

Self harming is a dangerous and pervasive problem especially common among adolescents and young adults (Craigien & Foster, 2009; Craigan & Foster, 2009). Self harming is considered to be a common reason for emergency admission to hospital and also a common reason for suicide (Low, Jones, Duggan, Power & Mac Leod, 2001).

However, research suggests that self harm and suicide are different whereby self harming does not occur as an attempt to end life (Gollust, Eisenberg & Golberstein, 2008). Self harming, or self injury as it is often referred to, is defined as a deliberate destruction of one's own body tissue without the aid of another person and without a conscious decision to suicide. Suicide refers to a self inflicted injury with an intent to end one's own life (Knock, 2007).

The definition of self harming behaviour encompasses two elements. These are; 1) there is acute damage to the self (this excludes behaviours that may induce harm through a chronic course such as smoking or eating an unhealthy diet) and 2) damage is intentional (therefore, excluding accidents or behaviours such as starving where the motive is to lose weight as in case of anorexia nervosa) (Straker, 2006).

Tattoos and body piercings are not generally considered self-injury because emotional relief is not the intended goal of these acts. They are usually an effort to decorate or alter the appearance of a person's body. Also, another person is usually involved. Engaging in self harm can generate negative social reactions, disrupt relationships, produce feelings of shame & isolation and can lead to serious physical harm. Self harming can also be difficult to detect because it often occurs in private (Gollust, Eisenberg & Golberstein, 2008).

Self harming behaviours include:

- Cuts (most common)
- Burning
- Breaking bones
- Hair pulling
- Picking at scabs and scratches
- Overdoses
- Wound interference
- Self-inflicted bruising
- Hitting
- Refusal to take needed medications
- Self poisoning

Functions of Self Harming

Motivations underlying self harming behaviour can occur for a number of reasons. Three common motivations for self harming are listed and defined below.

Affect regulation

In the face of turbulent or unsettling feelings, self harming can often act as a self soothing mechanism to the self harmer. This can be achieved through the way the self harming behaviour is seen to aid in; reconnecting with the body after a dissociative episode, calming of the body in times of high emotional and physiological arousal, validating the inner pain with an outer expression of self harming, and/or avoiding suicide in the decision to self harm instead as a way of dealing with unbearable feelings.

Communication

Some people may self-harm to express things they cannot voice. This is particularly in the context of highly intense emotion and/or significantly intense and difficult situations that cannot be easily put in to words. When self harming, as a form of communication, is directed at others it is often seen as manipulative.

Because manipulation is usually an indirect attempt to get a need met; if a person learns that a direct request, rather than self-harming, will be listened to and addressed, then the need for indirect self harming attempts can potentially decrease.

Thus, understanding what an act of self-harm is trying to communicate can help curb the self harming behaviour. Conversely, some dysfunctional relational environments will reinforce the self harming behaviour if the relevant needs being sought are actually met whenever the person chooses to self harm.

Control/punishment

The self-punishment view of self harming considers it to be an expression of anger towards self. It is believed that those who engage in self harming as a form of punishment have learnt to punish themselves after doing what they perceive to be "bad". This perception may have been influenced, encouraged and/or enforced by their current and present environment or past traumatic experiences.

Why Self-Harming Occurs?

Psychological Factors

Overall, self harming has been termed a maladaptive behaviour that serves as a coping mechanism for managing overwhelming negative feelings such as anger, sadness, loneliness, shame, guilt and emotional pain. (Gollust, Eisenberg & Golberstein, 2008). A person may begin to self harm when confronted by a painful experience or recollection of a past incident such as, rejection by a loved one, other's refusal to validate feelings, insults from loved ones or more intense forms of violence, trauma and abuse from significant others in either childhood or adulthood (Yip, 2006).

Such experiences may instil a sense of vulnerability and self doubt within the individual facing such things (Rao, 2006; Yip, 2006), thereby potentially resulting in self harming to decrease tension, provide relief from such troubling emotions and manage stress and distress (Gollust, Eisenberg & Golberstein, 2008). Research has suggested that people who self harm have difficulty coping or talking about their emotions. As a consequence, when coupled with intense emotion, self harming is then used as an alternative means to communicate these emotions and, more specifically, an attempt to articulate a need so it can be heard and taken seriously (Straker, 2006; Craigen & Foster, 2009).

Alternatively, victims of chronic abuse will often accommodate the abuse initially as an adaptive strategy for survival by; denying its occurrence, altering their affective responses related to the trauma, and altering their thought processes about those who are supposed to protect them but instead harm them. As a result, the victim will most likely experience anger or more intense feelings of disgust that is redirected toward them selves and as a consequence, such self directed anger and disgust could manifest or be expressed in the form of self-harming behaviours.

The distress from a traumatic experience, or an unhappy situation, will often lead to feelings of low self-esteem and in more intense cases even self-hatred. These emotions can build up in the context of being suppressed and denied and then as the intensity of such emotion increases, the person may not know who to turn too for help. As a consequence, self-harming may be a way to cathartically express or release these pent-up feelings and as a consequence may become the primary way through which the person copes with most of their problems and the emotions they can cause.

It is important to point out that self harming is not usually an attempt to seek attention as it is often believed. It is usually always a sign of emotional distress (Straker, 2006; Craigen & Foster, 2009; Yip, 2006) and, as stated previously, it can also be a primary way through which the person is expressing or communicating that emotional distress.

Self harming has also been linked to Borderline Personality Disorder (BPD). According to the DSM-IV-TR (2000), self harming is a criterion for borderline personality disorder and it is common in people who suffer the disorder (Ebrinc, Semiz, Basoglu, Cetin, Agargun, Algul & Ates, 2008). Self harming behaviour in Borderline Personality Disorder is also considered to be a maladaptive way of trying to cope with negative emotions that are not understood by those with BPD.

Those individuals who suffer BPD will also often display severe impulsivity exhibited by their self harming behaviour (Berlin & Rolls, 2004). Repetitive self-harm is generally considered to be an impulsive act, whereby impulsivity is a core symptom for the diagnosis for BPD (APA, 2000). This clear connection between BPD and self harming behaviour does not mean that those who self harm are also always suffering from Borderline Personality Disorder. Self harming does also occur independently from BPD.

Self harming has also been associated with anxiety, depression, post traumatic stress disorder and panic disorder (Klonsky, Oltmanns & Turkheimer, 2003; Ebrinc et al., 2008; Gollust, Eisenberg & Golberstein, 2008). While self harming is often associated with other mental health issues, it is important to note that self harming can be a direct reflection of the person's distress independent of any other mental illness.

Self harming has also been associated with Dissociative Disorders. In an attempt to understand this link between self harming and dissociative disorders, some have hypothesised that self harming terminates the discomfort of dissociative experiences and depersonalisation by allowing individuals who self harm to "feel" and connect with their environment.

Many self harmers report feeling emotionally numb and detached from themselves or dead inside prior to self harming. They also report little or no physical pain during self harming and feeling more "alive" after the self harming act. Because dissociation (losing touch with yourself and your surroundings) is the main characteristic of dissociative disorders, it may be the development of this dissociation that leads to a tendency to self harm. In this context, inflicting physical pain is often viewed by the self harmer as a way of coming to "life" (Ebrinc et al., 2008; Rao, 2006).

Social Factors

Self harming has also been linked to individuals from broken families, where there is drug and alcohol use and with low economic background (Gollust, Eisenberg & Golberstein, 2008). Literature also suggests that people who practice self-injury are more likely to be raised in an atmosphere that devalues their feelings (Linehan, 1993).

While such an atmosphere is, without doubt, common in families with troubled parental relationships displayed through acts of violence, relatively 'normal' families may create this atmosphere too. Feelings can become devalued due to the child not having opportunity to discuss his or her personal experience and emotions (Purington & Whitlock, 2004).

This lack of opportunity could be due to such things as poor relational dynamics, extraneous circumstances and/or stressors being faced by the family (e.g. caring for another child who is terminally ill, abuse and/or traumatic situations being faced by the self harmer and a range of other possibilities).

The absence of recognition and support at a time of extreme and distressing events can lead to a sense of powerlessness and an incapacity to understand and manage painful feelings. Linehan (1993) refers to this as an 'invalidating environment' because the individual's experience of reality and their responses to it goes unrecognised and unsupported. Invalidiation has two primary characteristics.

First, it tells the individual that they are wrong in both their description and analyses of their own experiences, particularly their views on what is causing their own emotions, beliefs, and actions. Second, it attributes experiences to socially unacceptable characteristics or personality traits within themselves. As a consequence of these two key factors, chronic invalidation can lead to a subconscious self-invalidation and self-distrust (Linehan, 1993).

As stated previously, evidence from research suggests that there is a relationship between child sexual abuse and self harming behaviours in adulthood. It has also been noted that while childhood trauma contributes heavily to the initiation of self harming behaviour, lack of secure attachments maintains it (Boudewyn & Leim, 1995).

Social isolation and living alone may also increase the risk to self harm. Unstable living conditions,

such as unemployment and divorce can also contribute (Vajani, Annett, Crosby, Alexander & Millet, 2007). However, it is important to note that some people who self-injure have no experience of these factors.

Biological Factors

Biologically speaking, cutting the skin releases “feel good” chemicals called endorphins. These chemicals can give the self harmer a sense of relief. After self harming they may therefore feel better for a time, but the chemical release does wear off. As a consequence, this can lead to an addictive cycle where the person cuts more and more frequently and deeply in order to experience the same emotional relief (Purington & Whitlock, 2004).

This is because, when tolerance to pain builds, the harmer may need increased episodes of self harming to achieve the same relief from the unwanted negative emotions (Purington & Whitlock, 2004). Despite the self harmer being perfectly aware of the destructive nature and overall negative impact of this kind of behaviour and the related health risks, they will often feel like they cannot help it.

As a result, self harming can become an impulsive response to any sort of distress, positive or negative. Low levels of serotonin in the brain is another factor that has been linked to both impulsivity and self injury whereby deficit's in serotonin heightens aggressive responses and has the potential to escalate in to self injury, suicide or attack on others (Chapman, Derbidge, Cooney, Hong & Linehan, 2009).

Varieties of Self Harming

The literature suggests three primary types of *deliberate self harming* (Favazza, 1996). The rarest and most extreme form is *major self-mutilation*. As a form of self harming, major self mutilation is direct, not repetitive, and of high lethality that usually results in permanent disfigurement (e.g. castration or limb amputation) and it is associated with psychotic states.

Another form is *stereo typical self-mutilation* which usually consists of head banging, eyeball pressing and biting. Stereotypic self-mutilation tends to be direct, repetitive, and of low lethality. The third and most common form is *superficial or moderate self-mutilation* which usually involves cutting, burning, hair-pulling, bone breaking, hitting, interference with wound healing and basically any method used to harm oneself.

Moderate/superficial self-harm is direct, repetitive, and of low lethality and can be further divided into impulsive and compulsive types. While individuals may have more than one method of self harming, they will usually have a preferred method (Favazza, 1996).

Compulsive self-harm

Compulsive self-harm comprises of hair-pulling (trichotillomania), skin picking, and excoriation when it is done to remove perceived faults or blemishes in the skin. These acts may be part of an OCD ritual involving obsessional thoughts whereby the person tries to relieve tension and prevent some bad thing from happening by engaging in these self-harm behaviours. Compulsive self-harm has a somewhat different nature and different origins from the impulsive, or the episodic and repetitive types of, self harm.

Impulsive self-harm

Both episodic and repetitive self-harm are impulsive acts, whereby the difference between them seem to be a matter of degree. Episodic self-harm is self-injurious behaviour that may be engaged in every so often by people who don't think about it as an issue and who don't see themselves as “self-injurers”. It generally is a symptom of some other psychological disorder like borderline personality disorder. What begins as episodic self-harm can escalate into repetitive self-harm (Favazza & Rosenthal, 1993; Kahan & Pattison, 1984; Miller, 1994).

Repetitive self-harm is marked by a shift toward ruminating on self-injury even when not actually doing it, and is also accompanied by a high self-identification as a self-injurer (Favazza, 1996).

Because self harming is impulsive in nature, if done repetitively it will eventually become a reflex response to any sort of stress, positive or negative. The impulsivity of the self harming act might also render the self harmer incapable of coping with unbearable affect and cognitions in more adaptive ways (Mangnall & Yurkovich, 2008).

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