Cutting through the Myths of Deliberate Self-Harm

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To avoid discovery of her painful secret, 16-year-old Shannon has hidden her arms for the past two years beneath long sleeves pulled over her wrists even in the hottest weather. Those around her brushed off the oddity of her dress as a teenage fad and her reluctance to participate in physical education or go swimming as embarrassment or modesty. Her secret was revealed when her math teacher caught a glimpse of lacerations, healing wounds and scars on her wrists and forearms. Immediately alarmed, he questioned her about the nature of her wounds and asked that she show him her arms. Pulling her sleeves down further, she refused and told him it was just some cat scratches. Fearing for her safety and not knowing what to do, he sent her to the office hoping that someone would be able to help.

Adolescents, such as Shannon, who deliberately self harm *can* be helped when their behavior is discovered, but often the negative attitudes of the helping adults compound rather than alleviate the pain these youth feel.

Extent of self-harming behavior

Deliberate self-harm (DSH), also referred to as self-injury, self-mutilation, para-suicide, or cutting, is the intentional destruction of one's own body tissue without suicidal intent. Superficial DSH is the predominant form with cutting or carving of the skin and underlying tissues. Razor blades, scissor edges, pins, or sharp glass are employed to cut arms, wrists, ankles, and lower legs along with other hidden sites including the armpits, abdomen, inner thighs, feet, and tissue below the breasts. Sometimes DSH appears as single or multiple superficial, well-defined scars configured in a pattern, design, symbol, word, or as a single line repeatedly injured. DSH also includes burning, scratching, hair-pulling, poisoning, bruising, and breaking of bones. The behavior typically begins during adolescence and seems to peak between 16 and 25 years of age.

Once a phenomenon thought to occur predominantly in psychiatric in-patients and developmentally disabled individuals, DSH is now recognized in the general population with increasing incidence and prevalence. A review of literature conducted by Cornell University's Research Program on self-injurious behavior in adolescents and young adults indicated that between 4 and 38 percent of adolescents are engaging in some form of self-harm behavior in the United States. The variability of incidence and prevalence rates is related to the successful concealment of DSH for extensive periods of time without the adolescent exhibiting behavior indicative of psychiatric illness or impaired coping. Limited research, the private nature of the act, and failure to recognize self-harm behavior also interfere with accurate estimates of incidence and prevalence.

Although DSH is not in itself suicidal behavior, youth engaging in DSH are more likely to contemplate suicide and engage in behaviors resulting in unintentional death and severe injury. According to Olfson et al., approximately 225 emergency department visits out of 100,000 are related to DSH. Countless encounters are experienced by primary care physicians, nurses, school personnel, and counselors.

Realities and myths of self-harm

Research by Reece and Rodam, Hawton, and Evans identifies self-harm as a coping mechanism used to provide relief from psychological pain. The use of DSH is not an attempt to gain attention but a conscious decision made in order to release emotional stress and communicate anger, pain, and distress to others while providing relief from intense feelings of distress, anxiety, and depersonalization. Just as a person in a state of extreme anger might feel an overwhelming compulsion to throw something or slam a door, individuals prone to DSH find their psychological pain so unbearable that they inflict physical pain on themselves as a form of temporary release.

Psychiatric illnesses including clinical depression, obsessive compulsive disorder, anxiety disorder, and border-line personality disorder may accompany deliberate self-harm behaviors but many adolescents who self-harm have no such symptoms and are outgoing, high-achieving, and likable.

Systematic reviews of literature conducted by Yip and Webb indicate that adolescents who are prone to self-injury often have high levels of anxiety, impulsivity, poor self-esteem, inability to regulate their emotions, hypersensitivity to rejection, and chronic anger with a tendency to

suppress their feelings. DSH individuals do not see themselves as skilled at coping or maintaining control over their life. They tend to focus on the present and are unable to communicate their pain or concerns in a way that is socially acceptable.

Associated risk factors include depression, exposure to violence, childhood physical or sexual abuse, parental divorce, and emotionally unavailable parents in conjunction with feelings of rejection, self-hatred, separation anxiety, and guilt.

Hostile care adds to problem

Mishandling by those who initially contact self-harming youth may cause further self-injury and attempts to hide self-harm. Those who do not personally experience or understand a maladaptive behavior such as DSH, often attribute moral fault or manipulation to the form of expression used by deliberate self-harmers. This moralistic attitude is one of the single greatest impediments to the recognition and treatment of DSH.

After an occurrence of self-injury, those engaging in DSH are often reluctant to access the health care system due to reports or experiences of inadequate, judgmental, humiliating, or hostile care. The literature on DSH, for example, includes reports of health care providers suturing self-inflicted wounds without the use of anesthesia in order to punish the individual for the behavior.

Various researchers have found that health care providers' responses can be related to their feelings of frustration, pessimism, lack of empathy, personal inadequacy, and helplessness directly resulting from their attitude toward DSH.

Health care providers tend to have greater sympathy and willingness to help self-harming individuals when the self harm is precipitated by uncontrollable events, such as the death of a family member or close friend. In contrast, providers tend to have less optimism and willingness to help youth who have a controllable precipitant such as school or work difficulties or who are identified as more likely to repeat the behavior. Providers who experience a sense of helplessness to alter the outcome and reoccurrence of the repetitive self-harm behavior often assume that regardless of their interventions the adolescent will continue to self-harm, making any attempt to provide therapeutic care pointless.

Supportive intervention can help

Shannon was lucky. When she reported to the office, she was directed to the school nurse, who recognized the signs of DSH. The nurse asked Shannon about her injuries, and reluctantly, Shannon exposed her lower arms revealing multiple superficial lacerations and clusters of scars. Shannon acknowledged that her injuries were self-inflicted and a way to express her anger, pain, and frustration. Without judgment, shock, or chastisement, the nurse began the process of parental notification and referral to providers specializing in the diagnosis and treatment of DSH, all the time emphasizing, in an honest, open, and attentive manner, the need to maintain Shannon's safety.

With increasing incidence and prevalence of DSH among adolescents, providers should be alert for behavioral signs consistent with DSH. These signs include excessive dress, resistance to exposure of skin, and the presence of cuts, scars, and clusters of scars on unexposed areas.

The need to focus on the individual's safety and appropriate referral should be balanced by the need to develop a positive and trusting relationship that will discourage further attempts by the adolescent to hide or deny the self-harm behavior. Providers can begin to establish a trusting relationship by actively listening to the concerns and emotional responses of the self-harming adolescent. Providers' active listening offers an opportunity for these troubled adolescents to express their emotional pain verbally, and allows providers to avoid shocked, shaming, punitive, or overly sympathetic responses.

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When providing care to DSH adolescents, health care providers can experience significant difficulties as a result of pervasive misperceptions, the lack of established guidelines, and inadequate assessment and interventions. Steps should be taken by providers to recognize the behavioral signs, provide care in a nonjudgmental manner, maintain safety, and refer to agencies or individuals qualified in the treatment of DSH.

Because health care providers are often the initial contact when the behavior is discovered, they have a unique opportunity to provide care and intervention with the goal of preventing unintentional suicide, injury, and life-long difficulties with social functioning and coping mechanisms for the self-harming adolescent. ■

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Resources

Cornell Research Program on Self-Injurious Behavior in Adolescents and Young Adults. www.crpsib.com.

Self Abuse Finally Ends Alternatives Program. www.selfinjury.com.

Find citations and more resources related to this article at www.nwpublichealth.org.