also been recognized (Crowe & Bunclark, 2000; McLane, 1996; Milia, 2000; Miller, 1994). Self-harm can also serve as a means of eliciting a caring response from others (Favazza, 1996).

Besides recognizing a difficulty in describing experiential states such as depersonalization—to which self-harm is seen as a remedy—researchers, clinicians, and their clients alike, in trying to characterize the function of self-harm, find themselves grappling

with something of a paradox. Self-harm is thought to bring about emotions as well as take them away (Brown, Comtois, & Linehan, 2002), or to manage dissociation by sometimes initiating it and at other times ending it (Connors, 1996). Kennerly (2004) writes:

Often, the purpose of self-injury is to achieve a dissociated state which promotes a profound distraction from psychological and/or physical distress. . . . Interestingly, self-injury is also used, by some, as a means of escaping from a dissociated state, breaking out of the experience of depersonalization or derealization or out of a flashback, for example. (p. 374)

Weierich and Nock (2008) identified re-experiencing symptoms, such as flashbacks, and avoidance and numbing symptoms of posttraumatic stress disorder (PTSD), as mediators between childhood sexual abuse (CSA) and subsequent self-harm. CSA is commonly thought to play an important role in the etiology of self-harm. As it turns out, many of the precipitants of self-harm experienced by participants in this study could be classed as symptoms belonging to one of the two symptom groups.

One of the reasons self-harm is so difficult to replace as an antidote to psychological distress is that any individual act can arise from a number of motives, and at the same time fulfill several apparently distinct functions. In 2005 we launched a Web-based questionnaire with the aim of examining self-harm through a number of open-ended and multiple-choice questions. After tabulating the responses, motives such as self-punishment, the expression/communication of inner pain, and making mental pain tangible/treatable were found to co-exist with motives related to emotion regulation and derealization/depersonalization.

The above-mentioned paradox was also present: A sizeable proportion of respondents to the survey (30.7%, $n = 254$) indicated that they used self-harm (specifically cutting or burning the skin) both in response to overwhelming emotions (to release or manage them) and to “feel something.” In other words, there appeared to be a group of people who suffered both from diminished and excessive affect,¹ and who found in self-harm a resolution to both of these seemingly contrary states.

Aim of the Study

To explore this phenomenon we engaged a sample of respondents in e-mailed interviews. Our aim was to generate a theory that describes both forms of pathological experience and the ensuing behavior in a less paradoxical manner. We hope the results will be of immediate relevance to the participants themselves, who are often confused about the behavior and the experiences preceding it.

Method

Recruitment

The first phase of the project was an exploratory, Web-based questionnaire designed primarily to inform beneficiaries, stakeholders, service delivery, and campaigning activities of a mental health charity in the United Kingdom. The questionnaire was in three parts; in the part relevant to this article, participants were asked about methods and frequency of self-harm, their motivations for it, and their mental state before and after acts of self-harm. The motivations and mental state descriptions before self-harm were multiple-choice options replicating expressions drawn from academic publications, forums, and message boards hosted by self-harm Web sites, and other similar sources of first-person descriptions of the

experience of self-harm. The questions about methods were free text, to avoid “triggering” effects or giving ideas to participants, as were the questions about the after effects. Participants were also asked some basic demographic questions and invited to leave their e-mail address if they agreed to take part in further research. Responders to the survey who indicated that they self-harm both when feeling too much and when feeling too little were invited to participate in the second phase of the study, which consisted of e-mailed interviews.

Choice of Method

The second phase of the research followed the principles of grounded theory (Glaser & Strauss, 1967), as developed by Glaser (1978, 1992, 2005). We chose the method for its ability to generate explanatory models of behavior that draw on self-report as the primary source of theoretical insight. The broad area within which the study takes place is the multiple dimensions and realities of lived experience—a subject matter typical for phenomenological studies (Starks & Brown Trinidad, 2007). However, unlike phenomenological studies, which tend to study individuals and their unique circumstances, in the present study we focus on particular experiences identified through their functional role as precipitants of a type of behavior and through similarities in individuals’ descriptions of them. Furthermore, the goal of the study, being explanatory and focused on processes rather than descriptive and focused on meanings, makes the grounded theory approach a more suitable methodology (Starks & Brown Trinidad, 2007). We make two assumptions, one philosophical and the other epistemological: first, that subjective realities have important shared qualities; second, that they are reportable, and to the extent that they are reportable they can be understood by another person. We believe that, despite having been created for the purposes of sociological theory, the methods of Glaser’s grounded theory approach were fitting for our study. The method of constant comparison (a procedure in which units of data are compared to each other and to emerging categories), for example, seems to us entirely appropriate for teasing out of participants’ self-reports the shared core of their subjective experiences.

Data Collection and Analysis

Data collection and analysis proceeded simultaneously. During open coding we worked independently,

but with regular meetings to establish consensus before commencing on the next phase of collection and analysis. Comparison of notes at these meetings helped us to identify the central concerns for the participants and to resolve disagreements either by readjusting categories until they fit both researchers' conceptualization of data, or by establishing the best fitting category. After the first round of broad questions, which were the same for all participants, the interview questions developed as a part of the analytic process, and reflected the individual participant's prior responses. When the core category (the category that accounts for most of the variation in the data) began to emerge, we introduced specific questions related to that category.

The analysis of each participant statement involved the participant's account as a whole. We read each response several times to establish familiarity, and added notes and ideas in the margins. These notes and ideas were then passed between us. We identified emerging categories and examined them in relation to one another. When we found connections between categories, we grouped them into clusters, and eventually added them into evolving tables. This formed the basis for generating theoretical propositions that we then reviewed in light of incoming data. During this process, some gained importance (e.g., "Not knowing how or what one is feeling' precipitates self-harm"), whereas others were dropped (e.g., "The Pendulum Hypothesis" that people who self-harm "swing" from feeling too little to feeling too much, and back again). We continued the process of analysis and collection until the core category was sufficiently saturated to formulate the theory. In other words, we continued until no new properties were emerging for the core category and the majority of the remaining data relating to the two experiential contexts (feeling too much and feeling too little) could be coded using the other two categories, and explained in terms of the core category (significant exceptions are noted in the Conclusions section, below). As recommended by Glaser (1992), we reviewed extant literature only after the core category had emerged, to integrate, sharpen, and extend the theory.

To test our theory, we paid critical attention to cases where the participant's account did not seem to fit the emerging theory and where possible, explored those cases in more detail with the participant. To examine the relevance of our theory, we subjected it to participant validation when the first draft of the article was complete. We e-mailed the draft, as well as an outline of the theory expressed in an informal

style, to all participants, with an invitation to comment and criticize. The uptake was relatively small (8 out of 37 participants responded), but all feedback concerning the theory itself was positive: participants indicated that the theory reflected their experience, suggesting high validity.

Ethical Considerations

Drawing from a potentially international, nonclinical population, we were unable to access the United Kingdom's National Health Service Research Ethics Committee. Our attempts to secure a university partner for the purpose were similarly frustrated. Instead, we carried out participant risk-benefit evaluation in-house; we discussed the research with representatives from each of the organization's six departments (including the head of mental health services, e-mail service officer, a representative of the clinical resource team, and qualified counseling staff). We used the six key principles of ethical research outlined in the research ethics framework published by the Economic and Social Research Council in the United Kingdom as a quality standard (Economic and Social Research Council-United Kingdom, 2005). In addition, we used participant feedback from earlier comparable studies to critically evaluate the study design.

Potential risks arising from reflecting on uncomfortable experiences were made clear to participants: We warned them about the possibility of bringing about negative emotions, and about the possibility of developing an urge to self-harm in response to writing about self-harming. We encouraged participants to be vigilant about either effect, and to discontinue responding immediately on observing them. The slow pace of interviewing facilitated this, and participants sometimes took several months to respond while they waited for a more vulnerable period in their life to pass. Although the questions were sharply focused, the overall style of the communications was informal. This created a rapport, which enabled participants to disclose any ill effects that could then be "talked through" with us in subsequent e-mails. The telephone number and operating hours of the organization's own mental health helpline was included in every e-mail, and we had access to a team of qualified telephone counselors, to whom a distressed participant could have been referred. No participants needed a referral during the study.

The first e-mail contact was a request for consent in accordance with the principle of continuous consent (American Anthropological Association, 1998). We

Table 1
Emotional Awareness

Reality & existence	Absent affect/emotional numbness: Things will wash over me very easily and everything inside me seems to have just stopped. / I tend to hit a point where I will be numb, anything could happen but at that time emotionally I just won't feel it. / [I feel] empty from the lack of emotion. Reality of emotion: These emotions, although very strong, felt very unreal. / [After self-harm] I'd feel "real" human emotion again. / When it's just in your mind you're not sure what's real and what's not. / The pain that I know is there, gives my mind a concrete feeling that is logical to focus on, rather than the abstract feelings.
Nature & quality	Unfelt/distant emotion: Feelings seem distanced and not quite there. / [I'm still] aware of the emotions, just that they are behind a vast icy barrier. / When my mind shuts down I know the emotions are there, I can identify them, but I do not feel them. Accelerated emotion/thought: My head is spinning with thoughts and feelings. / Sometimes I feel too much at once. . . . There's never silence, there's just everything. / I would feel overwhelmed with anxiety, depression, suicidal thoughts, self-hating thoughts and I just wanted my brain to "shut up." Ownership of emotion: As if you are looking at someone else hurting rather than it being yourself.
Knowledge	Recognizing/identifying: Feeling a mixture of feelings that can't be untangled . . . a big mass of feelings that jumble up and therefore get so much that I then feel numb. / Sometimes when I'm really low I don't actually know how I feel. / I got so split off from how I was feeling that I didn't even know it was emotion any more. I couldn't read the signs. / Even strong "good" emotions can make me hurt myself because I just don't understand them.

reminded the participants of their right to discontinue at any time, encouraged them to be vigilant about any possible adverse effects thinking about self-harm might have, and encouraged them to call the helpline or access other available services if they found themselves becoming distressed. Of the 102 individuals contacted, 62 gave their consent.

Results

A proportion ($n = 25$; 40%) of participants who consented did not respond to the first round. To ensure no one felt pressured to take part, we interpreted silence as withdrawal of consent. The final sample consisted of 37 participants. Of these, 34 (92%) were female and the mean age was 23 ($SD = 7.35$; range 14-49). Thirty-three (89%) were from the United Kingdom, and 4 (11%) were from the United States. The sample identified themselves as White ($n = 33$, 89%), Asian ($n = 1$; 3%), Black ($n = 1$; 3%) or Mixed Ethnicity ($n = 2$, 5.5%). The yield from the interviews was 120 e-mails over a period of 8 months.

Analysis of the first round of e-mails gave rise to the three categories, which we then explored in subsequent e-mails and coded for in the analysis:

1. emotional awareness
2. sense of self/reality
3. body-based experience²

Tables 1, 2, and 3 display the structure of associated subcategories (SC) and illustrate them with examples using the participants' own expressions. All three categories extend across both "experiencing overwhelming emotions" and "wanting to feel something."

Feeling Too Much

Being overwhelmed by emotions was most commonly characterized in epistemic terms; for example: "There are emotions there, but they all go by so fast, I do not have the chance to identify them," or a "mixture of feelings that can't be untangled" (see Table 1, SC: recognizing/identifying). Participants talked about not understanding their emotions or not being able to recognize emotions in themselves. Some reported their experience simply as "mental pain." Many also made reference to too many emotions or thoughts being experienced at once, using expressions such as "more emotions than I know how to deal with" to describe their emotional confusion (SC: accelerated emotion/thought). When a single, identifiable emotion was experienced as overwhelming, it was anger, anxiety/fear, or sadness/depression. Being overwhelmed by the latter could also be a case of losing a sense of how one feels, e.g., "When I'm really low I don't actually know how I feel." Also characteristic of overwhelming emotions was the experience of a mixture of tension and agitation (SC: tension/agitation):

Table 2
Sense of Self/Reality

Self	<p>Sense of self: I feel like I'm not me and I'm looking at someone else and I don't know who I am. / I feel like I'm watching what's happening to me from the outside, that it isn't me that everything is happening to, it gives you a very distorted sense of reality and what is and isn't me.</p> <p>Reality of self: I cut because I need to know that I'm alive and real and not just an empty shell of a body.</p> <p>Sense of action: The feelings go out of control without my realization and separate my conscious mind from my physical actions. / Feeling really numb—just going through the motions.</p> <p>Sense of being alive/human: I feel desperate just to "feel" something, anything really, just to make me feel like I am actually alive really. / [Self-harm] is a way of trying to feel human again.</p>
Reality & others	<p>Presence: Afterwards it's like I have grounded again, brought myself back in to this time and place. / I don't know where my head was in that time but it certainly wasn't in the room. / I need to reattach myself to my body and to reality. / I self-harm to bring back a feeling of being present. / You're somehow detached from everything that's going on around you. Self-harming pulls you back a bit. / Self-harm is the only way to be full back in the world. / I am slowly removed from the earth when my mind starts to wander back into the past recalling memories of the abuse I suffered.</p> <p>Isolation: Loneliness and isolation. / You begin to shut yourself off from people emotionally.</p>

It was all through my body and I couldn't sit still or get comfortable. It felt like when you've been sitting still for ages, and you need to shift your limbs—except the feeling came from inside rather than outside so shifting position didn't work.

Another participant, quoted below, labeled the experience she described as "tension":

[A] very physical sensation for me . . . tense and overwound, like something inside me had been cranked up to breaking point . . . frustrated restlessness . . . like not being able to say something you really need to say.

Others wrote about a sense of being trapped in their bodies or "clawing to get out" (SC: trapped), or reported feeling as if their physical integrity were in danger; that they were "being torn to pieces from the inside" (SC: containment). Physical discomfort was also frequently referred to, as were arousal phenomena such as an increase in heart rate (SC: malaise).

Several participants reported feeling numb during the experience of overwhelming emotions. The word "numb" was used in two senses here: the first referred to physical numbness (SC: physical numbness/loss of sensation), and the second to emotional numbness, or an absence of scope for affective variation and responsiveness (SC: absent affect). Also characteristic of the experience of being overwhelmed appeared to be an inability to focus on the body, and many participants were unaware of what they were experiencing in their bodies (SC: body awareness).

Particularly in the context of overwhelming depression or sadness, participants wrote about a body that was

"too heavy and full of emotion," often together with a sense of being immobilized (SC: immobilization/heaviness). In addition, inability to express emotion by shouting, crying, and so forth, despite being overwhelmed, characterized the experience for some (SC: inhibited expressive behavior).

Not Feeling Enough

Inability to feel emotion characterized the motivation to harm "to feel something." This was variously described as emotional numbness, having no emotions, not feeling/experiencing anything (see Table 1, SC: absent affect), or as anomalies in how emotions were experienced, such as being sad without feeling it (SC: unfelt/distant emotion). A central feature of the former was the absence of emotional reaction to the world; the participants knew that their environment should have been having an impact on them, but they were failing to resonate:

You could just wake up one morning and have no smile and no tears . . . nothing. You could be flung into the vast void of space and wouldn't even feel surprised. . . . When you do notice yourself slipping into this state it's only because you start looking at things that would make you smile or cry and there's little, if any, effect.

Some felt no ownership of emotion; it was as if the emotions were happening to someone else:

One level of feeling that is like being detached from your own feelings as if you are looking at someone else hurting rather than it being yourself. . . . Cutting is a way of bringing the two together or to feel some

Table 3
Body-Based Experience

Reduced sensation	Experience of pain: When I first start harming I can't feel a thing . . . I know my cutting . . . has indeed grounded me, as the anesthetic really hurts! / The pain . . . isn't painful, rather it is a sense of relief. Physical numbness/loss of sensation: I feel numb—physically and emotionally. / I can't feel my own skin . . . [after self-harming] I can physically feel again. My senses come back. / I get a surge of energy and regain sensation.
Disembodiment	Body awareness: When the emotions are too much, it feels as though my body shuts down. / Like I couldn't tell where the edges of my body were . . . self-harming kinda defined the edges of my body. / It feels like my brain is on fire . . . I don't experience anything else on my body. Mind/body alignment: My body feels kind of detached from my brain. / Like I'm looking over my own shoulder sometimes. / [It's] almost like an out-of-body experience. Reality of body: When I was feeling so emotionally overwhelmed, I would begin to feel as if . . . the body did not even exist and I had become just this flying mass of mental turmoil. Ownership of body: The main feeling [in] my body is like it's not mine. Empty: It's like an emptiness, I feel so numb that I can't even feel my body just my head and it's drifting away.
Suspension	Inhibited expressive behavior: [I'm] so upset that I cannot even express myself by crying or talking or anything. / I feel as if I'm going to cry but nothing happens. Tension/agitation ("trapped"): My body felt trapped. Like I was ready to run a mile but stuck in the walls of a 4x4 fence. . . . I felt like I was stuck in park. I had the abilities to go places but I couldn't move. / [I'm] tense and built up inside . . . restless and on edge . . . in need of doing something but the mind does not seem able to concentrate. Immobilization/heaviness: It's a great effort to raise my head and do anything. / I feel like my body is too heavy and full of emotion. / I feel lethargic. Lost function: If I cut I'll start feeling and working again. My body will start and my brain can function.
Threat to integrity	Containment: I felt I didn't have room inside me to hold the weight of [the emotions], I didn't have the physical strength to bear that kind of force. / It felt like someone was tearing me to pieces from inside out. Malaise: It becomes physically hard to breathe as it feels your emotions are smothering you.

pain even if it is mainly physical . . . with the physical pain comes emotional pain so you do end up feeling on both levels which to some extent is better than not feeling.

By "numb," participants meant not just emotional numbness but also the physical kind. Others found themselves misaligned with their bodies, or experienced a feeling of not being in their bodies (SC: mind/body alignment).

Loss of affective resonance appeared to impact the way in which reality was experienced; participants felt "detached" from their environment (SC: presence) and disconnected from others (SC: isolation); they "could not be part of" what was going on. No participant reported having judged the external world as being unreal. What had been lost was a feeling, a sense of reality. The very core of self-experience seemed also affected, and participants wrote about feeling dead, not human (SC: sense of being alive/human), or not real (SC: reality of self). Some experienced a separation between "the acting self" and "the observing self" (SC: sense of action) prior to and

during self-harm. An oft-repeated phrase was "just going through the motions," used to describe this "living death" which is neither embodied nor embedded.

Crying, or rather the inability to cry, featured more strongly in descriptions of not feeling enough than it did in descriptions of feeling too much. There was a sense of some kind of a deadlock: "No matter how much I needed or wanted to I couldn't cry, the tears weren't there, I felt them inside but something was stopping me."

From Feeling Too Much to Feeling Too Little—and Back Again

Some participants were able to detect a progression from anger, emotional confusion, and/or from overwhelming sadness, to being unable to feel (although not in every instance), and even those who observed no such progression sometimes recognized that the triggers for the two states were the same. The subjective experience of the transition seemed to coincide with that of a loss of the sense of being embodied (SC: disembodiment): the body begins to

be perceived as intangible, misaligned with the mind, or disconnected from it; e.g., “When I was feeling so emotionally overwhelmed, I would begin to feel as if my mind had come adrift from the body, that the body did not even exist and I had become just this flying mass of mental turmoil.”

Overwhelming emotions could follow being unable to feel, or even be experienced simultaneously: “Sometimes, feeling so numb frustrates me, and it gets out of control. I get really irritable and upset, which sounds completely contradictory, as I just said I didn’t feel anything.” The contradiction resolves with the appreciation of the results discussed above, that feeling too little is a matter of a disturbance in the self-world relation of affective resonance and/or irregularities in the manner in which emotions are experienced. Neither excludes the possibility of simultaneously being upset or irritable about one’s present state of being.

Experience of Pain

Whether pain sensation is reported during self-harm is known to vary (Bohus et al., 2000). The accounts of the participants in this study reflected this; some experienced no pain at all, and for the rest there was a tendency toward less pain during harming “to feel something” than there was during overwhelming emotions. Some participants made explicit reference to pain sensation coinciding with the therapeutic effect of self-harm; e.g., “a certain level of damage has to be reached before I can feel ‘ouch’ and re-integrate with ‘her.’”³ Pain could also serve as a kind of meditative object, something to focus on when emotional turmoil was depriving the person of his or her ability to concentrate: “The pain . . . gives my mind a concrete feeling that is logical to focus on, rather than the abstract feelings.”

Feeling Too Little and Too Much: Shared Characteristics

The fact that self-harm functions as a remedy in the two seemingly disparate experiential contexts suggests that the two are not entirely distinct. The findings presented thus far argue for the same. First, the categories of (a) “emotional awareness,” (b) “sense of self/reality,” and (c) “body-based experience” connect the contexts via many of their subcategories. Second, the states were recognized as historically connected by the participants. In what follows, we argue that describing the function of self-harm in terms of its effect on

body-based experience will capture its essence and resolve the apparent paradox referred to previously.

Body-Based Experience and the Function of Self-Harm

The data indicate that the affective extremes in question are accompanied by changes in body-based experience. The changes could be categorized as follows:

Reduced sensation: physical numbness, loss of body sensations, reduced pain perception

Disembodiment: being misaligned with one’s body, so that “one feels as if one is looking over one’s own shoulder”; a sense of “not belonging” in one’s own body; a detachment of mind from body; a reduction in body awareness or focus; a sense of the body not being real; loss of a sense of ownership of the body

Suspension: inhibited expressive behavior; action readiness that is blocked in some way; a feeling of being trapped in one’s own body; depressive immobilization; failure of routine active engagement with the environment

Threat to integrity: the body’s felt inability to contain emotion without danger to it; malaise related to high arousal

The word “empty” was frequently used to describe the state of feeling too little, and seemed to relate to the way the body was experienced; e.g., “It’s like an emptiness, I feel so numb that I can’t even feel my body,” and “I cut because I need to know that I’m alive and not just an empty shell of a body.” Participants wrote about being a body with no feelings, about not being able to feel their own skin, about there not being any sensations, about being physically numb. Perhaps as a consequence, the reality and the ownership of the body were also questioned.

Prior to or coexistent with this reduction in the body’s contribution to awareness was a reported sense of a deadlock with respect to emotive expression. The body, no longer a vehicle for the expression of mental life, was felt to be a trap for the mind and separate from it: “I’m clawing away inside my own skin to escape . . . I am trapped.” It was interesting that frequent reference was made to deliberate habitual suppression of expressive behavior, suggesting that when prolonged or frequent, willful suppression might become involuntary.

The sense of physical danger related to overwhelming emotions was communicated very strongly by participants. It was felt that the body would not be able to withstand the tension or agitation associated

with them; that it would explode or snap unless the state was defused by self-harm. In this sense, it is the body that is “screaming to be cut,” and the feeling that calm and stability must be reinstated is “physical.” If overwhelming emotions are not released, body awareness might drop: “When the emotions are too much, it feels as though my body shuts down” (SC: body awareness).

Self-harm was reported to return sensation, end disembodiment, release suspension, and relieve the strain on the body experienced as threatening to break under the emotional turmoil. Participants wrote about self-harm helping them to reconnect with their bodies and to become able to focus on their bodies. The immediate sensation was often described by the word “rush,” suggestive of something becoming activated. This was almost without exception followed by calm relaxation. Some indicated that self-harm returned the ability to cry but others thought self-harm served as a substitute, removing the need to cry. One participant described self-harm as a “release valve letting emotions surface again.” Self-harm was described as restoring the ability to function, to engage in routine activity such as cleaning, where it had felt impossible prior to self-harm.

The first three types of change to body-based experience (reduced sensation, disembodiment, and suspension) featured both in instances of feeling too little and of feeling too much. In the next section we attempt to relate these to the other shared significant features of the emotive extremes in the categories of emotional awareness and sense of self/reality. We hope this will support the argument that self-harm manipulates emotional awareness and sense of self/reality by manipulating body-based experience.

Discussion

Emotional Awareness and Body-Based Experience

In the experiential context characterized by disembodiment, participants reported having no emotion, having no sense of ownership of emotion, or not feeling an emotion despite being able to identify it. There is plenty of evidence to suggest that some body-based experience is necessary for full experience of emotion (Laird, 2007). Experimental work on emotion has shown that reducing autonomic arousal or inhibiting facial expressions can each result in less intensely experienced emotion (Laird, 2007), and Damasio

(2000) reports on patients who, after suffering neurological damage to the motor pathways that convey signals to the skeletal muscles, no longer experience emotion in the same way or as intensely as they had before the damage occurred. These findings support the view that what has been lost in the disembodied and/or suspended states is indeed an important aspect of emoting: body-based experience. The individual differences exhibited by those who simply say they have no emotion vs. those who say they have them but don't feel them might be explained by the finding by Laird and his team that some individuals' experience of emotion tends to rely more heavily on cues that are situational than cues that are personal and body-based, such as autonomic arousal, expressive behavior, and action readiness (Laird, 2007).

Two ways of knowing about emotions are contrasted in the following quotations from participants. On the one hand: “I knew I was sad but I couldn't really FEEL it,” and on the other: “Sometimes when I'm really low I don't actually know how I feel. . . . I feel so numb that I can't even feel my body.” Whereas the latter quotation illustrates a reliance on body-based experience in knowing about present emotional state, the former shows that physical sensations are not necessary—emotions have a causal, temporal, situational, and cognitive context, which forms a ground for knowing that one is sad despite the sadness being unfelt.

Unfelt emotions cannot be attended to through body-based experience, so one way to understand emotions (directly, tacitly, preconceptually) is lost. Does the loss of tacit understanding of emotion contribute to the emotional confusion experienced when emotions become overwhelming? Perhaps it does. First, a number of participants mentioned feeling physically numb when experiencing overwhelming emotions, and significantly, they tended to be those who did not report full-blown disembodiment with its implications for sense of self/reality. Second, loss of ability to focus on the body during overwhelming emotions was also reported, and one participant wrote explicitly about how disembodiment, which the participant thinks is at least partially self-imposed, prevented body-based understanding of emotions. The subtleties of emotional experience were gone, and replaced by physical symptoms of emotional extremes:

I got so split off from how I was feeling that I didn't even know it was emotion any more. I couldn't read the signs. Instead of getting angry, I got tense. Instead of getting scared, I got dizzy. Instead of sad, I felt blank and empty.

Third, there appears to be a progression from the agitated/tense state to the disembodied state. Given participants' choice of words when they described this process (e.g., "beginning to feel numb"), we believe that the additional assumption, that this progression is gradual, is also warranted. In our view, then, the process of becoming overwhelmed by emotions coincides with a gradual reduction in the contribution the body makes to the structuring of the experience of emotion.

Sense of Self/Reality and Body-Based Experience

Some neurologists have suggested that a sense of one's body is the basis for one's sense of self (Craig, 2002; Damasio, 1994). In disembodiment the mind is "adrift from the body," which feels numb, "like there aren't any sensations." Stanghellini (2004) distinguishes three layers of the sense of self: sensory self-consciousness, reflexive self-consciousness, and narrative identity. It seems to be the lack of the first, embodied self-consciousness, that characterizes the experience of the participants in this study. It was in this sense that they felt unreal, not like themselves, dead, fragmented. They cut to demonstrate that they were real. They believed (reflexively) that they were real, but they also needed to know (tacitly, directly, prereflexively) that they were.

Many participants remarked on how in each context (though more frequently in the state of wanting to feel) their sense of reality was affected. They also wrote about a state in which perceptions of objects, events, and people around them had no effect on them; perceptions had no bodily consequences for them, and they felt nothing about what they perceived. Such loss of resonance was found in our study not just in the context of sadness/depression, but wherever emotional numbness was present, whether it was depressive, a feature of the state of absent affect following overwhelming emotions, or of the heightened affective state itself. One participant explained how anxiety, for example, could "put [her] outside of whatever is going on around [her]": "The little bits of texture that make up other people's emotional experiences can't fit in any more . . . [the emotion] is filling you up so much that there's no room for anything else . . . so you're sort of simultaneously numb and running at a really high emotional pitch." Loss of a sense of reality is thus not necessarily a matter of lack of affect but lack of variation in it, or, put in another

way, lack of phenomenal awareness of the impact of one's surroundings on one's body state. This can be a feature of disembodiment and a loss of sensory/affective harmony, or suspension and loss of behavioral harmony, which the following quotation illustrates:

It's almost like I am there but I can't touch anything or I can't connect. Everything requires massive effort and I'm not really able to do anything. Like if I notice something needs cleaning or moving, it's like its out of reach, or the act of doing that thing isn't in my world at that time . . . like I can see so much detail but I cannot be a part of it. I suppose feeling disconnected is the best way to describe it.⁴

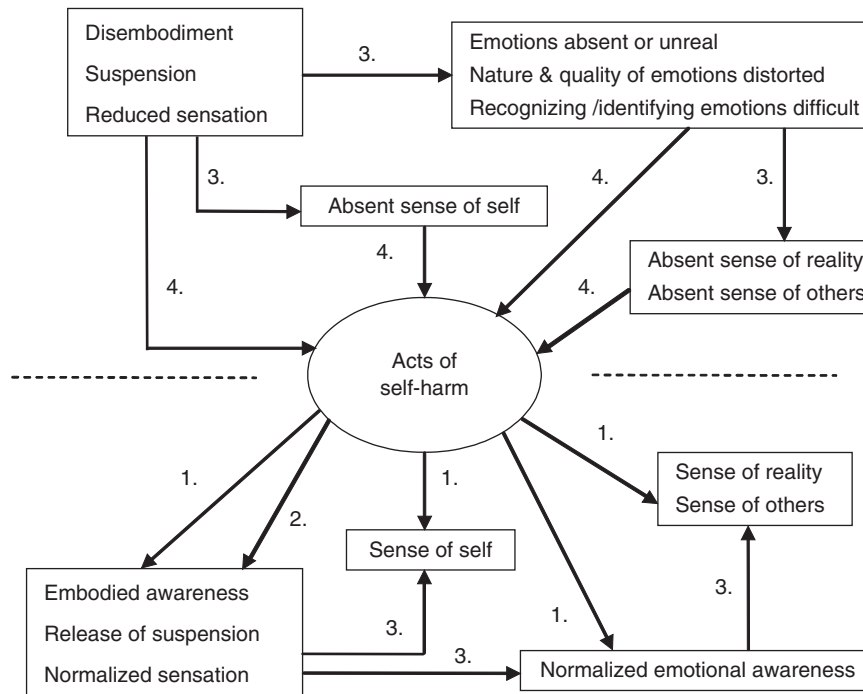
A number of theorists have noted an apparent connection between anomalies in body-based experience and failures of embeddedness. For example, Sass (2004) writes how in schizophrenia, in which the body can be experienced as not under one's own control or as failing to behave in a manner congruent to thoughts and behaviors, "a fragmented and alienated sense of the lived body tends to disrupt the world-directedness as well as the normal fluidity and flow of affective experience and expression, leading to a sense of disharmony, artificiality and distance" (p. 134).

In short, body-based experience can be linked with the sense of self/reality, and prior experimental evidence and theoretical insights recommend a view in which the body is integral for experiencing emotion and for interpreting it. Conversely, it can be expected that if the body fails to feature in the awareness normally, and if the usual flow of activity is disrupted, the ability to experience emotion and to think about it, as well as the sense of self and reality, would be impacted. We believe that this lends credibility to our explanatory model of the functions of self-harm, presented in Figure 1, which proposes that self-harm achieves its functional diversity by manipulating body-based experience.

The Function of Self-Harm

Reading about the subjective experience of those who harm themselves, the intense physicality of the affective states leading to it can hardly be doubted. There is suspension, manifesting either as agitated, restless tension that resists being discharged into action, or as an inability to initiate expressive behaviors, despite a felt need to cry or scream, or as immobilization characteristic of a major depressive episode or paralyzing fear. There is disembodiment, depressive or otherwise, where the body fails to feature in

Figure 1
The Proposed Model of the Functions of Self-Harm



Theoretical connections (direction of arrow: A to B)

- | | |
|--|---------------------------|
| 1. B is the outcome of A (participant point of view) | 3. A is a condition for B |
| 2. A causes B (theoretical point of view) | 4. A is a reason for B |

awareness in the usual way. Both can be resolved by self-harm, which is itself undeniably a body-based intervention. The interview data suggest that one of the basic functions of self-harm is to bring suspension to an end. That this has such a resounding effect on emotional state testifies for the importance of body-based experiences as constituents rather than mere effects of emotion. Insofar as the emotion in question is constituted by tension and action readiness (as is the case with anger and anxiety, for example), it is “released” when suspension resolves to relaxation and calm. An end to depressive immobility is interpreted as revitalization, a lifting of mood. William James, in the 19th century, put forward the view that emotions are feelings of bodily changes arising from perceptions, writing that “bodily changes follow directly [a] perception of [an] exciting fact, and . . . our feeling of the same changes as they occur IS the emotion. . . . [It is the case that] we feel sorry because we cry, angry because we strike, afraid because we tremble, and not that we cry, strike or tremble, because we

are sorry, angry, or fearful” (James, 1884, p. 128). It follows from James’ theory that emotive states can be manipulated directly by introducing a physical change to the system. This is precisely what self-harm does. In addition, we have argued that self-harm can simultaneously increase the extent to which the body is involved in the experience of emotion through restoring a sense of the body and the ability to sense one’s own movements. The seemingly divergent functions of decreasing and increasing affectivity can thereby be reconciled; both are the result of resolving suspension and enhancing embodiment.

Self-harm returns the aspect of emoting that gives it the experience of ownership and makes the emotion felt—the body-based experience of emotion. This has implications for sense of reality, as discussed above. The data also show that self-harm can be utilized to resolve emotional confusion. We have argued that the process of being overwhelmed by emotions that could not be attended to, focused on, and isolated as an object of thought might feature a loss of body-based,

tacit understanding of emotion as a contributing factor. The two functions of self-harm combine to enable body-based experience of emotion. Finally, self-harm, in ending “disembodiment,” returns the foundation of the sense of self: sensory self-consciousness.

Conclusions

The theoretical model we propose presents self-harm as an act that manipulates the way in which the body contributes to the experience of emotion. We recognize that the scope of the model is limited to self-harm among those who report overwhelming emotions and/or desire to “harm to feel something.” Future research could explore whether people who say they harm only to punish themselves or to express self-loathing experience similar states of suspension or disembodiment. This article is not comprehensive in the second sense that in their e-mails the participants introduced a number of other concepts that we believe could be connected with the categories presented here: “sense of control,” “frustration,” “ineffectiveness,” “focus,” and “self-loathing.” These and other motivations and precipitants of self-harm continue to present fertile ground for exploration.

Some potential limitations resulting specifically from the choice of method must also be acknowledged. No face-to-face contact was made between us and the participants. However, it has been argued that this can improve rather than reduce the quality of data; e-mail interviews allow time for reflection both for researchers and participants, and can achieve “deeper processing of information and a more complete review of the issues that are being discussed” (Hunt & McHale, 2007, p. 1416). It is also probable that the choice of method was able to reduce the extent to which the participants’ concerns about social desirability influenced their responses. In gathering the data, we followed the relevant recommendations outlined in Hewson (2003).

An added limitation is that the sample was predominantly female and White. Although in the initial stages of the research (the first questionnaire) the respondents were much more varied, it was not possible to influence who was willing to take part in the second stage of the study. It would further validate the findings if they could be replicated among other cultures and among male respondents.

The fit of the model could be, at least in principle, empirically verified. For example, a measure could

be developed to examine body-based experience, and the hypothesis that occurrent need to self-harm correlates with heightened abnormalities in body-based experience could be tested by comparing results obtained at a time when an individual wants to harm themselves to a baseline measure established when the need is not experienced acutely. It would also be interesting to apply a trait version of the measure to a control group with no experience of self-harm and compare the results with those drawn from a group of people with a history of self-harm.

The theory has some clinical applications. A therapeutic approach is suggested, recognizing that self-harm is a way of regulating emotion and focusing on embodiment. Much more research and development will be needed in this respect, but some therapies containing elements that adopt such an approach already exist. Dialectical behavior therapy (DBT; see Linehan (1993) for its original formulation) has been shown by randomized, controlled trials to be effective in reducing self-harm among people diagnosed with borderline personality disorder (Koons et al., 2001; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Verheul et al., 2003). The intervention is a collection of group and individual therapy methods and behavioral skills training. As Linehan, Bohus, and Lynch (2007) point out, the efficacy of each treatment component is not known, but the findings from the present study suggest that the core DBT skill of mindfulness might make a significant contribution to the treatment’s efficacy in reducing self-harm. DBT and other mindfulness-based treatment approaches⁵ emphasize the importance of being awake to one’s present experience in a nonjudgmental way, and of cultivating an intense connection with one’s activity (Robins, Schmidt, & Linehan, 2004). In contrast to the majority of traditional forms of therapy, mindfulness-based therapies include elements where the focus is on processing that is nonconceptual and body-involving. There are elements that support body awareness in a general way, such as meditation on breath, posture, and/or movement. Other elements target the experience of emotion directly; therapy clients are instructed in methods of observing and describing physical sensations, expressive behaviors, or action urges related to emotions. Mindfulness skills can thus support direct awareness of emotions and promote a sense of embodiment, and in the absence of local resources, they can be learned independently through the use of self-help books (see Williams, Teasdale, Segal, & Kabat-Zinn, 2007).

There are of course other ways of involving the body in therapy. They could include methods in which the patient's self-awareness is supported in the moment by the therapist's feeding back the autonomic responses she or he is observing (this was found helpful by one of our participants), and the use of touch in therapy. Schoppmann, Schröck, and Schnepf (2007) found that touch within the context of a trusting relationship can constitute a helpful intervention for those who self-harm.

Research shows that modulating one's physical state by manipulating facial expression, posture, breathing, muscle tension, and so forth, will result in an emotional alteration (see Laird, 2007, or Philippot, Baeyens, Douilliez, & Francart, 2004, for a summary of research findings). We have proposed that underlying the need to self-harm is in many cases a diminution of body awareness, which might make regulating emotion through such strategies difficult. Increasing body awareness through mindfulness practice and other body-involving methods could be expected to make a difference to how emotions are processed, and should result in a reduced need to self-harm.

Finally, many of the experiences that, in this analysis, were subsumed under the codes "presence," "absent affect/emotional numbness," "isolation," and others could have been coded using the existing conceptual framework for describing the symptoms of PTSD. Consequently, the theoretical framework presented here might have some interesting applications for understanding the disorder and the effects of trauma.

Notes

1. The term "affect" is used throughout this article to refer to the experience of emotion or mood.
2. Body-based experience is experience that cannot be fully described without reference to the body being experienced in a certain way (as crying, tense, numb, not real, and so forth).
3. It is interesting that some of these participants answered affirmatively when they were asked whether they experienced pain during self-harm but others didn't. This suggests that whether pain is reported during self-harm depends to some extent on the individual's understanding of what is meant by "during." Evidently, both states might feature a degree of analgesia, which disappears when the state is resolved.
4. The participant called this state "dread." When asked what she was afraid of, she became uncertain about the label. Plausibly, her interpretation of the emotion relied primarily on the paralysis she experienced.
5. See Baer (2006) for a useful collection of articles on this topic.

References

- American Anthropological Association. (1998). *Code of ethics of the American Anthropological Association*. Retrieved October 8, 2008, from http://www.aaanet.org/_cs_upload/issues/policy-advocacy/23970_1.pdf
- Baer, R. A. (Ed.). (2006). *Mindfulness-based treatment approaches: Clinician's guide to evidence base and applications*. Burlington, MA: Elsevier Academic Press.
- Bohus, M., Limberger, M., Ebner, U., Glocker, F. X., Schwarz, B., Wernz, M., et al. (2000). Pain perception during self-reported distress and calmness in patients with borderline personality disorder and self-mutilating behaviour. *Psychiatry Research*, 95(3), 251-260.
- Briere, J., & Gil, E. (1998). Self-mutilation in clinical and general population samples: Prevalence, correlates and functions. *American Journal of Orthopsychiatry*, 68(4), 609-620.
- Brown, M. Z., Comtois, K. A., & Linehan, M. M. (2002). Reasons for suicide attempts and non-suicidal self-injury in women with borderline personality disorder. *Journal of Abnormal Psychology*, 111, 198-202.
- Connors, R. (1996). Self-injury in trauma survivors: 1. Functions and Meanings. *American Journal of Orthopsychiatry*, 66(2), 197-216.
- Craig, A. D. (2002). How do you feel? Interoception: The sense of the physiological condition of the body. *Nature Reviews: Neuroscience*, 3, 655-666.
- Crowe, M., & Bunclark, J. (2000). Repeated self-injury and its management. *International Review of Psychiatry*, 12(1), 48-53.
- Damasio, A. (1994). *Descartes' error: Emotion, reason and the human brain*. New York: Harper Collins.
- Damasio, A. (2000). *The feeling of what happens: Body, emotion and the making of consciousness*. New York: Harcourt.
- Economic and Social Research Council—United Kingdom. (2005). *Research ethics framework*. Retrieved November 13, 2008, from http://www.esrc.ac.uk/ESRCInfoCentre/Images/ESRC_Re_Ethics_Frame_tcm6-11291.pdf
- Favazza, A. R. (1996). *Bodies under siege: Self-mutilation and body modification in culture and psychiatry*. Baltimore, MD: Johns Hopkins University Press.
- Fortune, S. A., & Hawton, K. (2005). Deliberate self-harm in children and adolescents: A research update. *Current Opinion in Psychiatry*, 18(4), 401-406.
- Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (1992). *Basics of grounded theory analysis: Emergence vs. forcing*. Mill Valley, CA: Sociology Press.
- Glaser, B. G. (2005). *Grounded theory perspective III: Theoretical coding*. Mill Valley, CA: Sociology Press.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine.
- Gratz, K. L. (2003). Risk factors for and functions of deliberate self-harm: An empirical and conceptual review. *Clinical Psychology: Science and Practice*, 10(2), 192-205.
- Gratz, K. L., Conrad, S. D., & Roemer, L. (2002). Risk factors for deliberate self-harm among college students. *American Journal of Orthopsychiatry*, 72(1), 128-140.

- Hewson, C. (2003). Conducting research on the Internet. *The Psychologist*, 16(6), 290-293.
- Hunt, N., & McHale, S. (2007). A practical guide to the e-mail interview. *Qualitative Health Research*, 17, 1415-1421.
- James, W. (1884). What is an emotion? In C. Calhoun & R. C. Solomon (Eds.), *What is an emotion? Classic and contemporary readings*. (pp. 127-141). New York: Oxford University Press.
- Kennerley, H. (2004). Self-injurious behaviour. In J. Bennett-Levy, G. Butler, M. Fennell, A. Hackmann, M. Mueller, & D. Westbrook (Eds.), *Oxford guide to behavioural experiments in cognitive therapy* (pp. 373-390). New York: Oxford University Press.
- Koons, C., Robins, C. J., Tweed, J. L., Lynch, T. R., Gonzales, A. M., Morese, J. Q. (2001). Efficacy of dialectical behavior therapy in women veterans with borderline personality disorder. *Behavior Therapy*, 32, 371-390.
- Laird, J. D. (2007). *Feelings: The perception of self*. New York: Oxford University Press.
- Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
- Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. L. (1991). Cognitive behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, 48, 1060-1064.
- Linehan, M. M., Bohus, M., & Lynch, T. R. (2007). Dialectical behavior therapy for pervasive emotion dysregulation: Theoretical and practical underpinnings. In J. J. Gross (Ed.), *Handbook of emotion regulation* (pp. 581-605). New York: Guilford Press.
- McLane, J. (1996). The voice on the skin: Self-mutilation and Merleau-Ponty's theory of language. *Hypatia*, 11, 107-118.
- Milia, D. (2000). *Self-mutilation and art therapy*. London: Jessica Kingsley.
- Miller, S. G. (1994). Borderline personality disorder from the patient's perspective. *Hospital and Community Psychiatry*, 45, 1215-1219.
- Philippot, P., Baeyens, C., Douilliez, C., & Francart, B. (2004). Cognitive regulation of emotion: Application to clinical disorders. In P. Philippot & R. S. Feldman (Eds.), *The regulation of emotion* (pp. 71-100). New York: Erlbaum.
- Robins, C. J., Schmidt III, H., & Linehan, M. M. (2004). Dialectical behavior therapy: Synthesizing radical acceptance with skillful means. In S. C. Hayes, V. M. Follet, & M. Linehan (Eds.), *Mindfulness and acceptance* (pp. 30-45). New York: Guilford Press.
- Sass, L. (2004). Affectivity in schizophrenia: A phenomenological view. *Journal of Consciousness Studies*, 11(10-11), 127-147.
- Schoppmann, S., Schröck, R., & Schnepf, W. (2007). Bodily sensations in moments of alienation related to self-injurious behaviour. *Journal of Psychiatric and Mental Health Nursing*, 14(6), 587-597.
- Stanghellini, G. (2004). *Disembodied spirits and deanimated bodies: The psychopathology of common sense*. Oxford: Oxford University Press.
- Starks, H., & Brown Trinidad, S. (2007). Choose your method: A comparison of phenomenology, discourse analysis and grounded theory. *Qualitative Health Research*, 17, 1372-1380.
- Verheul, R., van den Bosch, L. M., Koeter, M. W. J., deRidder, M. A. J., Stijnen, T., & van den Brink, W. (2003). Dialectical behaviour therapy for women with borderline personality disorder. *British Journal of Psychiatry*, 182, 135-140.
- Weierich, M. R., & Nock, M. K. (2008). Posttraumatic stress symptoms mediate the relation between childhood sexual abuse and nonsuicidal self-injury. *Journal of Consulting and Clinical Psychology*, 76(1), 39-44.
- Williams, M. G., Teasdale, J. D., Segal, Z. D., & Kabat-Zinn, J. (2007). *The mindful way through depression: Freeing yourself from chronic unhappiness*. New York: Guilford Press.
- Zila, L. M., & Kiselica, M. S. (2001). Understanding and counseling self-mutilation in female adolescents and young adults. *Journal of Counseling and Development*, 79(1), 46-52.

Outi Horne, MPhil, is a research manager at SANE, a national mental health charity based in London, United Kingdom.

Emese Csipke, PhD, is a program coordinator and senior research fellow at the Institute of Psychiatry, Kings College, in London, United Kingdom.

For reprints and permission queries, please visit SAGE's Web site at <http://www.sagepub.com/journalsPermissions.nav>.