

## Patients With Anorexia Nervosa Who Self-Injure: A Phenomenological Study

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**PURPOSE:** This study investigates self-injury from the perspective of patients with anorexia nervosa.

**DESIGN AND METHODS:** A phenomenological design was used. Twelve patients participated. Data were collected using a semi-structured interview guide.

**FINDINGS:** Participants display self-injurious behavior predominantly in situations when they are forced to eat. They are terrified of gaining weight and use self-injurious behavior to cope with their anxiety. Self-injury is envisioned as a technique to regain control of their own eating pattern without bothering anyone. They feel shame for not controlling their emotions more constructively.

**PRACTICE IMPLICATIONS:** Healthcare professionals should systematically observe signals and explore less harmful strategies that help to regulate overwhelming feelings.

## Introduction

Anorexia nervosa is an eating disorder predominantly affecting girls and young women aged 15–29. In industrial countries, the disorder prevalence is 370 per 100,000, with the yearly incidence being approximately 8 per 100,000 (Hoek, 2006; Netherlands Institute for Health Services Research, 2011; Smink, van Hoeken, & Hoek, 2012). Anorexia nervosa is a serious and potentially deadly medical condition. Approximately 5% of all patients suffering from anorexia nervosa die of the disorder (Steinhausen, 2009): two thirds of malnutrition, one third as a result of suicide (Dutch Committee for the Development of Multidisciplinary Guidelines in Mental Health Care, 2006).

Two types of anorexia nervosa can be distinguished: the restricting type and the binge–purging type. Patients with the restrictive type maintain their low body weight purely by restricting food intake and by increasing physical activity. Patients with the binge–purging type of anorexia binge eat and purge to maintain their low body weight (American Psychiatric Association, 2000).

This article concerns self-injurious behavior in patients with anorexia nervosa. The literature gives several definitions of self-injurious behavior. We use the definition of self-injury provided by Claes and Vandereycken (2007b): “socially unacceptable behaviour involving deliberate and direct destruction of one’s own body surface without suicidal intent, such as cutting, carving and burning of the skin”.

In the past decade, research has documented the association between self-injurious behavior and eating disorders. One literature review (Svirko & Hawton, 2007) and several cohort studies (Claes, Klonsky, Muehlenkamp, Kuppens, & Vandereycken, 2010; Claes, Soenens, Vansteenkiste, & Vandereycken, 2012; Claes & Vandereycken, 2007b; Claes, Vandereycken, & Vertommen, 2004; Muehlenkamp, Peat, Claes, & Smits, 2012; Paul, Schroeter, Dahme, & Nutzinger, 2002) have been carried out on this subject. These quantitative studies focused on the prevalence, personality traits, and possible functions of self-injury in patients with eating disorders.

In their review, Svirko and Hawton (2007) included three types of eating disorder: anorexia nervosa, bulimia nervosa, and an eating disorder not otherwise specified, diagnosed according to the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV; American Psychiatric Association, 2000). They reported a prevalence rate of self-injury between 25% and 55% in patients with eating disorders. This is in accordance with a cohort study (Claes et al., 2010) carried out in Belgium among 177 female patients diagnosed with anorexia nervosa, bulimia nervosa, or an eating disorder not otherwise specified. It was estimated that 45% of these patients had performed at least one type of self-injury in the past year.

One study used an all-male sample (Claes, Jimenez-Murcia, et al., 2012) of 130 patients with eating disorders and investigated the prevalence of self-injury among them. Overall, 21% of the male patients had engaged in at least one type of self-injury in the past year. In comparison, the prevalence of self-injury in a general psychiatric population is 33% (Zlotnick, Mattia, & Zimmerman, 1999), whereas the rate in normal controls is estimated at 2% (Moran et al., 2012).

Prior works suggest that patients with eating disorders and certain personality traits, such as obsessive-compulsiveness (Claes et al., 2004; Paul et al., 2002; Svirko & Hawton, 2007) and perfectionism (Claes, Soenens, et al., 2012), are at a higher risk of self-injury. Obsessive-compulsiveness can be explained as an uncontrollable repetitive urge to self-injure. Perfectionism refers to the tendency to worry about making mistakes or to doubt whether one's behaviors meet the expectations of others. Perfectionism is a dominant feature in patients with anorexia nervosa (Claes, Soenens, et al., 2012). Because of their self-critical orientation, patients with perfectionism may have deep-seated feelings of inferiority. Such negative self-evaluations may trigger self-injury as a means of self-punishment and self-torture (Claes, Soenens, et al., 2012; Svirko & Hawton, 2007). In other words, they may use self-injury as a way to punish themselves for their failures.

Existing research (Claes & Vandereycken, 2007a; Claes et al., 2004, 2010; Claes, Soenens, et al., 2012; Muehlenkamp et al., 2012; Svirko & Hawton, 2007) is consistent in explaining that the majority of patients injure themselves for the purpose of emotional regulation. Self-injury allows these

patients to cope with emotions such as anxiety (Claes et al., 2010; Claes, Soenens, et al., 2012), depression (Claes et al., 2010; Muehlenkamp et al., 2012) body image concerns (Muehlenkamp et al., 2012), or dissociation (Svirko & Hawton, 2007).

Standardized interviews and questionnaires have clarified several aspects of the quantitative association between self-injury and eating disorders. This study goes beyond the existing literature by examining the patients' perspective on self-injury. The patient perspective enriches the evidence for the correlation between eating disorders and self-injury. A comprehensive understanding of the lived experiences of these patients can provide a foundation for the interventions that allow the healthcare professional to manage the self-injury collaboratively with the patient.

In the present study, we address the following research question: what are the lived experiences of patients with anorexia nervosa who injure themselves? This main research question is divided into five sub-questions:

1. What are the specific factors and circumstances triggering self-injurious behavior in patients with anorexia nervosa?
2. Which emotions are dominant prior to self-injurious behavior and how do they build up?
3. How do the patients experience the actual execution of self-injurious behavior?
4. What are the positive and negative consequences of self-injury?
5. What are the personal experiences of patients with healthcare workers regarding their self-injurious behavior?

## Method

In order to understand the lived experiences of self-harming patients with anorexia nervosa, we used van Manen's qualitative phenomenological research design (van Manen, 1990; Polit & Beck, 2008).

The purpose of a phenomenological research approach is to identify and describe phenomena as perceived by the participants. This method is commonly used to describe a phenomenon which we are aware of but do not fully understand (Creswell, 2007; Polit & Beck, 2008). Phenomenology is concerned with the lived experiences of the participants. It facilitates interaction between the researcher and the participant during data collection and, as a result, makes it possible to gain profound insight into these lived experiences (van Manen, 1990). Therefore, this design is particularly suitable to explore the phenomenon of self-injury in patients with anorexia nervosa.

The study was conducted in two mental health departments of two mental health institutions in the Netherlands specializing in the treatment of eating disorders.

These departments offer inpatient and outpatient treatment to young people from the age of 12 who suffer from

eating disorders, including anorexia nervosa. Both departments are recognized throughout the Netherlands as centers of excellence for the treatment of patients with eating disorders.

This qualitative study is part of a larger research project that includes both qualitative and quantitative research. In this large research project, study participants from both hospitals were asked to participate. All 487 patients aged 16 or older who actually received treatment or had received treatment in the previous year were asked to complete the Dutch version of the Self-Injury Questionnaire (SIQ) (Claes & Vandereycken, 2007c). At the end of the questionnaire, they were asked whether they were willing to participate in a subsequent qualitative study. Forty-two patients (out of 158 who returned the questionnaire) agreed to participate in this qualitative study.

The target population for this qualitative study consisted of patients with anorexia nervosa who exhibited self-injurious behavior. Purposive sampling was carried out to guarantee sufficient homogeneity in the sample, because too much variation in our sample would hinder a consistent description of the phenomenon under study, given our limited research resources. Therefore, only patients with anorexia nervosa (diagnosed according to the DSM-IV criteria), aged between 18 and 30 years who employed at least one form of self-injurious behavior during the past year were included. Patients with insufficient command of the Dutch language were excluded. Also patients with severe treatment-resistant forms of anorexia nervosa were excluded in order to promote homogeneity of the sample.

A total of 15 participants met the inclusion criteria. Three participants were not included: one patient was no longer physically capable of participation and two participants could not be contacted.

All participants received oral and written information about both the quantitative and the qualitative study. If they agreed to participate in the qualitative study, they filled in their name and telephone number at the end of the questionnaire. These participants were all contacted by telephone, received additional oral information and were given the opportunity to ask further questions. Finally, an appointment for the interview was made. There was no professional relationship between the researchers and the participants.

The interview location was chosen on the basis of patients' preferences. Six interviews took place in the clinic where the patient resided, two interviews were held in a nearby university hospital, and four patients were interviewed at home.

The data collection took place between May 2011 and May 2012. Each interview started with the interviewer discussing the patient's individual scores on the Self-Injurious Questionnaire (Claes & Vandereycken, 2007c). Following this discussion, semi-structured interviews were used to collect data. An interview guide ensured that each sub-question was

explored in-depth. The interview guide contained four sub-questions that explored the process of self-injury chronologically: the first sub-question focused on the triggers and the circumstances before the self-injury, the second on the build-up of tension, the third on the actual execution of the self-injurious behavior, and the fourth on the positive and negative consequences of self-injury. At the end of the interview, the researcher asked the participants about their experiences with healthcare workers. Twelve interviews, varying from 60 to 90 min, were recorded on audiotape and transcribed verbatim. For each patient, one interview was conducted, so no follow-up interviews took place. All interviews were held, transcribed and analyzed in Dutch.

The data analysis and data collection were iterative (Boeije, 2008). After the first four interviews, an initial analysis was performed. The results from this analysis indicated directions for further data gathering. Each of the sub-questions in the interview was analyzed in three phases in line with van Manen (1990): (a) identifying sententious expressions that possibly captured the fundamental meanings concerning the research questions; (b) reading the text several times; and (c) examining highlighted phrases and answering the question "what does this phrase reveal about the process of self-injury?" Once the phases of the self-injury process had been identified and explored in this stage of the research, they became the object of reflection and interpretation in the following interviews, thus leading to a comprehensive understanding of the phenomenon of self-injury in patients suffering from anorexia nervosa.

The quality of the analytical process was assured by means of peer-reviewing; the research group discussed the interview techniques and the methodological aspects of the research at length after interview 5. The primary supervisor (BvM) and the researcher (SV) met after the first, fourth, eighth, and 10th interview to discuss the progress of the research process. Interview techniques and analytical (coding) procedures and outcomes were discussed. The article was reviewed in subsequent stages of development by the complete panel of co-researchers.

Data saturation is the point in data collection when no new or relevant information emerges from the data (Boeije, 2008; Creswell, 2007). At the 10th interview, the research team agreed that sufficient data saturation was reached to describe the phenomenon of self-injury in our patient group satisfactorily. The description of the phenomenon was robust, with no gaps or unexplained aspects of the phenomenon. The last two interviews were used to check for the level of data saturation and confirmed our conclusion that sufficient saturation was reached, because no essential new information was found in these interviews.

The Scientific and Ethical Committees of both participating mental health institutions reviewed and approved the research protocol, in accordance with the Ethical Principles of

Medical Research Involving Human Subjects (Declaration of Helsinki), before the start of the research activities. Only the researcher and supervisor had access to the original data files and the tape-recorded interviews. All participants gave written informed consent. Patients received a gift of 25 euros for their participation in this study.

In order to reduce the burden on the participants, the following two preventive measures were undertaken. First, at the end of each interview, the burden of the interview was discussed with the patient. Nine participants stated explicitly that there was no need for aftercare because they did not expect to experience any negative personal consequences from the interview. The remaining three patients were contacted after 3 days and asked if there was any need for aftercare: they all declined. Second, to limit the psychological burden on the participants, it was decided that the patients would be interviewed only once.

## Findings

The sample consisted of 12 participants, all of whom were women. The mean age of the sample was 23, ranging from 18 to 28. Participants were at various stages of treatment: one participant was being treated as an inpatient when interviewed, and four participants were being treated in an outpatient setting. Three participants had been discharged from treatment 1 year before, and three other patients 6 months previously. The sample consisted of five patients with the binge-purging type of anorexia nervosa, and seven patients with the restricting type. Based on the analysis of the interviews, the process of self-injury can be divided into three phases:

- Phase 1: circumstances triggering self-injury.
- Phase 2: losing control and the act of self-injury.
- Phase 3: the consequence of the self-injury.

These three phases are described in more detail later.

### Phase 1: Circumstances Triggering Self-Injury

The first goal at the start of treatment was for the patients to learn to eat again. In most cases, the participants' physical condition was extremely poor before admission to the inpatient centre or the start of outpatient therapy. As a result, they felt numb and without energy. They found the dietitian's nutritional advice in the initial treatment phase severely frightening and disturbing. This advice was based on their physical condition and recommended that they consume a specific number of calories in order to regain the weight expected of them. Participants experienced extreme stress during their initial meals. In the inpatient setting, they were closely supervised by the nurses; in the outpatient setting, their parents, or in some cases friends, supervised them. The

forced food intake caused them to feel considerable aversion. They did not want to eat and were terrified of gaining weight. When they were forced to eat, they suffered intense despair. The participants responded to these extreme stressful situations by injuring themselves. One of the participants described her despair as follows:

At some point, I was living with friends and they pushed me to eat things I did not want. They told me why it was important for me to eat. But I thought, I cannot do this, and I do not want this. They were pushing more and more and as a result I was getting angry with myself for not being able to eat. Then I started hurting myself by bruising or hair pulling. I felt like I was losing all my control, because I was no longer able to make my own eating decisions. (R 4)

In the early stages of treatment, self-injury was used to control emotions when the patient was forced to revert to a regular eating pattern. But it was also used to deal with feelings of saturation after the obligatory meal. Satiety provoked extreme anxiety because it reminded them that they were gaining weight.

Besides controlling overwhelming emotions, self-injury was used as personal punishment. Self-injury was the perfect way for patients to punish themselves for their (self-perceived) uncontrolled eating behavior. Self-injury was a reaction to feelings of self-hatred, which occurred, for example, when they felt they had been talked into something by not refusing to eat. As one of the respondents stated:

When I gained weight I was angry with myself. I thought: "why do I let others force me to eat?" And I was pissed off with myself for agreeing to something I did not want. As a result I had to punish myself. (R 3)

Self-injury was also used to deal with burdensome interactions with others, for example, in conflicts or misunderstandings at work or with friends. They blamed themselves for not being kind or friendly enough, or for making unintelligent comments. Again, self-punishment appeared to be a strong motivator for self-injury, as illustrated by the following quote:

We were having a sleepover at a friend's house. I promised to bring a sleeping mat for a friend. Unfortunately I forgot it. I blamed myself for that and I felt so stupid. At that moment, all I could think of was self-injury. (R 2)

Besides merely controlling negative situations, participants also emphasized that self-injury is a means of rewarding themselves. It was used in situations where they were able to undermine the dietitian's advice or when they lost weight. Some participants emphasized the multifunctional role of self-injury:

When I gained weight, I had to punish myself; when I lost weight, I rewarded myself with self-injury. At one point I



realized that it did not make sense. Whether I was happy or not, self-injury was always there. It was a perfect way of getting along with everything. (R11)

## Phase 2: Losing Control and the Act of Self-Injury

Participants described the process leading to self-injury in detail. They would start the day with some tension, which built up gradually until they reached a tipping point, for example, when confronted with their compulsive eating habits and the need to end them. In this situation, it was impossible to withstand the powerful temptation of self-injury. Intense despair would arise without the self-injuring act. Sometimes they would not have the opportunity to injure themselves, for example, because other people were around. In the clinical treatment setting, nurses kept the participants within eyeshot after they completed their meal. In outpatient settings, some participants experienced a great deal of stress because their parents kept a close watch on them. They would then seize the first opportunity to self-injure. When they were unable to perform their self-injury act, they would turn to less severe forms (scratching and bruising) to temporarily reduce overwhelming feelings. Although less powerful than cutting, the self-injury behavior that they actually desired, these forms were invisible to bystanders and relatively easy to perform; they could inflict them under the table during the meal. If they did not have the opportunity to perform the self-injury, it was impossible for the participants to cope with the overwhelming emotions and they feared ending up crazy. Participants envisaged self-injury as an “emergency break.” It offered prompt relief that prevented them from suicidal thoughts.

The pain intensity and the sight of blood were considered the most important factors influencing the effectiveness of self-injury. Participants stressed the importance of prompt relief in moments when they felt overpowering emotions. Self-injury provided much quicker relief than jogging or physical labor, for example. When the pain intensity was high, the self-injury was felt to be more effective. For example, when the physical pain caused by the self-injury lasted a couple of days, the patients felt less need for further self-injury. If they bled heavily, they considered this strong confirmation of self-punishment. As one participant puts it:

Blood is the visible evidence of having hurt myself.  
(R 6, outpatient)

The participants’ lived experiences also revealed that they felt less need to self-injure if they could undermine the dietitian’s advice. Instead, their anorexia nervosa symptoms increased:

It was either the anorexia nervosa or the self-injury. So when I gave up the self-injury, I was losing weight again. I was always searching for the right balance. Whenever I

gave up one thing, the other thing occurred, and vice versa. (R 10)

## Phase 3: The Consequences of Self-Injuring

The self-injurious behavior made it possible for the participants to gain weight. When the weighing scale showed a weight increase, they were terribly afraid and felt disgusted. Self-injury helped dissipate these emotions and that is why they viewed it as something positive.

Participants experienced self-injury as a technique to regain control of their own eating pattern autonomously without bothering anyone. It allowed them to control the compulsive feelings related with anorexia nervosa, for example, when the food was unexpectedly high in calories or when they were served a sauce they were unfamiliar with.

The positive thing about self-injury was that I was able to eat. I kept everybody happy during mealtime because I ate all the food. Nobody recognized that I was having a difficult time. (R5)

The participants experienced negative consequences when confronted with their damaged body in the form of scars and thinner skin. They felt the need to carefully select their clothes, for example, to wear long sleeves to hide the scars on their arms. When others, such as their parents, detected visible injuries, it put strain on their relationship. As one participant puts it:

I considered it very painful and difficult for my parents to be faced with my self-injury. It was very stressful to see how much that affected them. That made me sad or angry with myself. (R10)

The self-injurious behavior led to feelings of shame, for example, because the participants felt they might be seen as weak for not controlling their emotions more constructively. They felt shame because they needed the self-injury to overcome the anorexia nervosa, or because they feared being seen as “mentally unbalanced.” Self-injury was seen as an effective short-term solution, a very powerful tool for controlling their fear of eating and for regulating other overwhelming emotions they had experienced in their lives.

Another negative consequence emerged as the patients’ awareness and self-esteem grew: they realized that they had been misleading themselves by thinking that they could control their emotions with self-injury. In fact, the act of self-injury did not change anything; emotions were not handled constructively and could only be suppressed temporarily:

I realized that I actually wasn’t in control. I was not able to resist the urge of self-injury and then it became apparent to me that self-injury did not solve anything. Nothing really changed. The cause of my problems did not

disappear. You have to find other ways to solve your problems. (R 2)

### Experiences With Healthcare Workers

In most cases, self-injury was not a topic of conversation and there were therefore no positive or negative experiences with healthcare workers. The majority of participants kept their self-injury hidden from their healthcare workers. They saw it as a secret solution for their overwhelming feelings and their resistance against gaining weight. Participants feared the controlling interventions of healthcare workers:

I think if I were to talk about it with healthcare workers that they would try to make me stop. They wouldn't say: you go girl. (R 4)

But when the participants did raise the self-injuring issue, the healthcare workers took it seriously. The participants felt supported and were encouraged to talk about their feelings and consider other less harmful strategies to control their emotions and regulate their behavior. The participants valued being able to discuss the subject respectfully within their working alliance with the healthcare worker. It encouraged them to speak openly because they were confident that their story would be taken seriously:

When the nurses take the initiative to explore this topic in a respectful manner, you know they are interested. When you open up the topic yourself, you do not know for sure how they will react to it. (R 3)

Toward the end of their treatment for anorexia nervosa, the participants realized that the negative consequences of their self-injurious behavior outweighed the positive consequences. They saw that self-injury was not a solution for their compulsive anorectic thoughts. They became more willing to consider rules laid out by healthcare workers to reduce the frequency of self-injury. For example, they agreed to reduce the frequency of self-injury from four to three times a week. Nevertheless, it was felt that they had a long way to go to overcome their fear of eating and to get more control over their feelings and behavior.

The participants expressed their desire for specific professional attitudes during the interviews. They frequently mentioned such attitudes as involvement, reliability, and determination. A sense of humor was considered important because it took the weight off the delicate subject of self-injury and made it easier to discuss. The participants emphasized that it was important for healthcare workers to recognize the scars and the thinning of the skin. When a healthcare worker mentioned these signs explicitly, they felt that their injuries were important enough to discuss. The participants also considered professionals' expressions of confidence in them as valuable. As one participant explains:

If they had told me during treatment that they did not trust me, I immediately would have stopped the treatment. Why should I go on with healthcare workers who do not trust me? (R 12)

### Discussion

The qualitative interviews indicated that the participants experienced self-injury as necessary and functional behavior. Self-injury serves to reduce negative emotions (such as fear related to feeling overweight) and as a method of punishing oneself. The existing literature identifies difficulties with emotional regulation as an important underlying factor in anorectic and self-injurious behavior (Claes et al., 2010; Claes, Soenens, et al., 2012; Espeset, Gulliksen, Nordbø, Skårderud, & Holte, 2012; Muehlenkamp et al., 2012; Paul et al., 2002). Our study contributes to this literature by describing how anorectic patients themselves explain the function of self-injury when dealing with their emotions and managing their anorectic behavior.

First, we found that the participants in our study performed self-injurious acts (e.g., cutting, scratching, bruising, burning, hot showering, hair pulling, biting, vomiting, overuse of alcohol and salt and pepper, and slapping oneself) as a means to control all different kinds of anorectic thoughts and emotions when pressured to eat. There appears to be a balance between anorexia nervosa and self-harm. Being pressured to eat means losing control over the eating disorder and this promotes feelings of anxiety and anger. Self-injury can reduce these emotions and allow the participant to regain a renewed sense of control. As Muehlenkamp et al. (2009) described it: losing control in one domain requires compensation in the other domain.

Second, our study adds to the existing literature by describing how self-injury in patients with anorexia nervosa can serve as a means of self-punishment. The patients often punish themselves because they feel they have failed to meet their own (stringent) standards. For example, one patient explained that she hated herself for disappointing a healthcare worker. She did not know how to handle these feelings other than by hurting herself. Previous research confirms that patients with eating disorders who injure themselves are relatively more concerned about meeting the expectations of others than patients with eating disorders who do not injure themselves (Claes, Soenens, et al., 2012). These patients' self-criticism can lead to self-injury as a way of punishing themselves for their failures.

Self-criticism and subsequent self-punishment may explain why "self-protection plans" sometimes do not work. One aspect of these plans is that the patient is rewarded after a period of abstinence or reduction in self-injury. However, patients with a high level of self-criticism often find it difficult and even emotionally stressful to reward themselves; their self-criticism makes them feel undeserving of their rewards.

The participants were in different stages of recovery from their illness. Some patients were in the acute stage of their illness, receiving inpatient treatment, and struggling with their eating disorder, the overwhelming emotions, and the self-injurious behavior. Other patients were almost recovered from the anorexia nervosa and had almost abandoned the self-injurious behavior. We did not observe any significant differences in their perspectives on and functions of self-injury in these subgroups of patients. However, the recovered patients showed more awareness of the negative consequences of self-injury compared with the patients in the acute phase of the illness.

Some methodological limitations must be noted. The study was limited in that all the participants were women and of Dutch origin, all aged between 18 and 30 years. This must be taken into account when generalizing the findings to other populations. It should also be noted that the sample size was rather small, making saturation limited.

One of the strengths of this study is that we used appropriate research methods to obtain an in-depth understanding of the participants' lived experiences of self-injurious behavior. The professional experience of the primary researcher who conducted and analyzed the interviews (SV) also made it possible to better understand the patients' personal stories.

In some cases, the participants experienced the interviews as confrontational because they had never discussed self-injury in such detail before. Sub-questions two and three, concerning the increasing tension and actual execution of self-injury, were difficult for most of the participants to answer. They felt ashamed when exploring the self-injury in such detail and they were afraid of the interviewer's judgmental or negative reactions. However, all participants valued the anonymity, which made it easier for them to discuss the subject. Participating in this study also gave them a feeling of appreciation; they were able to help others by contributing to a better understanding of their experiences and behavior.

Given the high prevalence of self-injurious behavior in patients with eating disorders, there is an urgent need for more research on this topic. In our study, we focused on the phenomenology of self-injury in patients with anorexia nervosa. Similar research could be conducted in patients with bulimia nervosa, in order to obtain a better insight into the lived experiences of these patients concerning their self-injurious behavior.

To promote homogeneity of our sample, we excluded patients under 18 years and older than 30 years. We also excluded patients with severe treatment-resistant forms of anorexia nervosa who performed self-injurious behavior. In future research, the phenomenon of self-injury should also be studied in these excluded subgroups of patients. The results can be compared with the results of our study to explore differences in the manifestation of self-injurious behavior.

Priority should be given to the development and testing of evidence-based interventions for managing self-injury in the population of patients with eating disorders. These interventions should be applicable in nursing practice, as nurses are frequently confronted with self-injurious behavior in their daily contact with patients. When developing and testing these interventions, a distinction should be made between self-injurious behavior in the different subgroups of patients with eating disorders (i.e., anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified) given the specific patient characteristics and the specific nature of the self-injury within these subgroups.

## Conclusion

This study demonstrates that patients with anorexia nervosa use self-injurious behavior to handle their compulsive anorectic thoughts and behaviors when they put on weight. Because they fear gaining weight, their emotions are overwhelming and unbearable. Self-injury helps them control these overwhelming feelings. Toward the end of treatment, they recognize that the negative consequences of self-harm overshadow the positive consequences, and they therefore realize that self-injury is only a temporary solution. That realization is needed for the patient to become more willing to consider alternatives that will help them reduce or cease self-injury.

## Implications for Nursing Practice

Given that our research findings show that self-injury in patients with anorexia nervosa serves as a way to control their emotions and behavior, professional care needs to focus on several aspects: (a) discussing the subject with the patient openly and having an accepting, non-judgmental attitude; (b) exploring the meaning of self-injurious behavior for the individual patient while paying explicit attention to the underlying emotions and problems that contribute to this behavior; (c) systematically observing triggers and first signs/symptoms as precursors of self-injury for a better understanding of the process that leads to self-injury; (d) exploring alternatives to self-injury together with the patient, that is, less harmful strategies that help the patient regulate overwhelming emotions; and (e) developing a professional attitude of determination, reliability, and attentiveness.

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