

# RESEARCH



# FACTS and

# FINDINGS

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## Self-Injury Fact Sheet

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The Youth Development framework focuses primarily on understanding how to help young people thrive. To do this, however, it is important to also understand young people's expressions of discomfort and malady. Although not a new phenomenon, "self-injury" is a practice that hampers efforts to promote thriving and which may reflect toxic conditions in the social environments youth inhabit. Self-injury is the most common label for behaviors in which a person deliberately harms him or her body. Precisely what constitutes self-injury is a matter of some debate, but it is most commonly associated with intentional carving or cutting of the skin and subdermal tissue, scratching, burning, ripping or pulling skin or hair, bruising, or breaking bones. Some researchers include excessive piercing and tattooing. Recent films such as *Thirteen* and *Girl, Interrupted* along with disclosures of self-injurious behavior by well known people such as Johnny Depp and Princess Diana have begun to draw attention to this difficult to understand behavior. Since there are signs that self-injury is becoming increasingly prevalent, it is important to understand both the practice of self-injury and the conditions that contribute to the seemingly increasing popularity of the behavior in the general youth population. This FACT sheet is designed to briefly summarize what is known.

### What is Self-Injury?

Sometimes called "cutting," "self-mutilation," or "self-harm," a precise definition of the behavior is difficult to come by. In its broadest definition self-injury is an act where an individual intentionally alters or destroys body tissue for purposes that are not aesthetic nor socially sanctioned. Cutting of the subdermal tissue is by far the most frequently reported form of self-injury (Favazza & Conterio, 1989). Self-injury can be performed on any part of the body, but most often occurs on the

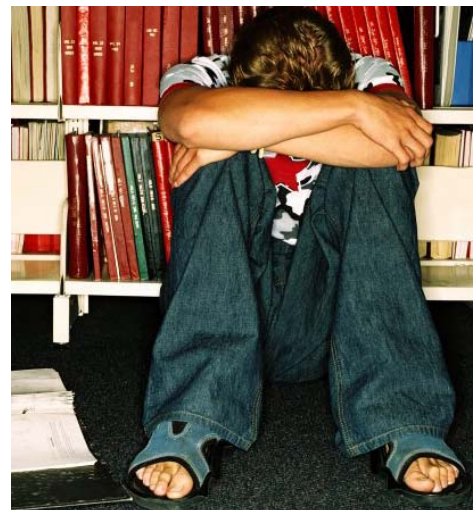
arms and wrists (Rosen & Heard, 1995). The severity of the act can vary from superficial wounds to those resulting in lasting disfigurement (Rosen & Heard, 1995).

### What does research tell us about self-injury?

Unfortunately, very little is known about self-injury – particularly within the general adolescent population. Scientific studies of this subject, which began in the 1960s and 1970s, mostly focused on self-injury as a precursor to suicide. Investigation into the underlying motivations for self-injury reveals important distinctions between those attempting suicide and those who self-injure in order to manage their feelings and cope with overwhelming negative feelings. Consistent with this, most studies find that self-injury is often undertaken as a means of avoiding suicide.

*Perhaps one of the most paradoxical features of self-injury is that most sufferers report doing it in order to relieve pain or to just feel something.* Many self-injurers report overwhelming sadness, anxiety, or emotional numbness and the act of self-injury provides a way to manage intolerable

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feelings or a way to experience some sense of feeling. *Those who self-injure may do so to feel in control of their bodies and minds, to express feelings, to communicate needs, to create visible and treatable wounds, to purify themselves, to reenact a trauma in an attempt to resolve it, or even to protect others from their emotional pain* (DiLazzerro, 2003). Self-injury can best be understood as a maladaptive coping mechanism, but one that works – at least for a while.

What underlying factors contribute to self-injury? Again, a lack of research in this area presents the biggest problem in answering this question. While virtually nothing is known about the causes of self-injury in a general population, clinical studies shed some light on this question. In these populations, self-injury is strongly linked to childhood abuse, especially childhood sexual abuse (Brodsky, Cloitre, & Dulit, 1995; Kolk, Perry, & Herman, 1991). In addition, there is evidence that earlier, more severe abuse and abuse by a family member may lead to greater dissociation and thus greater self-injury (Brodsky et al., 1995).

*Once the behavior is started, the endorphins released by self-injurious behavior can become quite addictive.* The process can be likened to that of a growing drug addiction, where at first, small amounts (of the drug or self-injury) provide a sense of calm and well-being that provide a temporary escape from the pain of life. As tolerance builds, the user needs increasing amounts (drug or self-injury) to achieve the same effect. In some cases, a suicide might result as an “overdose” for the habitual self-injurer. While this may be the link between suicide and self-injury, anecdotal evidence reveals that self-injury may also sometimes be a “practice run” for a later suicide attempt. In this way, self-injury and suicide might be understood as two potential outcomes on a continuum of coping responses.

Many adults worry that adolescents engage in self-injurious behavior because it is somehow a cool thing to do, and that it spreads through peer groups like eating disorders. Research has not yet showed whether the “social contagion” effect is a real factor in adoption of the behavior, but there is some evidence that some individuals who try or begin self-injury do so because they have learned about it through others (Yates, 2004). Nevertheless, most available evidence suggests that the majority of habitual self-injurers discover it through private or accidental experimentation. Favazza and Conterio (1989), for example, found that 91% of their self-injuring sample had neither known nor read about self-injury before engaging in the behavior.

### **Who Self-Injures?**

Because it so often occurs in private, it is very difficult to identify one or more discrete self-injurer “profiles.” *Unless they are being treated for another condition related to the behavior, such as*

*depression or anxiety, identifying and reaching self-injurers can be very difficult.* Thus, most studies of self-injury have relied on samples in clinical settings being treated for other disorders (Brodsky et al., 1995).

Because of this, reliable estimates of the prevalence of self-injury in a general population are difficult to obtain. A 2002 study of a Canadian high school population found that roughly 13.9% of the urban and suburban high school student population had performed acts of self-injury (Ross & Heath, 2002). Other studies report general population rates (not specific to adolescents) as low as 4% (Deiter, Nicholls, & Pearlman, 2000).

*Rates of self-injury, “cutting” in particular, appear to be increasing in both community and clinical adolescent populations.* During a decade long longitudinal cohort study of adolescent self-injury in Great Britain, researchers found a 28 percent increase in the number of adolescents who presented for self-injurious treatment at a general hospital in Oxford, England (Boyce, Oakley-Browne, & Hatcher, 2001). Although no such study has been conducted within the US, the presence of self-injury in new and popular forms of media, such as in newspapers, have increased significantly in the past several years – from no reports in 1984 to 210 in the last year (Factiva, July 17, 2004). In addition to a growing number of new reports on the subject, *a recent Los Angeles Daily News article reports that self-injury is the fastest-growing adolescent behavioral problem.* It reports that referrals for cutting and other forms of self-injury within the Los Angeles Unified School District increased dramatically in the last year; the School District’s suicide-prevention hotline fielded 600 calls on self-mutilation in a single 18 month period (Radcliffe, 2004).

Whether the increasing attention to self-injury is due to the fact that more youth are actually engaging in the behavior, to increased likelihood to seek help, or to an increasing ability among service providers to correctly identify and report the behavior is unclear. It may very well be a combination of all three.

Available evidence suggests females are only somewhat more likely to self-injure than males. While Ross and Heath (2002) found that 64% of adolescents who engaged in self-injury in their study were female, other studies have found similar rates for both males and females (Gratz, 2001; Martin, Rozanes, Pearce, & Allison, 1995). The slight tendency for females to be more involved with self-injury mirrors the prevalence of those with eating disorders (Farber, 1997; Favazza & Conterio, 1989; Ross & Heath, 2002). Those who self-injure and those with eating disorders seem similar in other ways, too. A majority (77%) of the self-injurers studied by Ross

and Heath (2002) were Caucasian, and studies of eating disorders find similar rates. Researchers have found both of these behaviors typically start in early adolescence, around thirteen or fourteen years of age. In fact, there is some evidence that eating disorders and self-injury stem from similar individual characteristics, such as the tendency to act impulsively (Farber, 1997). Unlike eating disorders, however, self-injury is quite easy to keep secret for long periods of time, which can delay identification and treatment considerably.

### Treatment

**Schools, parents, medical practitioners, and other youth-serving professionals all have an important role to play in identifying self-injury and in assisting youth in getting help.**

Unfortunately, lack of information on self-injury has hampered the creation of informational materials and/or treatment options. The S.A.F.E. Alternatives program in the Linden Oaks Hospital in Edward, Illinois is the one of the only existing inpatient treatment program specific to self-injury in the nation (see [www.selfinjury.com](http://www.selfinjury.com)). Moreover, while a small but growing body of evidence exists to assist those

helping individual self-injurers, virtually no literature exists to explain and address the environmental factors that contribute to adoption of the practice.

***What is known about youth self-injury suggests that the intensely private and shameful feelings associated with self-injury prevent many sufferers from seeking treatment.*** Often, they only appear in emergency rooms when their self-inflicted wounds are so severe they require medical treatment such as stitches or bone-setting. Because so little is known about self-injury, it is often misunderstood by medical staff members who provide the initial treatment. This misunderstanding may lead to extremely inappropriate treatment, such as stitching without anesthetic or intense feelings of frustration for the provider who asks, “Why is this person hurting *herself*?” ***Care providers should avoid displaying shock, engaging in shaming responses, or showing great pity. Such reactions may reinforce the self-injurious behavior and its underlying causes, and encourage the self-injurer not to seek care in the future.*** Instead, care providers should respond in unemotional, medically-appropriate ways (Deiter et al., 2000). In addition, it is important to differentiate between a self-injurious act and a suicide attempt at this initial point, as the two require different treatments after this primary physical care. Mental health and counseling resources should be provided since self-injurers often have deep-seated anxiety or depression that may respond to psychological therapy (Ross and Heath, 2002).

More long-term treatments may involve psychiatric and/or medical therapy. ***Research suggests explicitly teaching more appropriate coping strategies may be one way to provide self-injurers with adaptive alternatives.*** It is important to substitute a more positive coping strategy and not just eliminate the self-injury, as another self-destructive behavior, such as drug abuse, may take its place. Also, some patients using prescribed drugs for depression have found a reduction in the urge to self-injure while taking these medications (Favazza & Conterio, 1989). Therapy may be useful in exploring the underlying causes of self-injury. A combination of the above treatments may significantly reduce or completely eliminate self-injury for many sufferers.

Self-injury is a burgeoning area of research; many questions have yet to be answered. Knowledge about its causes, prevalence and nature will help those who encounter self-injurers to better identify and treat the behavior. Understanding the way in which the behavior fits in with larger mental health trends among youth and the role that environmental factors play in promoting or thwarting the behavior will assist in development of strategies aimed at changing the environments in which youth grow up.

## Approaching Self-Injury from a Youth Development Perspective

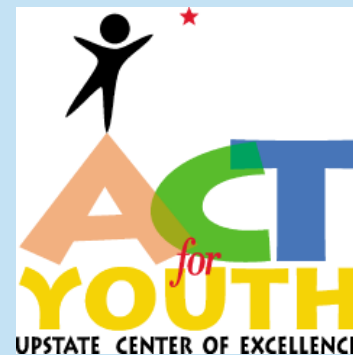
- Self-injury is most common in youth having trouble coping with anxiety. It is important to focus on skill building in individual youth, and to identify and remedy the environmental stressors that trigger self-injury.
- Self-injury is most often a silent, hidden practice aimed at either squelching negative feelings or overcoming emotional numbness. Being willing to listen to the self-injurer while reserving shock or judgment encourages them to use their voice rather than their body as a means of self-expression.
- Self-injury serves a function. An important part of treatment is helping youth to find other, more positive ways to accomplish the same psychological and emotional outcome, i.e. explicitly teach coping skills.
- Assessment and treatment should seek to understand why youth self-injure and then build on the strengths youth already possess.

## Bibliography

- Boyce, P., Oakley-Browne, M. A., & Hatcher, S. (2001). The problem of deliberate self-harm. *Current Opinion in Psychiatry*, 14, 107-111.
- Brodsky, B. S., Cloitre, M., & Dulit, R. A. (1995). Relationship of Dissociation to Self-Mutilation and Childhood Abuse in Borderline Personality Disorder. *American Journal of Psychiatry*, 152(12), 1788-1792.
- Deiter, P. J., Nicholls, S. S., & Pearlman, L. A. (2000). Self-Injury and Self Capacities: Assisting an Individual in Crisis. *Journal of Clinical Psychology*, 56(9), 1173-1191.
- DiLazzero, D. B. (2003). *Addressing Self-Injury in a College Environment: A Psychoeducational Program*. University of Hartford, Hartford.
- Farber, S. K. (1997). Self-Medication, Traumatic Reenactment, and Somatic Expression in Bulimic and Self-Mutilating Behavior. *Clinical Social Work Journal*, 25(1), 87-106.
- Favazza, A. R. (1989). Why Patients Mutilate Themselves. *Hospital and Community Psychiatry*, 40(2), 137-145.
- Favazza, A. R., & Conterio, K. (1989). Female habitual self-mutilators. *Acta Psychiatrica Scandinavica*, 79, 283-289.
- Gratz, K. L. (2001). Measurement of deliberate Self-Harm: Preliminary Data on the Deliberate Self-Harm Inventory. *Journal of Psychopathology and Behavioral Assessment*, 23(4), 253-263.
- Kolk, B. A. v. d., Perry, C., & Herman, J. L. (1991). Childhood Origins of Self-Destructive Behavior. *American Journal of Psychiatry*, 148(12), 1665-1671.
- Martin, G., Rozanes, P., Pearce, C., & Allison, S. (1995). Adolescent suicide, depression and family dysfunction. *Acta Psychiatrica Scandinavica*, 92, 336-344.
- Radcliffe, J. (2004, March 28, 2004). Self-destructive "cutters" live their lives on the edge. *Los Angeles Daily News*.
- Rosen, P. M., & Heard, K. V. (1995). A Method for Reporting Self-harm According to Level of Injury and Location on the Body. *Suicide & Life-Threatening Behavior*, 25(3), 381-385.
- Ross, S., & Heath, N. (2002). A Study of the Frequency of Self-Mutilation in a Community Sample of Adolescents. *Journal of Youth and Adolescence*, 31(1), 66-77.
- Yates, T. M. (2004). The developmental psychopathology of self-injurious behavior: Compensatory regulation in posttraumatic adaptation. *Clinical Psychological Review*, 24, 35-74.

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