2006

Self-harm : a review of its nature, assessment and treatment

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Abstract

Self-harm is becoming more and more prevalent in clinician offices and is still an occurrence that mental health professionals do not agree upon in several ways. To this day, there is a debate among mental health professionals, as even to what term it should be referred to as, the exact definition that should represent selfharm, and most importantly the proper and most effective way to treat it. Amongst all of the professional disagreeing there are clients who are presenting with self-harm and are not getting proper treatment and, in some cases, may be walking away with worse self-harm ideations than when they initially came in for treatment. Mental health professionals need to know and understand the information that surrounds this concern in order to assist those clients that are looking to them for help and an answer for their internal pain.

SELF-HARM: A REVIEW OF ITS NATURE, ASSESSMENT AND TREATMENTS

A Research Paper

Presented to

The Department of Educational Leadership, Counseling,

and Postsecondary Education

University of Northern Iowa

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts in Education

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by

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June 2006

This research paper by: CJ Yerington

Entitled: SELF-HARM: A REVIEW OF ITS NATURE, ASSESSMENT AND TREATMENTS

has been approved as meeting the research requirements for the Degree of

Master of Arts of Education.

June 20 2006
Date Approved

Linda Nebbe
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5/22/06
Date Received

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Self-harm is becoming more and more prevalent in clinician offices and is still an occurrence that mental health professionals do not agree upon in several ways. To this day, there is a debate among mental health professionals, as even to what term it should be referred to as, the exact definition that should represent self-harm, and most importantly the proper and most effective way to treat it. Amongst all of the professional disagreeing there are clients who are presenting with self-harm and are not getting proper treatment and, in some cases, may be walking away with worse self-harm ideations than when they initially came in for treatment. Mental health professionals need to know and understand the information that surrounds this concern in order to assist those clients that are looking to them for help and an answer for their internal pain.

Self-Harm: A Review of its Nature, Assessment and Treatments

Self-harm, deliberate self-harm, self-injury, self-wounding, and self-mutilation are all terms that are used to describe this topic area. However, members of the mental health profession fail to recognize any one definition or set of terms to describe this behavior. As a result, treatment approaches are not consistent and their effectiveness may suffer as a result.

Redfern (1998) stated, in relation to self-harm, "individual stakeholders—nurses, doctors, therapists, managers, patients/clients—are all soloists at heart wanting to produce their own interpretation of the music" (p. 464). In looking into some specific definitions, this ideology holds true. Self-harm is defined as: "intentional self-poisoning or self-injury, irrespective of the apparent purpose of the act" (Hawton and Catalan, 1987). Deliberate self-harm is: "the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent, but resulting in injury severe enough for tissue damage to occur" (Favazza, 1998, p. 259). Simeon and Favazza (2001) described self-injury as "a volitional act to harm one's body with no intention to die as a result of the behavior" (p.1). Finally, self-mutilation is stated to be, "actions taken by a person causing intentional damage to a part of one's own body without a conscious intent to die" (Feldman, 1988, p. 252). In observing these definitions, it is easy to understand the frustration that mental health professionals are experiencing with this growing act of self-harm among presenting clients. Terms such as intentional and

deliberate are used interchangeably in the definitions. Also, some make reference to death, while others do not. Without a consistent term and resulting definition there is little research that lends assistance to mental health professionals trying to conceptualize this behavior and learn the effective ways to provide treatment (Hawton, et al., 1998, Arensman, et al., 2001).

In order to promote consistent interpretation and resulting treatment, it is important that mental health professionals have a clearer vision of self-harm and its associated components. Below is a summarization of relevant facts, including: reasons for self-harm, types, demographical information, associated disorders, assessment, and theoretical treatment options. This may help give direction to the mental health field and provide some reference for future work.

Facts and General Information Pertaining to Self-Harm

Reasons for Self-Harm

There are many different reasons for why an individual may begin and continue to physically harm themselves. A person may exhibit one or more of the following examples.

Pressure Release. Most often for many people who self-harm there is a feeling of pain that never subsides or decreases. This could be as a result of consistently recalling a painful memory, intense negative feelings of self, etc. The individual's only release comes when he or she self-harms and the "pressure"

seems to decrease and assists him or her with coping with their feelings (Conterio and Lader, 1998).

Feeling Real. Emotionally, self-harmers may experience a feeling of not being real or have a general physical feeling of numbness. In a society that stresses no pain equals no gain, for self-harmers physical pain is their goal and the only way to feel "real" (Levenkron, 1998). Conterio and Lader (1998) stated:

> Many self-injurers feel chronically unaware of physical pain. For them, self-injury serves to jar them back in touch with themselves and their bodies. It is a "focusing" maneuver that seems to serve as a quick antidote to disturbing states of mind. It reassures them that they are alive, intact, and have personal boundaries. Self-injury is the remedy that "brings the skin alive," connecting the physical self to the emotional. (p. 64-65)

Control. One of the preceding events that has been noted to take place before a person self-harms is physical or sexual abuse. There may have also been other experiences, other then abuse, such as role/boundary confusion between the members of a family as a person ages that can account for the actions of self-harm. A self-harmer will begin to harm him or herself as a way of controlling these painful experiences because at the time of the occurrence they were not or did not feel they were in control. By being able to determine the amount of pain they inflict on themselves they, in essence, become in control of these experiences (Levenkron, 1998). Not only do they control the amount of pain, but also the

duration of the act. Thus, reversing the power or "command" of the trauma to him or herself (Conterio and Lader, 1998).

Cleansing. Some people who self-harm my have negative feelings toward themselves and think that they are "bad" or "dirty". Conterio and Lader (1998) explained that these feelings might be due to a negative early childhood experience with a parent, an opinion that the self-harmer holds about their physical self that is now negative possibly due to previous abuse, or a particular religious practice that observes certain body parts with a negative connotation. As a result, when a person, who self-harms, feels this way about themselves they turn to self-harm as a way to release the "bad things" or "poisons" from there body and this influences a feeling of cleanliness.

Expression of Feelings. As stated above, most of the time there is a history of abuse for the person who self-harms and as a result this experience has often taught them that trying to express their feelings through verbalizations does not effectively solve the situation and they turn to solving their concerns through physical actions. By self-harming the individual feels that this will demonstrate just how much pain they are in (Conterio and Lader, 1998).

Gaining a Response From Others. Many times with the act of self-harm in front of others is to get a specific reaction from them. Levenkron (1998) discusses that there is often a "secondary gain" associated with self-harming in front of others. These actions often result in negative attention from others but it

gives the self-harmer a sense of identity or something to be known for. The unfortunate aspect of this scenario is when they, the respondents, act upon seeing the person self-harm they reinforce the behavior for the self-harmer, who has now gotten the attention they were desperately seeking. Conterio and Lader (1998) discussed that:

> Many self-injurers learn to love the "negative" attention they get for their wounds: attention from doctors, nurses, and psychotherapists, as well as family, teachers, friends, and coworkers. In the sufferer's mind, the injuries send a message of being "tough" and "different" and "strong enough to take it." Conversely, she may be attempting to convey, "Can't you see how much I hurt?" "Can't you see how badly I need you?" (p. 68)

Rescue Ideation. Often self-harmers believe that if they bring it to enough peoples attention that someone will care enough and come to rescue them (Conterio & Lader, 1998). However, his/her behavior has the opposite effect and people are drawn away and this reaffirms the ideation, in the mind of the self-harmer, which no one cares and they continue to self-harm. Only upon realizing that it is no one else's responsibility to save the self-harmer does he/she realize that it is their responsibility and they need to hold themselves accountable.

Vengeance. Many times, self-harmers would like to take revenge on the person that has caused them to feel this horrible pain, however, a self-harmer is often reluctant to act for various reasons. Levenkron (1998) explains that while

revenge would be, in the mind of the self-harmer, beneficial, causing physical pain to another human being is forbidden on many different levels. Negative actions would raise legal concerns with the authorities and the self-harmer may lose the caring of that person. Conterio and Lader (1998) reflect that self-harmers are not only concerned about losing the caring of that person but that the abuser will not come forth and admit to fault and the instances of abuse will go unnoticed. Thus, action will not be considered or taken.

Types of Self-Harm

There are many different types of self-harm and often a person who self-harms will use more than one method. Helpguide (2006) provides a list of types:

- Cutting
- Burning (or branding with hot objects)
- Picking at skin or re-opening wounds
- Hair-pulling (trichotillomania)
- Hitting (with a hammer or other object)
- Bone-breaking
- Head-banging (against a wall or other object)
- Multiple piercing or tattooing

One must keep in mind that these acts are done intentionally, not accidentally, to relieve mental pain or anguish and need to be evaluated within the context in which they are being committed. A person who has chosen to have

multiple tattoos may not be committing acts of self-harm but may rather enjoy the visualization of having their body tattooed with different images.

Demographical Information

With demographics, researchers never know if they are attaining a representative sample and sample size. It is unknown, especially in the case of self-harm, how many people are coming forward and asking for help or how many are keeping this act hidden and go on with their lives as if nothing is wrong. Next, is a summary of some of the demographical findings that have been reported from various research experiments.

Age. Kessler, Borges, & Walters (1999) reported that the first experience with self-harm comes at the age of 16. A large study done in Europe concluded that the greatest risk for hospital presentations was in women ranging in age of 15-24 and men 25-34 (Schmidtke, Bille-Brahe, DeLeo, et al., 1996). Hepple and Quinton (1997) explained that as people age the risk for self-harm decreases, however, the risk for suicide increases.

Gender. Typically found in most, if not all research, conducted on the topic of self-harm there are more reports of women self-harming then men. However, it is widely known that women are more likely to reach out for assistance with their concerns, as men are less likely, and be more open about their concerns. According to Skegg (2005), girls self-harm more than boys due to other risk factors, which include depression, eating disorders, and romantic issues.

This sentiment is also reflected in a research study conducted by Muehlenkamp, Swanson, & Brausch (2005) who found that while self-objectification was not directly linked to self-harm, it was directly correlated with negative self-image, which is directly related to depressive mood, which affects self-harm. However, there has been research that has suggested that the rates of self-harm for men may be comparable to women. In a study done with college men and women, Gratz, Conrad, & Roemer (2002) found that thirty-six percent of men reported self-harming, while the rate for women was forty-one percent.

Socioeconomic status. Gunnell, Peters, Kammerling, & Brooks (1995) discussed that self-harm admission rates are higher in low economic areas. This is also reflected in the research of Fergusson, Woodward, & Horwood (2000) who conducted a longitudinal study finding that low economic status continued to predict self-harm aside from later mental-health concerns or stressful events. However, this could be as a result of self-harm being more visible with these populations and people from a higher socioeconomic being more able to hide their self-harming behavior.

Self-Harm and Associated Disorders

Historically, there have been many different mental health disorders that have been associated with self-harm. These disorders are identified and their relationship with self-harm will now be discussed.

Mood Disorders

Depression. This disorder is a very comorbid disorder and, at times, can be difficult to sort out from other disorders. Signs of depression play a role for a high percentage of self-harmers. It has been observed, by mental health professionals, that self-harm can be seen as a beneficial experience for the client suffering from depression because it provides a distraction from their depressed feelings (Conterio and Lader, 1998, Farber, 2000).

Bipolar Disorder. As mental health practitioners know, bipolar disorder is a disorder by which the sufferer will move through a period of mania, where they are highly energized and often impulsive and then move into a period of severe depression. The acts of self-harm are more likely to happen during the periods of mania or as the person recognizes they are approaching their period of depression as an act to try and regulate their mood swing (Conterio and Lader, 1998).

Anxiety Disorders

There is a strong correlation between self-harm and anxiety disorders, with the period of heightened anxiety usually being the causing agent (Conterio and Lader, 1998). Levenkron (1998) explains that individuals who experience consistent periods of stress/anxiety often learn to anticipate them. Thus, for self-harmers if they realize one of these periods of stress is coming they could potentially self-harm before the event and after to help alleviate their stress/anxiety.

Obsessive Compulsive Disorder (OCD). This is a disorder by which sufferers have obsessive thoughts about something, which causes anxiety, and then, along with their thoughts, they can and often develop any number of compulsive behaviors to help alleviate their increased level of anxiety. Levitt, Sansone, & Cohn (2004) observe that self-harm closely resembles OCD due to the behaviors, for both, acting as a sense of relief from the tension/anxiety the person is experiencing and providing soothing feelings.

Post-Traumatic Stress Disorder. This is a disorder where the sufferer experiences severe flashbacks or nightmares, concerning a past trauma, and this affects their ability to function in daily life. It is thought that a lot of people who self-harm have experienced some previous traumatic event. To deal with their feelings of heightened arousal, Strong (1998) states that often self-harmers will dissociate and utilize any number of self-harming behaviors to assist them in keeping the strong thoughts/memories under control. This act of dissociating creates a lower sense of hyperarousal but, as Farber (2000) suggests, self-harm can also be used to stop an extended state of dissociating and initiate a period of hyperarousal.

Thought Disorders

Schizophrenia. While this disorder is not one that would commonly be associated with self-harm, however, with some of the ideations that self-harmers have, they often come close to schizophrenic tendencies. Conterio and Lader

(1998) discuss that in some cases they may hallucinate and hear voices that order them to harm themselves.

Personality Disorders

Borderline Personality Disorder (BPD). This is the most commonly diagnosed disorder for anyone who shows signs of or does commit self-harm, largely due to the fact that self-harm is an actual diagnostic criterion for BPD. Conterio and Lader (1998) state:

> Perhaps more than any other description, the borderline diagnosis captures the quality and tenor of some self-injurers' relationships: they are full of mistrust, fear, vulnerability, and unpredictability. Rather than implying a pejorative view of the person, we think the borderline diagnosis highlights the suffering of the individual and the obstacles that impede her from forging safe and trusting bonds with people. (p. 177-178)

Some professionals believe, that mental health clinicians often use self-harm alone as a sufficient symptom, by itself, to give the diagnosis of BPD (Farber, 2000). Unfortunately, because of the stigma BPD has with mental health professionals as being a highly untreatable disorder, self-harmers who present themselves for assistance often have difficulty in finding a mental health professional to treat them.

Assessment

Criteria

With the potential risks that are involved with self-harm, most importantly suicide, it is very important that the counselor/therapist do a thorough examination and be detailed in their collection of information with the presenting client. Farber (2000) provides a list of criteria that should be used when assessing for self-harm:

- The potential lethality of the behavior
- The frequency or repetitiveness
- The chronicity
- The directness of the harm
- The extent to which the behaviors are compulsive or impulsive, or both
- The extent to which the behavior is acceptable to the ego
- The level of consciousness or dissociation that accompanies the act
- The adaptive functions that are served by the self-harm
- The degree to which the intent is suicidal

Diagnosis

With the information that has been presented so far, it is easy to visualize how difficult it may be, for a mental health professional, to diagnose a self-harmer. With so many varying factors that are affecting the client's current status, at the time of presentation, a counselor/therapist could list several

diagnoses. However, there is an on-going discussion amongst mental health professionals as to whether self-harm should receive its own individualized diagnosis. Muehlenkamp (2005) states that self-harm, suicide, and other mental health disorders all have unique and distinct features. But, as with any other mental health disorder, the clinician needs to assess the situation to the best of their ability and choose, potentially, the most effective treatment for their client.

Treatment

As with any other mental health disorder, the best treatment would probably be the combination of medication and psychotherapy, with the goal of stabilizing moods and working on mental ideations. However, there has been little research done to confirm specific medications or therapeutic interventions that can reduce/stop self-harm and the research that has been conducted has often produced insufficient evidence (Arensman, et al., 2001, Hawton, et al., 1998). There are, however, some ideas that have been presented that have the potential to assist those who self-harm. Dallam (1997) states there are two components that aid in improvement from self-injury: gaining awareness of ones feelings and being able to communicate them verbally and becoming educated on the use of other behavioral options. Below are some theoretical approaches to assist clients who self-harm but as all mental health professionals understand, it takes well-developed rapport, first, to aid clients. This point could not be any more important than with clients who self-harm.

Rapport

With as confusing as self-harm may be, as has been shown above, it is critical that the counselor/therapist take their time to get to know the client, be patient, and develop rapport. Farber (2000) explains that the "...answer session during history taking should be avoided as it is likely to be experienced by the patient as an interrogation. The therapist should appear knowledgeable and competent, but also warm, empathic, and above all, not authoritarian" (p. 374-375). Strong (1998) adds that in order for positive progression to occur the client must feel they are worthy of it and trust that the therapist will do them no harm.

Psychotherapy

Feminists. Feminist approaches assist the client in recognizing that, for females, they belong to a less superior group and that the client needs to become empowered to rediscover their voice (Levitt, Sansone, & Cohn, 2004). In some cases, the client may be self-harming as a result of societal expectations they feel they are not meeting and need to meet. An example could be in Western civilizations it is frowned upon for a female to go above a certain weight or not to have a certain body type.

Humanistic. Aimed at improving self-esteem and control, this approach, in theory, lessens feelings of hopelessness and helplessness. Thus, reducing the client's temptation to self-harm (Rayner and Warner, 2003).

Psychoanalysis. This approach attempts to reduce self-harming behavior, within the client, by reducing the interpersonal difficulties and increasing self-esteem (Rayner and Warner, 2003). This can be completed by having the client express their feelings verbally, instead of through negative behavior, and attempting to make the unconscious conscious. Through this process, it is hoped that, the relationship grows strong between the client and counselor and the client becomes more comfortable in sharing their feelings. However, due to the nature of this approach some clients may have a negative experience and walk away from counseling with a feeling of inferiority (Turp, 2003).

Behavioral. Behavioral approaches identify the negative behavior and the frequency by which it is occurring. Through therapy, the counselor and client make a plan to develop more desired behaviors by introducing new reinforcers. However, Levitt, Sansone, & Cohn (2004) warn that sometimes the client may stray from the targeted behavior and move to another more covert behavior to self-harm. Thus, making it difficult for the counselor to track positive progression at times. This approach also lacks the strong therapeutic relationship that is considered more important in other theoretical approaches.

Cognitive-Behavioral. Cognitive therapy aims to assist the client in reducing the amount of negative thoughts they experience, thus increasing their amount of self-esteem and decreasing the amount of self-harm behavior. According to Farber (2000) it is key that the self-harming client understand that

their negative cognitive distortions and how they will lead to a snow balling effect, causing more and more negative thoughts. Upon increasing their self-esteem, work could also be done to assist the client with becoming more assertive towards others. As shown above, aggression, for a self-harmer, is often turned toward himself or herself and by aiding the client to be more assertive this will reduce the amount of self-harming behavior because they will become better at expressing their feelings externally (Rayner and Warner, 2003).

Psychopharmacology

As of now there are no medications that reduce or stop self-harm. Usually, in situations were self-harm is occurring any medication that would be prescribed would be to control other symptoms that could be present and contributing to the self-harm. These could include, but are not limited to, symptoms such as depression, mood swings, agitation, or confusion

Conclusion

No matter how one wants to observe/define self-harm, self-injury, self-wounding, or self-mutilation it is a concern that needs to have further research conducted in order to provide mental health professionals with the tools and competency they need to assist their clients. Hopefully, with the information that has been provided, there will be more knowledge to assist counselors/therapists in their research or improving their work with self-harming clients. If the situation

stays the same and everyone has "their own interpretation of the music" (Redfern, 1998) then clients will not be receiving the most beneficial treatment they need.

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