

The issues pertinent to self harm psychology essay



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A single definition of self-harm, as well as the vocabulary used to describe the behaviour, has been difficult for researchers and clinicians to identify because there is no generally accepted terminology and various terms have been used in the literature (Ross & Heath, 2002). The term self-harm has often been used interchangeably with self-mutilation, deliberate self-harm, self-injurious behaviours, parasuicide and self-wounding. Weber (2002) identifies that the terms used often, such as self-injury, Para-suicide and self-destructive behaviour, reflect the theoretical standpoint of the clinician using them rather than the client who is harming. Furthermore the term used to describe the self-harm can imply a different meaning of the act, for example self-abuse suggests a psychodynamic understanding of the motivation for the behaviour whereas direct self-harm conveys the person has chosen to act in this way and that it is a behaviour rather than an illness. Onacki (2005) defines self harm as a deliberate, repetitive, impulsive, and non-lethal harming of one's body. Where as the National Institute for Clinical Excellence guidelines for the short-term management of self-harm define self harm as 'self poisoning or self injury, irrespective of the apparent purpose of the act' (NICE, 2004, p7) The term 'deliberate' has been removed from their definition, in acknowledgement of the fact that some people may self harm in a dissociative state and that intent varies from individual to individual and on each occasion that someone harms themselves. Their broad scoping definition aims to ensure people presenting with a wide range of self-harm will be offered access to a psychosocial assessment and appropriate support and follow-up.

Research has categorized self-harm and there is a general agreement based on the severity of the behaviour and the act itself. The most recent theoretical classification discussed in the literature is proposed by Favazza (1998). In this classification system, self-harming behaviour has been classified in to three observable categories, including major, stereotypic, and superficial/moderate based upon tissue destruction and the rate and pattern of the behaviour. According to Favazza (1998), Major self-Harm consists of rare acts in which a major amount of body tissue is destroyed for example a limb may amputated in the act and stereotypic self-harm includes acts of moderate behaviours such as head banging, hitting, throat and eye gouging, and self-biting and are primarily rhythmic and repetitive. Superficial or moderate self-harm is the most common and varied type of self-harming behaviour and it comprises of acts of low lethality that occurs both sporadically and repetitively (Rao, et al 2008).

Whalen (2006) identifies superficial or moderate self-harm (herein referred to as self-harm) as the most common type of self-harm among the psychiatric inpatient population. Self-harm can take many forms including self-injury and self-poisoning. The most common form of self-injury is skin cutting with a variety of implements targeting areas of the body that can be covered by clothing and most likely the lower arm. There is some evidence that cutting is more repetitive than other forms of self injury (Lilley et al, 2008). Other forms include burning, scratching banging or hitting body parts and interfering with wound healing (Klonsky, 2007a). Self-poisoning is the intentional use of more than prescribed or recommended doses of any drug and includes poisoning by non-ingestible substances, overdoses of

recreational drugs and severe alcohol intoxication where this seems to be intended as an act of self-harm. Furthermore, Substance misuse, physical risk-taking, sexual risk-taking and self-neglect are sometimes labelled as indirect self-harm (Royal college of Psychiatrists, 2010). In addition, when people who repeatedly harm themselves through cutting or taking overdoses are helped to overcome these behaviours, eating disorders or other self-damaging problems may emerge. With research suggesting that the prevalence of self harm among patients with an eating disorder is 25% (Randy et al, 2003). For the purposes of this dissertation the discussion will be limited to self-injury and self-poisoning.

Self-harm is recognised as an international problem, yet rates in the UK are among the highest in Europe. In the UK, self-harm is one of the top five causes of acute medical admission in 2000-2001 around 220, 000 people presented to accident and emergency departments requiring treatment for self-harm (Hawton et al, 2007). With admission to a psychiatric ward occurring for around 10% of people treated by accident and emergency and repetition of self-harm in individuals aged between 13 and 18 is high (Hawton et al. 1999; Nadkarni et al. 2000). Self-poisoning accounts for most of the admissions where as self-injury is the more common type of self-harm, suggesting these figures do not reflect the true impact of the problem (Hawton et al, 2003). Nevertheless, these findings suggest concern for future suicide rates, given that one of the strongest correlates of completed suicide among young people is a previous attempt of self-harm (Cooper et al, 2005).

The strong correlation between self-harm and completed suicide may suggest why some researchers feel self-harm only exists when the intent is

to kill oneself (Klonsky et al, 2003; Ross & Heath, 2002). However, Conaghan & Davidson (2002) are of the opposite view and suggest self-harm is a behavior with the outcome being not to kill oneself. This View is supported by Favazza (1998) who suggests that self-harm is a ' morbid' form of self-help that is opposing to suicide. Furthermore, Suyemoto's (1998) ' anti-suicide' model focuses on self-harm as an active coping mechanism to avoid suicide. Thus suggesting that suicide and self-harm are two very different phenomena and therefore in this dissertation self-harm will continue to be discussed without suicide intent.

Self-harm can occur because of a wide range of psychiatric, psychological and social problems. Meltzer et al (2002) found that individuals with current symptoms of a mental disorder are up to 20 times more likely to report having harmed them in the past. However, self-harm does not currently fulfil the criteria for an independent category of mental or behavioural disorder in the DSM-IV-TR (Diagnostic and Statistical Manual 4, Text Revision, 2004) or the ICD-10 (International Classification of Diseases, 1994). In both classificatory systems the DSM-IV and the ICD-10 self-harm is only referred to as a symptom of Borderline Personality Disorder. Conversely, Klonsky et al (2003) discuss that self-harm is also commonly found in clients with a number of psychiatric disorders. Haw et al (2001), for example, found that 92% of individuals receiving inpatient treatment for self-harm were also suffering from psychiatric disorders, with the most common being depression and anxiety disorders. The vast research that illustrates self-harm co-occurs with a variety of diagnoses, and not just Borderline Personality Disorder, has lead to a proposal for the DSM-V to include a new diagnosis specific to non-

suicidal self-injury (Shaffer and Jacobson, 2009). Signifying that self-harm is an issue in itself irrespective of the co-occurring diagnoses.

Some of the other psychological or social problems stem from early childhood experiences and may include: sexual abuse, neglect, emotional and physical abuse, loss or separation and parental mental health problems (Skegg, 2005). Current psychological or social experiences, aside from a mental health diagnoses, rape, domestic violence and substance misuse have been found to increase the risk (Tuisku et al, 2009). The risk factors identified could have a significant impact on everyone, and even more so if someone has a mental health diagnoses, however not everyone predisposed to these experiences and/or with a mental health diagnose self-harms.

Therefore, these contributing factors alone do not control the behaviour.

More recently, both academics and professionals have recognised that until there is an evidence base indicating why adolescents self-harm, it is unlikely that the correct treatments and interventions will be proposed (Klonsky and Glenn, 2008). Fortunately, the functions of self-harm have been subject to increased research in recent years (Klonsky, 2007b).

Research has identified multiple functions of self-harm (Hanley et al, 2003).

Converging evidence suggests that adolescents self-harm with a primary intent to alleviate negative emotions and to release tension (Klonsky, 2009).

Utilising self-harm to reduce tension does seem to result in an immediate release and Crowe & Bunclark (2000) have found biological evidence to suggest that a physiological stress reduction after an episode may last up to 24hrs. These findings emphasise the risk of repetition and further more why self harm is a very complex behaviour to treat which will be discussed

further in chapter 3. Another prominent function is reported by Machoian (2001), who describes self-harm as a means to communicate the degree of pain that is being felt. It seems that those who self-harm feel that no one can offer emotional support or show they understand (Magnall, 2008). These beliefs suggest the importance of a therapeutic collaborative relationship because if self-harm is being used to communicate, the skills of a nurse should be adapted to overcome this. Although these functions are commonly identified to explain why someone may self-harm they are not inclusive thus emphasising the importance of a comprehensive assessment (both of these points will be discussed further in chapter 2). Nevertheless self-harm is a maladaptive coping strategy (Linehan, 1993).

Self-harm can occur at any age but it is most prevalent in adolescence and young adulthood. The Centre for suicide prevention (2001) found that self-harming behaviour typically begins in early adolescence around 14 years of age and the disorder seems to peak between the ages of 16 and 25. The rate of self-harm is relatively low in early childhood, but it increases rapidly with the onset of adolescence (Hawton et al, 2003). A study by Meltzer et al (2001), based on parental reports, suggests that the rate among 13 to 15 year olds is one and a half times that of 11 to 12 year olds (2.5 and 1.6 per cent, respectively). This may of course mask the fact that some children self-harm earlier without presenting to any services. (ref here) Additionally the prevalence of self-harm is much higher in in-patient settings, with 80% of an adolescent psychiatric inpatient sample self harming (Nock and Prinstein, 2004) compared to a prevalence rate of 15-20% in the community t (Heath et al, 2009). Although these findings suggest that self harm is significantly

more predominant in an in-patient setting it doesn't mean that all adolescents will disclose this behaviour. This is mainly because self-harm has been reported by the adolescents themselves as a secretive behaviour (Shiner, 2008).

To summarise, the NICE have ensured their definition is broad to ensure that all individuals who self-harm are assessed, supporting the risks that come hand in hand with self-harm not only suicide but the strong correlation between self-harm and mental illness. Self-harm predominantly starts in adolescents usually at age 14 and peaks at 16 through to the age of 25 and it is most likely to be in the form of self-cutting to the lower arm. The varied causes and functions that self-harm serves highlight the importance of in-depth therapeutic assessment which will be discussed in the next chapter.