

National Self-Injury Awareness Day

March 1, 2000

Self-Injury: Beyond the Myths

Self-injury basics

- Most researchers agree that self injury (SI) is self-inflicted physical harm severe enough to cause tissue damage or marks that last for several hours, done without suicidal intent or intent to attain sexual pleasure. Body markings or modifications that are done as part of a spiritual ritual or for ornamentation purposes generally aren't considered SI.
- SI generally is done as a way of coping with overwhelming psychophysiological arousal. This can be to express emotion, to deal with feelings of unreality or numbness, to make flashbacks stop, to punish the self and stop self-hating thoughts, or to deal with a feeling of impending explosion. SI is more about relieving tension or distress than is it about anything else.
- Although cutting is the most common form of SI, burning and head-banging are also very common. Other forms include biting, skin-picking, hair-pulling, hitting the body with objects or hitting objects with the body.
- SI is a crude, ultimately destructive coping mechanism, but it *works*. That's why it sometimes seems to have addictive qualities. To help a client, you must offer more effective coping strategies as replacement. Learning these ways can take time; punishing a client or patient for coping in the only way he or she knows can make therapy unworkable.
- Most people who self-injure *hate* the term "self-mutilation." That phrase speaks to intent and maiming the body is usually not the intent of SI anyway. Better terms are self-inflicted violence, self-harm, and self-injury.

Why people self-injure

Self-injury is probably the result of many different factors. Among them:

- Lack of role models and invalidation — most people who self-injure were chronically invalidated in some way as children (many self-injurers report abuse, but almost all report chronic invalidation). They never learned appropriate ways of expressing emotion and may have learned that emotions are bad and to be avoided.
- Biological predisposition — evidence is accumulating that indicates self-injurers have specific problems within the brain's serotonergic system that cause an increase in impulsivity and aggression. Impulsive aggression, combined with a belief that expressing it outwardly is unthinkable bad, might lead to the aggression being turned inward.
- Studies have suggested that when people who self-injure get emotionally overwhelmed, an act of self-harm almost immediately brings their levels of psychophysiological tension and arousal back to a bearable baseline level. In other words, they feel a strong uncomfortable emotion, don't know how to handle it, and know that hurting themselves will reduce the emotional discomfort quickly. They may still feel bad, but they don't have that panicky, jittery, trapped feeling.

Who is likely to self-injure

- Self-injurers come from all walks of life and all economic brackets. People who harm themselves may be male or female; gay, straight, or bi; Ph.D.s or high-school dropouts; rich or poor; and live in any country in the world. Some people who SI manage to function effectively in demanding jobs; they are teachers, therapists, medical professionals, lawyers, professors, engineers. Some are on disability. Some are highly achieving high-school students.
- Their ages typically range from early teens to early 60s, although they may be older or younger. In fact, the incidence of self-injury is about the same as that of eating disorders, but because

it's so highly stigmatized, most people hide their scars, burns, and bruises carefully. They also can have excuses to offer when someone asks about the scars (there are a lot of really vicious cats around).

- People who deliberately harm themselves are no more psychotic than people who drown their sorrows in a bottle of vodka are. It's a coping mechanism, just not one that's as understandable to most people and as accepted by society as alcoholism, drug abuse, overeating, anorexia, bulimia, workaholism, smoking cigarettes, and other forms of problem avoidance are.
- Self-injury is VERY RARELY a failed suicide attempt. People who inflict physical harm on themselves are often doing it in an attempt to maintain psychological integrity -- it's a way to keep from killing themselves. They release unbearable feelings and pressures through self-harm, easing their urge toward suicide. Some people who self-injure do later attempt suicide, but they almost always use a method different from their preferred method of self-harm. Self-injury is a maladaptive coping mechanism, a way to stay alive. Unfortunately, some people don't understand this and think that involuntary commitment is the only way to deal with a person who self-harms. Hospitalization, especially forced, can do more harm than good.

What helps people who self-injure

Medications (mood stabilizers, anxiolytics, antidepressants, and some of the newer neuroleptics) have been tried with some success. There is no magic pill for stopping self-harm (naltrexone, though effective in people with developmental disabilities, doesn't seem to work nearly as well in other patients). Many therapeutic approaches have been and are being developed to help self-harmers learn new coping mechanisms and teach them how to use those techniques instead of self-injury. They reflect a growing belief among mental-health workers that once a client's patterns of self-inflicted violence stabilize, work can be done on the problems and issues underlying the self-injury.

This does not mean that patients should be coerced into stopping self-injury. Any attempts to reduce or control the amount of self-harm a person does should be based in the client's willingness to undertake the difficult work of controlling and/or stopping self-injury. Treatment should not be based on a practitioner's personal feelings about the practice of self-harm.

Self-injury brings out many uncomfortable feelings in people: revulsion, anger, fear, and distaste, to name a few. Medical professionals who are unable to cope with their own feelings about self-harm have an obligation to themselves and their clients to find a practitioner willing to do this work. In addition, they are responsible for ensuring that the client understands the referral is due to their own inability to deal with self-injury and not to any inadequacies in the client.

People who self-injure do generally do so because of an internal dynamic and not in order to annoy, anger or irritate others. Their self-injury is a behavioral response to an emotional state and is usually not done in order to frustrate caretakers. In emergency rooms, people with self-inflicted wounds are often told directly and indirectly that they are not as deserving of care as someone who has an accidental injury. They may be treated badly by the same doctors who would not hesitate to do everything possible to preserve the life of an overweight, sedentary heart-attack patient.

Doctors in emergency rooms and urgent-care clinics should be sensitive to the needs of patients who come in to have self-inflicted wounds treated. If the patient is calm, denies suicidal intent, and has a history of SI, the doctor should treat the wounds as they would treat accidental injuries. Refusing anesthesia for stitches, making disparaging remarks, and treating the patient as an inconvenient nuisance simply further the feelings of invalidation and unworthiness the self-injurer has. It is useful to offer mental-health follow-up services; however, psychological evaluations with an eye toward hospitalization should be avoided in the ER unless the person is clearly a danger to self or to others. In places where people know that seeking treatment for self-inflicted injuries are liable to lead to mistreatment and lengthy psychological evaluations, they are much less likely to seek medical attention for their wounds and thus are at a higher risk for wound infections and other complications.

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