Addiction to self-harm? The case of online postings on self-harm message boards

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Abstract

Presently there is limited research investigating the addictive nature of self-harm, even though Non-Suicidal Self-Injury disorder has been included in the DSM-V (American Psychiatric Association, 2013) for over 5 years. The aim of the present study was to build on the existing literature by examining self-harm discussions on Internet message boards to examine if themes related to addiction are present. A sample of 500 online postings from four forums were analysed to examine whether self-harm has an addictive nature. Postings were extracted, read, and re-read before being coded using inductive content analysis to identify themes. Six themes were identified: "Urge/Obsession", "Relapse", "Can't/Don't want to stop", "Coping mechanism", "Hiding/Shame", and "Getting worse/Not enough". Postings revealed there can be cravings to engage in self-harm behaviour, not wanting or being able to stop, returning to the behaviour, self-harm being a coping mechanism, shame, and the behaviour becoming worse. This study has demonstrated that repetitive self-harming seems to have addictive aspects.

Keywords: Self-harm; Addiction; Internet; Content Analysis.

Introduction

The Internet is a predominant means of gathering health-related information (Griffiths, Tang, Hawking, & Christensen, 2005) because it is perceived as being a convenient and accessible source for confidential health knowledge which can circumvent confidentiality concerns (Gray, Klein, Noyce, Sesselberg, & Cantrill, 2005). The Internet has been shown to be a valuable resource for people seeking support regarding a wide variety of health concerns, including cancer (Lieberman & Goldstein, 2006; Ziebland et al., 2004), eating disorders (Doran & Lewis, 2011), HIV/AIDS (DeGuzman & Ross, 1999), schizophrenia/schizotypal personality disorder (Schrank, Sibitz, Unger, & Amering, 2010), and self-harm (Frost & Casey, 2016; Johnson, Zastawny, & Kulpa, 2010; Lewis, Rosenrot, & Messner, 2012; Murray & Fox, 2006; Rodham, Gavin, & Miles, 2007; Whitlock, Powers, & Eckenrode, 2006).

In Great Britain in 2016 the Internet is used every day, or most days, by 41.8 million adults (82%), a rise of 4% from 2015 and over 50% more than the reported estimate of 35% in 2006, which is when directly comparable archives began (Office for National Statistics, 2016). In the European Union in 2016, 61% used the Internet every day or almost every day (Statista, 2017). In 2016, 88.5% of Americans were Internet users (Internet users in the USA, 2016). Preliminary logging studies have highlighted that smartphone use could be as much as 2.7 hours per individual per day, and smartphones have ongoing Internet network connectivity (Oulasvirta, Rattenbury, Ma, & Raita, 2012).

The Internet can potentially be a source of support for those who feel the need to alleviate loneliness and shame (Duggan, Heath, Lewis, & Baxter, 2012), such as those who feel compelled to self-harm. The freedom gained from more open communication may exert positive or negative influences on a person's psychological health (Daine et al., 2013), and hence exacerbate or ameliorate the urge to self-harm. The anonymity of chat room dialogue can also bring relief to those who do not feel comfortable communicating taboo topics (Becker & Schmidt, 2005), such as for example eating disorders (Doran & Lewis, 2012), sexual health (Kanuga & Rosenfeld, 2004), and self-harm (Lewis, Heath, Sornberger, & Arbuthnott, 2012), because of the support and information provided (Reinhold, 2003).

Secrecy about self-harm has been described as part of what makes a "genuine" self-harmer (Crouch & Wright, 2004). Self-harm such as self-cutting is usually carried out in private. Shame can become associated with self-harming behaviour because it is misunderstood by family, friends and professionals (McAndrew & Warne, 2014; Simpson, 2006). Self-harm can also be associated with internal shame. Internal shame is connected to negative self-evaluations and viewing oneself as flawed, inadequate, bad or incompetent (Gilbert et al., 2010). The sense of shame may be perpetuated by perceived punitive treatment from staff in hospital, which can bring about humiliation, avoidance, and hence trigger more self-harm (Owens, Hansford, Sharkey, & Ford, 2016). It is estimated that the incidence of presentation to hospital after an episode of self-harm each year has risen to 400 per 10,000 people in just one city in Great Britain (Horrocks, House, & Owens, 2002). The majority of people who self-harm do not go to the hospital (Hawton, Rodham, Evans, & Weatherall, 2002), secrecy and shame probably relate to this.

Self-harm, young people and the Internet

The onset of self-harm behaviour typically happens between the young ages of 14 and 24 years old (Nixon, Cloutier, & Jansson, 2008). Young people aged 10-17 years old who engage in self-harm possibly participate in more Internet use than those who do not self-harm (Mitchell & Ybarra, 2007). The Internet can be a way to communicate and seek support and validation (Lewis & Baker, 2011; Lewis, Rosenrot, & Messner, 2012; Whitlock, Eckenrode, & Silverman, 2006). The total amount of Internet sites devoted to a variety of health and social care topics has grown exponentially in the last 20 years (Rodham, Gavin, & Miles, 2007). A review of 38 studies involving the health and social effects of Internet-based support groups has been undertaken (Eysenbach, Powell, Englesakis, Rizo, & Stern, 2004) and it was reported that "there is little evidence regarding the efficiency of non-healthcare professional led electronic support groups and virtual communities" (p. 352). Clinicians have noted that Internet forums have been referred to as being generally a positive influence on coping by the sharing of experiences with service users (Haberstroh & Moyer, 2012; Horrigan & Rainie, 2006). Almost 30% of self-harming individuals report using e-message boards a variety of times daily, and almost half report using them once a day (Johnson, Zastawny, & Kulpa, 2010). The Internet may have pertinence for those who self-harm because it offers a low-risk venue for

encountering similar people who share perceived or real differences, and the exchange of information which can be challenging to communicate in person or when using a real-life identity (McKenna, Green, & Gleason, 2002). Many individuals who self-harm go online and share their injuring experiences through online communities, video-swapping sites, personal websites, and discussion boards (Lewis & Baker, 2011; Rodham, Gavin, & Miles, 2007; Johnson, Zastawny, & Kulpa, 2010; Whitlock, Lader, & Conterio, 2007). Self-harm communities flourish on the Internet because self-harming is a sequestered and stigmatised behaviour (Whitlock, Lader, & Conterio, 2007) and there is a degree of anonymity due to the use of profile names, similar to eating disorder sites for example (Borzekowski et al., 2010; Norris, Boydell, Pinhas, & Katzman, 2006). In 2005 over 400 self-harm message boards were documented, and this rose to over 500 a year later (Whitlock, Lader, & Conterio, 2007; Whitlock, Powers, & Eckenrode, 2006).

Social media relies on users to deliberately propagate information to other users (Hodas & Lerman, 2014), and there is contradiction regarding whether Internet use influences self-harming behaviour (Bell, 2014). Self-harm being discussed more openly on the Internet as a practiced, normalised routine could have a contagion effect. Social contagion is the augmentation of information spreading. Self-harm communities on Internet message boards are increasingly widespread, visited often and hence could be a means of normalising and spreading harming behaviour (Whitlock, Powers, & Eckenrode, 2006).

There is growing evidence of the use and value of internet message boards as a way of receiving and/or providing support for those who have mental health problems (Malik & Coulson, 2013; Mo & Coulson, 2014). Although, there is presently no data on how widely such forums are used by self-harmers, however it can be argued that this population may use them frequently because there are quite a number of virtual self-harm communities (Whitlock, Powers, & Eckenrode, 2006), video sharing sites (Lewis, Heath, St Denis, & Noble, 2011), and personal websites (Lewis & Baker, 2011) in which to communicate.

The Internet and exacerbation of self-harming behaviour

Using self-harm websites may normalise self-harm behaviours and so prevent website users from seeking the professional help they need (Baker & Fortune, 2008; Messina & Iwasaki, 2011). Self-harm websites may encourage or trigger self-harm

behaviour (Whitlock, Powers, & Eckenrode, 2006). Young people who self-harm may have less opportunity to easily seek help through family and friends because of unfavourable attitudes towards self-harm and little social support (Frost & Casey, 2016; Martin, Bureau, Cloutier, & Lafontaine, 2011), which can mean they turn to the Internet to find people who appear to understand them. Media such as online videos can be affective stimulation or cognitive message spreaders, and unintentionally glorify self-harm (Lewis, Heath, St Denis, & Noble, 2011). Online posts can be edited or deleted if deemed inappropriate, members banned or boards removed by forum moderators. Graphic disturbing images or posts can remain unchecked by poorly moderated sites. Unmoderated content can be controversial, especially since numerous young people use the Internet (Swannell et al., 2010). Moderators and social communication site owners have become increasingly aware that some self-harm communities can promote certain maladaptive behaviours. The moderation of self-harm websites plays a key role in having a safe and positive community (Webb, Burns, & Collins, 2008).

More than 80% of 42 hospitalised youths with repetitive self-injuring behaviour reported having almost daily urges to self-harm as measured by a modified version of the Ottawa/Queens Self-injury Questionnaire (Nixon, Cloutier, & Aggarwal, 2002). Having the frequent urge to self-harm was included in the final proposed criteria for *Non-Suicidal Self-Injury Disorder* (NSSID) (Andover, 2014) in the fifth edition of the *Diagnostic and Statistical Manual* (APA, 2013). In a review of empirical literature about the existence of NSSID, there was a high level of validation for criteria C3, urge to self-injure (Washburn, Potthoff, Juzwin, & Styer, 2014). However, inter-rater reliability of NSSID was unacceptably low in the preliminary DSM-V field trials (Regier et al., 2013) so is included in Section 3 of the DSM-V, *Disorders Requiring Further Research* (APA, 2013). Several self-harm forums do post trigger warnings to indicate that urges to self-harm may be triggered by online content (Lewis & Baker, 2011), and all four forums employed in this study use trigger warnings. Whitlock, Lader, and Conterio (2007) note that moderators can be forum board-designers, and have little self-harm or mental health training. Graphic online posts may exacerbate self-harm urges in some people who self-harm (Lewis & Baker, 2011; Lewis, Heath, St Denis, & Noble, 2011). This suggests that it may be beneficial for clinicians who work with self-harming individuals to consider

the possible harms or benefits to clients using such websites (Whitlock, Lader, & Conterio, 2007; Whitlock, Powers, & Eckenrode, 2006).

Addiction

There has been an important change in Substance-Related and Addictive Disorders in the DSM-V, as gambling disorder is now included as a Non-Substance Related Disorder (American Psychiatric Association, 2013). This is the only Non-Substance-Related Disorder that has been included. There are no diagnostic criteria for an unspecified behavioural addiction in the DSM-V, there is proposed diagnostic criteria for internet addiction however (Tao, Huang, Wang, Zhang, & Zhang, 2010). The word "addiction" has been used to refer to excessive undertakings of different activities without chemical substances being involved, such as eating disorders (Lesieur & Blume, 1993), use of technology (Horvath, 2004; Sadeghian, 2006), and physical exercise (Morgan, 1979). While Griffiths (1996) has proposed a diagnostic criteria for behavioural addiction that comprises of six criteria: 1). Salience, 2). Mood modification, 3). Tolerance, 4). Withdrawal symptoms, 5). Conflict, and 6). Relapse.

The aim of the present study was to build on the existing literature by examining self-harm discussions on four self-harm Internet message boards to examine if themes related to addiction are present.

Method

Procedure

Four online message boards [1). The National Self-Harm Network, 2). Crazy Boards Self-injury – The Cutting Board, 3). Live Journal and 4). Psychforums] for people who self-harm were selected for analysis in order to provide a wide range of data from different sources. These forums were selected because they are all considered safe spaces for people to talk about self-harm.

1). The National Self-Harm Network (http://www.nshn.co.uk/) is an online support forum which provides crisis support, information and resources, advice, discussions and distractions for people who self-harm and for family and carers of those who self-harm. The site is available 24 hours a day, every day and is closely monitored. All applications to join the site are manually checked for member safety.

New accounts have to be approved before posts can be made or additional rooms can be viewed. The Network was established in 1994.

2). Crazy Boards (http://www.crazyboards.org/forums/index.php?/forum/30-self-injury-the-cutting-board/), is a safe forum space open all day every day for people to talk about their journey to quit self-harm. The forum began in 2005, is moderated and recovery-focused. The aim of the board is for the discussion of self-harm in a recovery-context. The romanticising of self-harm is not tolerated, posts are edited or deleted by moderators if deemed to be doing so. Graphic descriptions of self-harm such as details about wounds, bruises, blood, size of injuries, tools, and photographs are not allowed

3). LiveJournal (http://livejournal.com/) is an open-access community publishing platform, users must register an account to post on boards. LiveJournal began in April 1999. Messages were collected from http://bleeding-beauty.livejournal.com/ (an open membership moderated board, all new members must be accepted by moderators initially and all posts are checked before being approved. Once a member has shown themselves to be a genuine member, free posting access is granted. All pictures must be placed behind a livejournal-cut tag, they are not visible unless clicked upon. Disrespectfulness results in members being deleted and banned), and http://community.livejournal.com/-secret-scars-/ (also an open membership moderated board, where the encouragement of self-harm is not tolerated and people breaking the rules are banned. Anything triggering, such as descriptions of self-inflicted injuries or photographs, must be placed behind an lj-cut, with a warning).

4). Psychforums (http://www.psychforums.com/cutting-self-injury/) is part of Psychology and Mental Health forums, a safe place where all members can openly discuss self-harm and cutting. All members should show sensitivity to, respect for, and support for other forum members. Postings on psychforums are only edited by staff when somebody's identity may be compromised, such as names and specific locations. If posts are deemed to be triggering, trigger warnings are added. Accessing psychforums through an anonymous proxy is not authorised and people trying to do so are banned. The earliest posts date from 2003.

All four of the message boards used in this study are moderated.

Participants

The authors of 500 messages were participants. A total of 359 differently named participants were included. Participants were not aware that their postings may be used for research purposes.

Ethical Considerations

Informed consent can be waived when members' communication takes place in a public place when participators can expect to be observed (British Psychological Society, 2006; Coulson, Malik, & Po, 2007) so ethical approval did not have to be sought. Guidelines for internet-mediated research (British Psychological Society, 2017; Childress & Assamen, 1998; Coulson, Malik, & Po, 2007) were observed and closely followed.

Qualitative Analysis

The authors read messages on the four message board sites and selected those that were characterised as having addictive elements. A total of 614 messages were extracted from the four message boards because they had addictive elements, 286 from Crazyboards, 190 from LiveJournal, 119 from National Self-Harm Network and 19 from Psychforums. Of these messages, 500 met the diagnostic criteria for behavioural addiction (Griffiths, 1996) and were selected for content analysis (Morse & Field, 2002) to investigate the possible addictive nature of self-harm. 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-Wamboldt, 1992; Krippendorff, 1980; Sandelowski, 1995). The 500 messages were read and re-read, and the data coded by identifying continuing themes, concepts or words (Morse & Field, 1995). Data was coded and categorised by the authors. Differences in coding and categorisation were discussed and consensus reached.

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 & Amundson, 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) or themes. Each theme was illustrated with a selection of three representative quotations.

Results

The content analysis of the 500 messages revealed six themes. The first theme was labelled as "Urge/Obsession", the second was "Relapse", the third was "Can't/Don't want to stop", the fourth was "Coping mechanism", the fifth was "Hiding/Shame" and the sixth was labelled as "Getting worse/Not enough". Of the 500 messages selected as having relevance to addiction, 378 messages related to one theme, and 122 messages related to two themes. Three quotes from each theme are presented verbatim in order to illustrate each theme.

Theme 1: "Urge/Obsession"

Of the 500 messages, 222 (44.4%) involved the theme of an "Urge/Obsession" with harming oneself. Messages describe thinking about the act of self-harming a lot and the craving to engage in the behaviour taking over their thoughts:

> I have been thinking about cutting for a long time. I finally gave in to the urge last night. I did very superficial cuts but they are cuts nonetheless. I feel so embarrassed and disappointed. I live in a boarding home so I am on checks every fifteen minutes because I told them about the cutting. That is a big part of my freedom being taken away. I can't leave the boarding home without staff accompaniment. I wish I wouldn't have done this. But I was so obsessed with the thought of doing it, I felt like I had no choice.
>
> The ritual itself was so calming. I just wish I hadn't done it.
>
> But, part of me likes looking down at my arm and seeing the marks. Isn't that messed up? Ugh. (Message 21),

Others describe the difficulty of the challenge to distract themselves from the urges:

> I'm SO trying not to cut…I've tried talking to a friend, watching TV, playing games, cooking…NOTHING is helping and I'm so, so, so close to caving. I think the problem is my reason for trying to quit was because I was seeing someone new. Now that it seems to be over…or at least leading that way…I am completely overwhelmed by urges. I don't know what to do…I feel like I can't even breathe. (Message 71).

The urges to self-harm have been described as being "overwhelming" and "overpowering":

> "holidays sucked. want the blade to my skin...when i think about cutting its too overpowering. overwhelming...takes over body and mind" (Message 235).

Theme 2: "Relapse"

Of the 500 messages, 19.8% (99) contained the theme of "Relapse". Some of the messages describe relapsing after weeks,

> "…Yup...I had stopped for 6 weeks...relapsed just over a week ago...have cut more nights than not since.  …" (Message 87)

Others have gone several months,

> I have several months of nothing, then something happens and I slip, then the whole thing starts again. I've accepted that self-harm is a strong addiction of mine but I'm getting there and trying alternatives at desperate times. (Message 106),

and some describe starting harming themselves again after years of stopping,

> "I have been free of SI for over 2 years, with one recent relapse…" (Message 75, Staff).

Theme 3: "Can't/Don't want to stop"

Of the 500 messages, 19.2% (96) included the theme of "Can't/Don't want to stop". Not being able to stop self-harming is demonstrated in messages such as:

hello i am new i am married with two children and live in *** have been cutting since i was sixteen i have been cutting for almost 35 years while i think about cutting i try not to for my kids sake sometimes the thoughts are obsessive and wanted to join this board for help. (Message 8),

> Not wanting to stop self-harming even when the behaviour causes problems: Im not a 'regular' self harmer, as in I don't do it everyday like I used to. It only ever happens when I start to become ill. Thats all good, but once I start, I can't stop. It gets more serious, I'm in a&e daily, then I end up being sectioned within about a week. I can't remember the last time I self harmed where that process did not happen. Thus, my main coping strategy is the fact that I don't want to end up on the psych ward. Most of the time its works but sometimes, the urges just get way too strong, I convince myself I can do it once and then stop. Of course that never happens. (Message 41),

And not wanting or being able to stop although promising themselves they would:

> It's way of changing my state of consciouness and a way of feeling better. I guess it's a coping mechanism (it doesn't *quite* sound right), but I wouldn't even say it's a bad one. I still find it very helpful even though I rarely need or want it anymore. The rare times I do need it, it's a much better choice than the alternative. Sorry if that's not okay to say here, but it's the truth. (Message 34).

Theme 4: “Coping Mechanism”

Of the 500 messages, 17.6% (88) contained the theme of “Coping Mechanism”. The theme of self-harm being a “Coping Mechanism” was evident in messages describing self-harming behaviour as the only thing keeping them alive:

> I 'm 32 and I've been self harming off and on since like 15

> I broke a streak of not harming for nearly a year recently

> I felt it was my only option outside of suicide so I do not feel guilty… (Message 15),

And a way of "changing consciousness", and making people feel better:

> Right now...I feel like I can't breathe. And, that if I cut, I'll feel better. My head is spinning and screaming.  I need to talk to my therapist, and she's out of town this week...and I'm out of town next week. I don't see her until the 28th. (Message 60)

And a way of seemingly easing negative emotional and psychological problems:

> Near as I can tell, my active self harming period (ten years ago or so) was akin in the "why" to why I sometimes revert to it in small, short, rare relapses. It dissociates me from intense emotions. Bipolar moods, depression, anxiety, sensory overload and subsequent meltdown, gender dysphoria, trauma memory loops, etc… (Message 32).

Theme 5: "Hiding/Shame"

Of the 500 messages, 13.2% (66) involved the theme of "Hiding/Shame". Messages describe hiding self-harm from therapists because of negative consequences such as being hospitalised:

> Sometimes, I am lucky to be able to hide my self harm.
>
> … I have gotten smarter and I have found better ways to hide it.
>
> The last time I couldn't stop self-harming, my therapist forced me into the psych ward. She wouldn't let me leave day program. She said if I tried to leave, she would call 911 and the cops would get me. All this for self-harming when it wasn't even suicidal self harm.....
>
> No wonder I hide things and lie to people. I pretend to be ok so that I don't get punished. (Message 48),

Hiding self-harm from partners:

> I haven't sh'd in so long
> Tonight I've really messed up my arm
> I don't know what to do. I'm hiding it from bf.
> Don't know what excuse I can come up with at work.
>
> Don't even know why I did it…. (Message 239).

And self-harming, or discussing self-harm, causing feelings of guilt and shame,

> I still cut and I'm in my 30's. I stopped for almost 2 years but recently started back. I see a therapist and have been through DBT that have provided me w other, great coping strategies but sometimes only cutting works...anybody out there understand what I mean? It's nice to know I'm not the only adult out there that cuts. I have so much shame and guilt attached to it, it's hard to talk about. (Message 372),

Theme 6: "Getting worse/Not enough"

The theme of self-harming becoming worse was portrayed in postings such as:

> …I have self harmed for about 7 years now. And as I get older I seem to get stupider and the self harm gets worse. It went from just scratches to digging motions to burning to losing control and finding myself with entire limbs dripping in blood… (Message 12),
>
> Im new here. I really need help. Im 31 next month and have been self harming since I was 11. I stopped all by myself abt 5yrs ago but have recently started again. Now its worse cuz I have to go deeper to get any release. No1 understands y I do it even when I try to explain that it helps me. My partner thinks its an affront to him cuz I dont think abt him when I do it. I just wanna talk with ppl who will understand why I do what I do. (Message 63).

The theme of self-harm not being enough was demonstrated in messages such as:

> Cutting isn't enough. It's just not making me feel like it used to. I'm really scared I don't know what else to do. I wanna be here I cut to stay alive to survive. I don't know how I am meant to survive anymore  . It's the only way I get through. I'm so scared someone please help me... (Message 265).

Discussion

The aim of the present study was to build on the existing literature by examining self-harm discussions on Internet message boards to examine if themes related to addiction are present. Data were successfully extracted from the boards and analysed, six themes of interest were found.

The results show that an "Urge/Obsession" with self-harming behaviour was a major theme, identified in 45.8% of the messages. This finding supports the view in the literature that some people who engage in self-harm have the inability to control the urge to do so (Lewis, Heath, Michal, & Duggan, 2012; Nixon, Cloutier, & Aggarwal, 2002; Washburn, Juzwin, Styer, & Aldridge, 2010; Whitlock, Powers, & Eckenrode, 2006).

The second theme, "Relapse", is a fundamental component of addiction. "Relapse" was identified as a theme in 19.2% of the 500 messages, and supported in the literature. Both substance and behavioural addictions have natural histories that can show chronic and relapsing tendencies (Grant, Potenza, Weinstein, & Gorelick, 2010). Self-harm being discussed more openly on the Internet and message boards being visited often may be a means of normalising and spreading harming behaviour (Whitlock, Powers, & Eckenrode, 2006), and thus increasing the chance of relapse. Relapses can happen when previous habit memories are activated by context cues and old routines (Wood & Rünger, 2016), even if new habits are learned old memory residues are not always replaced (Bouton, Todd, Vurbic, & Winterbauer, 2011).

The third theme, identified in 19.2% of the messages, was labelled as "Can't/Don't want to stop". This theme is also noted in the literature; self-harm becomes increasingly more difficult to stop the longer the behaviour is engaged in

(Whitlock, Powers, & Eckenrode, 2006). Whitlock, Powers, and Eckenrode (2006) analysed 3,219 online posts about self-harm from 10 forums and found messages containing "addictive elements", including the inability to stop engaging in the behaviour even when wanting to stop. Online messages stating that self-harm is difficult or impossible to stop may reinforce the behaviour and decrease the chances of people seeking professional help (Lewis, Heath, Michal, & Duggan, 2012; Lewis, Heath, Sornberger, & Arbuthnott, 2012).

The fourth theme, self-harm being a "Coping Mechanism"**,** was identified in 18% of the messages. The theme of "Coping Mechanism", is prevalent in much of the literature about self-harm (Daine et al., 2013; Klonsky, 2007; Rayner & Warner, 2003); self-harming behaviour is characterised as being a maladaptive coping mechanism, or emotion regulation strategy (Adler & Adler, 2007; Favazza, 1998; Gratz, 2001; Haines & Williams, 1997). Research directly suggests that self-harm and difficulties in the regulation of emotions are linked (Franklin et al., 2010; Klonsky, 2007). Self-harming young adults who have trouble with expressing emotional states or feel neglected use self-harm as a coping tool to relieve inner emotional pain (Do & Lee, 2010). Adolescence has been defined as a critical phase where self-harm can be relied upon as a maladaptive coping strategy due to a child being expected to behave in a moral and socially competent way, and be able to distinguish between appropriate and inappropriate ways to behave (Barton-Breck, 2010; Anderson, Woodward, & Armstrong, 2004). The theme of self-harm being a "coping strategy" was identified as being "correct" by 95.9% of a sample of 243 in a questionnaire containing 10 myths and 10 accurate statements about self-harm (Warm, Murray, & Fox, 2003).

The fifth theme, "Hiding/Shame", was identified in 13.2% of the postings. This theme is ubiquitous in the self-harm literature (Klonsky, 2009; Nixon, Levesque, Preyde, Vanderkooy, & Cloutier, 2015; Steggals, 2013). Self-harming behaviour can be associated with shame because of misinterpretations by family, friends and professionals (McAndrew & Warne, 2014; Simpson, 2006). Virtual ministrations, such as online message boards and chat rooms, can be particularly useful for those who want help but do not want to access services due to shame (Duggan & Whitlock, 2012). The anonymous nature of the Internet holds appeal for

those who self-harm because it is comforting for individuals who feel shame, distress, and isolation (Whitlock, Powers, & Eckenrode, 2006). Hiding and shame may be one reason why many self-harmers do not seek medical treatment for their injuries (Hawton, Rodham, Evans, & Weatherall, 2002). A considerable number of online postings from self-harmers concentrate upon camouflaging wounds and scars (Whitlock, Powers, & Eckenrode, 2006), which can be linked with shame. Both behavioural and drug addictions share some emotional contrecoup, including guilt and shame (Schaub, 2013; Shaffer, 1996). The internal shame and shame after reactions from others when scars are seen can mean self-loathing arises (Welch, Meriwether, & Trautman, 1999), and wanting more physical pain to remove emotional pain.

The sixth theme, "Getting worse/Not enough", was identified in 9.8% of the postings. There is data which highlights that repetitive self-harming is correlated with higher pain tolerance (Gordon et al., 2010) which suggests self-harm injuries become more severe to cause the same amount of physical pain. Self-harm being discussed more openly on the Internet may be a means of normalising and spreading harming behaviour (Whitlock, Powers, & Eckenrode, 2006), due to social contagion. Self-harm being discussed on the Internet has been reported as having a negative impact on users, such as increased isolation, worsening mood and exacerbation of self-harm behaviour (Harris & Roberts, 2013). Concerns have been noted regarding the potential of internet self-harm messaging worsening self-harming behaviour, although evidence suggests that forums can provide valuable emotional support (Messina & Iwasaki, 2011).

Using inductive content analysis has enabled a greater understanding of addiction to self-harm in internet social reality, the respondents communicating how they feel has made a reality over the internet. The data extracted from the 500 messages has credibility because it has "adequate representation of the constructions of the social world under study" (Bradley, 1993, p. 440). There is also transferability, the ability to transfer the working hypothesis to other contexts such as chemical addictions. This was ensured by "rich description and reporting of the research process" (Foster, 2004, p. 230). The data has 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, & Gleason, 2002). The participants may have felt able to disclose more feelings about self-harm due to the anonymity of Internet forums. The coding is transparent and there is no ambiguity. The use of Griffiths' (1996) diagnostic criteria provides some external validity to the selection of the messages identified by the authors as pertaining to addiction. This study has added to the literature which indicates that when some individuals repeatedly access electronic self-harm material, the sharing of self-harm experiences can lead to reinforcement of the behaviour (Lewis & Baker, 2011; Lewis, Heath, St Denis, & Noble, 2011; Lewis, Heath, Sornberger, & Arbuthnott, 2012; Whitlock, Lader, & Conteiro, 2007; Whitlock, Powers, & Eckenrode, 2006). However, the anonymity the Internet provides can draw in individuals who do not feel comfortable discussing such matters offline (Lewis & Baker, 2011; Lewis, Heath, St Denis, & Noble, 2011; Lewis, Heath, Sornberger, & Arbuthnott, 2012). Internet discussions about self-harm can also be a means of obtaining social or peer support (Lewis, Heath, Michal, & Duggan, 2012), which may help individuals feel less lonely and ashamed (Duggan, Heath, Lewis, & Baxter, 2012).

The strengths and limitations of self-harm internet communications have been widely debated and it is still unclear why such sites can be helpful for some self-harming individuals and hinder others. All the message boards accessed are moderated. It must be noted that this may affect how individuals post messages because when forum rules are broken messages are removed and members are warned about forum rules. Further research examining messages on moderated, unmoderated and pro-self-harm message boards to explore differences in message content would be useful. It is important to understand self-harming individuals' use of internet communication because this may play a role in the amelioration or exacerbation of potentially dangerous behaviour. It is not known whether the use of discussion groups and online forums increases a self-harming individual's network of people with whom self-harm is normalised and supported (Mitchell & Ybarra, 2007; Murray & Fox, 2006; Whitlock, Powers, & Eckenrode, 2006). This could lead to worsening or amelioration of the behaviour, and should be documented in clinical case notes. It may be beneficial for clinical professionals and those affected by self-harm to progress the findings of this study by using online questionnaires measuring the addictive nature of self-harm on internet self-harm message boards. In

conclusion, this present study shows the usefulness of utilising on-line message boards as a research tool for conducting research with populations who find it difficult to discuss taboo matters (such as people who self-harm) (Lewis, Heath, Sornberger, & Arbuthnott, 2012).

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