Self-Harm: Types, Causes, and Treatment

Cody R. Grimm

Mr. Henne

English 202A

November 29, 2012

TURNITIN Score-3%

Self-harm, also known as self-mutilation or self-injury is the direct and purposeful destruction of human tissue severe enough for tissue damage to occur, but the act is not necessarily done with conscious suicidal intent (Gratz, Latzman, Young, Heiden, Damon, Hight & Tull, 2011). Self-harm it is more common today than any other time in history, and research says that it most common in adolescents and young adults (Lewis, Rosenrot & Santor, 2011), and though it may be seen primarily in these age groups, self-harm can occur at later ages. The reason someone would purposefully injure themselves is not always clear; some studies believe that self-harm is entwined with other psychological disorders such as depression and alexithymia (definition: the inability to describe and interpret emotions in the self) (Dobie & Donatelle, 2007), while other studies suggest that self-harm is actually a coping mechanism for these disorders (Bolognini, Plancherel, Laget, Stephan & Halfon, 2003). This paper will discuss self-harm in further detail and examine the types, causes, and treatment strategies.

What Is Self-Harm?

Types

As Bolognini et al. (2003) explain, self-harm can be divided into two categories: (1) culturally sanctioned self-harm and (2) deviant pathological self-harm. Culturally sanctioned self-harm, as derived from its name, is widely accepted in the culture from which it emerges (ex: ear-piercing or genital circumcision). Deviant pathological self-harm is the purposeful self-destruction of the body without conscious suicidal intent. This category can be split into three subcategories:

1.) Major self-harm involves significant or serious damage to the body. Some examples include self-castration and the amputation of one's own limbs. This form of self-harm is most commonly

found in individuals who are extremely intoxicated or who suffer from a severe psychological disorder.

2.) Stereotypic self-harm involves a fixed pattern and is often rhythmic in nature; examples include banging one's head against a wall, chewing one's fingertips, and pressing of one's eyeball.

3.) Moderate (or superficial) self-harm can occur many times daily and can become ritualistic. This form of deviant behavior is by far is the most common out of the three listed; examples range from cutting oneself (most common), burning of oneself, pulling of hair, and even breaking bones (least common).

Causes

Most scientists believe that self-harm stems from a current or previous mental disorder. Selby, Bender, Gordon, Nock, and Joiner (2011) have suggested that self-harm is often attributed to borderline personality disorder, but may belong to a distinct category on its own. Selby et al. note that self-harm is found in patients who do not suffer from borderline personality disorder and can be characterized by depressive symptoms, anxiety, and suicidal thoughts. The authors go as far as to propose specific criteria for the identification of self-harm as a separate disorder. The authors continue to explain that an individual may suffer from this disorder if they have self-harmed five or more times over the past year, or if they possess two of the following motivations for self-harm: stress reduction, difficulty resisting urges to self-harm, having urges to take part in self-harm, or the engagement of behavior for emotional/social functions. However, identification of specific symptoms overall may provide only a small portion of individuals who self-harms.

Selby et al. (2011) also note that self-harm is strongly associated with common personality disorders (AXIS I disorders) such as depression, dysthymia, bipolar, extreme anxiety, substance abuse, substance dependence, eating disorders, A.D.D, stereotypic movement disorder, and trichotillomania (definition: irresistible urge to pull one's own hair). The authors associate self-harm with these disorders because both self-harm and AXIS I disorders share similar high levels of distress and impairment. This seems to be partially true as their study found that individuals who suffered from self-harm had higher rates of mood disorders and that all individuals studied had a co-occurrence of mood disorders. Other authors also concur with Selby et al. by stating that self-harm is associated with higher depression symptoms (Ougrin, Zundel, Kyriakopoulos, Banarsee, Sthal & Taylor, 2011). It is also important to note that that although depressive symptoms may increase the risk of self-harm, not all who have depressive symptoms self-harm (Lewis et al., 2011). Other authors suggest that self-harm is used more for sensation seeking and also because of an emotional dependency (Bolognini et al., 2003). When there is no evidence of these factors, Luiselli (as cited by Bloom, Holly, & Miller, 2012) relate self-harm to attention seeking or avoiding the demand of a task.

Generalities of Self-Harm

Who Does It?

As mentioned before, adolescents and young adults are most at risk to partake in self-harm. A growing body of evidence suggests that self-harm is becoming more common among nonclinical populations (Gratz et al., 2011), and becoming much more common in the adolescent to young adult age group. In fact, high school students are most at risk for self-harm. In a study done by Gratz et al. (2011) at a high and middle school, out of a total of 779 students, 39%

reported a history of self-harm, and 21% of those students reported self-harm had occurred more than five instances; Dobie and Donatelle (2007) report in their study that at least 2% of the student body self-harm, but also note that some studies have found percentages upwards to 14%. Many individuals who self-harm report tension that they cannot control; by harming themselves they try to reduce this level of tension (Bolognini et al., 2003). Self-hitting is much more common in males, and self-cutting is much more common in females (Gratz et al., 2011). Hitting and cutting may be the most common forms of self-harm, but even, severe scratching and burning were found in high school students, but in lesser amounts.

In addition to the last statistic regarding females, women are more likely to engage in self-harm than men, and thus most studies focus on women more than men. Bolognini et al. (2003) statistics show that 42% of these self-harming women are drug abusers. Though Dobie and Donatelle (2007) agree that women are the focus of self-harm research, they attest that men make up 40% of self-harmers as well.

Intent

Is it possible to foresee a cause for intent in self-harming individuals? Lewis et al. (2011) found evidence that there are such actions that could show intent for self-harm. Those authors believe that that certain behaviors have been identified to predict the intention for self-harm. The authors mention anxiety, distress, hopelessness, personality factors, and depressed mood as some of those behaviors. Lewis et al. however, also suggest that three global components can be used to predict intent: attitudes, subjective norms, and perceived behavior control (PBC). PBC as it pertains to self-harm, may be a lack of self-control when self-harm takes place, and through self-

harm, this is an action that increases control. Families with members showing signs of such behaviors/mood factors listed above are most likely dealing with an individual who self-harms.

An individual who self-harms is more likely to place themselves in environments where self-harm can be performed, giving themselves intent to do so. Once in that environment, the individual may feel as though they cannot resist the urge to self-harm and the act is performed. The question may be asked why self-harming individuals would place themselves in an environment where they would be tempted to harm themselves. Ajzen (cited by Lewis et al., 2011) explain this thought as his theory of planned behavior (TPB), a social-cognitive model of behavior—that offers explanations for factors predicting or influencing behavior. Within the TPB model, one's intentions play an important role, and perhaps individuals place themselves subconsciously in the environment to self-harm—resulting in feeling a lack of control.

Treatment

School Counselors

As previously mentioned, adolescents and young adults are most at risk for self-harmng behavior. Seventy precent of adolescents who self-harm have said they had also attempted suicide at least once (Selby et al., 2011); and suicidal adolescents are most likely going to be women (Lewis et al., 2011). Adolescents that self-harm increase their chance of suicide by tenfold (Ougrin et al., 2011). With upwards to 14% of students committing self-harm, school counselors are on the front lines when helping adolescents with this problem. In a study by Dobie and Donatelle (2007) out of 443 councilors, 81% reported that they worked with an individual with self-harming tendencies, but only half of students feel comfortable talking to school staff about any type of problems; though school counselors can play an important and

unique role in helping students. These authors explain that fellow students are more likely to tell counselors about a friend that self-harms (67%), classroom teachers (65%) would next, followed by the harmer themselves (51%), or counselors that recognize the symptoms (48%), or informed by the school nurse (26%) or parents (18%). Ninety-one percent of (of 443) school councilors in Dobie and Donatelle's study had reported to be giving the students individual counseling by providing therapy for this mental health problem, but this is not the job of the school counselor—nor has it been the best model for treatment of self-harm. The job of a school counselor is when recognizing the symptoms, referring the individual to a psychiatrist; this is perhaps the most important step in the treatment of self-harm. The school counselor should be the middle man between the student and the psychiatrist. The school counselor should keep in touch with parents, and keep in touch with the individual seeking therapy. Counselors should arrange tutoring for the individual and speak with friends, and families to address concerns.

Psychiatrists

An individual who self-harms should be referred to a psychiatrist by a member of the helping profession, friends, or family. Psychiatrist have seen an increase in clients over the past decade and they explain this by possibly the collapse of the extended family, a body focused culture, body alienation, emotional deprivation, abuse, or even biology; and emotional disorders such as depression, anger management, and posttraumatic stress disorder (Dobie & Donatelle, 2007). A self-harm diagnosis is a serious matter and calls for specific therapeutic approaches (Selby et al., 2011). There has been many therapeutic breakthroughs in helping individuals who self-harm, but there is still a factor that stands in the way—poor engagement (Ougrin & Latif, 2011). The lack of engagement is defined by an individual attending four or more session; poor engagement, less than four. Self-harmers for the time being have two treatment options: (1)

specific psychological treatment or (2) treatment as usual. Psychological treatment refers to the individual going to the psychiatrist and doing treatment at their facility. While treatment as usual refers to the psychiatrist going to the individuals home where, in most cases, the act is carried out (Ougrin & Latif, 2011). Ougrin and Latif's study has shown that there is little evidence that specific psychological treatment trumps treatment as usual, but in fact showed treatment as usual actually improved engagement overall.

Self-harm is a major public health concern, and an actual creation of a new disorder specifically for self-harm would produce positive benefits (Selby et al., 2011). There is currently no specific treatment guaranteed to cure all individuals who self-harm, but researchers have produced evidence that a combination of medication and psychotherapy can induce some therapeutic success (Ougrin et al., 2011). There has been a long held hypothesis that the urge to self-harm comes from a dysfunction in the endogenous opioid system in the body (Bloom et al., 2012). Bloom et al. (2012) report a repertoire of drugs that have had some success reducing self-harm such as: risperidone, valproate, topiramate, sertraline, dozepin, and pisperidone. These drugs were used with some success to treat a 39-year-old man with a severe case of self-harm. The drug naltrexone has also been reported with some success as an option of treatment. Researchers still do not know the physical causes for self-harm or specific treatment strategies to rid an individual of self-harm tendencies.

Conclusion

Self-harm has no specific diagnosis, but as referred to earlier, the creation of a self-harm disorder would attribute to the success of treatment (Selby et al., 2011) because of labeling self-harm as a disorder would stimulate new research and in retrospect improve individual success in

treatment, rather than the now broad categories of treatment (Selby et al., 2011). At this moment, self-harm is most often attributed to another psychological and mood disorders (Lewsi et al., 2011; Bolgnini et al., 2003), and treatment continues to be too broad and is not always successful.

Self-harm can last a lifetime, but usually subsides by 18 years of age (Dobie & Donatelle, 2007). This doesn't always happen, and the ever-growing act of self-harm is still a problem in this country. It has been suggested by Lewis et al. (2011) that strong social supports may actually prevent self-harm, and their findings suggest that young adults with strong supports will not self-harm when they imagine what their friends and families would think of the behavior.

Any incidents of purposeful self-harm should be taken very seriously and treated with appropriate care (Bolognini et al., 2003). Through the action of self-harm, purposeful/accidental suicide is omnipresent, and the discussion of suicide prevention should be discussed in detail with the individual (Bolognini et al., 2003). If an individual is suspected that they are committing the act of self-harm, do not lose hope. Attempt to establish strong social supports with that individual, and refer them to a psychiatrist where a psychological assessment can be obtained and further help and support can be provided to aid in their recovery.

References

Bloom, C., Holly, S., & Miller, A. (2012). Self-injurious behavior vs. nonsuicidal self-injury. *Research Trends, 33,* 106-112.

Bolognini, M., Plancherel, B., Laget, L., Stephan, P., & Halfon, O. (2003). Adolecents' self-mutilation-relationship with dependent behavior. *Swiss Journal of Psychology, 62,* 241-249.

Dobie, S., & Donatelle, R. (2007). School counselors and student self-injury. *Journal of School Health, 77,* 257-264.

Gratz, K., Latzman, R., Young, J., Heiden, L., Damon, J., Hight, T., & Tull, M. (2012). Deliberate self-harm among underserved adolescents: The moderation roles of gender, race, and school-level and association with borderline personality features. *Personality Disorders: Theory, Research, and Treatment, 3,* 39-54.

Lewis, S., Rosenrot, S., & Santor, D. (2011). An integrated model of self-harm: Identifying predictors of intent. *Canadian Journal of Behavioral Science, 43,* 20-29.

Ougrin, D., & Latif, S. (2011). Specific psychological treatment versus treatment as usual in adolescents with self-harm. *Research Trends, 32,* 74-80.

Ougrin, D., Zundel, T., Kyriakopoulos, M., Banarsee, R., Stahl, D., & Taylor, E. (2011). Adolescents with suicidal and nonsuicidal self-harm: Clinical characteristics and response to therapeutic assessment. *Psychological Assessment, 24,* 11-20.

Selby, E., Bender, T., Gordon, K., Nock, M., & Joiner, T. (2011). Non-suicidal self-injury (NSSI) disorder: A preliminary study. *Personality Disorders: Theory, Research, and Treatment, 3,* 167-175.