What's the harm?

It's vital to understand self-harm as a way of coping, not as a suicide bid, writes **Jeanine Connor**

When was the last time you knowingly did something harmful to yourself – smoked a cigarette or nicotine substitute; drank a glass of wine over the recommended allowance; swallowed a couple of paracetamol above the prescribed amount; took a recreational drug; skipped a meal or binge ate? Usually we do these kinds of things because we think they'll change our mood in some way by helping us to unwind, de-stress or relieve psychological pain. On occasion, we might do things we know are harmful in order to manage our emotions or dissociate from them. Is this self-harm?

Most people think of self-harm in terms of cutting or burning, and associate it with adolescent girls using it to 'act out' or follow a 'copycat' trend. All too often it's labelled as 'attention-seeking behaviour' and is misunderstood or dismissed. Self-harm is far more complex than these simplistic stereotypes suggest, as I hope this article will illustrate, and it is prevalent across all genders, cultures and age groups. If we are to work with it, it is important that we counsellors and therapists are clear in our own minds about what we understand self-harm to be, as this will influence our clinical work, from contracting to discharge, as well as inform our decision-making around safeguarding and disclosure throughout the period of therapeutic engagement.

In this article I draw on a number of definitions of self-harm, mostly expressing or derived from a medical, diagnostic model, even if they are written in lay language. While I do not necessarily endorse these definitions, they provide a valid starting point for a critical exploration of self-harm and how we can work with it safely, appropriately and therapeutically. They also remind us how our colleagues in mental health and medical settings may view it. As I work almost exclusively with children and young people, the clinical examples I include are from the adolescent age group, although similar models of working can be applied whatever the client's age. These examples are amalgamations of multiple client experiences rather than identifiable individuals.

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Motivation

NHS Choices, the public-facing health information website, defines self-harm as '... when somebody intentionally damages or injures their body... usually as a way of coping with or expressing overwhelming emotional distress'.[1] This is uncontentious but restricted, and does little to inform our understanding or treatment of self-harming clients.

The online Medical Dictionary is more nuanced, defining self-harm as: 'The deliberate infliction of damage or alteration to oneself without suicidal intent, in particular by those with eating disorders, mental illness, a history of trauma and abuse: eg emotional or sexual abuse – or mental traits such as low self-esteem or perfectionism.'[2]

Both these definitions lay stress on 'intentional' or 'deliberate', which, for many, have judgmental resonances. While there has been a welcome shift away from use of 'deliberate self-harm' (DSH) in some settings, the new language of 'non-suicidal self-injury' (NSSI), which feels less condemnatory, is taking a while to become fully embedded.

I contest the use of the word 'alteration' in the Medical Dictionary definition, as would most of my clients. I have debated with counselling and psychotherapy colleagues whether tattooing, piercing, ear stretching or cosmetic surgery are forms of self-harm. To me, even people who go to seemingly extreme lengths of piercing and stretching to alter their body and/or face are not demonstrating self-injury. The crucial difference is the motivation, which for these individuals is to enhance and embellish their bodies rather than harm them, however extreme their methods might seem.

I also find problematic the suggestion that self-harm often accompanies eating disorders (although, confusingly, eating disorders are sometimes described as a form of self-harm),[3] mental illness, or a history of trauma and abuse. I think that this definition perpetuates an increasing trend towards pathologising behaviours that, seen from the individual's perspective, may be regarded as an understandable response to an unbearable situation. Pathologising suggests that someone who self-harms is ill. Some people with a diagnosed eating disorder or mental illness might self-harm, and the behaviour could be an

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expression of trauma, but that is not the place from which to start the conversation. It is helpful to note that the National Institute for Health and Care Excellence (NICE) states explicitly that: 'Self-harm is not used to refer to harm arising from overeating, body piercing, body tattooing, excessive consumption of alcohol or recreational drugs, starvation arising from anorexia nervosa or accidental harm to oneself.' [4]

I considered this definition useful in my work with Dan, a 19-year-old student who came to me for psychotherapy because of problems with intimacy. He was an unconfident, shy young man with lots of visible tattoos and enlarged earlobes through stretching. A couple of sessions into therapy, he arrived with deep scratches on his face, and told me he got them when he was drunk but couldn't remember how. Later, he admitted that the scratches were self-inflicted, and over the following weeks his visible injuries became more extreme. He arrived at one session with a deep wound on his cheek having intentionally cut himself with a razor blade. Over several months of therapy, we worked through Dan's hatred of his appearance and ambivalence about his sexuality. We disentangled the 'alteration' – tattoos and ear-stretching – from the 'self-injury'. We explored the meaning of Dan's behaviour in establishing his identity, and I tried to encourage him to self-harm safely and helped him to find healthier and non-violent ways to express his emotions.

Ask the question

The Mental Health Foundation defines self-harm as: '... a wide range of things that people do to themselves in a deliberate and often hidden way'.[5] I think it is a mistake to think of self-harm as often hidden – in my experience it may be selectively hidden, in that it may be concealed from parents, peers, partners or professionals, or the individual might self-injure on a part of their body that isn't readily visible to others, for a multitude of reasons.

This definition also states that, 'in the vast majority of cases, self-harm remains a secretive behaviour that can go on for a long time without being discovered'. The chances are then that some of our clients may be self-harming and we don't even know it. Whether they disclose or not is up to them, but I think it is also up to us. As with any subject that is remotely taboo, clients pick up on cues from us about what is OK to talk about. When I'm working with someone who presents with low mood or anxiety – which is almost every young person who comes to me for therapy – I always ask about self-injury. Most tell me they are hurting themselves, or have done so at some point in the past. If you don't ask the question, you might be sending a message that you are uncomfortable talking about it, and therefore your client will be too, thus perpetuating the secrecy.

When I asked, 12-year-old Shaila told me that she had been self-harming since she was nine. I asked if she could tell me what she did, in as much detail as she felt comfortable to share. She was embarrassed, and said she had never told or shown anyone before because she didn't want to be accused of attention-seeking. I hear this a lot. I said I didn't need to see unless she wanted to show me, which she didn't. She explained that she used the flat side of a scissor blade to graze the upper parts of her thighs. She had never broken the skin or caused bleeding.

As we talked further, I began to understand that Shaila had been struggling in silence with overwhelming emotional distress that she felt powerless to control. She was academically successful and popular at school, but had buried the pain of her parents' separation and become isolated and depressed. Her mother was dealing with her own grief following the end of her marriage and the death of her father. Shaila did not want to add to her mother's distress or make her feel responsible for her unhappiness, and so she kept her feelings hidden. For some people, the act of self-injury is what helps; they replace emotional pain with physical pain. Over time, we worked out that the important thing for Shaila was not hurting herself physically per se, but that she had the power to stop the pain. She couldn't stop the emotional distress, but it helped her that she could stop the physical pain, and to be able to do that, she had to inflict it.

I meet so many girls like Shaila who have concealed their psychological pain and the physical harm they have relied on to manage it. They are the antithesis of the 'attention-seeking' adolescent. I helped Shaila to uncover the distress and put her feelings into words – a painful process, but with it came relief from no longer having to hide a secret that felt shameful, and, in time, Shaila no longer felt the need to rely on self-injury as a way of managing her emotions.

Self-poisoning

The NICE definition of self-harm includes '... any act of self-poisoning',[4] and I think this inclusion is useful. I have worked with young people who self-poison by inhaling ▶

gas or aerosols or swallowing toxic substances. Their motivations are different from those of young people who take recreational drugs, and it is important, therefore, to establish the meaning behind the act of self-poisoning – to cause harm or to get high – in the same way that it is important to distinguish alteration of the body from self-injury.

Robert was 14 and had just been excluded from school for the third time when he was referred to me for psychotherapy. He found it difficult to settle physically or mentally. His mother was emotionally distant and was self-medicating for depression with alcohol. Robert had low self-worth and had internalised the script that he was 'useless like his father', who was serving a prison sentence for aggravated burglary. Robert was aggravated too, and had a tendency to aggravate people around him.

Over six initial assessment sessions, I discovered that Robert had worked hard to keep his family narrative a secret and that he felt enormous shame when people found out. He had presented as angry and aggressive throughout primary school and had now turned that aggression on himself. When I asked about self-injury, Robert told me he had, in the past, used aerosols to burn his skin. This started out as a dare but had developed into something more like self-punishment. He then began inhaling aerosols, in order, he said, to 'feel dead'. We began to understand this as a means of temporary escape: Robert didn't want to die; he wanted some relief from the emotional pain of his experiences. Self-poisoning was a way to numb that pain by replacing it with another.

Non-suicidal self-injury is not, and never has been, listed as a mental disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), the guide developed in the US and routinely referred to by medical professionals throughout the UK. It is, however, included in a new category in the latest edition, *DSM-5*,[6] called V-codes, which describe 'other conditions or problems that may be a focus of clinical attention or that may otherwise affect the diagnosis, course, prognosis, or treatment of a patient's mental disorder'. (Of note, V-codes also include parent-child relational problems, relationship distress and academic/educational problems.) The new V-code categorisation explicitly recognises that NSSI (and other V-codes) are 'relational problems requiring relational solutions', rather than mental disorders, with the stigma this implies.[7] While a primary function of inclusion in the *DSM* in the US is that it gives access to insurance funding for medical treatment, the new coding system provides a welcome shift away from medicalising behaviour and encourages professionals to think differently.

DSM-5 defines NSSI as 'the deliberate, self-inflicted destruction of body tissue without suicidal intent and for purposes not socially sanctioned, including behaviors such as cutting, burning, biting and scratching skin as a way of coping with difficult emotions'. This is the most inclusive of all the definitions I have found, as it addresses the what, how and why of self-harm, as well as what it is not. I think the 'socially sanctioned' part helps distinguish piercing, tattooing, etc from self-harm, as does the NICE definition, and *DSM-5* also highlights the distinction between self-harm and suicidal intent. Self-injury is often a means of staying alive, a bid for survival, not death, although it may be accompanied by suicidal thoughts, and persistent self-harm can be a risk factor for suicide.

Lucy was 13 and had a history of risky behaviour, including serious self-injury, sexual promiscuity and absconding, when she was referred to me for psychotherapy. She was small, heavily made-up and fragile looking. To me, she seemed empty inside, like a china doll. She said she hated her 'no-good' mother and described her father as a relentless bully who 'doesn't know when to stop'. Shortly after we started to work together, her self-injury escalated. When her mother tried to make the home safe by removing any sharp implements, as I had insisted, Lucy smashed a window and used the glass to cut herself so deeply that she had to have stitches. She pierced her face with a compass point and the wound became infected. She refused to eat or wash. She dyed her hair blue. She had unprotected sex with older men 'because they wanted to'. She constantly said she'd be better off dead, although she had no suicide plan or intention to kill herself.

I wondered about the escalation in Lucy's self-harm and what the attacks on her body might be about. I understood the uninhibited flaunting of her physical injuries as an attempt to draw attention to her distress. It felt important to show her that I understood that these visible displays were communicating pain that she was, as yet, unable to verbalise. I didn't want her to perceive me as either an intrusive father or useless mother; I needed to 'hold' Lucy (psychologically) and proceed at her pace. My being able to bear her behaviour allowed Lucy to finally disclose that her father was sexually abusing her. We later came to understand her attacks on her own body as symbolic attempts to eradicate the intolerable memories of the trauma she had endured. They might also have illustrated her attempt to control her feelings of murderous guilt and rage towards both her abusive father and her mother, who failed to protect her, by displacing them onto herself.[8] My work with Lucy came to an abrupt end when she was removed from her family for her own safety.

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Disclosure

With Lucy, I had no reservations about sharing information with the statutory authorities about her self-harm and her disclosure of abuse. But it is rare that I need to raise self-harm as a safeguarding concern, even though most of my clients self-injure. When I contract with new clients, I tell them that, if I am worried about their safety, I might need to talk to someone else about it, but that I will always talk to them first. If a client tells me they are self-harming, I keep in mind the *DSM-5* definition - that the behaviour is ‘a way of coping with difficult emotions’, and that it is different from suicidal intent.[9] I explore their means and motivation by asking what, how and how often they injure themselves. I tell them that it is not for me to either condemn or condone their behaviour, but that my role is to understand what they are doing and why, and to work with them, and their family if it’s appropriate, to keep them safe. I usually say that I have met lots of young people who self-harm, to demonstrate that I can bear it, but I always emphasise that I know it means something different for each of them. I tell them that I want to understand what it means for them, to reassure them that I am making no assumptions.

For me, risk assessment is not a one-off event; it is entrenched in every session of psychotherapy. It includes an appraisal of each client against what might be ordinary, age-appropriate behaviour within their family and social context. Assessment is also informed by organisational protocols and procedures, and professional ethical guidelines, as well as by my own clinical experience and instinct. The NICE guideline on self-harm provides a helpful framework for working with clients safely. For clients who repeatedly self-harm, NICE recommends offering advice on how to treat their own superficial injuries and on harm-minimisation, for example by using clean blades and antiseptic products, rather than trying to stop them from doing it, which is seldom effective.[4]

In my work with both Dan and Robert, I understood their self-injury as an expression of distress rather than suicidal intent, and embedded in our sessions suggestions for ways they could self-harm more safely. With Shaila, I didn’t share with the statutory authorities or with her family her disclosure of self-injury, despite her young age, but nor did I collude with her secrecy. I encouraged her mother to acknowledge and ‘bear’ her daughter’s feelings of grief as separate from her own.

If we continue to monitor the level of risk, we should be able to hold our clients’ distress. Putting words to their pain, in my experience, leads to a reduction in the reliance on self-injury, whatever the client’s age. ■

HARM-MINIMISATION

Harm-minimisation is based on the understanding of self-harm as a coping mechanism – one that has an important purpose and meaning for the individual, but carries potentially serious physical health risks. The aim of harm-minimisation is to reduce those risks as far as possible, so the person can stay safe and avoid doing severe, potentially life-threatening, unintended and irreversible harm to themselves. It accepts that someone is self-harming, and looks for ways to enable them to stay safe, rather than trying to stop them (which generally doesn’t work or help).

A helpful guide to harm-minimisation is Kay Inckle’s book, *Safe with self-injury*.[1] The book sees self-harm through the lens of a social model of distress. It explains harm-minimisation in the context of an exploration of the meanings of, and reasons for, self-injury, drawing on the words and experiences of people who self-injure. It includes a section on ‘staying safe’, covering harm-reduction practices, self-care and alternatives to self-injury.

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