PATIENTS AS PARTNERS
Brought to you by The South African Depression and Anxiety Group

Tel: +27 11 262 6396 Fax: +27 11 262 6350 E-mail: zane1@hargray.com website: www.sadag.co.za

The mystery and paradox of self-injury

By Dr Cithra Bheamadu

The conundrum of self-injury is that it is simultaneously seen as self-defeating and self-destructive, yet paradoxically also cited as life-sustaining, soothing and a coping mechanism in times of emotional crises. However, despite the progress and research to date, self-injury still remains a highly stigmatised and misunderstood phenomenon and continues to evoke negative attitudes, fear and repugnance in society. This is understandable, as self-injurious behaviours challenge our most basic human drives of self-preservation and self-nurturance, and seem beyond human logic. Self-injury is often shrouded in secrecy, addressed in a simplistic or sensationalistic manner, confused with suicide, and it evokes fear, inadequacy and incompetence. The first step toward coping with self-injury is the awareness that self-injurious behaviours are far more prevalent than society acknowledges. An awareness of the dynamics and prevalence of the behaviour is essential to promote understanding and develop the skills to treat individuals who self-injure.

Self-injury is defined as the intentional infliction of pain on one's body, resulting in cuts, scars, welts, wounds and bruises, without any suicidal intent and presents a challenge, as it subsumes a broad continuum of behaviours that appear across numerous clinical and non-clinical populations (Nock, 2010). The many labels, terms and abbreviations assigned to the spectrum of behaviours viewed as self-injurious reflects and compounds the confusion surrounding the definition and treatment of self-injury. A large part of the terminology debate appears to be about the lack of consensus about what is being named and what the parameters are for inclusion as self-injurious behaviours. Some of the terms used to refer to this phenomenon include deliberate self-injury, self-inflicted violence, self-harm, self-injurious behavior, self-mutilation and non-suicidal self-injury. Additionally, the multiplicity of labels used synonymously and interchangeably complicates understanding, as some terms are suggestive, sensationalistic and pejorative, such as self-mutilation, which is considered a misrepresentation as the large majority of self-inflicted wounds involve only modest physical damage that leaves long-term scarring but does not involve the mutilation or complete destruction of the body. The fact that self-injury is not classified as a disorder, syndrome or behaviour in its own right in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR) or the International Code of Diseases (ICD 10) – two of the major classification systems for diagnosing mental and behavioural disorders – means a lack of professional guidelines to assist in assessing and treating self-injury (Simeon & Hollander, 2001). However, this is set to change in the proposed revision of the DSM V to be published in 2013 – the inclusion of self-injurious behavior can be seen as acknowledgement of the gravity and pervasiveness of self-injury in society.

In addition to the ongoing debate on the use of the appropriate term to describe self-injury, there is also much discussion about the differentiation of self-injury from suicide. Although self-injury and suicide may exist on the same continuum of behaviours, there is unequivocal consensus that the underlying intent in suicide is distinctly different from that in self-injury (Nixon & Heath, 2009). Although self-injury is predominantly a strategy aimed at alleviating, communicating and even advertising intense distress, the risk of suicide is not to be taken lightly. Research studies indicate that 50% to 70% of individuals with a history of self-injury make a suicide attempt at some point (Nock, 2009), and self-injury can unintentionally result in death when individuals potentially underestimate the lethality of their self-injurious behaviours (Plante, 2007).

Individuals who self-injure represent both genders and come from different racial groups, socio-economic backgrounds, age groups and occupations, and extend across different developmental stages and may be emotionally or psychologically vulnerable to coping maladaptively (D' Onofrio, 2007; Favazza, 1996, Plante, 2007; Walsh, 2006). There is consensus among researchers that the age at which self-injurious behaviours typically begin is around 12 to 15 years, and that the behaviour can continue into the 20s and 30s (Gratz, 2004; Klayman-Farber, 2000, D' Onofrio, 2007). Reports of gender disparity in cases of self-injury vary considerably, but one robust gender difference that emerges is males are likely to injure themselves more severely, to hit themselves (whereas females are more likely to cut themselves) and there is a higher incidence of males dying through self-injury than females (Whitlock & Eckenrode, 2006).

Individuals in distress use a wide array of methods to self-injure and the method used depends on emotions, circumstances and needs. The most common methods of self-injury are cutting, scratching, carving, hitting and burning, head banging, interfering with wounds, picking scabs, scratching the skin, hair pulling and peeling off layers of skin (Klonsky, 2009). The

PATIENTS AS PARTNERS

Brought to you by The South African Depression and Anxiety Group

Tel: +27 11 262 6396 Fax: +27 11 262 6350 E-mail: zane1@hargray.com website: www.sadag.co.za

repertoire of instruments used by individuals seems to be limited only by the creativity, resourcefulness and desperation of the individual (Plante, 2007). These include blades, knives, scalpels, scissors and shards of glass, pieces of metal or any other sharp object available at the moment of need. For most people, selection of the body area to be injured is symbolic or has practical meaning. The arms, wrists and legs are the body areas most commonly chosen, as they are within easy access and the wounds can be easily hidden with clothing, whereas other target areas are the head, chest, thighs and stomach (Walsh, 2006).

The question that often baffles people is what sort of person can actually deliberately hurt themselves (Nock, 2009). Contrary to the belief that individuals who self-injure are crazy, weird or are seeking attention, it is essential to raise awareness of the fact that self-injury is often used by intelligent and fully functional individuals in an effort to cope with distress and manage overwhelming emotions. The fact that self-injury remains a taboo subject and is not well researched within the South African context exacerbates the general understanding and treatment of this phenomenon. The first step toward coping with self-injury is awareness that it is far more prevalent than society acknowledges. We need to understand that for some individuals, inflicting pain is a physical solution to an emotional or psychological pain. They are self-injuring to cope. Self-injury is predominantly about changing mood states and about feeling better through inflicting physical harm on the body and controlling the chaos of psychological pain. Consequently, when emotions cannot be discharged or integrated on a mental level, they are expressed physically through cuts, welts, bruises and burns (Walsh, 2006; Nixon & Heath, 2009; Gratz, 2007; Nock, 2009). Over time, the self-injuring individual becomes increasingly tolerant to the mood, thereby increasing the frequency and severity of the self-injury (Yates, 2004).

An awareness of how prevalent self-injury is can help mobilise people into investing time and effort in intervention programmes. This means that individuals who work with self-injury must learn to destigmatise and depathologise self-injury, so that it warrants a calm and non-judgmental appraisal. It is very difficult to connect empathically with individuals who court death and initiate pain, so we tend to resist the complex attachments that must develop if we are to treat them. The drama of self-injury and its complicated processes immobilises highly skilled and competent clinicians eliciting helplessness, horror, guilt, fury, betrayal, disgust and sadness, and undermining their confidence in their ability to provide appropriate clinical care. These ambivalent reactions can result in failed attempts to make meaningful connections with the self-injuring clients or to make an impact on self-injuring behavior. Too often a struggle emerges between the client and the therapist, leaving the client feeling misunderstood and the therapist feeling ineffective and overwhelmed.

Self-injury communicates a powerful statement about the psychological distress of the individual and the individual's distorted attempts to soothe emotional pain. The scars left by the self-injury are a visible manifestation of unarticulated pathos and a reflection of the personal and contextual problems that need to be resolved. For the adolescent who practises self-injury as a problem-solving strategy, relearning to self-soothe and to cope more adaptively will require a multilevel, lengthy and painstaking intervention process. An integrated intervention should target restoring intrapersonal and interpersonal development

SELF-HELP

If you are self-injuring, here are some self-help tips to keep in mind:

- Take yourself away from the situation – something as simple as removing yourself from the presence of knives and razors works for some.
- Try and focus on something around you rather than the pain you may be feeling. By 'grounding' yourself, it helps to be more in control of your reaction to those bad feelings.
- Make a list of supportive friends who you can talk to who understand your situation and who you can call when you feel you need to. However, sometimes friends can find it difficult to cope – if you find this is happening, you may need to talk to a professional.
- Try deep breathing and relaxation exercises.
- Write in a journal – record how you feel and what might have made you feel like you wanted to self-harm.
- Hold ice cubes in your hand – cold causes pain but is not dangerous to your health.
- Learn to confront others, making your own feelings known.
- Make a list of reasons why you are going to stop self-harming and set yourself some realistic goals to help you stop.
- When you feel overwhelmed and find it hard to think about the future, remind yourself that the problems that seem unsolvable will change, that life is always changing and that you are in control.
- Call a crisis line if you feel that your behaviour is becoming dangerous – you can contact SADAG between 8am and 8pm 7 days a week on 0800 21 22 23 to speak to a counselor for free.

PATIENTS AS PARTNERS

Brought to you by The South African Depression and Anxiety Group

Tel: +27 11 262 6396 Fax: +27 11 262 6350 E-mail: zane1@hargray.com website: www.sadag.co.za

through awareness, psychotherapy, training, psycho-education, support and knowledge. The success of managing self-injury requires an awareness of the practice of self-injury, an understanding of the dynamics of the phenomenon and tolerance on behalf of professionals to work outside their comfort zones.

For any queries, contact Dr Cithra Bheamadu by sending an e-mail to cbheamadu@uj.ac.za

References

- *American Psychological Association (APA) (2012) DSM V http://www.apa.org/*
- *D'Onofrio, A. A. (2007). Adolescent self-injury: a comprehensive guide for counsellors and health-care professionals. New York: Springer Publications.*
- *Favazza, A. R. (1996). Bodies under Siege: Self-Mutilation and Body Modification in Culture and Psychiatry, 2nd ed. Baltimore: The Johns Hopkins University Press.*
- *Gratz, K. L. (2001). Measurement of Deliberate Self-Harm: Preliminary Data on the Deliberate Self-Harm Inventory. Journal of Psychopathology and Behavioural Assessment, 23,(4).*
- *Gratz, K. L. (2003). Risk factors for the functions of deliberate self-Harm: an empirical and conceptual view. Clinical Psychology, Science and Practice, Massachusetts, Boston: American Psychological Association.*
- *Gratz, K. L. (2007). Targeting Emotion Regulation in the Treatment of Self-Injury. Journal of Clinical Psychology: In Session, 63, (11), 1091-1103.*
- *Klayman-Farber, S. (2000). When the Body is the Target: Self-Injury, Pain and Traumatic Attachments. Northvale: Jason Aronson*
- *Klonsky, E. D. (2009). The functions of self-injury in young adults who cut themselves: clarifying the evidence for affect regulation. Psychiatry Research, 10, (10) 16.-26.*
- *Nixon, M. K. & Heath, N. L. (2009). Self-injury in youth: the essential guide to assessment and intervention. United States of America: Routledge, Taylor Francis Group.*
- *Nock, M. K. (2010). Self-injury. Annual Review of Clinical Psychology Current Directions in Psychological Science, 6(3). 339-363.*
- *Plante, L. G. (2007). Bleeding to Ease the Pain: Cutting, Self-injury and the Adolescent Search for Self. United States of America: Praeger Publishers.*
- *Simeon, D. & Hollander, E. (eds.) Self-injurious Behaviours: Assessment and Treatment. Washington, D.C.: American Psychiatric Publishing Inc.*
- *Walsh, B. (2006). Treating self-injury: a practical guide. New York: Guilford Press.*
- *Walsh, B. (2007). Clinical assessment of self-injury: a practical guide. Journal of Clinical Psychology: In Session, 63, 1057–1068.*
- *Whitlock, J. L., Eckenrode, J. & Powers, J. L. (2006). The virtual cutting edge: the internet and adolescent self-injury. Developmental Psychology, 42(3).*
- *Yates, T. M. (2004). The Developmental Psychopathology of Self-Injurious Behaviour: Compensatory Regulation in Posttraumatic Adaptation. University of Minnesota, Minneapolis: Elsevier Ltd.*

IMPORTANT NUMBERS TO REMEMBER

Suicide Crisis Line: 0800 567 567 or SMS 31393

Pharmadynamics Police and Trauma Line: 0800 20 50 26

AstraZeneca Bipolar Line: 0800 70 80 90

Sanofi Aventis Sleep Line: 0800-SLEEPY (0800 753 379)

Dept. of Social Development Substance Abuse Line: 0800 12 13 14 or SMS 32312

Dr Reddy's Helpline: 0800 21 22 23

Office Lines: 011 262 6396

Website: www.sadag.co.za