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# Self-Harm Narratives of Urban and Suburban Young Women

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*This qualitative study explored the motivations, meanings, functions, and consequences of self-harm for young women in urban and suburban contexts. It found that all 6 participants deliberately harmed themselves in response to traumas, family stress, and relationship problems. However, the suburban girls connected their self-harm behaviors to an overall sense of despondency, whereas the urban girls attributed these to release of unresolved anger. Key differences between the groups also emerged in the functions and consequences of their self-harm behaviors. These findings can increase social workers' capacity to respond to intentional self-injury among ethnically and socioeconomically diverse populations of young women.*

**Keywords:** *self-harm; adolescent girls; distress; cultural competence*

In the past few decades, mental health and health professionals have reconsidered their working understandings of *self-harm*, defined as intentional self-injury or self-mutilation without suicidal intent. Clinicians and experts had previously viewed self-harm as a repetitive, compulsive behavior that was unique to individuals with developmental disabilities or psychoses. Although self-harm is prevalent among persons with these diagnoses, rates of self-harm among mainstream Americans are rapidly increasing (Strong, 1998; Suyemoto, 1998; Suyemoto & MacDonald, 1995). The lifetime prevalence rate of self-harm among adolescents and young adults (aged 15 to 35) in the general population is estimated to be 2%, and the annual incidence rate is .5% (Suyemoto, 1998). In the psychiatric population, the annual incidence rate is much higher, estimated by Darche (1990) to be as high as 20% of all psychiatric inpatients and as high as 40% for adolescent inpatients.

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The most typical cases of deliberate self-harm are found among single females who range in age from middle adolescence to early adulthood (Darche, 1990; Favazza & Conterio, 1989; Suyemoto, 1998; Suyemoto & MacDonald, 1995). Popular psychology literature has also raised public awareness that self-mutilation is becoming more prevalent and normative among White middle- and upper-middle-class adolescent girls and young women (Pipher, 1994; Strong, 1998).

Self-harm behaviors vary widely. Skin cutting—the use of knives or razors to cut the forearms, wrists, or legs—is the most common method. Other forms of intentional self-injury include scratching, burning, self-hitting, hair pulling, and bone breaking (Favazza & Conterio, 1989; Lloyd, 1998; Smith, Cox, & Saradjian, 1999). It is difficult to determine the fine line between self-harm and suicidal acts, partly because of the range of possible injuries associated with these behaviors. However, scholars generally agree that deliberate self-harm may be related to suicidal ideation yet represents a distinct form of behavioral or psychological disturbance.

Several clinical researchers have theorized about the psychological and emotional functions of self-harm behaviors. These authors have suggested that intentional self-harm serves a range of functions for individuals and may even serve several functions simultaneously (Connors, 1996; Suyemoto, 1998). Connors (1996) consolidated these various theories into four main functions: reenacting past traumatic experiences, expressing feelings and needs, managing chaotic environments, and controlling internal dissociation processes. The dominant clinical belief is that self-harm is an internalized response to family, sexual, or other traumas that allows survivors of traumas to organize their feelings and express their suffering (Connors, 1996; Favazza, 1989; Suyemoto, 1998). However, not all individuals who intentionally injure themselves are survivors of traumas, and for these individuals, self-harm may serve other functions entirely.

Research has also examined the influences of gender, mental health status, and ethnicity/race in the development of self-harm impulses and behaviors. These studies have concurred that women, particularly young women, are at a much greater risk of self-harm than are men (Darche, 1990; Favazza & Conterio, 1989; Ross & Heath, 2002; Suyemoto, 1998; Suyemoto & MacDonald, 1995). Moreover, studies conducted in mental health facilities have found that self-harm co-occurs with diagnoses of borderline personality disorder, major depression, substance abuse, obsessive-compulsive disorder, eating disorders, anxiety disorders, adjustment disorders, or other personality disorders in the *Diagnostic and Statistical Manual of Mental Disorders* (Briere & Gil, 1998).

Less attention has been given to the significance of ethnicity, culture, or social context in the understanding of self-harm. Preliminary studies on trends in ethnicity and self-harm in the United Kingdom (Goddard, Subotsky, & Fombonne, 1996; Neeleman, Jones, Vanos, & Murray, 1996) have found that Black adolescent self-mutilators had higher levels of social

stress than did Caucasian adolescent self-mutilators when all other sociodemographic variables were similar, and they concluded that self-mutilation may serve different functions for different ethnic groups. They also suggested that further research is needed to gain a better understanding of the influences of ethnicity on the meanings of self-harm behaviors. In the United States, one prevalence study in a community sample of urban and suburban high school students found that female students, Caucasian students, and suburban students were more likely to self-mutilate than were male students, students of color, or urban students (Ross & Heath, 2002). However, no studies have qualitatively investigated the motivations, functions, or meaning of self-harm for young women in the context of different cultural and community norms and discourses.

Common U.S. stereotypes define self-mutilation as a "White, middle-class problem" that occurs nearly exclusively among privileged young women with eating disorders (Egan, 1997; Pipher, 1994). These stereotypes, coupled with the absence of empirical information about self-harm among young women of color, leave social workers without adequate knowledge to assess or treat this problem comprehensively among young women from diverse backgrounds (Goddard et al., 1996; Neeleman et al., 1996). The study presented here sought to build a more refined understanding of self-harm behaviors for young women in two different social contexts: an urban, working-class, and predominantly ethnic-minority community and a suburban, affluent, and predominantly White community. Because of the small sample and the goals of the project, the authors did not seek to determine whether it is race, culture, ethnicity, or social class that distinguishes these young women's self-harm experiences and narratives. Rather, this article offers a much-needed foundation for understanding young women's self-harm behaviors in their own words and within their experiential and contextual frames of reference.

## METHOD

This article is part of a larger study of sociocultural variations in "at-risk" adolescent girls' expressions of distress, conducted in spring 1999 (Abrams, 2000, 2001). The larger project entailed a survey ( $N = 77$ ) and open-ended interviews ( $n = 40$ ) with young women who were attending continuation high schools in the San Francisco Bay Area. Fifty-five "urban girls" and 22 "suburban girls" participated in the study. In the aggregate, the respondents to the survey self-identified as African American (42%), Latina (20%), White (31%), and Asian/Pacific Islander (8%) (see Table 1 for the respondents' demographic characteristics). The suburban school was mostly White (77%), and the urban schools were much more ethnically diverse (87% of the students were African American, Latina, or Asian/Pacific Islander). The urban schools were located in working-class neighborhoods

with mixed ethnic compositions; the suburban school was in an upper-income and affluent area. The caregivers' educational attainment reflected these socioeconomic differences (see Table 1). Hence, racial, class, and cultural differences were part of the differential social contexts in this study.

### **Study Sites and Recruitment**

The study sites included one suburban and two urban continuation high schools located in northern California. Students are typically placed in public continuation high schools (also known as "alternative schools") on account of truancy, poor academic achievement, behavioral problems, or life circumstances that interfere with their success in school, such as pregnancy or caregiving responsibilities. These sites were selected purposively on the basis of their locations in urban and suburban social settings, and the participants were selected by convenience. To recruit participants at all three schools, the first author spent about 1 month getting to know the female students through meetings, informal "yard time," and direct recruitment in classrooms and assemblies. The research was described as a "girls' study" that sought to document the life experiences of young women in continuation high schools. Students who expressed an interest in the study were asked to obtain written consent from their parents or guardians for their participation, a process that slightly decreased the pool of eligible participants.

### **Data Collection**

The study included a written, self-administered survey and semistructured, qualitative interviews. Here, we focus on the protocol for the qualitative interviews, the primary source of data for this article. The one-time interviews, all conducted by the first author, lasted 45 to 90 minutes and took place in private offices in the schools. The interviews covered a range of topics, including life-history information; school experiences; family, peer, and romantic relationships; participation in risky behaviors; and mental health concerns. A guided interviewing technique afforded the participants ample opportunity to narrate their experiences in their own terms, a strategy recommended for engaging young people in qualitative research (Holmes, 1998; Way, 1995). As a White, middle-class woman, the first author was initially more positively received by the suburban girls. However, her background as an urban high school social worker helped to forge positive connections with the urban girls as well. Once they found that she was familiar with their communities, the process flowed smoothly for nearly all the interviews. Moreover, her mentor and adviser, an African American woman, provided a great deal of guidance on interviewing techniques for young women of color.

**TABLE 1: Demographics of Urban and Suburban Participants From the Larger Study (in percentages)**

	<i>Aggregate</i> (N = 77)	<i>Suburban</i> Sample (n = 22)	<i>Urban</i> Sample (n = 55)
Primary ethnicity			
African American	41.6	4.5	56.4
Caucasian	31.2	77.3	12.7
Latina	19.5	13.6	21.8
Asian/Pacific Islander	7.8	4.5	9.1
Mothers completed college	23.4	45.5	14.5
Fathers completed college	26.0	54.5	14.5

### Selection of the Subsample

For this article, we chose to analyze the transcripts of interviews with 6 young women who spoke in depth about their self-harm experiences. During the interviews, the participants were not directly questioned about deliberate self-harm, but several talked about the topic when they were asked how they coped with stress, the reasons why they entered continuation high school, or in relation to questions about depression. When participants wanted to talk about their self-harm experiences, the topic was pursued in greater depth. The participants whose experiences are discussed in this article were selected purposively on the basis of their willingness to disclose their self-harm behaviors and to pursue an in-depth conversation about their experiences. The full transcripts ranged from 20 to 30 pages for each of the six cases and formed the basis of analysis for the study.

### Data Analysis

We separately analyzed the transcripts and coded the narratives into several thematic categories, including precipitating factors and life traumas; history of self-harm; the motivations for and the functions, meaning, and consequences of self-harm; and coping skills. We selected these categories on the basis of a review of the literature because we assumed that they might serve as salient points of comparison and contrast between the young women who were selected for the subsample. We then coded these data into subthemes and compared them for interrater reliability. To assess interrater reliability, we directly compared our coding of the subthemes and reached a consensus when disagreements arose. When all agreements were reached, we reduced the codes into conceptual matrices (Miles & Huberman, 1994) to understand the six cases and their characteristics. In addition, pertinent quotes from the transcripts were imported into separate thematic files. The interpretations that constitute the Results section stemmed from these conceptual matrices, along with the quotations from the participants.

## RESULTS

### What I Do to Hurt Myself

This section briefly introduces the 6 participants and their self-harm histories, beginning with the 3 suburban participants.

*The suburban participants.* Cicily is a White, 16-year-old, self-identified "chronic self-mutilator" from a wealthy suburban environment. During the interview, she articulated her history of struggle with several mental health problems, including eating disorders, depression, low self-esteem, and substance abuse. Her mental health history also included several hospitalizations for self-harm, depression, and one suicide attempt. Cicily routinely harms herself in a variety of ways, including burning herself, cutting herself with a knife or razor, and scratching away the surface of her skin, mostly on her arms. For treatment, she takes medication for depression and she sees a psychotherapist once a week. She lives with both her parents, whom she described as "very supportive." Cicily definitely presented the most extreme and serious case of self-harm among all the participants in this study.

Jenna is a 15-year-old, White, outspoken, and lively young woman who suffers from what she defined as "bouts of depression," eating disorders, and substance abuse. During her middle school years, she frequently cut herself with a razor on the tops of her arms, usually when she was under the influence of speed, cocaine, or other hard drugs. She lives with both her parents, whom she described as struggling with their own dependence on drugs and alcohol. She stated that she only "sometimes" resorts to cutting herself at this point in her life. She is no longer plagued by eating disorders and feels positively about her body and her appearance. At the time of the interview, she had been hospitalized only once for a suicide attempt.

Natasha is a White, 17-year-old senior who is interested in pursuing a career in art. For several years, she carved into her arm with a knife and used cigarettes to burn her skin. Her self-mutilation behaviors began when she was young—11 or 12—about the time that her mother became ill with and died from cancer. She also described herself as "frequently suicidal" yet has never made a serious attempt. Natasha is now sober and recovering from a serious addiction to heroin and no longer cuts or burns her skin. She perceives herself as "on the road" to mental, emotional, and spiritual recovery.

*The urban participants.* Crystal is a 17-year-old, African American resident of a low-income urban neighborhood that is overwhelmed by crime, drugs, and violence. She was raised primarily by her seven older siblings after her father died when she was young and her mother subsequently suffered from periods of addiction to crack cocaine. She revealed only one major episode of self-harm, when she punched her arm through a glass window

during a violent family fight. Although Crystal has experienced some suicidal thoughts, she has never tried to kill herself.

LeShaun is a 17-year-old, African American young woman from a working-class neighborhood. She was raised by both her parents, who divorced when she began high school. LeShaun disclosed only one major incident of self-harm when she cut her wrists with a razor with the intention of self-harm but not suicide. Her one hospitalization occurred as a result of this event. Although she still experiences depression and problems with body image, she has not hurt herself since that time. She is currently taking medication for depression and sees a therapist weekly.

Saundra is a 16-year-old, Latina young woman from the same urban neighborhood as LeShaun. She is also a member of a gang. She participates in frequent and severe acts of self-mutilation, such as carving drawings or signatures onto her arms or legs with a razor or a knife. Saundra spoke in detail about her struggle to find other ways of coping with feelings of distress but felt that she could not fully control her impulses to self-mutilate. She was hospitalized once for cutting her wrists with a knife. She has also been addicted to "crank" (a powder form of speed) and alcohol. At the time of the interview, it had been nearly a year since she had last used any substances.

#### **Motivations: Why Do I Do it?**

Several similarities link the events or circumstances that motivated the urban and suburban participants' self-harm behaviors. Themes concerning "motivations" centered on past family traumas and current relational concerns. Although specific traumas were unique to each case, all 6 participants identified family problems as a source of pain, including parental death, drug use, divorce, affairs, violence, and family financial instability. Crystal, one of the urban participants, and Natasha, one of the suburban participants, both talked about the trauma of losing a parent to cancer. For Crystal, the loss of her father left her and her seven siblings to fend for themselves. With a solemn tone, she described that period of her life:

'cause he died when I was 7, and after he passed, everything was just, just gone. Everything was like my mom went to alcohol and drugs. She left us, and from there on, we had to raise ourselves. It was just terrible. I mean, a lot of things we went through in the home are untellable, unspeakable.

Natasha experienced the death of her mother when she was 12 years old. She attributed her heavy drug use at that point to the pain and denial associated with this tragedy.

Cicily, Jenna, Crystal, LeShaun, and Saundra all mentioned family fighting, divorce, or financial strain as major sources of past and current stress. LeShaun stated,

My parents had split up, and so it was a total mess and that was the main thing that possibly made me depressed. . . . I had straight A's up till all this started with my parents, and then my grades just dropped.

Jenna shared LeShaun's feelings about the disturbances caused by family problems. In her case, she was troubled by her parents' use of cocaine and financial struggle to "make it" in the affluent suburbs.

Well, our family has a lot of money problems. We used to be so rich, and then now we're so poor. I work a lot, and that's really stressful, and then I come home and fight a lot because there's a lot of money problems.

A major thematic commonality among the narratives was that the young women disclosed family difficulties and traumas as sources of underlying distress.

Among the various traumas that these young women described, a difference emerged between the urban and suburban participants in their disclosure of sexual assault. All 3 suburban young women described being sexually molested within the previous 5 years. Cicily directly linked her ritualistic cutting behaviors to the time she was sexually assaulted at a high school dance. Jenna and Natasha also mentioned experiences of sexual assault and talked openly about how these traumatic events contributed to their self-destructive tendencies. In contrast, none of the urban participants mentioned sexual abuse or assault. Although this finding may only point to distinctions in styles of disclosure, it was still a noted difference in the narratives.

#### **Meanings: What Does the Behavior Represent?**

A significant point of contrast between the urban and the suburban participants emerged in how they described the meanings of and feelings that surrounded their self-harm behaviors. The suburban group all linked their cutting, carving, or burning acts to general feelings of depression, emotional turmoil, and at times, suicidal ideation. From their standpoints, self-mutilation became part of their overall sense of despondency. Cicily, the chronic suburban self-mutilator, explained,

I'm a major cutter. I began cutting myself after the dance [when she was molested by three classmates] and then after I broke up with my boyfriend. I just thought I had lost everything . . . and I was going to school all depressed and everything.

Natasha also viewed burning her skin as a matter of just being depressed and "in emotional turmoil" about her mother's illness and death. She stated, "I thought it was cathartic or something. Somehow, just transferring the emotional to the physical thing." Jenna said that her cutting behavior began when "I was really depressed in eighth grade. . . . I also tried to slit my

wrists before that year, too." All three of these suburban young women connected their self-harm histories with general emotional distress and depression.

In contrast, the urban young women overwhelmingly linked their self-harm behaviors to being "angry" or "mad." They described hurting themselves as a way to release anger at family members or boyfriends. Crystal's story is a clear illustration of this process. She described in detail her major self-harm episode, as follows:

My two sisters started beating my mama down, and I wish I'd stopped it . . . 'cause they be saying, you know, I wish Mama died, I'd spit on her grave. And one day, they were just beating her down. I was screaming 'cause blood was coming from her nose, her teeth. And so I couldn't stop them. So I started beating on the wall in my house. And I was just, I don't know, I just lost it, and I punched my arm through the glass.

Similar to Crystal's narrative, LeShaun explained that she slit her wrists with a razor because she was mad that her boyfriend ended their relationship shortly after her parents announced their separation. She emphasized that she "didn't want to die but just wanted to release some pressure. . . . I was just really *mad*" (emphasis added).

Saundra's self-harm narrative differs from the narratives of the other two urban young women, primarily because she is a more chronic self-mutilator. The circumstances that caused Saundra to carve on her skin were many, but according to her, all highly related to feeling mad at her parents or her boyfriend. As she put it,

I just get pissed, and whenever I get mad, I like . . . throw things, and I'm like really aggressive . . . and sometimes when I get mad, I just carve things on myself. Whenever I was mad, it was just like a way to calm down. So, sometimes I still do that. Like one time I was mad at my boyfriend, and I did something wrong. And I was sorry. He was pissed, and he didn't want to talk to me. So I carved it in my arm. But you can't see it no more.

Although Saundra's chronic self-harm behaviors more closely resembled the patterns of the suburban participants than the other urban participants, she still used the language of "anger," rather than "pain," to describe why she injured herself. This interpretation comes directly from the statements just quoted, along with other transcript portions that were coded and analyzed, in which she talked about getting "mad" as a trigger to self-injury. In this sense, the language used by the urban and suburban young women points to different frames of reference for their self-harm motivations.

### **Functions: What Do I Gain From Hurting Myself?**

Among the suburban young women, the common underlying theme was that self-harm generated a feeling of intense release or, as Natasha put it, a

“catharsis of some sort . . . an outlet for general emotional turmoil. It made me feel better at the time.” For all three suburban young women, self-mutilation helped to provide relief—albeit temporary—for their overarching pain and distress. For Jenna, seeing her own blood had a powerful representation. “But the blood, coming out of my body, was the pain releasing. That’s what made sense to me . . . and after a while, it was like ‘OK, I’m OK now.’ I don’t know why, but that’s what I felt.”

Cicily offered the most detailed description of what she gained from her various forms of self-mutilation, including what she specifically felt when she hurt herself in different areas of her body or with different instruments. As she visually pointed out the scars on her arms, she described them one by one:

When I cut myself, I cut either here, here, or here [wrist and forearm], it’s usually, I’m trying to cut a vein. I really want like, a lot of blood. Here, [on her inner elbow area] these are scratch marks, where I scratched all the skin away. And this is like, knives or razors [upper arm]. And up here, this is when I just want to see blood. ‘cause I hate blood. It scares me. But when I see it, like when I cut myself, it’s like, all the bad escapes in the blood. And it’s like you can physically watch everything just wash away. . . . It doesn’t hurt when I do it; it feels like I deserve it or something.

Cicily’s narrative illustrates the functions of her self-harm behaviors through the lens of her own intricate system of understanding. For these three young women, self-harm functioned mainly as a catharsis, represented in watching the “blood” escape from the body, for Jenna and Cicily, and watching the skin burn for Natasha. Through self-injury, the suburban participants experienced temporary relief from their overarching pain and emotional distress.

The urban young women described gaining a similar sense of relief—although for them, it was relief from their anger—through self-harm. In Sandra’s case, carving on her skin helped her to “calm down” when she was mad. Sandra described a “sense of calm and a release like crying” when she chose to carve onto her skin after a fight with her parents or her boyfriend. LeShaun also stated explicitly that her one experience of cutting her wrists was a way of “just releasing—releasing some pressure.”

Two of the three urban young women described an additional function of their self-harm experiences: specifically, that their family members finally noticed how angry or distressed they felt at that time. For LeShaun, cutting her wrists got her parents’ attention and eventually helped her to get into therapy and receive a prescription for antidepressants. She claimed it “helped at the time” because it caused her parents to see the upset she was experiencing about their divorce. Crystal explained that when she punched her arm through the glass, “at the time, I felt good ‘cause it got everybody’s attention. They stopped beating my mom and started screaming about my

arm." These isolated events forced their families to notice their distress and to locate professional resources to address some of their problems. Hence, for both groups, self-harm functioned as a release of pain or anger. For two of the urban participants, it served an additional function of flagging their families' attention to their underlying emotional distress.

### **Consequences: What Happened to Me Afterward?**

All six participants had spent some time in a psychiatric hospital on account of their acts of self-mutilation. Despite protests from the three urban young women that "I wasn't trying to kill myself," they were treated in the hospital as if they had suicidal intent. The experience of hospitalization was unfamiliar and scary for them. As Saundra said, "They took me to the hospital, and then like, put me in restraints, and they took my blood. And then they took me to the mental hospital for 3 days." Although she was not sure why she was hospitalized, she claimed that she eventually learned something from her experience. The emergency room staff similarly treated Crystal as if she was suicidal when she punched her arm through the glass window, although she had no intention of killing herself. The authorities detained her at the psychiatric unit of the local hospital, and she missed a month of school on account of inpatient mental health and medical treatment.

The suburban young women described feeling comfortable in a psychiatric hospital and even suggested that they could "manipulate" the system to their advantage. In the eighth grade, Natasha's teachers called the police for a psychiatric evaluation when they discovered severe cigarette burns on her arm. She said,

I was in class, and I get pulled into the office and then the fucking sheriffs are there, and they like handcuff me and take me to the hospital. But I'd been to the hospital three times, and every time I talked myself out of it somehow.

Jenna was also brought to the hospital for cutting her wrists but pretended that she was suicidal because she enjoyed being away from home and school and was more comfortable in the hospital than anywhere else at that time.

Of the three suburban participants, Cicily seems to have learned the most from her numerous psychiatric hospitalizations. Spending much of the previous 3 years in and out of the hospital, she explained,

I hated being there, but it was probably one of the best experiences of my life because for the first time, there were people who understood what I was going through. There were people who had more scars than I did, more stories than I did, and all of the sudden, I met these people who had real problems, and like, a lot of their problems were worse than mine.

Although she did not want to go back to the hospital, Cicily still viewed it as a peaceful refuge from her enduring emotional pain. From these stories, it seemed that the suburban young women were comfortable in the hospital and were able to use the setting for their own advantage. For the urban girls, the hospital represented an unfamiliar and potentially threatening place.

### **Coping Strategies**

In addition to using self-harm to cope with pain and anger, the participants also talked about their positive coping methods, such as writing and creative expression. Saundra stated, "Sometimes I write poems, or I'll write, I have a diary, and I write in my diary how I feel, and it makes me feel better." After years of substance abuse and self-mutilation, Jenna found that she needed to replace her old self-destructive strategies with other ways to manage her difficult feelings. As she put it, "Smoking weed isn't gonna fly too much longer. I'm not gonna smoke that much anymore. So, I write a lot. If I'm mad or sad or something, I'll write, and it totally helps me." Writing, art, and creative expressions constituted the strongest coping theme in all of the participants' narratives.

Natasha said that she had learned many "tools" from 12-step programs that she can draw on when she gets a craving to use substances. "I have prayer and my phone . . . I can call people and do whatever. Go to a meeting, but . . . I feel like I'm just kinda floating by." She attends Alcoholics Anonymous everyday, attends a drug group two times a week, and sees a counselor once a week. She said that these have been important coping strategies for her to maintain her sobriety, but she was realistic and said that she found it difficult at times not to revert to self-destructive behaviors.

Similar to Natasha, Crystal and LeShaun also identified spirituality as a way to handle problems, fears, and grief. Crystal explicitly stated that she did not have a strict religion but that her belief in Jesus helped her to "wake up and get through the day." She explained that sometimes after church ended, her brother would "get on the organ, and I'll get on the drums, we'll make up music, like a beat. And my sister sings, and my brother sings—that's fun. That's pretty cool. That's kinda relaxing." For Crystal, her church and siblings served as a positive outlet for handling family stress, the loss of her father, and poverty. All these young women described a range of strategies for coping with distress, fear, and anger and were clearly struggling to use their positive outlets, rather than their self-destructive ones, for expression.

### **IMPLICATIONS FOR SOCIAL WORK PRACTICE**

These six stories provide some deeper insights into the motivations, meanings, functions, and consequences of self-harm among young women in

urban and suburban environments. The participants resided in vastly different social contexts: one, which was White, wealthy, and suburban, and the other, which was working class, urban, and ethnically diverse. They also faced different life circumstances. The urban young women were more challenged by violent neighborhoods and family poverty, and the suburban young women were more exposed to illicit drugs and pressures in relation to body image and appearance. Nevertheless, these participants were united in their search for psychological strategies to deal with frustration, anger, and pain related to family issues, traumas, and relational concerns. Although all the young women had the potential to exercise positive or pro-social coping mechanisms, they also relied on self-harm to manage their distress. This finding echoes previous findings in the clinical psychology literature that self-harm functions as a self-soothing mechanism and a coping strategy for individuals who have suffered traumas or who experience psychological distress (Connors, 1996; Favazza, 1989; Suyemoto, 1998).

Although all of the participants sought emotional or psychological relief through intentional self-injury, the urban and suburban participants ascribed different meanings to their behaviors. The suburban young women tended to use a language of "pain" that attributed their behavior to overarching despondency or despair. By comparison, the urban young women conceived of their self-harm behaviors as a reaction to pent-up anger toward their family members or romantic partners. Even Sandra, the urban chronic self-mutilator, still described her motivation for self-harm as being "mad." These differences may be attributed, in part, to patterns of chronic versus one-time self-mutilators, rather than to urban and suburban contexts. However, Sandra's use of language that paralleled the other urban girls may point to different modes of expression and meaning for these two groups. These different frames of meaning, applied to similar (but not always equivalent) behaviors, reveal some potentially compelling contextual differences in how these young women constructed their personal self-harm narratives.

Social workers and other helping professionals can use this knowledge to increase their awareness of variations in young women's self-harm behaviors and experiences. Intentional self-injury need not indicate a "chronic" problem, nor does it necessarily signify an association with a mental health diagnosis. Urban young women of color, who are not generally exposed to a "language of pain" (Strong, 1998), may need to process their experience using terms of anger, frustration, or others that relate to their experiential frame of reference. Clinical and research literature has largely ignored cultural and community norms surrounding the language that clients use to describe psychological or emotional distress. These findings show that these various terms and meanings may play a key role in the assessment and treatment of young women of color who have symptoms of self-harm or engage in self-harm behaviors.

An analysis of these narratives also suggests that for all the participants, deliberate self-harm functioned as a release for difficult or unresolved feelings. Yet the suburban girls described this emotional catharsis as located in the actual physical injury, such as the scars, burns, or blood pouring from the skin. The urban girls' functional "release" centered more on what resulted from the act itself, such as being "noticed" or getting help. LeShaun and Crystal, in particular, experienced a great sense of relief by just flagging their family's attention that they were not "OK." This finding could be useful in the assessment and treatment of urban girls who have had single or isolated acts of deliberate self-harm. A possible function of these acts could be to become "noticed" in family systems or communities that are overwhelmed by numerous challenges and psychosocial stressors. This would be an important axis of assessment for a young woman who presented with a one-time act of intentional self-injury.

In regard to the consequences of self-harm behavior, it is notable that for all three of the urban young women, mental health or health professionals mistook their acts of intentional self-harm as suicide attempts. The suburban young women did not share this experience. On the contrary, the suburban girls felt that they were able to manipulate and navigate the hospital system for their own gain and did not fear the system in the same way as did the urban girls. Hearing Saundra's powerful plea that "I wasn't trying to kill myself" points to another key implication of this study. Medical and emergency social workers should take note that isolated incidents of self-harm do not necessarily indicate suicidal intent or even suicidal ideation. Particularly among the urban participants, it seems that some degree of misdiagnosis occurred. Certainly, one cannot be sure of the events that occurred on the basis of these three young women's self-reports. However, these findings may warrant additional investigation in a larger scale or different type of study. In the meantime, crisis mental health workers and other helping professionals should be trained to understand the differences between deliberate self-harm and suicidal intent, and different treatments should flow logically from this understanding.

Finally, despite destructive behavioral patterns and the challenges of adverse circumstances, both the suburban and urban young women had access to positive coping skills that helped them to move forward in their lives. These skills could serve as important resources for mental health professionals in their work with young women in distress, particularly as a springboard to working with the young women's strengths.

## CONCLUSION

This study had a number of associated limitations that warrant discussion. With only six cases, it is certain that these findings cannot be generalized to a larger population. Although qualitative research is not typically intended to

be generalizable, a sample size of six, selected by the researchers purposively for their richness in narratives and detail, cannot be said to represent even the larger population from which the data were drawn. Moreover, it is not known whether some of the differences detected between the urban and suburban groups could be attributed to the differences between chronic and one-time self-harm patterns or perhaps even between survivors of sexual abuse and those who have not experienced sexual abuse. Without "member checking" the data (Padgett, 1998) and the interpretation of the narratives, this question may linger. We recommend that this information be used in an exploratory, preliminary study with multiple angles to follow up on a larger or more comprehensive sample.

Despite these aforementioned limitations, social workers have an expressed concern with understanding cultural and community differences in the origins and symptoms of social problems, and young women's risk behaviors are indeed shaped by the intersection of gender with race, class, and community norms (Abrams, 2002). However, the findings of this exploratory study point to several questions that warrant further investigation. Are young women of color misdiagnosed as suicidal when they enter a medical or mental health setting because of self-mutilation? What do helping professionals assume about self-harm cases in their assessment and treatment strategies? Do these assumptions translate well to underserved population groups, such as young women of color? Can we build a more dynamic understanding of why young people choose self-harm above other coping strategies? These questions, along with the findings presented here, can serve as a basis for further inquiry into this growing problem among American young women.

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