Centre for Suicide Prevention

CENTRE FOR SUICIDE PREVENTION

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A Closer Look at Self-Harm

Definition:

Self-harm is defined as a deliberate and often repetitive destruction or alteration of one's own body tissue, without suicidal intent (adapted from Favazza, 1987 & 1989, and Walsh & Rosen, 1988). Many terms have been used to describe this behaviour including self-harm, self-injury, self-mutilation, self-inflicted violence, auto-aggression, and para-suicide.

Demographics:

Statistics on people who self-harm tend to be unreliable due to the private nature of the act, and the fact that many incidents will not reach the attention of professionals. Estimates for prevalence rates range from 400 - 750 per 100,000 population (Kahan & Pattison, 1984; Favazza & Conterio, 1988). Some researchers report an equal distribution among males and females with females being more likely to seek help, or be discovered (Kahan & Pattison; Alderman, 1997), while others report that females constitute about two-thirds of habitual self-mutilators (Favazza & Conterio, 1989). It appears that self-harm cuts across the boundaries of race, gender, education, sexual preference, and socioeconomic bracket (Favazza & Conterio, 1989).

Self-harming behaviours typically begin in early adolescence, around 14 years of age (Favazza & Conterio, 1989), and the disorder seems to have a peak incidence in the decade from 16-25 years of age. In one study, seventy-one percent considered their self-harm to be an addiction (Favazza and Conterio, 1989).

The most common practice of self-harm is skin cutting, but other methods include burning, self-hitting, interference with wound healing, severe skin scratching, hair pulling, and bone-breaking (Favazza & Conterio, 1989). With cutting and burning, people will choose places on the body that are not likely to be seen by others, or can be easily covered up afterwards like the arms, legs, or chest area.

Most people who self-harm report little or no pain during the act. (Conterio & Favazza, 1986). Most know when to stop a session of self-mutilation. After a certain amount of injury, the need is somehow satisfied and the abuser feels calm and soothed.

Reasons for Self-Harm:

Coping is a behaviour which we use to get through stressful and difficult times. People who self-injure have chosen a method of coping that is extreme, but effective for them. Although the act of self-harm is often regarded as a morbid behaviour, it can be understood as a type of self-help practice that provides temporary, often rapid relief from psychological distress (Favazza & Rosenthal, 1993).

- ***to ease tension & anxiety***
- ***to escape feelings of depression & emptiness***
- ***to escape feelings of numbness***
- ***to relieve anger & aggression***
- ***to relieve intense emotional pain***
- ***to regain control over one's body***
- ***to maintain a sense of security or feeling of uniqueness***
- ***as a continuation of previous abusive patterns***
- ***to obtain a feeling of euphoria***
- ***to express or cope with feelings of alienation***
- ***as a response to self-hatred or guilt***
- ***as a symptom of a more severe mental disorder, e.g. borderline personality disorder***

Self-Injury and Suicide:

It can be very difficult for friends, families, and even practitioners to distinguish between a suicide attempt and an act of self-harm. This is understandable since both behaviours are self-directed and dangerous. However, researchers now recognize that the person who engages in self-harm does not intend to die as a result of their acts (Favazza & Rosenthal, 1993; Simpson & Porter, 1981; Pattison & Hahan, 1983).

People who are dealing with this disorder hurt themselves not to end their life but rather to enable them to carry on living by getting relief from intense emotions or by creating feelings when they feel numb inside. In other words, a person who truly attempts suicide seeks to end all feelings whereas a person who self-mutilates seeks to feel better (Favazza, 1998).

However, while it is possible to distinguish between suicidal and self-harming behaviours, it is possible for both to coexist in one person. We cannot assume that people who self-harm will never be suicidal. People who self-harm often suffer social ostracism and other direct consequences resulting from this behaviour, and may attempt suicide in desperation. In addition, it is possible for self-harm to result in an accidental death by, for example, cutting into an artery and being unable to stop the bleeding.

Special thanks to Nadine Jodoin, researcher for the Suicide Prevention Training Programs (SPTP), who selected and compiled excerpts from her more detailed paper "Self-Harm" for this edition of SIEC Alert. Contact SIEC for the full report.

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Predisposing factors:

- drug & alcohol abuse
- eating disorders
- signs of depression, e.g. weight loss, insomnia
- history of childhood physical & sexual abuse
- institutionalization in correctional facilities or drug treatment centers
- inability to tolerate & express feelings
- feelings of worthlessness, hopelessness, & helplessness
- sense of abandonment, loneliness, & un-lovability as children
- early history of surgical procedures or medical illness requiring hospitalization
- disruption or lack of supportive relationships or systems, e.g. social isolation secondary to imprisonment, death of a valued person, & family disruption such as divorce or separation

Treatment for the Person Who Self-Harms

Therapy:

Therapy usually focuses on helping the person to:

- tolerate greater intensities of emotions without resorting to self-harm
- develop the ability to articulate emotions and needs
- learn alternative, healthy means for discharging these feelings, e.g. problem-solving, conflict resolution, anger management, and assertiveness training (Rosen, 1985; Suyemoto & MacDonald, 1995)

Medication:

Medications are sometimes prescribed to control the symptoms of self-mutilation, but there is still a lot of uncertainty as to which type is the most effective (Hawton, et al., 1998).

Hospitalization:

Hospitalization usually represents a last resort measure. While hospitalized, the person has less freedom and more supervision. The main goal of hospitalization is to keep people safe by preventing them from hurting themselves. Intensive individual and group therapy is readily available in the hospital, as well as medication options (Clarke, 1999). In the end, hospitals remain artificially safe environments, and the necessary tasks of learning to identify the feelings behind the act, and of choosing a less destructive method of coping need to be practiced and reinforced in the real world.

Hope for the Future:

Although self-harming behaviour may continue for decades, in many cases it seems to run a natural course of five to ten years. Many adolescents with help, will outgrow their self-harming behaviour as they mature and learn better coping skills. Thus, patients and families can be offered the hope that the behaviour will not continue forever (Favazza, 1987).

SIEC Resources*

SIEC #890222
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