Self harming behaviours

IMPORTANT NOTICE: This information sheet does not constitute medical advice or guidance. Its purpose is to give general information about self-harming behaviour. Beira's Place is not a medical service and cannot diagnose physical or mental health conditions.

If you have been hurt or injured and think you need immediate medical treatment, call 999, or call NHS 24 on 111 for physical or mental health advice.

What is self-harm?

"It's not just cutting your arms."

The term 'self-harm' is most often used to describes cutting or scratching, usually across the arms or legs. However, self-harming behaviour includes a wider range of behaviours that cause harm to the self, such as:

Self-injury: cutting, burning, scratching, piercing, stabbing, hitting oneself, swallowing harmful substances/poisons, inserting dangerous objects into the body, picking skin or scabs.

Substance abuse: using substances to numb feelings and desensitise the survivor to the emotional and psychological pain of the memory of the abuse – alcohol, drugs (this can be prescription or non-prescription drugs, illegal drugs) or a mixture of drugs and alcohol.

Obsessive or compulsive behaviours: some obsessive behaviours can be physically harmful such as pulling out hair, washing the body, perhaps with harmful household or chemical substances. Obsessive or compulsive behaviours can also involve excessive exercising, obsessive cleaning the home or surrounding environment, and may have long term effects on physical and mental health.

Eating disorders: anorexia, bulimia, over-eating or binge eating, being unable to eat solid food, only eating certain foods, hoarding food.

Risk taking behaviours: risky sexual behaviour, taking physical risks (driving, on roads or railways, stealing/shoplifting) or refusing prescribed medicines

"I concluded that, if you carry a memory of having felt safe with somebody long ago, the traces of that earlier affection can be reactivated in attuned relationships when you are an adult, whether these occur in daily life or in good therapy. However, if you lack a deep memory of feeling loved and safe, the receptors in the brain that respond to human kindness may simply fail to develop. If that is the case, how can people learn to calm themselves down and feel grounded in their bodies?"

Childhood Origins of Self Destructive Behaviour: Bessel van der Kolk, 1991

Trauma and chronic stress are well known and well researched factors in a range of self harming behaviours. In a 2002 study for Greater Glasgow NHS[1], Gail Gilchrist found many links between sexual violence, child sexual abuse and domestic abuse (including witnessing domestic abuse as a child) with homelessness, drug and alcohol addiction, prostitution, poor mental health, and suicidal thoughts or attempts. Coping with intrusive mental images, inability to sleep, anxiety, panic attacks and flashbacks are common among survivors where there

[1] 'Psychiatric morbidity among female drug users in Glasgow'; Gilchrist G, 2002, Glasgow.

is little or no support for survivors and where the triggers are unpredictable and outwith the survivor's control.

There are significant and well researched links between trauma and self-harming behaviours[2][3][4]. The reasons why trauma survivors self-harm and the relief or outcome they get from it are different for every survivor. For trauma survivors, self-harming behaviours begin as a way of coping, of regulating feelings such as pain, fear or terror, anxiety, or of helping block intrusive images or inducing sleep.

For some survivors, the emotional pain they feel can be so overwhelming that inducing physical pain can be a way of releasing those feelings. For others the ritual of self-care in the aftermath of self-injury can be soothing.

When children are young, they learn ways to soothe their distress, usually by seeking out an adult (commonly a parent) who will comfort and reassure them. But if that option isn't available to a child because the person who should comfort and reassure them is the person/people causing the distress, the only option for that child is to look for comfort and reassurance within themselves. And if in adulthood, the person who is sought out to help comfort and ease the distress is the cause of that distress, or rejects the trauma survivor, then the only way to help the pain reduce is to depend on the self, often by numbing the pain with substances.

It's often believed that some types of self harm, usually self injury, causes pain and is therefore used as self punishment, or a cry for help, by the trauma survivor[5]. But the reality for survivors is that in the main the purpose of the self injury is often pain relief, releasing tension or regaining a sense of control. Overall, it is an attempt to cope with the pain rather than cause it.

Examples of self harming behaviour can also include:

Substance abuse

"Not 'why the addiction?' but 'why the pain?'"

Gabor Matè

Trauma survivors often have to rely on themselves to regulate these feelings at times when they are no longer able to self regulate. Then substances can be, and often are, used to numb or block out the anxiety, pain, and terror. In the beginning the use of alcohol or drugs may work for the trauma survivor in that they serve a function, but with over dependence they can cause addiction and further stress, anxiety, and loss of control, increase in impulsive behaviour or loss of impulse control, and increase in other behaviours that may be dangerous to the survivor. With the use of substances over time, the effect decreases, and the survivor needs more or stronger substances to maintain the same state.

Dr Janina Fisher has a huge body of work on self harm and trauma and her website[6] has some excellent resources that can be downloaded. She says:

[2] Connors, R. (1996). Self-injury in trauma survivors: 1. Functions and meanings. American Journal of Orthopsychiatry, 66(2), 197–206.

[3] Rachel M. Hoffman, Victoria E. Kress, Narrative Therapy and Non-Suicidal-Self-Injurious Behavior: Externalizing the Problem and Internalizing Personal Agency, The Journal of Humanistic Counseling, Education and Development, 10.1002/j.2161-1939.2008.tb00055.x, 47, 2, (157-171), (2011).

[4] R. Maniglio, The role of child sexual abuse in the etiology of suicide and non-suicidal self-injury, Acta Psychiatrica Scandinavica, 10.1111/j.1600-0447.2010.01612.x, 124, 1, (30-41), (2010)

[5] 'Self harm and suicidality', Janina Fisher PhD, Paper presented at the Trauma Lecture Centre series, Boston, Mass

[6] www.janinafisher.com

"The first assumption is that any addictive behavior begins as a SURVIVAL STRATEGY: as a way to numb, wall off intrusive memories, self-soothe, increase hypervigilance, combat depression, or facilitate dissociating. The ADDICTION results from the fact that these psychoactive substances require continual increases in dosage to maintain the same self-medicating effect and eventually are needed just to ward off physical and emotional withdrawal. Thus, the substance use gradually acquires a life of its own that, over time, becomes increasingly disruptive to the patient's functioning until it is a greater threat to that individual's life than the symptoms it attempts to keep at bay. For this reason, the addiction issues must always be addressed concurrently in trauma recovery because the substance abuse will consistently undermine all other treatments by impairing the patient's memory, perception, and judgment."

Obsessive compulsive behaviours

"Studies have shown that it's really common for patients to suffer from both Post Traumatic Stress Disorder (PTSD) and Obsessive Compulsive Disorder (OCD) simultaneously. It's thought that in some circumstances, obsessive behaviours such as repetitive washing or checking may be a way of coping with post traumatic stress – in fact studies have shown that the severity of a person's OCD symptoms is connected to the number of traumatic events they have experienced in their lifetimes."[7]

The website www.ptsduk.org suggests that there could be as many as 22% of people with PTSD who also have a diagnosis of Obsessive Compulsive Disorder as the two are linked with very similar symptoms. In both there is a need for the trauma survivor to regain some control over her life, help to reduce some of the anxiety, the hypervigilance and increase feelings of safety.

Many myths surround self-harming behaviour and with those myths comes judgement, blame, and shame. Some of those myths include:

- Assuming that all self injury is self punishment
- Assuming that cutting is a failed suicide attempt
- Attention seeking or manipulation
- Believing that self harming behaviour is mental illness
- Only young people self-harm
- Believing that anyone who self harms is a danger to others

Dr Janina Fisher also tells us that the most common mistakes that therapists, counsellors, in fact anyone supporting someone who self-harms, make are:

- Not understanding the degree of relief associated with self harm
- Not understanding the need of trauma survivors to rely on their own resources or to avoid relying on others
- Not understanding that care of the body is not a priority for them
- Not understanding the shame and secrecy that surrounds self harming thoughts and behaviour

[7] www.ptsduk.org

- Becoming engaged in a struggle with the patient about safety in which the therapist becomes the spokesperson in favour of safety and the patient the spokesperson in favour of self harm
- Neglecting the task of helping the patient to struggle with her own internal conflicts about self harm

(from www.janinafisher.com/resources)

High risk behaviour

High risk behaviours are often overlooked, and even less understood, when it comes to self harm. High risk behaviours can give the trauma survivor an adrenaline rush or increased endorphin production that can result in excitement, pleasure, reduce feelings of fear, and increase all round feelings of wellbeing. But high risk behaviours also come with an added danger of serious injury or accidental death so it is worthwhile trying to find other, less risky coping strategies while support or therapy is ongoing.

Telling someone to 'just stop doing it' is unlikely to work. Unless the root cause of the self-harming behaviour is treated, the trauma survivor may find that she has no other way of coping with the distress she is feeling and return to the self-harming with an added sense of guilt, shame, and failure.