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## *Chapter 1*

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# The Basic Facts about Self-Injury

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This book focuses on people who repeatedly injure themselves by cutting, burning or otherwise damaging their skin and its underlying tissue. This ‘self-injury’ is one of the two main types of self-harm, the other being self-poisoning with household or agricultural chemicals or with medication. Self-injury and self-poisoning are often regarded as sufficiently similar to be considered as two facets of one problem. This fits with the observation that many of those who cut themselves also take overdoses, but it is not consistent with the very different cultural and psychological roots of self-injury and of self-poisoning. We argue that it is important to consider self-injury in its own right, as we do in this book.

Self-injury remains poorly understood despite being a powerful emotional trigger. Put another way, self-injury is a strong ‘emotor’. Its emotive power is certainly relevant to health, but it is also made use of by the fashion industry, by religion and in social rituals marking the transition to adulthood. It has an emotional impact on others that is correspondingly intense. In our view this is because there is an emotional ‘safety-catch’ that prevents careless self-injury. People who are able to cut or burn their skin intentionally must therefore be able to switch off this safety-catch. We think that evidence of this safety-catch being switched off creates for the onlooker a feeling of danger, in much the same sense as does being around someone with a gun that is ready to fire, and that this is the main reason why self-inflicted injuries are upsetting to other people.

Contrary to popular misconception, self-injury is often carried out in secret and does not usually lead to a demand for attention. Medical care is rarely sought and even when it is, is often not taken up. In a recent unpublished study in Sheffield (Baston, Cross, Thompson and Hockley, personal communication) 45% of those who harmed themselves and for whom an ambulance

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was called did not travel to hospital, and 17% of those who did go to hospital did not stay in the emergency room long enough to be assessed. Those who injured themselves were more likely than those who poisoned themselves to be in the non-travelling and non-assessed groups.

It is the very private nature of the self-injury that we will be considering in this book. The knowledge that others would disapprove differentiates it from socially sanctioned self-injury,<sup>1</sup> which is mostly religiously inspired. Private self-injury and religious self-injury differ in two main ways. First, private self-injury is secretive and usually hidden from others. In contrast, religious self-injury takes place in cultural rituals and therefore in public (although we are aware that some behaviours, such as self-flagellation, may also be carried out in private as a penance). Second, private self-injury is associated with stigma when discovered and often with shame. By contrast, religiously inspired self-mortification is so often associated with pride that devotees often have to be counselled against this as being a sin.

### PRIVATE SELF-INJURY

The key features of ‘private self-injury’ are as follows:

- Self-inflicted damage to the skin and to underlying tissue.
- Anticipation, either with craving to self-injure, or with mounting tension associated with a struggle to avoid self-injury.
- Thoughts of the consequences of the injury are not entertained or are set aside. People who repeatedly self-injure commonly do so without consideration of the gain or punishment that might follow.
- The goals of the action are wound(s), pain, bleeding or a combination of these. There is no wish to bring about any significant anatomical change and no clear suicidal intent, although death may sometimes follow as a result of recklessness. The act of self-injury appears to be an end in itself.
- Private self-injury may occur in a dissociated state, in which case the person may not be aware of their control over the action. However, it is not the result of command hallucinations, or feeling controlled by an alien presence or in response to a delusional threat as sometimes occurs in people who are psychotic and injure themselves.
- Following the act there is often a temporary feeling of relief, which may sometimes (but not always) be associated with specific thoughts associated with the outflow of blood or with feeling more ‘real’.
- There is often reluctance to seek relief from the subsequent pain and trauma; medical care may only be sought after a delay, if at all.

Many individuals who privately injure themselves will do so only occasionally. They may return to it, perhaps as a last resort, at times of overwhelming distress or when they feel unable to cope in any other way. Others find that self-injury can be very difficult to give up once started. Their cutting or burning becomes more frequent and more entrenched as time goes by. As such, it resembles other habit disorders like binge eating, smoking, gambling or Internet addiction. Indeed, many report feeling as if they have become addicted to the behaviour. Even in the absence of any distress, they find themselves developing a strong craving for the next injury. Sometimes, very little time elapses between finishing one cut and thinking about the next, and cutting becomes the dominant theme of a person's life.

Self-injury does not always become entrenched, but when it does it is often accompanied by an escalation of psychological and physical problems. Wound care becomes increasingly challenging, and this in turn can exacerbate interpersonal difficulties. This kind of 'repeated' self-injury is the type that most often leads to a person seeking help, and that most often attracts a psychiatric diagnosis such as 'borderline personality disorder'.

Repetition is often associated with increasing depletion of coping resources, so that cutting that persists over many years often leads to increased anxiety and sensitivity to emotional precipitants. Chronic self-injurers are often significantly less able to cope with emotional stress. Their range of coping resources steadily reduces, and self-wounding itself becomes less effective as a coping mechanism over time. Life becomes very difficult when reduced resilience is combined with impoverished coping resources, plus (as with many addictive behaviours) a diminished return from the one thing that had seemed to help.

Self-injury that continues to be repeated despite therapeutic intervention often results in a particular kind of hopelessness in carers, too. People who repeatedly harm themselves are perceived as requiring a disproportionate amount of health care, perhaps because each episode is often so emotionally draining for all concerned (including the person who injures themselves).

We focus on this kind of repeated, private self-injury in this book because it is the kind that is often most troubling to carers, and because we think that much more can be done to help people who repeatedly wound themselves than many professional carers believe.

## **PREVALENCE OF SELF-INJURY**

Many people injure themselves and it has been estimated that at least 1 in 600 adults wound themselves sufficiently to receive hospital treatment (Tantam & Whittaker, 1992). In one survey of 440 adolescents, 13.9% reported having

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injured themselves (Ross & Heath, 2002); here self-cutting was the most common behaviour, followed by self-hitting, pinching, scratching, biting and then burning. Young people whose psychological difficulties are severe enough to have led to hospitalization are even more likely to injure themselves, with estimates of the proportion of young people having done so ranging from 40% (Darche, 1990) to 61% (DiClemente et al., 1991).

Teenagers in the UK injure themselves about twice as often as poisoning themselves (Hawton et al., 2002). However a much higher proportion of people who poison themselves end up in hospital with 80%–90% of all hospital admissions for self-harm being for self-poisoning and the remainder being for self-injury. For example, one study in 1997 found that 16% of 934 admissions to one hospital in Central England for self harm were for self-injury, with 10% for wrist-cutting (Dennis, 1997). More recently, Horrocks (2003) found that 21.2% of all attendances to general hospitals in Leeds for self-harm were for self-injury.

### **SELF-INJURY IS ON THE INCREASE**

Private self-injury appears to be on the increase (Nada-Raja et al., 2003), along with self-harm in general. Hawton and colleagues found hospital attendances in Oxford for self-harm rose each year from 1990 to 1997, and the rate of repetition increased significantly during the study period (Hawton et al., 2003).

Some of this increase may be due to better ascertainment with people becoming more willing to admit to self-injury, but this is unlikely to be the whole explanation. Alternative explanations include the social acceptance of tattooing and skin piercing (which we believe can weaken the ‘safety-catch’ against self-injury); a generally greater tolerance of non-socialized violence (i.e. violence committed outside of socially sanctioned circumstances such as war); and ‘copy-cat’ or ‘modelling’ leading to teenagers injuring themselves in emulation of friends and acquaintances.

### **SELF-INJURY AND GENDER**

Findings from community studies are inconsistent about whether self-injury is more common in boys than girls (Hawton et al., 1996) or vice versa (Ross & Heath, 2002). Self-injury certainly affects both genders although, until recently, most attention appears to have been focused on women. Its prevalence is probably similar for both men and women in the general population

(Briere & Gil, 1998; Klonsky et al., 2003) and two studies within Casualty departments in the UK found that over half those who had injured themselves were male (Robinson & Duffy, 1989; Hawton & Catalan, 1987). However, men are more reluctant to seek treatment and so their self-injury may only come to light when it is particularly severe. There is some evidence that self-injury is becoming more common in men. In contrast, rates of reported self-harm (which includes both self-injury and self-poisoning) are higher in women in the UK and throughout Europe (Hawton, 2000).

## **SELF-INJURY AND YOUNG PEOPLE**

It has been estimated that as many as one teenager in ten self-harms in the UK, and a significant proportion of this self-harm appears to be self-injury in the form of skin cutting and, to a lesser extent, burning. A revealing study of 6020 adolescents in English schools found 6.9% had harmed themselves in the previous year and 13.2% reported harming themselves at least once at some time: the proportion was much higher in girls than boys. Many of the reported incidents were by self-cutting, but only 12% resulted in hospital attendance (Hawton et al., 2002). Figures from Australia are not dissimilar: in one study, 5.1% of a large community sample of adolescents reported having self-harmed, the most common methods being self-cutting and deliberate recklessness, although true suicide attempts were only reported by 0.5% (Patton et al., 1997). In a similar study, Martin et al. (1995) found 8.9% of an adolescent sample group reported self-harm, with a similar rate for males and females.

Self-injury often begins in teenage years or even earlier in some cases. In Arnold's (1995) survey of 76 women in the UK, 30% reported that they began injuring themselves before 12 years of age. Similarly, Favazza and Conterio (1989) found 14 years to be the most common age of onset in a study of 240 US residents.

More recent investigations confirm that a significant proportion of young people are injuring themselves at least once, with superficial self-cutting reported in one-fifth of a sample of Turkish high-school students (Zoroglu et al., 2003), and in more than one-third of a sample of Canadian female undergraduates (Paivio & McCulloch, 2004).

Young people often repeat self-injury. The Mental Health Foundation considers 1 in 10 adolescents who have harmed themselves will do so on more than one occasion (Donnellan, 2000, p. 7). In the Oxford self-report study, more than half of those who self-harmed had done so more than once (Hawton et al., 2002), and a survey of female adolescent drug abusers found 29%

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of those who self-injured reported cutting themselves only once or twice, while 36% had done so at least six times (Schwartz et al., 1989).

Little information is available on self-injury in older people, but the behaviour does seem to decline with age. This may be due in part to under-reporting, possibly because the shame associated with self-injury is felt more keenly as one grows older. However, as Crowe (1997) observes 'it is quite common to find that in their 30s and 40s many patients who had previously harmed themselves are now no longer doing so'. Older people who do harm themselves are thought to be at higher suicide risk than are younger patients, and are more likely than younger people to be assessed by a mental health professional in the accident and emergency department following self-harm, and are more likely to be offered aftercare (Marriott et al., 2003).

### **SELF-INJURY AND CULTURE**

Self-injury, in the general sense of the term, is certainly not confined to Western culture. In fact, in many parts of the world 'public' self-injury is commonly associated with religious festivals, and in these it is usually young men who injure themselves. For example, self-injury is an integral part of the Shi'ite festival Muharram to mourn the death of Ali, and of various Hindu festivals honouring Shiva or his son Murakan. Religiously inspired, public self-injury of this kind is rare in the West. Indeed, it might be considered obscene.

Suicide rates vary across the world, and may be particularly high in some cultures, such as Sri Lanka and China, but the reasons for this are unclear and may be connected to self-harm with agricultural chemicals and more recently dowsing oneself with paraffin (kerosene) and then setting fire to it. Statistics on private self-injury have not been collected in many of these countries, but in the 13-country WHO/EURO study of parasuicide (Schmidtke et al., 1996) there were very large differences in age-standardized rates of self-harm, with low rates in southern European areas and high rates in the north of Europe.

### **SELF-INJURY AND ADVERSITY**

A considerable number of studies have indicated a strong association between a history of childhood adversity and self-injury later in life. Types of adversity include separation and loss (Walsh & Rosen, 1988) and parental neglect, plus traumatic childhood experiences that includes incest (De Young, 1982): childhood abuse (van der Kolk et al., 1991): sexual abuse (Briere & Gil, 1998): bullying at school (Matsumoto et al., 2004): and witnessing domestic violence

(Boyle et al., 2006). Connors summarizes this body of research by noting that in the history of people who self-injure ‘there appears to be a working consensus that one or more childhood trauma and loss experiences exist’, although she also observes that some studies have not found any correlation between self-injury and trauma (Connors, 2000, p. 39), and the same statement could probably be made of depression.

The frequency with which mental health professionals see people who have experienced childhood adversity can give a false impression that self-injury is always preceded by a history of difficulties in early life. Self-injury can also be precipitated by adversity in teenage years, by rape in adult life (Greenspan & Samuel, 1989; Zlotnick et al., 1997), by combat experience (Pitman, 1990) and by domestic abuse (Arnold, 1995).

## **SELF-INJURY AND DISADVANTAGE**

Private self-injury occurs in people from all walks of life, but may be more likely in those who are disadvantaged socially or financially. A study of the 2828 individuals who sought hospital treatment in Oxford after self-harm between 1988 and 1996 found rates much higher in those from lower social groups (Hawton et al., 2001). Socio-economic deprivation was closely associated with rates of self-harm among both genders, but was particularly marked in young men even when the effect of social fragmentation was taken into account. Unfortunately the data were not analysed for the sub-group of self-injurers in this study. Ayton et al. (2003) report similar findings in East Yorkshire where socio-economic deprivation was associated with self-poisoning and self-injury.

Of course, people of all social classes do injure themselves and social stress is not confined to the economically disadvantaged. The pressure to succeed may also lead to self-injury (Babiker & Arnold, 1997), as may transgenerational conflict in first-generation children of immigrants. Marginalization may also be the explanation for the high risk of self-injury in gay teenagers, which emerged in a recent survey carried out in the UK by the Lesbian and Gay Foundation.

## **SELF-INJURY AND MOOD DISORDERS**

Self-injury has a complex relationship with mood disorder. A person who cuts their throat for the first time in their 60s after the unexpected death of their wife would be suspected of having a depressive disorder until proven

otherwise. If they had other signs and symptoms of depression, it would be the depressive disorder that would be the main diagnosis. The depression would be seen to be the main problem, and the self-injury merely a symptom of that. On the other hand, a person who has been in a social group where tattooing and piercing were the norm may become depressed for the first time when moving into another social group where such skin decorations are looked down on, and lead to stigmatization. This depression may still need treating, but here it is not the cause of the self-injury, but its consequence. Finally, a young woman who is being abused by a partner may become low in her mood in consequence and find that cutting herself actually heightens her mood. In this case the self-injury is a kind of treatment for low mood.

Depressed mood rarely occurs in the absence of anxiety and anger, especially in young people. The complex relationships between self-injury and mood are even more difficult to keep straight when anxiety is included in the picture. Mounting tension with elements of anxiety and irritability often precedes self-injury. Trying not to injure oneself adds to this tension, but other sources of anxiety or frustration do too. Repeated self-injury, like repeated sedation with alcohol or drugs, may actually kindle anxiety. The short-term anxiety relief that immediately follows self-injury may be more than offset by a greater susceptibility to anxiety in the longer-term because the repeated sedation has lowered the threshold at which anxiety develops.

Stigma and social rejection following the discovery of past self-injury may also lead to anxiety and depression, and this may lead to people who self-injure seeking treatment for a mood disorder. Finally, low self-esteem or – as Scheff points out, the frequent experience of shame that is the emotional experience that psychologists have attributed to a deficiency in a hypothetical psychic fuel called self-esteem – may be sufficiently severe as to amount to a depressive disorder. So adolescent mood disorder may sometimes pave the way for self-injury, which may then become self-sustaining.

Psychiatry, as a branch of medicine, has its roots in applied biology. Psychiatric approaches to self-injury have therefore understandably been biased in favour of biological explanations. A simple explanation for the links between self-injury and mood disorder is that self-injury is a symptom of mood disorder that may be more or less obvious, but which is always due to an underlying alteration of brain chemistry. Since the medical treatment of mood disorder has been one of the success stories of modern psychiatry, it should follow that one of the drugs that has been shown to be effective in the treatment of depression and anxiety should be effective in preventing self-injury, too. Regrettably, this has not proved to be the case. The failure to find

a drug that effectively prevents self-injury is a further reminder that self-injury is not merely a behaviour – it is an expression of a wish or a desire, and not just a bodily malfunction.

If there is sufficient evidence of a clinically significant mood disorder, independent of the severity or frequency of the self-injury or other self-harm, then offering a treatment for the mood disorder will be appropriate. In fact, the treatment that would normally be given if these symptoms occurred in the absence of self-injury should not be withheld simply because self-injury is also present. An antidepressant may, for example, be indicated in someone who has developed early morning waking, low mood, reduced appetite with weight loss, or some of the other biological symptoms of depression. But even if the antidepressants are effective in treating the low mood, they are unlikely to abolish the self-injury.

## **SELF-INJURY AND OTHER DISORDERS**

People who cut or burn themselves often experience depression, anxiety and panic. Self-injury has also been associated with dissociative identity disorder (Putnam et al., 1986). Self-injury is often (but not always) associated with other forms of self-harm such as misuse of alcohol, committing offences, substance misuse as well as over-dosing on prescribed and over-the-counter medication. The relationship between self-injury and being diagnosed as having certain personality disorders is well-established, although there has been disagreement about whether such a diagnosis is helpful. A history of repeated acts of self-harm is sufficient to satisfy one of the criteria for borderline personality disorder (BPD), and it has been estimated that 70–80% of patients meeting DSM-IV criteria for BPD self-injure (Bohus et al., 2000).

People who injure themselves are more likely to have an eating disorder and vice versa. In single studies, repeated self-cutting has been reported in 40% of a bulimic sample (Mitchell et al., 1986) and in 35% of an anorexic sample (Jacobs & Isaacs, 1986). Using prevalence data from many studies, Sansone & Levitt (2002) estimated remarkably similar rates of self-injury among bulimic outpatients (25%), bulimic inpatients (25%), and anorectic outpatients (23%).

Possible explanations of the association include shared adverse childhood experience, or a common biological substrate of impulsivity (Lacey & Evans, 1986). It has also been suggested, more fancifully, that both eating disorders and self-injury often involve purgation although this seems to assume that the aim of self-injury is not so much to create a wound but to let blood flow (Warren et al., 1998).

## SELF-INJURY IS ESPECIALLY COMMON IN PRISONS

Prisons in the UK vary in their recording of incidents of self-harm, and may not distinguish between hanging and self-strangulation with suicidal intent from the kind of self-injury we are discussing in this book. However, in 2001 an improved method of recording self-harm was initiated as a pilot in 10 British prisons to address these difficulties and provide more accurate information. Data from the first six months of this study showed that the overall rate of self-injury was surprisingly high at 840 incidents per 1000 prisoners. More than half the recorded incidents were attributed to self-cutting or scratching, and more than 40% of those who self-harmed did so at least twice in the 6-month period (Howard League, 2003, p. 7). The risk may be higher in those held 'on remand' than in sentenced offenders. Furthermore, in the eight years from 1991 to 1999 there was a 142% rise in the number of prisoners who were self-harming compared with an increase of only 42% in the overall prison population over the same period (Howard League, 1999, p. 8).

Most self-injury in UK prisons is carried out by men, but male prisoners outnumber female inmates by 17:1. The Directorate of Prison Health Care in 1997–8 found rates of self-harm 5.5 times higher among female prisoners than their male counterparts, although a separate study by the Office for National Statistics in 1997 (which excluded suicide attempts) found self-injury affected 7% of sentenced male prisoners and 10% of sentenced female prisoners in their current prison terms (ONS, 1997). This is comparable to the widely quoted figure of 6.5% for male prisoners reported in Toch's earlier study in North America (Toch, 1975). A more recent survey of prisoners in the UK found 23% of women who had spent more than 2 years in prison had self-harmed during their current sentence (Melzer et al., 1999).

In prisons, as in the outside community, there is a strong association with youth. Young prisoners of both sexes appear particularly vulnerable to repeated self-injury and it has been suggested that young people have greater difficulty in adjusting to prison life than those who are older (Liebling, 1998). In fact, concern in 1997 about the extremely high levels of 'cutting up' among female prisoners under 18 years (and summarized in a report by the Howard League) culminated in a change in the law such that teenage girls are no longer sent to adult prisons in the UK.

Self-injury is also more common in other residential institutions, like hospitals and care homes, especially where there is a lack of social stimulus. Solitary confinement is a particular risk (Cullen, 1985). Social isolation may be the common factor in all of these situations (Simeon & Favazza, 2001).

## METHODS OF SELF-INJURY

Skin cutting appears to be the most common type of self-injury, but many other methods are used depending on circumstances and individual preference (see Text Box 1.1).

### Text Box 1.1 Common methods of private self-injury

**Cuts** – often made with a blade or glass shard; a cut is usually classed as an incision if its length is greater than its depth. Cuts are often described incorrectly as lacerations, which strictly speaking, are tears arising from blunt force injury.

**Puncture injuries** – made by a pointed object inserted at right angles to the surface and then withdrawn, or inserted at an angle and then left under the skin. An injury is usually classed as a puncture if its depth is greater than its length.

**Dry burns** – by contact with a flame or hot object (e.g. iron, cigarette); electrical burns.

**Scalds** – by contact with hot liquid or steam: external (e.g. via kettle, bath) or internal (e.g. over-hot drinks).

**Chemical burns** – by contact with caustic substances (e.g. bleach, oven cleaner).

**Other presentations** – re-opened injuries; bruising (potential for fractures) following wall punching, head banging or self-hitting; tissue damage arising from ligaturing an appendage; injuries caused by abrading or scouring the skin; internal damage from reversible insertions (typically urethral, rectal or vaginal); injecting contaminants into the skin or deliberately contaminating wounds.

## TARGET AREAS FOR SELF-INJURY

Individuals who self-injure often have two or three preferred sites and tend to concentrate most of their cutting or burning at those locations. One study of women who cut themselves by Favazza and Conterio (1989) found the areas most frequently damaged were the arms and wrists (74%), followed by the legs (44%), abdomen (25%), head (23%), chest (18%) and genital area (8%). Another survey of 128 self-inflicted injuries in a sample of adolescents and young adults confirmed the arms as the most popular site (62%), but found the wrists less frequently targeted (23%) (Rosen & Heard, 1995). Choice of location may be determined by convenience (for example, the left forearm is preferred by right-handed individuals), by attraction to areas where a deep

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injury could be fatal (as with wrist cutting) or by the ease with which the injury can be concealed with clothing. There may also be symbolic factors: for example, Smith and colleagues found that many of the women they talked to had concentrated on areas such as the face, breasts and genitals that were associated with their female identity or were connected with the experience of being sexually abused (Smith et al., 1998, p. 10).

### **SELF-INJURY CAN LEAD TO DEATH**

It is sometimes suggested that people who cut or injure themselves repeatedly are at no particular risk of dying through suicide. This may arise because of enthusiasm, especially among community groups, to teach that repeated self-injury is very different from attempted suicide. We acknowledge that making this distinction is helpful when getting others to understand the behaviour – indeed, we have included lack of clear suicidal intent in our definition of self-injury. At the same time it is essential to be aware that the repetition of self-injury does not indicate that the risk of suicide is low, or that it will remain low. Those who attempt suicide and those who self-injure do not form mutually exclusive groups – the two populations often overlap. Statistically, a history of self-harm increases the risk of suicide by up to a 100 fold (Morgan & Owen, 1990), and follow-up studies of people who self-injure have found suicide rates of 13% (Reilly, 1983) and 16% (Nelson & Grunebaum, 1971).

Risk of suicide is hard to assess since self-injury is varyingly reckless. Sometimes there is very little risk, other times it is major. In addition, the chance of a fatal outcome when indulging in risky behaviour is likely to increase when the individual is ambivalent about living and dying and makes less of an effort to keep safe. The situation is further compounded if cutting takes place while in a dissociated state. Individuals who find they tend to cut themselves ‘on automatic pilot’ are at risk of doing serious damage without realizing this at the time.

Suicide may be a kind of surrender. Sometimes death may even seem inviting as if it offers warmth or at least relief. Surrendering becomes more likely if a person feels hopeless or if everyone else thinks that they should stop fighting on.

### **SELF-INJURY AND RELUCTANCE TO SEEK HELP**

In community settings, individuals who self-injure vary enormously in the degree to which they seek and accept professional help. This seems to be the case in both physical and psychological domains. Contrary to popular belief, however, most do not seek to draw attention to self-inflicted injuries. The kind of self-injury we consider in this book is a normally performed in private

(hence our term ‘private’ self-injury) and the wounds are hidden from others, perhaps because of feelings of shame. Assistance is not always welcomed, and may even be rejected angrily.

People who self-injure are considered less likely to seek medical help than those who self-poison, particularly young people (Hawton et al., 2002). This may be because the majority of self-inflicted wounds are relatively minor, and even those that warrant attendance at Casualty departments are not usually seen as potentially life-threatening. When assistance from the health care profession is sought, it is often from services that are not hospital-based. One recent study of young adults in New Zealand who presented after self-harm (including self-injury) found that family practitioners, psychologists and counsellors were the commonest sources of help (Nada-Raja et al., 2003).

Older adolescents and young adults have the most difficulty asking for help. A recent survey of over 3000 young adults in the UK found a widespread reluctance to seek help when experiencing mental distress, especially among young males (Biddle et al., 2004). It is also known that many acts of self-harm in adolescents do not come to the attention of their families (Melzer et al., 2002).

Women are more likely than men to seek help for both physical and psychological difficulties, and are more likely to remain engaged in treatment when it is offered. Many studies have reported a well-defined trend of men delaying seeking professional help when they become ill. When they do seek help, physical symptoms appear to be the defining factor, with men less likely to report distress or psychosocial problems as an additional reason for consulting a professional (Galdas et al., 2005). This certainly seems to be the case for self-injury. One possibility, suggested by Taylor (2003, p. 83), is that self-harm is seen in western society as essentially a female behaviour and that this causes men who self-injure to feel ashamed and further marginalized by being men, rather than women. There may be fear that for a man to seek help for self-inflicted injuries is to appear neurotic.

Cultural differences in seeking help among those who self-injure may also be significant, although this topic seems to have attracted little research. One study found that South Asian women in Manchester who self-harmed tended to access services only ‘at a point of desperation’, rather than prior to the crisis (Chew et al., 2002).

### **DO EMOTIONAL RESPONSES TO SELF-INJURY HINDER DECISION MAKING?**

Self-inflicted cutting, burning or other injury is often distressing to the person who does it as well as for other people who witness the results. It may or may not be associated with suicidal thoughts or intent, but whatever the aim there

can be little doubt that self-inflicted damage to the skin is remarkably emotive for all who become involved. It is not unusual for people who self-injure to experience shame and self-loathing. Those who attempt to provide care often find themselves engulfed by strong emotions such as anger, frustration and disgust.

This may be one reason why professionals are often so divided about how to respond to particular clients. This is not helped by the skimpy evidence on what does help. The most studied interventions, for which there is most evidence of efficacy, are often the most complex, the most costly and the least available because extensive training may be required.

People who self-injure can be difficult to understand and manage, and self-injury exerts a powerful impact whether the people injuring themselves intend this or not. Partners, family and close friends often feel out of their depth. GPs, psychiatrists, nurses, social workers and other professionals may also struggle to cope, for the behaviour can powerfully challenge their skills, competency and role.

Although this book is intended for health care professionals, we hope that it will also be useful for those people who repeatedly injure themselves and those who are about them and who wish to become more involved in, and knowledgeable about, therapy.

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