PHOENIX PLACE

Understanding Self-Harm

Information and Treatment Suggestions for Practitioners

When you're referred a client who keeps banging their head against the wall, or when a client you're working with reveals they've been cutting themselves, it can be hard to know how to react and what to do. We've compiled some information and treatment suggestions, drawing from current research, which may be of help.

What is self-harm, and why do people do it?

Self-harm, self-mutilation, non-suicidal self-injury…it has a range of names, but at its core, it's *the act of deliberately inflicting hurt upon yourself*. Pretty straightforward. For most of us, the hardest thing to make sense of is the why. Why engage in self-harm? The thing is, there's no single easy answer. There are various reasons why people engage in self-harm, and treatment will be shaped around whatever that reason is. Some of the main ones are,

- A way of feeling something other than numb/emotional pain
- To control or get distraction from unwanted feelings, thoughts, or memories
- For those who dissociate, to feel real (grounded in the body)
- To feel in control of one's body
- As a punishment, to deal with feelings of shame or guilt
- To say, "I'm not coping, please help me"
- To say, "Leave me alone, I don't want to deal with people"

Ultimately, self-harm is a maladaptive coping mechanism. It's distinct from suicide, because it's not about trying to die. Instead, it's about trying to find a way to cope with, or bear, the world. However, it is important to be aware that individuals who self-harm are at increased risk of committing suicide (whether accidently, or due to escalation of distress). The risk factors that lead to someone self-harming look very similar to the risk factors that lead to someone committing suicide.

Many of us, if we think of self-harm, think of cutting, and maybe burning. According to Headspace, the most common methods young people use are cutting and self-poisoning (i.e. a medication overdose – not to the point of suicide, but to the point of making themselves sick). Other methods used are pinching/scratching self, banging body against walls, interfering with wound healing, and pulling out hair. One more often seen in males than females, which might not always get classified as self-harm, is punching walls.

Does *where* the self-harm occurs matter?

Yes and no. Self-harm directed at the eyes and genitals indicate extreme emotional disturbance. It has been suggested that if a client is directing their self-harm towards their breasts and genitals, the practitioner should query a sexual abuse background. But as of writing, I'm not aware of any actual research into this. My feeling is that considering the location of self-harm is a bit like interpreting art, or sand trays, or dreams – it's more about what the individual's meaning is than yours.

What are the risk factors? Who self-harms?

Accurate and meaningful statistics are hard to find, but a report by Orygen in Melbourne (the National Centre of Excellence for Youth Mental Health) suggests that 24.4% young women and 18.1% young men aged 20-24 have self-harmed. It's important to note that the data is usually based off hospitalisations, but we know that the majority of self-harm doesn't result in hospitalisation, resulting in skewed statistics. Many individuals who self-harm take great care tending to their injuries and seeking to avoid infection (e.g. using a sterile blade, cleaning the wound and applying antiseptic ointment). The more inexperienced or emotionally escalated individuals are, the less likely they are to do so, and it's here than you're more likely to get accidental suicide, or significant bodily damage. Harm reduction (that is, how can we minimise the risk and damage) should form part of early treatment in therapy.

So, we know that self-harm is more common in females than males. And we know that most self-harm starts between the ages of 12 and 16, and the prevalence reduces by the age of 19 or 20.

The risk factors are, as noted above, very similar to suicide risk factors

Sociodemographic factors	Significant life events and family adversity	Psychiatric and psychological factors
Sex (female for self-harm and male for suicide) Low socioeconomic status Lesbian, gay, bisexual, or transgender sexual orientation	History of trauma Parental separation Adverse childhood experiences History of physical or sexual abuse Family history or mental disorder or suicidal behaviour Bullying Interpersonal difficulties	Mental disorder (in particular, depression, anxiety, ADHD, Bipolar, manic episodes, psychosis, eating disorders, Borderline Personality Disorder) Misuse of drugs and alcohol Low self-esteem Poor social skills and/or problem-solving skills Perfectionism Hopelessness

See list on https://headspace.org.au/health-professionals/understanding-self-harm-for-health-professionals/

According to Orygen, of all the adolescents who present for treatment for self-harm, about 2/3 could be diagnosed with depression.

The cycle of self-harm

As research has progressed into self-harm and ways of managing and treating it, one very significant finding has been that self-harm has a lot in common with addictions. A number of inpatient treatment centres and hospital wards that treat self-harm, across the UK and the US, conceptualise it as essentially, a type of addiction, which shapes treatment and expectation for treatment. For a lot of young people who self-harm, their experience is cyclical. There's a build-up of pressure/distress which leads to the self-harming action which results in emotional relief. But the relief is short lived, and before long, the pressure builds up again.

And, in the same way that people build up a tolerance to drugs, alcohol, and sexual encounters, it's not unusual for people to find that they need to self-harm more often, and/or to a greater degree, to experience the same effect, the same emotional release, that they did before.

Treatment: So what can we do?

"…look beyond the behaviour and instead explore the intention behind the behaviour."

(Andrew Reeves)

I love this quote from Andrew Reeves, an American counsellor who works extensively with clients who self-harm.

First of all, the literature coming from the therapists and treatment centres that specialise in self-harm is consistently this: don't try to force people to stop (e.g. insist they hand over their method of self-harming before treatment can continue, or tell them that they have to sign a contract that promises that they won't do it) – because it's disempowering, and because that's their decision to make. Not yours. The reality is, if someone is serious about self-harming, they will find a way, but they may not feel safe to talk to you about it anymore.

Instead, focus on working with what is behind the behaviour, the **why**, and on resourcing them with alternatives to self-harm. Identify triggers, the source of the emotional pain, and develop strategies to manage and reduce that pain. If you can help them stabilise emotionally, and see that they have other, healthier coping mechanisms available, the need to self-harm goes away. Not overnight. But it gets fainter, and fainter, until its power is broken.

Ask the client, *what purpose does the self-harm serve? How do they feel during and after self-harming?* Questions like this help the client to stop and reflect, and they also give you cues to what's behind the behaviour, and how motivated they are to change.

This is where an activity like Life Charting can be useful. Life Charting is often used with bipolar clients to track their emotional ups and downs and the context around them, but it is also highly relevant for self-harm. Have your client write out a timeline, starting from just before they first began self-harming. Encourage them to record what happened before and after they self-harmed. This may reveal triggers and patterns, which you can then target and work with individually.

As you work with your client, you're looking to strike the balance between non-judgement (*I'm not going to recoil in disgust*) and gravity (*I am going to take it seriously, because it* is *serious*). We do that with a lot of different things in therapy, but self-harm can be particularly difficult to find the balance in. Perhaps because it can be quite graphic, and discomforting.

For adolescents who cut, rubbing ice or snapping elastic bands against one's skin can be a substitute for cutting, the sensation triggering the emotional release without actually damaging the body. If the visual cue of the blood is important, drawing on the skin with red permanent marker can be helpful for some teenagers. An extension on this would be to write or draw on the skin, for example, affirmations, quotes, words, or verses from religious texts.

You can also encourage your client to channel their distress into creative self-expression (art, journaling, poetry, song-writing…). This is another, safer way of getting the hurt and negative feelings out, without harming themselves.

Many clients can also be enormously helped by learning relaxation, self-soothing, and/or grounding techniques that they can use when triggered, to help them "ride out" the distress. Distraction techniques can be helpful too, as even though you're not dealing with the root of the problem, you're weakening the distress → self-harm → relief cycle. You may want to help your client build a "Coping Toolbox" or "Coping List" that they can readily refer to when feeling distressed.

Distraction techniques from the SH organisation Lifesigns in the UK

- 15 Minute Rule – client **can** cut (maintaining sense of control/power in situation), but they have to wait 15 minutes
- HALT – Ask yourself, are you Hungry, Angry, Lonely, Tired (AA, but SH organisations use it too)
- Listen to upbeat music
- Talk to support people
- Express distress through journal/poem/song writing/art work
- Create something tangible (painting, clay, sewing, baking…)

http://www.lifesigns.org.uk/

Specific modalities that have had success with treating self-harm

Dialectical Behaviour Therapy (DBT) was originally developed to treat Borderline PD, which has a high incidence of self-harm. DBT teaches individuals to learn to pay attention to and manage their thoughts and emotions, to widen their distress tolerance, and to communicate their feelings more effectively, all skills that may help overcome compulsions to self-harm.

Narrative Therapy, specifically, the technique of externalisation. Externalise the self-harm. This can make the self-harm easier for clients to talk about, and feel separate from. It decreases the power of the self-harm, and can help the strengthening of the therapist and client alliance, because they're presenting as a united front vs the self-harm

Expressive Arts Therapy can be helpful when clients struggle to verbalise their experiences, help them to process emotions and experiences without necessarily having to rely on words. In the case of trauma, experiences may have been pre-verbal. Clay, movement, visual arts, and music are all unbound by language. Although writing and poetry is verbal, clients are able to use metaphor and symbol in their creative writing, which makes them easier to engage with than direct dialogue.

Group therapy has also been found to be effective. Seeking support from peers who self-harm can be a double edged sword, so be careful recommending online communities/forums/etc. On the one hand, these can be a tremendously powerful tool for helping teenagers realise they're not alone. On the other hand, communities can spur each other on and keep each other stuck in the maladaptive behaviours. In a therapy group, there's more of a clear focus, established norms and goal.

The **Motivational Interviewing** approach recognises that many clients are ambivalent about stopping, because self-harming works – it alleviates symptoms. If it didn't, they wouldn't be doing it. So some clinicians will seek to increase motivation to stop, by asking questions like, *how is self-injury getting in the way of you reaching your life goals, or in the way of your daily life? What negative consequences have occurred, because of the self-harm? What is important to you in life, and how does self-harm get in the way of those things? What would your life look like without self-harm?*

Finally, don't forget about medication (whether the client is on medication that needs to be adjusted, or is not on medication but may benefit from it) and lifestyle factors (especially sleep, exercise, diet). These can have a powerful impact on the client's ability to cope with life. Basic self-care is the foundation upon which a person's mental, physical, and emotional health rests.

Self-harm is not an easy presentation to work with. It can be complex, stressful, confronting, frustrating, and challenging. But it is also responsive to treatment, and there are a wide range of techniques and approaches you can try, as you work with your client towards hope and healing.