Bristol Crisis Service for Women

WOMEN and SELF-INJURY

a survey of 76 women

A report on women's experience of self-injury and their views on service provision

Supported by the Mental Health Foundation

WOMEN AND SELF-INJURY

A SURVEY OF 76 WOMEN

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for Bristol Crisis Service for Women

March 1994 - March 1995

ISBN 0 953 1346 5 7

Published by Bristol Crisis Service for Women
P.O. Box 654, Bristol BS99 1XH
Tel. 0117 925 1119

Acknowledgements

The participation and contributions of the following are gratefully acknowledged:

All the women who generously and courageously shared their own experiences of self-injury with us.

Dr Rachel Perkins, Consultant to the Self-injury Project, who has provided guidance, enthusiasm and support.

The Mental Health Foundation, who have financed the Project and offered ongoing interest and support.

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INTRODUCTION

Professionals are often terrified by self-injury. Their normal empathy with others' distress and their confidence in their ability to help often desert them when faced with someone who persistently hurts herself. This problem reflects a serious and widespread lack of understanding of self-injury, which results in great inconsistency and inadequacies in services.

This survey was carried out as part of a two-year project, funded by the Mental Health Foundation, whose aim is to increase understanding of self-injury amongst professionals and the public. The Project was set up as a result of the large volume of requests received by the Bristol Crisis Service for Women for information, help and advice about self-injury. Alongside this research we are looking into the experience and needs of professionals, producing information and training, and holding a national conference to develop good practice guidelines for agencies working with people who self-injure.

Literature review

The literature on self-injury is comparatively small, scattered and not widely accessible, but encompasses a multiplicity of theories. Many approaches are based on the theories of academics and clinicians, rather than on what people who themselves self-injure say about their experience and needs. Several researchers have investigated the backgrounds of people who self-injure, drawing their own conclusions about which factors may be relevant and how. Many authors have analysed what may motivate someone to self-injure, most making their own inferences from clinical experience. Few seem to have asked individuals directly how they understand and interpret their own self-injury. Many have suggested treatment models, but little evaluation of these has been carried out and again few appear to have asked people who self-injure directly what sort of help, if any, they would like or have found useful.

Most authors view self-injury as evidence of some sort of psychopathology. Favazza (1989) reported on three prevalent clinical approaches which see self-injury variously as manifestations of borderline personality disorder (e.g. Walsh and Rosen, 1988), a disorder of impulse control (Pattison and Kahan, 1983) and a multi-impulsive personality disorder (Lacey and Evans, 1986). Tantam & Whittaker (1992) argue a case for recognition of a 'deliberate self-harm syndrome', but criticise personality disorder diagnoses, arguing that there is no personality disorder unique to self-wounding and that "The attribution of upsetting behaviour to abnormal personality tends to blunt the normal caring response.....Too often, further inquiry into the reasons for the behaviour, in particular into the situational determinants of self-wounding, stops once a diagnosis is made".

Other authors (such as Wise (1989), Shapiro (1987), Burstow (1992), Arnold (1994) and Pembroke (1994)) have rejected notions of 'mental disorder', seeing self-injury rather as a means of coping with unbearable experiences. Wise concludes that "Self-injury, though destructive, is actually a signal of inner health and survival, a signal of 'sane' reactions to incomprehensible abuse, a signal that the person is insisting on the reality of the pain/betrayal/loss that she/he has experienced".

Many authors understand acts of self-injury to serve some purpose or function. Favazza (1989), whilst seeing it as resulting from 'psychopathology', goes on to conclude that self-injury is 'a purposeful, if morbid, act of self-help'. Views vary widely as to the nature and complexity of the purposes which may be involved in self-injury.

There is a range of psychodynamic theories whose themes (reviewed in Favazza (1989)) include seeing self-injury as an attempt to differentiate ego boundaries; a tension-reducing act of gratification analogous to masturbation; an attempt at ending depersonalisation; appeasement of threatening figures in hallucinations; a symbolic wish for and fear of sexual penetration by the father; atonement for the unconscious wish to injure the frustrating mother; a way of dealing with sexual conflicts, including the relief of guilt resulting from sexual abuse and the punishment of an abuser 'in effigy'; and a redirection of anger towards the self, perhaps as an internalised representation of a powerful 'object' towards whom rage is felt.

Other theories include those of Miller (1994), who argues that self-injury is an aspect of a 'Trauma Re-enactment Syndrome', in which an individual symbolically replays and attempts to resolve some childhood trauma. Walsh and Rosen (1988) put forward a psychoanalytic explanation of self-injury, proposing a sequence of events including a loss or perceived threat of loss; mounting intolerable tension which the individual is unable to verbalise; a state of dissociation and an irresistible urge to mutilate oneself. Self-injury brings relief of tension, ego reintegration and a return to 'normalcy'.

Several authors (and many clinicians) see the purposes of self-injury primarily in terms of its possible effects on other people. Feldman (1988), like Walsh and Rosen, has suggested that self-injury may be carried out for secondary gain - to force others to provide love and attention. Other social explanations include the 'identity' or conformity which may be achieved by cutting, usually in institutional settings (Walsh and Rosen, 1988). The view that self-injury is carried out mainly to influence others has been disputed by several authors, including Pembroke (1994) and Arnold (1994), both drawing on the accounts of women 'survivors' of self-injury.

A number of themes emerge from the literature based on individuals' self-reports on the purposes of their own self-injury. Favazza (1989) quotes the themes most commonly articulated by patients as including tension release; returning to reality after feeling dead or unreal; establishing control; security and uniqueness; influencing others; negative perception (of self); pressure from multiple personalities; enhancement of sexual feelings; euphoria and titillation (from risk-taking); venting anger; relief from alienation and self-punishment for irresistible urges. Burstow (1992) reports that self-injury may fulfil many essential psychological survival

functions for a woman, including seeking self-worth by continuing the abuse she suffered from her parent(s), proof of her humanness, bringing back feeling and/or distracting herself from feelings, communication, achieving a 'high' or rush of energy, control, resistance and demonstrating strength and success.

Many theorists have seen the need to investigate the backgrounds of people who self-injure, although this factor is frequently neglected in clinical practice. Tantam & Whittaker (1992) noted that "Disturbed behaviour is produced by disturbing situations or disturbed relationships as well as by disturbed personality, but the former is much harder to investigate and has, since the early days of psychoanalysis.....been as systematically neglected by as many psychotherapists as it has by neuropsychiatrists".

Self-injury is often reported to follow childhood trauma or abuse, particularly sexual abuse. Van der Kolk (1991) reported that in a study of 28 subjects "79% gave histories of significant childhood trauma and 89% reported major disruptions in parental care....sexual abuse was most strongly related to all forms of self-destructive behaviour". Walsh and Rosen (1988) found that childhood illness or surgery, loss of a parent and self-destructiveness and impulsivity in the family were also important 'predictors' of adolescent self-injury. Fewer authors have examined the role of adult experiences in leading someone to self-injure. Greenspan & Samuel (1989), drawing on a very small sample, suggest that self-injury may begin after adult experiences of rape or trauma, irrespective of childhood experiences. Potier (1993), in a rare examination of the role of institutions in causing women to self-injure, reports on the 'power game' and suppression in a Special Hospital which force women to attempt to regain the initiative through various sorts of self-injury.

Professional responses to self-injury vary according to theoretical stance, but also according to the attitudes of staff involved, which can often be problematic. Frances (1987) reported that "Of all disturbing patient behaviours, self-mutilation is the most difficult for clinicians to understand and treat....The typical clinician (myself included) treating a patient who self-mutilates is often left feeling a combination of helpless, horrified, guilty, furious, betrayed, disgusted and sad". Tantam and Whittaker (1992) have also commented on the fear, anger and anxiety that a person deliberately harming themselves produces in carers and fellow-patients, who may stigmatise the patient as 'bad', attention-seeking' or 'manipulative'.

A number of authors have reviewed and made recommendations on treatment approaches to those who self-injure. Hospitalisation and drug treatments are commonly used. Tantam & Whittaker (1992) conclude that compulsory psychiatric treatment is "sometimes inescapable, that very occasionally it helps and that quite often it makes subsequent self-harm worse". Reviewing reports on drug treatments, they conclude that "Medication carefully chosen with clear therapeutic motives and for specific symptoms may well be of value in this group of patients but there is no evidence that drugs have any direct effect on the propensity to harm the self, and considerable evidence that they are often abused, sometimes with fatal consequences". They add that benzodiazepines tend to have a disinhibitory effect and can make self-injury worse.

Many authors have recommended behavioural approaches to self-injury. Walsh and Rosen (1988) propose a cognitive-behavioural model, whereby the individual is taught to change her thought patterns and 'internal and external reinforcement' factors are removed. The behavioural element involves learning "alternative methods for discharging and tolerating emotions", and eliminating "external positive reinforcement". Their recommendation to professionals is "to reduce the level of care, empathy and concern as much as possible for the period immediately following the infliction of the wound".

Some notion of behaviour-modification often seems to underlie treatment in hospital settings. Tantam & Whittaker (1992) report that punishment "may be an overt or a covert element in behavioural treatment", warning that "irrespective of the ethical issues concerned, there is no evidence that it is of benefit" and that it leads to a deterioration of the relationship between staff and patient which outweighs any transient value it may have in reducing the frequency of self-injury.

The idea that self-injury can be reduced by 'withholding attention' is common in the literature and even more so in clinical practice, but is criticised by many authors, including Pembroke (1994), who argues that where professionals show compassion and respect following self-injury this increases the individual's self-worth and may help to delay further acts of self-injury.

Several authors recommend some form of psychotherapy for people who self-injure. Nelson & Grunebaum (1971) conducted a rare survey of the views of people who had injured themselves, asking them to identify the factors they felt to be most significant in their improvement. These included the verbal capacity to express feelings and the presence of an accepting therapist who would act constructively in crises. However, Nelson and Grunebaum commented that 'insight into the genesis of the cutting behaviour did not afford relief'.

Tantam and Whittaker (1992) conclude that the interpretation of feelings is effective if it assists the development of the relationship with the therapist, but not if it seeks to explain the historical development of self-injury, which they warn can lead to the escalation of self-injury. In contrast, authors such as Wise (1989) and Burstow (1992) advocate therapeutic approaches involving the respectful exploration with clients of the feelings and experiences which give rise to self-injury and the survival functions which it serves. Wise reports that self-injury may escalate temporarily at some stages during therapy but that this passes as 'new patterns of survival' are developed.

Some authors have reported on the outcomes of group therapy. Walsh and Rosen (1988) express reservations about the possibility of groups developing a 'counter-culture' of self-injury and advocate a highly structured approach with the aim of "changing the way group members use social interaction to meet their needs" . Tantam and Whittaker (1992) point out the benefit of gaining self-understanding through sharing common experiences. Pembroke (1994) advocates the setting up of user-run self-help groups and support networks.

The survey: aims and method

The aims of this research were to increase understanding of self-injury and to identify how services might best help women who self-injure, by investigating women's own interpretations of their experience. We were interested to find out what insights women who self-injure had into their own actions. In particular, we wanted to find out what feelings or circumstances seemed to women to precipitate episodes of self-injury, what meanings or functions injuring themselves had for them, and what bearing they felt past or current life experiences to have. We also wanted to know what women felt about any services they had come into contact with in connection with their self-injury, what they had found helpful or unhelpful, and how they saw their service needs.

Seventy-six women participated in the research. Twenty-six took part in semi-structured interviews, while fifty answered written questionnaires. Women were contacted through local and national advertising. Around Bristol, posters and fliers were distributed to GPs' surgeries, colleges, a Women's centre, voluntary agencies and self-help groups. News items about the project on local television and radio and an advertisement in a listings magazine also resulted in women coming forward. Women outside Bristol heard of the Project through items in the national press.

A wide range of women took part in the survey. Some had spent many years in psychiatric care, others had never been in contact with any service in connection with their self-injury. Several participants were or had been in prison. Some were mothers, some married, others single, and there were lesbians and heterosexual women. A wide variety of occupations were represented. Of the 76 women taking part, just over half said that they still self-injured, while 39% reported that they no longer hurt themselves. Ages ranged from 18 to late 50's. No data was collected on ethnic origin, and this would be valuable in future research.

The questionnaires which formed the basis of interviews as well as written contributions fell into two sections, the first concerning women's own self-injury, the second their experience and views on services. Questions allowed each woman to respond in her own words and covered such areas as:

- the ways in which she had self-injured, when this had started, frequency, and how long it had continued
- any other 'self-harm' in which she saw herself as engaging
- what she understood about the reasons for her self-injury in terms of feelings associated, functions served and experiences she felt were related
- which services she had been in contact with, what was offered and how helpful this was
- her views on services she would like provided.

FINDINGS

"Putting the pain on the outside": Women's experience of self-injury

Ways women injured themselves

Table 1

Type of injury	% of sample
Cutting	90
Inflicting blows	32
Burning/scalding	30
Picking/scratching	12
Pulling out hair	7
Biting	5
Swallowing objects	4
Other	5

Cutting was by far the most common type of injury reported, with ninety percent of respondents saying that they had cut themselves. Women used such implements as knives, razor blades and broken glass. The area most commonly cut was the arms and/or hands, while a fairly large proportion cut their legs and some their stomach, face, breasts or genitals. Some women reported cutting several areas of their bodies, or 'all over'.

The two other most common sorts of injury were inflicting blows and burning. Women reported punching or hitting themselves with their fists or with an object, and striking themselves against something, such as a wall. Over half of these struck their head or face. Burns included scalds and, like cuts, were most commonly inflicted on the arms and hands.

Many women reported inflicting more than one type of injury on their bodies, most commonly either cutting and burning themselves, or cutting and inflicting blows upon their bodies.

"Mostly I cut myself with broken glass. Sometimes I'd hold a cigarette or a match flame against my arm. When I haven't wanted to leave scars I've done things like smash my arms against the banisters again and again until they were all bruised."
(Woman A)

Other, less common types of injury included persistently scratching or picking the skin, pulling out hair or eyelashes, biting oneself, swallowing objects or harmful substances (other than drugs), inserting sharp objects into the urethra or bladder and scrubbing the body in such a way as to cause pain and injury.

Age of onset, frequency and duration of self-injury

Table 2

Age of onset of self-injury	% of sample
Child up to age 12	30
Teenager (13-19)	44
Adult (20+)	26

Table 3

Duration of self-injuring behaviour	% of sample
Less than 5 years	30
5 - 10 years	22
10 - 20 years	33
over 20 years	14

Most women had begun injuring themselves during childhood or adolescence. It was startling that many women had begun hurting themselves at such a young age - the youngest age of onset reported was six.

"I have been self-harming since I was very young, starting from a slight scratch to bruises, burns and serious wounds to various parts of my body" (Woman B)

This finding contrasts with previous research (e.g. Favazza (1987)), which has found most self-injury to begin in adolescence. The difference in findings may be explained by the fact that we did not restrict our enquiry to specific sorts of 'obvious' self-injury, such as cutting. It was common for women to report that they had begun hurting themselves in a haphazard and fairly superficial way as children (perhaps by scratching or knocking into things in a way which could be disguised as an accident), and then progressed to inflicting more serious and systematic injuries as teenagers.

Most women had injured themselves at intervals over a long period - some as long as 20 years. Of the women who had been injuring themselves for less than five years, many had begun fairly recently and were still hurting themselves.

It was not possible to collect precise data about the frequency of women's self-injury, but it appeared that this was often periodic, with gaps of weeks, months or years between periods of more regular self-injury. Very few women reported injuring themselves regularly over long periods. Some women indicated that they hurt themselves one or more times daily during certain periods, others that there were days or weeks in between individual instances.

Other sorts of self-harm carried out

Many authors (e.g. Tantam & Whittaker (1992) have reported that people who self-injure frequently also self-harm in other ways, particularly through overdoses, misuse of alcohol or drugs, eating problems, and offending. We were interested to know whether women in our sample saw themselves as self-harming in other ways, what these were, and whether these tended to occur alongside self-injury, or at other times.

Table 4

Other self-harm reported	% of sample
Some other self-harm (total)	*84*
Eating problems	53
Overdosing	39
Alcohol misuse	37
Drug misuse	35

Most women reported that they had engaged in other sorts of self-harm, in addition to inflicting injuries on themselves. Most striking was the high incidence of eating problems, while overdosing and misuse of alcohol and drugs were also common.

There were many other ways in which women saw themselves as self-harming. These included overwork, over-exercising, excessive shopping, abusing glue/solvents, suicide attempts (other than overdoses), staying in abusive relationships, unnecessary and repeated risk-taking, self-sabotage (for example in career, academic work, relationships), and smoking.

"I still hurt myself in lots of ways, really. Worrying, blaming myself for things, doing too much, not letting myself sleep - they're just as bad for me" (Woman A)

For some women there seemed to be a trade-off between self-injury and other sorts of self-harm. For example a woman might injure herself less during periods of drug abuse, or might drink less during periods when she was injuring herself.

"I have periods of not eating. It helps me cope if I am not cutting. " (Woman C)

Discussion

The picture of self-injury which emerged from the survey is that this often began in a superficial or disguised manner in childhood or adolescence. Self-injury later became more severe and remained a periodic feature of women's lives for very substantial periods of time. This indicates that parents, teachers and others involved

in the care of young people need to take seriously any indications of possible self-injury, including 'accident-proneness'.

Cutting was the most common form of self-injury, which reflected the importance for many women of the relief brought by causing an injury which bleeds. Contrary to the findings of Favazza (1987), the site of injuries seemed to be determined less by the significance of a particular part of the body than by considerations such as ease of access and concealment. However, a few women chose to injure parts of the body associated with particular shame or self-hatred, such as the face or sexual areas.

Most women who took part saw their self-injury as one aspect of a range of harmful ways in which they coped. Often they felt all these stemmed from the same difficulties in their lives, although self-injury seemed to carry its own particular and important meanings. A number of women commented on the varying degrees of social acceptability of different forms of self-harmful behaviour, feeling it to be unfair that self-injury seems to be so much more harshly viewed than, say, getting drunk and picking a fight, whilst activities such as chronically overworking are socially applauded.

For many there seemed to be some 'trade-off' between self-injury and other forms of self-harm. Several inferences can be drawn from this finding. The first is that different forms of 'self-harm' may have similar causes, and health professionals could usefully generalise from their understanding of these to help them approach the less well understood problem of self-injury. (This is not to deny that causing injuries to oneself has specific meanings. Understanding may also be enhanced if the differences between self-injury and other self-harm were more fully explored.) A second important inference is that, should self-injury simply be treated as a behaviour to be 'extinguished', other forms of self-harm may be instituted or increased to take its place.

Other significant adult experiences mentioned included miscarriage, the loss of a child (through bereavement or separation) and inability to have children. For some women, self-injury began or became more frequent or severe following incarceration in prison or psychiatric hospital. Others had injured themselves to cope with enormous feelings of loss and desperation following the break-up of a relationship. A few women reported injuring themselves because of their own serious illness.

Discussion

Many of the childhood experiences which women felt had led them to self-injure were similar to those reported by other researchers (e.g. Van der Volk et al, 1991). However, sexual abuse, though common, was less prevalent than many authors report. Other important factors which have not emerged so clearly in other studies included emotional abuse and severe problems in communication in the family.

The information women gave about adult experiences which they felt underlay their self-injury was of particular interest, since most studies have tended to focus on childhood factors. Rape was the most commonly cited experience, which supports Greenspan and Samuel's (1989) findings. Other important factors which have seen little attention elsewhere included abuse and lack of support in adult relationships as well as experiences involving loss and powerlessness.

This survey's findings about the experiences women felt led to their self-injury are valuable in that they suggest that those seeking to help would do well to set aside any preconceptions they may have in favour of exploring what women themselves feel to be most significant in their lives. Most women had a very clear understanding of the links between their experiences and their self-injury. Professionals may usefully tap such understanding, taking particular care to attend to aspects of a woman's recent and possibly current experiences as an adult, as well as to her interpretations of her experiences in childhood.

"Cutting out the pain": Feelings precipitating self-injury

It was clear from the survey that self-injury was carried out in response to extremely strong and distressing feelings. Many women said that the feelings which seemed to lead them to self-injure varied from time to time, or that they might feel a whole range of powerful emotions in the period immediately before hurting themselves.

"If I am feeling overwhelmed by life I start getting depressed and feel I am losing control. I then become extremely anxious and, when this state becomes unbearable, I am likely to cut myself." *(Woman D)*

Table 8

Feelings precipitating self-injury	% of sample
Overwhelming emotional pain	57
Self-hatred	51
Anger	50
Anxiety	34
Neediness	30
Unreality	9

Women taking part named their feelings in their own way, but there was considerable consistency in responses, so that the feelings involved could be grouped as shown.

Over half of those taking part reported overwhelming feelings of emotional 'pain', misery, sadness, grief, desperation, depression or hopelessness as at times leading them to self-injure.

"I became trapped in a world of my own, suffering the hurts and pains in silence. Cutting was my only release from the unbearable chaos inside me." (Woman B)

Almost as many women said that they had sometimes injured themselves in order to deal with feelings of self-hatred, guilt, shame, 'dirtiness' or 'badness'. Sometimes these feelings stemmed clearly from particular experiences, such as where a woman felt as though she or parts of her body had been 'implicated' in abuse; for others the feelings were more generalised.

"Sometimes at night I would walk for hours in the rain wondering why I'd been born so bad, useless and ugly. The only way I found of coping was to self-harm."
(Woman B)

Half of the women taking part said that anger, frustration or a sense of powerlessness were involved in their impulses to hurt themselves. Often these feelings arose in response to being badly treated, ignored or controlled by others, and being unable to protest verbally or to take action to change their situation.

"I was in a manipulative relationship and my partner just would not listen or talk about things. I would get so frustrated and cut myself in a blind rage." (Woman E)

Many women said that their self-injury was sometimes sparked off by feelings of great anxiety, panic, fear or tension.

"The times when I would want to cut myself I would be feeling panicky, small and unreal. I'd feel myself falling faster and faster into this scary place from the past."
(Woman A)

Some women said that they had injured themselves when feeling very needy, unsupported or unheard by others. Sometimes these feelings were a painful legacy from childhood, at other times they arose because of isolation in adult life. Many women also felt unable to provide sympathy and care for themselves.

"When I was a child it was partly a response to having my needs rejected and ignored. Now I only cut myself after I have tried talking to someone else about how I am feeling. I cut myself if no-one seems to care." *(Woman D)*

A small group of women said that they sometimes hurt themselves in response to feelings of unreality, numbness or 'deadness'.

"I used to feel like the world was going on around me but I was not part of it. I interacted with it like a robot. The real me was locked up inside but I couldn't reach it. I was sealed off and I would get really desperate to break out. " *(Woman A)*

"Cutting keeps me alive": Functions served by self-injury

Many women responding to the survey seemed to have a very clear understanding of the ways in which self-injury had functioned for them. Time and again women told us how important self-injury had been as a way to cope, to feel better, to bear what might otherwise be unbearable.

"It's a solution that means I'm not going to flip out completely and kill myself. It's something I do for myself, it's mine, a way of feeling. I am in control of what I am doing." *(Woman E)*

Table 9

Functions served by self-injury	% of sample
Relief of feelings	57
Self-punishment	37
Control	33
Communication	15
Comfort	13
Feel real or alive	6

As with the feelings precipitating self-injury, there were many similarities in women's comments about the functions which they felt self-injury served for them. For most self-injury had a number of overlapping purposes and meanings, from which six main themes emerged.

By far the most commonly mentioned purpose of self-injury was the relief of feelings. For many women self-injury felt like the only way of expressing or releasing the unbearable distress they experienced. Some said a wound on the outside of the body helped them to translate unbearable inner pain into something they could see and deal with. Others said that hurting their bodies helped numb or distract them from their feelings.

"I'd go for a while then it would build up again and eventually I would explode like a volcano, smashing everything in sight. Only when the blood poured out of me was I able to let go and cry, like the bad was coming out of me." *(Woman B)*

Another common function which self-injury fulfilled was to alleviate feelings of self-hatred, guilt or dirtiness. Often women said that self-injury was a means of self-punishment or atonement. For some it gave a sense of washing or cutting out what felt like bad or contaminated parts of themselves - often expressed as 'bleeding out the badness'. Unfortunately, the relief this provided was only short-lived and so the punishment had to be repeated again and again.

"Sometimes I would get a sick feeling in my stomach as if I had done something awful. I knew I hadn't but the feeling of being bad would not go until I cut it out of me. That helped me feel better for a while." *(Woman A)*

For some women self-injury provided an important sense of control. Where a woman felt powerless, hurting herself helped her feel that she could exercise some control, even if only over the injuries, pain, bleeding and scarring of her own body. Some women also felt that by injuring themselves they controlled their feelings of anger and the possibility of their hurting someone else. A few women injured themselves to make their bodies unattractive in the hope this would deter an abuser, while some reported hurting themselves as children to try to elicit mercy from an adult who would otherwise punish them.

"The world felt a very unsafe place. I never knew when or why I would be beaten. It was as if there were rules that no-one had told me about. Everything felt chaotic and out of control. It was so frightening for me as a child and the only way I knew how to regain some feeling of control was to cut myself." *(Woman A)*

Communication was identified as an important function for a relatively small number of women. As children and perhaps as adults they had attempted through their injuries to alert others to their difficulties or feelings.

"My mother had cancer but it was never talked about. My father was an 'ostrich' - he wouldn't deal with things. I couldn't talk about how my mum's illness affected me to anyone. I think when I self-harmed I was trying to say 'look, I hurt too'."
(Woman E)

For a number of women self-injury felt calming or comforting. It could provide a rare opportunity for nurture; perhaps the only time when they felt deserving of care. In most cases women would tend and comfort themselves, often telling no-one else about their injuries. Some women would seek help from others.

"When I was a child cutting was safe, reassuring, consistent, something that would be there for me whatever happened. Now once I have cut myself I go into 'nurse mode' and can enjoy taking care of my wounds." *(Woman C)*

Contrary to the findings of some authors, only a few women reported that self-injury functioned as a way for them to regain a feeling of being real or alive when they were feeling numb, 'dead' or unreal.

Discussion

What emerged most strongly from this survey was the depth of women's own understanding of their self-injury. They could describe vividly the powerful feelings which drove them to hurt themselves. Many authors (e.g. Favazza, 1989) have reported that people self-injure in response to tension, self-hatred and anger and these feelings were also reported here. However, the most common experience cited involved overwhelming pain and grief, feelings which seem less often to be acknowledged by theorists or by clinicians.

A further very important finding was the clarity which many women had about their motives for hurting themselves - the functions which self-injury served for them. Whilst theorists have attributed a range of motives to self-injury, professionals who encounter women in services often feel baffled by their persistent self-injury. Again, it seems that the most important thing to do here is to ask the women themselves, and to be prepared to receive answers of great variety, depth and subtlety. Most of the women taking part in this survey were very clear that their self-injury was a way of coping; it was not a problem of itself but a means of expressing and dealing with other problems. It was not a suicide attempt; on the contrary it was often a means of carrying on with life. One important implication of this is that professionals need to be aware of the possible harmful effects of prematurely stopping a person's self-injury, before they have developed other coping strategies.

The specific functions which women themselves felt their self-injury served bore some similarities but also many differences to those attributed by others. It was clear that most women injured themselves in order to make their own inner experience more bearable, rather than for 'secondary gain', to 'manipulate others' or 'for attention', the motives which tend often to be assumed by others. In fact only 15% of women said that they ever injured themselves in order to communicate with others, while of the 13% who sometimes self-injured in order to deserve nurture, many tended themselves rather than seeking help from others. Again this finding suggests that those wishing to help would proceed best by exploring individuals' own understanding of what their self-injury achieves for them.

"No bastard has helped me":

Women's experience of services

Women taking part in the survey were asked whether they had come into contact with any health or social welfare services in respect of their self-injury or related issues, and to comment on how helpful these services had been. They were also asked what services they would like to be provided for women who self-injure.

The service providers most commonly encountered were psychiatrists and psychiatric hospitals, GP's, Accident and Emergency departments and counsellors or therapists. Some women had also seen social workers or clinical psychologists. A wide variety of other agencies had also been contacted, often small, local, voluntary groups and helpline services, as well as private counsellors/therapists and 'alternative' practitioners.

The table below shows numbers of women coming into contact with the main identifiable services and whether they were generally satisfied, dissatisfied or partially satisfied by the service they had received.

Table 10

Service used	Total nos. Attending	% Satisfied	% Dissatisfied	% Partially satisfied
Psychiatrist	34	15	82	3
*Counsellor/therapist	30	63	30	7
GP	24	37	46	17
Psychiatric hospital	23	4	96	0
A & E	16	6	69	25
Social worker	10	20	70	10
Psychologist	9	22	77	0

*Counsellors/therapists came from a variety of disciplines and it was not always possible to identify these; for example some Community Psychiatric Nurses and psychologists are probably represented in the figures and comments given. Counsellors working privately or within voluntary projects are also represented.

It can be seen from the table that there was a high degree of dissatisfaction with many services, with the exception of counselling/psychotherapy services. Women gave details of responses felt to be unhelpful, as well as of some more helpful experiences, and a number of themes emerged which were common to many of the services.

"Told off and blamed": Unhelpful responses

Condemnatory, dismissive and punitive attitudes

By far the most commonly reported issue for women in their contacts with services was the attitudes of staff. Over and over again women told us of being criticised, ignored, told off, dismissed as 'attention-seeking', 'a nuisance' or 'wasting time'. Many were derided as being 'childish'; one 15 year old was told to 'grow up'. Some felt they were punished for being 'a self-harmer', sometimes being made to wait far longer than other patients for treatment, refused treatment altogether or treated cruelly, for example being sutured without local anaesthetic. These attitudes were encountered in at least some individual staff in all types of service, and caused women terrible distress, sometimes deterring them from seeking help, at other times reinforcing the self-hatred and desperation which contributed to their need to self-injure.

"*I saw a psychiatrist. I waited months for the appointment and then he was so cold, clinical, impersonal, firing intrusive questions which left me reeling from the pain of disclosure and lack of support. The next psychiatrist I saw was much better but I didn't dare tell her about my self-harm. After six months I did and she was so shocked, ignorant, punitive, saying 'if you don't stop cutting we can't do any work'."*
(Woman C)

Ignorance and misunderstanding

Many women felt that professionals with whom they came into contact had very little knowledge about self-injury, and even less understanding, often resorting to very crude models of causation (typically, that the injury was either a failed suicide attempt, manipulation or 'attention-seeking') and treatment.

"I used to see a clinical psychologist but she was very unsympathetic. She thought cutting myself was an attempt to manipulate her and that it was disgusting. She used to make me show her my arms to prove I hadn't hurt myself, which is when I started cutting my legs." *(Woman D)*

Failure to listen or to address underlying issues

Many women said that there had been few or no opportunities offered to them to talk to staff about their feelings or problems, and still less about their self-injury. Appointments were often brief and far apart and many professionals seemed uninterested in finding out and addressing what had driven a woman to hurt herself.

"I went to casualty in desperation, after cutting, needing to talk. I was given nothing, they just said 'there's no duty psychiatrist at weekends, go and see your GP on Monday.' I felt very let down." *(Woman E)*

Inappropriate or inadequate treatment

Many women felt that the treatment they had been offered for their emotional difficulties, including their self-injury, was minimal, inappropriate and unhelpful. Some said their experiences of treatment had made them feel worse, more 'mad' or had taken away their sense of being able to be responsible for themselves.

Often women were offered no help other than a hurried prescription for drugs. Many felt that drugs prescribed (and in some cases, Electro-Convulsive Therapy) did not help or made them feel 'deadened' and less able to cope.

Counselling and psychotherapy were very seldom offered. Some women were told that it would be 'dangerous' for them to attempt to uncover the feelings and experiences which underlay their self-injury. Whilst counselling was generally felt to be helpful, what was offered was sometimes experienced as far too brief, infrequent or superficial. Some counsellors were felt to have encouraged the client to open up painful material and then failed to provide enough time or support.

"I saw a psychiatrist who just said 'you're too angry to treat, psychiatry can't help you." *(Woman E)*

Often women had real practical problems in their lives as children or adults which those helping them had failed to address adequately. For children this included bullying and abuse. For adults issues such as poor, unsafe accommodation, isolation and being overburdened with responsibilities worsened their distress. Any therapies that were offered were undermined if these problems were not tackled. Another important issue was lack of any support which could be accessed at times of crisis.

Many women reported being subjected to distressing 'behavioural' attempts to control their self-injury, such as ignoring it or threatening to discharge them. Several reported having been excluded from services they wished to use because of their self-injury. Some women had gained access to such facilities but dared not talk about their self-injury.

"I wanted to go to the day hospital but they said they wouldn't take me until I'd sorted out my eating and my cutting. I thought if 'I could do that then I wouldn't need to come here'." *(Woman C)*

Being subject to excessive or abusive power or control

Several woman felt they had been subjected to unwarranted abuses of power, for example by being compulsorily admitted or kept in hospital (or threatened with this). A number had been placed on continuous observation to prevent them injuring themselves. This was felt to be oppressive and intrusive, especially where staff observing women did not talk or carry out any activities with them. Several women expressed the feeling that "they don't care as long as you don't cut on their shift".

Women who had been in prison reported parallel experiences of being put 'in strips'. Infantilising regimes, locked wards and lack of privacy led to feelings of powerlessness and fear. Many women reported verbal abuse; a few sexual harassment and abuse by staff.

"I was in hospital because I had a breakdown after years of my father sexually abusing me. I took another overdose because I thought they were going to discharge me and send me home. While I was still recovering from that a male nurse who came to check on me in the night forced himself on me. It was the same old thing, all over again." *(Woman A)*

"Being heard and supported": Helpful responses

Sympathetic and supportive responses

Despite often encountering negative attitudes in services, many respondents told us that individual professionals had been sympathetic and supportive, with instances of staff taking time to talk with a woman about the feelings which drove her to hurt herself. This kind of response was felt to help women's efforts to avoid or reduce self-injury.

"My GP is very good. She listens and is respectful. She didn't know much about self-harm but was willing to spend time." *(Woman E)*

Effective and appropriate treatment and support

The 'treatment' women most commonly reported to be helpful was talking; to be able to talk to someone supportive about their feelings and situation. Even one-off or short-term experiences of being truly listened to (for example by A&E staff, a GP or helpline) were felt to have been valuable, although regular and ongoing contact was needed to enable a woman to tackle her self-injury long-term.

Several women said counselling had finally enabled them to turn their lives around after many years of distress and self-injury, and, in some cases, repeated hospital admissions. For some women counselling and therapy had been provided by statutory services, but many had found this help privately or through voluntary agencies, such as those working with survivors of sexual abuse, young people or those with addiction problems.

"My therapist didn't know much about self-harm but said she'd find out. She sees it as a symptom, not the problem. She doesn't ask about it or make a fuss but we do talk about it and what makes me do it. In the last year I've been hurting myself a lot less and I can see a time coming soon when I won't need to do it any more."
(Woman E)

Some women had found it helpful to work with a therapist on developing alternatives to self-injury. Typically this had involved a variety of methods, such as finding other ways to express emotions; retracing the steps leading to self-injury in order to identify routes out of these, and anxiety management techniques. A few women mentioned having found drugs helpful in the short-term in lifting their mood or reducing tension. However, these approaches to self-injury were only felt to be adequate when coupled with opportunities to tackle the experiences and feelings which underlay self-injury.

Therapy and self-help groups offered the opportunity of support and caring from others who had been through similar experiences and feelings. This was felt to be of enormous value in breaking down isolation and raising self-esteem, both of which were important in providing a way out of self-injury.

"The group I go to is great because it's the one place where I can be honest about my cutting. For the first time I saw that others do it too, it's a way of coping. I'm accepted, I don't have to pretend. We can even laugh about self-harm. I've made supportive friends I see between meetings. It's made me less isolated ." (Woman C)

Creative arts therapies, though rarely available, were also seen as extremely helpful, especially by women who found it difficult to verbalise feelings.

Several women referred to practical help which had helped them to tackle the causes of their self-injury. For example, some had received help in finding good, safe accommodation or a decent job. Others were offered support which enabled them to get away from abusive partners or family members. Unfortunately this sort of attention to the real circumstances of women's lives was rare.

Where available, crisis support was felt to be very valuable. Helplines were useful, but many women said that they also needed face-to-face support. A few had support from professionals who they could telephone at times of crisis. Women in support groups often felt that their most valuable source of help was other group members.

Discussion

What emerged clearly from the survey was that the most important factor in determining whether a woman's experience of services was helpful was the attitude and approach of the professionals involved. Most of women's distress and dissatisfaction with services was caused by the negative or dismissive attitudes of staff, whether this was expressed in terms of condemnation, disinterest or failure to provide any real help. Where women felt positive and satisfied with services, this was usually due to the caring and support offered by individuals. Whilst some of the problems in services may be caused by lack of resources, individual professionals in existing services can make a huge difference to the value of the response offered to those who self-injure simply by being accepting and supportive, listening and taking seriously the person's experience and needs.

"A good safety net": What else had helped

Many women gave valuable information about people, circumstances and other factors in their lives which had helped them to reduce or stop self-injury.

Changes in life circumstances

Sometimes the most important factor in enabling a woman to leave self-injury behind was a change in her life circumstances. Important changes included getting away from abusive or hurtful people and ending bad relationships. Other women had found it helpful to move into decent or supportive accommodation. For some a job or college course which fed their self-esteem had been important.

Support

Many women said that one of the most helpful things had been the support of friends and partners; having people who cared, accepted and valued them.

"Sometimes if I'm feeling really 'out of it' I ring a friend. It just helps to hear their voice and know they're on my side, even if I find it hard to talk." (Woman C)

Self-expression and other strategies for avoiding self-injury

Women saw it as particularly important to have outlets (in addition to talking) for expressing feelings and ideas. For some this involved writing (journals, poetry, etc.), painting and drawing, clay and sculpture. Others preferred physical means of expressing themselves, such as shouting, screaming, crying, hitting something, breaking china.

"Over the last four months I have thought about cutting myself but haven't actually done so. I feel this is related to learning to express my emotions. I have cried constantly for the past four months. I used to think crying meant I was weak and I would be too frightened of permanently losing control." (Woman D)

Some women reported strategies which they had found successful in helping them to avoid injuring themselves. These included putting off hurting oneself until the next day (by which time the urge had often gone); driving, cycling or walking (activities which use up energy and make it hard to injure oneself); self-expression.

"The main thing is to calm myself down and avoid cutting until I can think things through. I try to do this by going for a walk, writing my journal, painting or reading. I'm getting better at knowing when I'm likely to do it, putting it off and working out why." (Woman C)

A number of women mentioned the value of relaxation in helping them to avoid self-injury. This was achieved in different ways including relaxation techniques, moderate use of alcohol, aromatherapy oils, baths, flower remedies, exercise, movement and dance, yoga, massage, reading, and contact with nature.

Self-esteem and personal development

Whilst short-term strategies for avoiding self-injury were valuable, a number of women referred to the importance in the long-term of increased self-esteem, belief in oneself and assertiveness. Interestingly, of those women responding who no longer injured themselves, most said that their own desire and determination for 'something better' had been a major factor. Working towards personal change in this way can be a painstaking process and women mentioned important sources of support and inspiration such as friends, books, groups, courses and counsellors, spirituality and major life crises which had led them to review their lives.

"I got so sick of going in and out of hospital, cutting myself, drinking, being a 'mental patient'. I thought, 'I don't want my life to be like this'. So I just decided to get myself together. I had no support really, and it was very hard, but I wasn't going to give in. I wasn't really okay underneath - I squashed everything down and it came out through things like starving myself and bingeing. Later on I got the help I really needed. But it was me that decided I was going to change things." *(Woman A)*

For some women, receiving the nurture, comfort and caring they did not receive as a child or adult, or learning to provide this for themselves had been very important in helping them to overcome self-injury.

"I'm gradually learning to look after myself better. To do what I need to for me, rather than rushing around doing too much and getting myself in a state."

(Woman C)

Discussion

These findings showed that women were not solely reliant on professionals to help them overcome the problems which gave rise to their self-injury. Many also built up personal resources and drew on these and the support of others around them to make changes in their lives. This is of interest and value to those seeking to help women still struggling with self-injury. It may be important for professionals to facilitate a woman in making changes in her circumstances, in building up her social- and self-support, in finding the things which will be of most value to her as an individual in overcoming her difficulties. Tackling self-injury and what lies behind it may be something a woman does in her own way, in partnership with different sorts of helpers, rather than something which is done **to** her by means of 'treatment' prescribed by others.

It was clear from the survey that women were highly dissatisfied with much of their experience of services. The major reasons given for this dissatisfaction were:

- the negative attitudes and misunderstanding displayed by many staff
- professionals' failure to recognise and address women's distress and its causes
- inadequate, inappropriate and oppressive nature of services
- failure to provide adequate support, particularly at times of crisis.

The most helpful services were those offering:

- acceptance, respect, caring and listening
- time and willingness to explore the issues underlying a woman's self-injury
- help to find alternative ways of coping with distress
- support from professionals and/or peers, particularly at times of crisis.

Women's comments on factors other than services which had been helpful to them also pointed to a number of issues which service providers might fruitfully take up, such as the value of recognising and encouraging women to develop their own resources, facilitating changes in life circumstances, self-expression, the development of social support, self-esteem, and so on.

These findings have many important implications for service providers and purchasers who wish to provide a more effective service for women who self-injure. They give clear messages about some of the changes and developments which need to be made in services and in the attitudes of staff working within them.

The inadequacies of many existing services may have a number of causes. Whilst resources are clearly implicated, the most important problem reported was the negative approaches taken by many professionals. This finding supports other authors' observations about the difficulties professionals experience when faced with clients who self-injure. Changing such attitudes would cost nothing, but would lead to a profound improvement in women's experience of services. Other professionals were seen as sympathetic but ignorant. There are important implications here for the training and support of those working with women who self-injure.

The limitations of help offered by services seemed as often to have been determined by policy as by shortage of resources. In some cases decisions seemed to have been made to treat self-injury in a particular way, for example by excluding women who persistently self-injure. This may be because such women are seen as 'difficult', or not in real need of help. Whatever the reason, it is apparent that many people suffering severe and continuing distress are being denied the help they deserve. Other services, or individual professionals, do provide the effective support and help which many women feel they need to at last find their way out of years of pain and self-injury.

RECOMMENDATIONS

"Education and understanding": Women's own recommendations

Information

One of the main themes emerging from women's comments was the need for education and information for the public and professionals. Women felt this would combat the ignorance and stigma associated with self-injury. Self-help literature was also needed. Some suggested that there should be national policy guidelines for responding to patients who self-injure, particularly for A&E departments.

"Information on how common self-injury is would be helpful. I used to feel abnormal and weird as I thought I was the only person to do this. Information could have helped reduce the shame and isolation this caused me." (Woman D)

Improved professional attitudes

From professionals women said that they needed sensitive and respectful treatment, understanding, acceptance, caring and listening.

"I would like to see a more accepting, non-judgmental response and a willingness to ask about past experiences such as sexual abuse." (Woman D)

Counselling and therapy

Specific service needs included free counselling or therapy (including creative arts therapies) which would address the causes of women's distress.

"I was lucky that when I went to College there was a counselling service and I finally got the help I needed. That was after several years in the psychiatric system, during which no-one ever tried to help me get to the reasons I was in such a state. There should be places where you can just walk in and get some real help without having to be seen as 'ill'. (Woman A)

Support groups

A lot of women said that they would like to go to some sort of support group. Some wanted a group specifically for women who self-injure, others a place to share experiences such as sexual abuse. Often this need was associated with desperation to find others who would accept, understand and give support.

Crisis support

Many women said that in addition to long-term help, they sometimes needed someone to call or somewhere safe to go at times of emotional crisis. Many felt they would prefer crisis support services not to be located in psychiatric settings.

"It's all very well seeing a therapist once a week, but what do you do in between if things get bad? There ought to be some sort of non-psychiatric support services - non-labelling, non-stigmatising, where you can go when you're feeling bad and talk to someone instead of cutting." *(Woman E)*

Practical help

Several women pointed out the need for professionals to recognise and offer help with practical problems or oppressive circumstances in their adult lives. Others said that they would have benefited from the provision of more help as a young person - services which would pick up and address the problems of children and teenagers before they became entrenched in patterns of self-harm.

"I was being sexually and physically abused at home and bullied at school and I feel that it is significant that I started cutting myself when the abuse stopped. I was 12 the first time - I took a knife to school. Secretly, I wanted someone to notice and know what it meant." *(Woman D)*

Other recommendations arising from the research

If agencies and individual professionals which come into contact with women who self-injure are to meet their needs more effectively the following are necessary:

- approaches to self-injury should be reviewed in the light of this and similar research, drawing on the views of women who self-injure as their starting point
- users should be fully and genuinely involved in the planning and provision of services
- local and national guidelines should be introduced for good practice in all the various services coming into contact with those who self-injure
- funding should be provided or diverted to allow services to be developed in line with users' wishes, for example the provision of long-term counselling, groups and community-based crisis support services
- staff should be provided with appropriate training, supervision and support to enable them to work sensitively and effectively with this difficult issue.

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Women and Self-Injury Survey
ISBN 0 9531346 5 7