

Understanding self-harm

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▪ Introduction

Non-accidental self-harm without suicidal intent by cutting, scratching or burning the skin and other tissue, by taking overdoses of prescription and over-the-counter medications, by bruising, by ingesting harmful substances or objects and by other methods is finally being discussed in the media and researched by academics. Little by little, its meanings and functions are uncovered in writings by survivors and reports based on clinical experience and academic studies. SANE wanted to add to this research effort and in 2005 we launched a web based questionnaire charting the journey from first acts of self-harm through to the time when self-harm can be left behind, with a special focus on the social context in which self-harm takes place. This report is intended as a source of information and most importantly, a discussion point for people who self-harm, their families, treatment professionals who work with people who self-harm and research professionals and students who work on the subject.

The report is in two parts: the 'Short Report' is web-based and summarises and discusses the results. The 'Full Report' is only available as a PDF and it starts by giving full details of the results from the study and concludes with the 'Short Report'. You'll need Adobe Acrobat to view the full report – it can be downloaded for free from this address: http://www.adobe.com/uk/products/acrobat/readstep2_allversions.html.

Most of the questions we asked in this survey were open-ended, rather than e.g. tick boxes or menus to select pre-defined answer from. We chose this method of working to minimise the possibility of pre-judging the results we were going to get. Despite this, the best we can offer (the best anyone can offer) is an interpretation of what the survey participants have said. Consequently, if you disagree about something we have said, it may well be because our interpretation wasn't the most appropriate one. Or if you don't understand something, it may be because we haven't expressed ourselves clearly enough. That is why we ask you to tell us what you think; ask questions and request clarifications; throw in examples or counter-examples – in other words, help us improve our report. There are instructions on how to go about it at the end of the 'Short Report'. The 'Short Report' will be peppered with discussion questions throughout, to indicate where we think the most interesting areas for development of ideas and understanding are. But naturally, you can comment on anything you read. If you would be happy to have your name, net name or other nickname to be added to the 'Contributors' list, please let us know when you contact us.

▪ **About the participants**

Nine hundred and forty-six people filled in the questionnaire. Ten people were excluded from the analysis because their understanding of ‘self-harm’ did not fit the study criteria – they were talking about suicide attempts only. That is, they had only ever cut or overdosed with an intention to kill themselves and they understood the term ‘self-harm’ to be implying such an intention. (See ‘Introduction’ for a clarification of the definition of the concept ‘self-harm’ as it is used in this study). Of the remaining participants, 61% (n=568) had harmed within the six months prior to filling in the questionnaire. (In the remaining report they are sometimes referred to as ‘current harmers’ for shortness’ sake. We hope that nobody takes this the wrong way – we would not want to imply that people should be identified through their behaviour alone.) Another 28% (n=259) had self-harmed in the past, i.e. more than six months prior to completing the survey (henceforth, ‘past harmers’), and 12% (n=109) had never harmed themselves (‘non-harmers’). Table 1a below presents a summary of demographic information for each group of participants, and Table 1b a more detailed breakdown of participant ages at the time of filling in the questionnaire.

Table 1a.

	All who have harmed (N=827)	Currently harming* (N=568)	Have harmed in the past* (N=259)	Have never harmed (N=109)
Age (yrs)				
Range	12 to 59	12 to 59	13 to 53	13 to 56
Mean	25.65	24.97	27.15	28.95
Median	23	22	25	26
Std. Deviation	9.064	9.157	8.687	10.453
Gender				
Female	88% (n=726)	91% (n=517)	81% (n=209)	76% (n=83)
Male	12% (n=101)	9% (n=51)	19% (n=50)	24% (n=26)

*Participants were taken for their word in the construction of these categories. That is, those who stated that they had stopped harming were classed as “having harmed in the past”, even if their most recent episode was within the last six months. All those who considered themselves to be current harmers had harmed at least once during the previous six month period; consequently, those who made no statement about whether they were still harming were deemed to be no longer harming if they had not harmed in the past six months.

Age at the time of participation		Participant group			All participants
		Currently self-harming	Not currently self-harming, but with a history of self-harm	Has never self-harmed	
under 15 years	Count	32	5	4	41
	% of Group	5.6%	1.9%	3.7%	4.4%
15-19 years	Count	163	39	14	216
	% of Group	28.7%	15.1%	12.8%	23.1%
20-24 years	Count	137	82	27	246
	% of Group	24.1%	31.7%	24.8%	26.3%
25-29 years	Count	86	49	19	154
	% of Group	15.1%	18.9%	17.4%	16.5%
30-34 years	Count	59	33	10	102
	% of Group	10.4%	12.7%	9.2%	10.9%
35-39 years	Count	36	23	16	75
	% of Group	6.3%	8.9%	14.7%	8.0%
40-44 years	Count	29	13	8	50
	% of Group	5.1%	5.0%	7.3%	5.3%
45-49 years	Count	19	11	5	35
	% of Group	3.3%	4.2%	4.6%	3.7%
50-54 years	Count	5	4	5	14
	% of Group	.9%	1.5%	4.6%	1.5%
55-60 years	Count	2	0	1	3
	% of Group	.4%	.0%	.9%	.3%
Total	Count	568	259	109	936
	% of Group	100.0%	100.0%	100.0%	100.0%

Tables 2 and 3 show details of residence and ethnic background for all participants.

Table 2.		Table 3.	
Country		Ethnicity	
United Kingdom & Northern Ireland	91% (n=854)	White British (All)	81% (n=760)
United States & Canada	3% (n=44)	White Irish	2% (n=19)
Australia & New Zealand	2% (n=22)	White European	5% (n=42)
Europe Other	1% (n=6)	Other White	3% (n=26)
South & Central America	<1% (n=3)	Asian British	1% (n=6)
Africa	<1% (n=2)	Asian Indian	1% (n=13)
Far East	<1% (n=2)	Black British	1% (n=5)
South East Asia	<1% (n=2)	Black Other	1% (n=10)
Middle East	<1% (n=1)	Chinese	<1% (n=4)
		Mixed Ethnic Group	4% (n=39)
		Other Ethnic Group	1% (n=6)
		Don't know	1% (n=6)

Of those who had at some point in their lives self-harmed, 61% (n=501) reported having been diagnosed with a mental illness. Sixty per cent of those who were still harming (n=336) reported having a mental health diagnosis.

▪ Methods

The most common methods of harm were cutting/scratching (93.1%), burning (27.6%), overdosing (19.6%) and bruising the body (16.9%). The body part damaged most often was arms (83.2%), followed by thighs/legs (50.2%), stomach (19.1%) and wrists (13.7%). Majority of participants, when answering further questions about self-harm, appeared to be thinking mainly of cutting/scratching or burning. The functions and motives of overdosing seemed to differ slightly from those associated with cutting and burning.

Choice of method was most often determined by its easy availability (40.9%); sharp objects, burning cigarettes or other hot implements are present in every household and opportunities for bruising are present in nearly every environment. Overdosing on prescribed psychiatric medication is an easily available method for some but self-harm by consuming large amounts of non-prescription medicines sold at supermarkets is also a well documented fact.

Effectiveness of harm in fulfilling its intended psychological function was the second most common reason for choosing a particular method (15.4%). Some of the other determinants involved in the decision about method, such as its capacity to induce pain (7.1%) or bleeding (8.0%), may also be factors that contribute to making self-harm effective. The specific desired effects of self-harm will be discussed in the next section. Immediacy of relief brought by self-harm guided the selection of method for 6.3% of participants, suggesting that the situation in which self-harm takes place is often one of urgent need.

For a fifth of participants (20.5%) the choice of method was not felt to derive from a conscious decision process; 5.4% reported that the acts are fully spontaneous or impulsive and another 5.4% felt that they were guided by an instinct to harm in a specific way. One in ten simply reported being unaware of any reasons they had for choosing a particular method. Similarly, nearly a fifth (19.2%) had detected no decision process behind their choice of *body part* to harm, some because the act was spontaneous (2.6%) or instinctive (4.5%).

The ability to hide any wounds, burns, bruises or scars (e.g. through covering with clothes) or to easily explain the harm as accidental damage was an important consideration for ten per cent of participants when deciding on *method*. This was also the most frequently cited reason for choice of *body part* harmed (49.6%), surpassing ease of access, which was reported as an important criterion by 33.7%. Often participants cited a preference for arms but had changed site for fear of being discovered, e.g. "I prefer to cut my arms (not sure why), but I often cut my thighs or stomach instead because I don't want people to see."

▪ **Before and after an episode of self-harm**

As shown in Table 4, of emotions experienced prior to an episode that are listed below, sadness, self-hate and anger were the most common. The way in which emotions were experienced was also important, and the majority felt the emotions they were experiencing were overwhelming. Sense of reality was also commonly impacted.

Table 4.

Experience prior to episode	(N=827)
Sadness	74.4% (n = 615)
Experiencing emotions as overwhelming	62.4% (n = 516)
Self-hate	55.0% (n = 455)
Anger	48.9% (n = 404)
Feeling detached or unreal	42.0% (n = 347)
Anxiety (directed)	35.7% (n = 295)
Racing thoughts	33.3% (n = 275)
Disturbing memories (events)	31.7% (n = 262)
Anxiety (undirected)	31.0% (n = 256)
Disturbing memories (own actions)	24.4% (n = 202)

The ten most common descriptions of feelings after self-harm are presented below in Table 5. Almost as common as the feelings of relief and calm associated with the therapeutic effect of self-harm were the negative social emotions of guilt and shame, and the (perhaps also socially motivated) feelings of self-loathing.

Table 5.

Feelings after self-harm	(N=815)
Relief/release	46.5% (n = 379)
Guilt/shame/embarrassment	25% (n = 204)
Calm/peaceful	23.8% (n = 194)
Hate/anger/disgust directed at oneself	12.3% (n = 100)
Just 'better'	8.1% (n = 66)
Sense of control/confidence	7.7% (n = 63)
Relaxed	6.3% (n = 51)
Able to function/focus	6.1% (n = 50)
Happy/euphoric/good	5.5% (n = 45)
Sleepy/tired/exhausted	4.0% (n = 33)

Besides the abovementioned, participants also reported feeling more alert, alive, more real or human following self-harm. Many felt content. Participants also reported detachment, a sense of being in your own world. Perhaps related to this, some wrote about feeling safe after self-harming. On the flipside though, participants reported feeling sad/low and regretting their harm, and some were disgusted with what they had done. These feelings often followed the initial feelings of relief, release or calm.

▪ **Functions of self-harm**

What does self-harm do for the person who harms? Table 6 presents the most common descriptions of the role self-harm plays in the participants' lives (subcategories in italics).

Table 6.

Function of self-harm	(N=553)
Releases / regulates emotions	38.9% (n=215)
<i>Releases / brings relief from / gets rid of emotions</i>	<i>24.8% (n=137)</i>
<i>Regulates / manages / controls emotions</i>	<i>17.0% (n=94)</i>
Controls behaviour	28.4% (n=157)
<i>Prevents suicide</i>	<i>20.1% (n=111)</i>
Gives control	6.5% (n=36)
Manifests mental life in a physical form	6.3% (n=35)
Enables better functioning	5.4% (n=30)
Offers an escape / diverts attention from mental turmoil	5.1% (n=28)
Alerts others and/or results in getting help	4.3% (n=24)
Re-establishes connection with life and reality	3.8% (n=21)
Other	22.8% (n=126)
Self-harm has not helped	4.9% (n=27)

As shown, less than five per cent of participants thought that self-harm had had no positive impact on their lives. The most often mentioned benefit was that it helped to process emotions. Some of the people thought of this in terms of releasing pressure or letting emotions out in some sense (e.g. “helped release feelings”), others wrote using language where emphasis was on controlling emotion or managing it (e.g. “it helps me to be in control of my feelings”).

Second on the list is behaviour control, and one in five participants who answered this question wrote about self-harm being a way to prevent suicide. Participants felt that without self-harm, the way that they were feeling would have got too much and they would have “lost control” and made a serious suicide attempt. These findings will be discussed further in sections titled ‘Secret Self’, ‘Frequency of harming’ and ‘Summary & Discussion (‘Short Report’)', but here it’s worth noting that this, along with ‘controlling emotions’ offers one possible interpretation of what someone may mean when they self-harm for control. It seems though, that emotion control and behaviour control together still fall short of capturing the whole meaning of the concept of control in self-harm; there is a hard-to-define ‘sense of control’ that some have lost, and which can be temporarily found again through self-harm.

The fourth most frequently named function had to do with people experiencing their thoughts and emotions as elusive, intangible, hard to get hold of and think about. How does self-harm help in this respect? In several different ways, it turns out. First, a cut, a burn or a bruise can be a record of the distress suffered, a communication not necessarily



to others but to oneself, a sort of a diary. Second, a physical injury can validate the person's status as someone who hurts, especially in a cultural or a family environment where negative thoughts and feelings are typically brushed aside rather than taken up for serious discussion. Third, a physical injury provides an occasion for self-care, something that is far more difficult to deliver when the injury is a hurt feeling or self-esteem. In addition, for many, self-soothing when physically injured is thought to be more acceptable than simply trying to make yourself feel better emotionally.

Participants also found that self-harm helped them to function better, helping them to stay connected with reality and afloat in the ebb and flow of day-to-day life.

- **The evolving motives for and meanings of self-harm**

Making sense of self-harm

Acts of self-harm are frequently interpreted as attacks on self for reasons of punishment or self-hate, and the results presented above confirm that these feelings often precede acts of harm. However, self-harm, paradoxical as it may seem, can clearly also be about self-preservation. Sometimes, the motives falling in this category make for easily understandable explanations, which make immediate sense to those who harm and to others who they might seek to explain their behaviour to. Examples of this might be communicating or recording inner pain on the skin, or causing an injury that is easier to attend to and to treat than emotional hurt. The desire to express thoughts and feelings in physical formats is universally accepted (think for example of diary-keeping and art), as is the need to find ways to care for oneself when feeling bad. Consequently, these explanations of self-harm will resonate even with those who do not harm themselves. Other functions of self-harm, particularly those related to emotion regulation, are far less easy to make sense of. That self-harm releases anger or brings back the ability to feel again is often a surprise to the person who harms (see the section 'Onset of self-harm') and the experience is not easily explained or described to others. As one participant said: "I try to explain why I do it but I find it hard to put into words. I think if I could put it into words I wouldn't need to do it in the first place." Acts of self-harm are often intuitive responses to emotional distress, which become confusing when trying to explain the experience to others or otherwise attempting to justify it in words.

Changes in motives and meanings

Each act of self-harm can arise from a multiplicity of motivations and have many meanings. The 827 participants to the study gave hundreds of different combinations of motives for their first episode of self-harm, chosen from the options shown below in Table 8. No motivation appeared to exclude or imply another; it is likely that some of the expressions are used interchangeably and also that the same expression can have different meanings for different people. Some of the meanings are explored in more detail in this report, others will be discussed in future reports or in future incarnations of this report.

Motivations for self-harm did not differ just between participants; there was change within many individuals across time also. Three-quarters of participants (74.8%, n=619) had chosen slightly different motivations for their first and more recent episodes, suggesting that they had experienced *some* change in the reasons they harmed themselves, and 43.5% (n=360) stated explicitly that their motives for harming had evolved over time. The following subsections will trace the path from onset to discontinuation of self-harm.

Onset of self-harm

Reported age of onset for self-harm ranged from 4 to 58 years (Mean = 17.1, Std. D. = 7.63). Table 7. presents data on years passed since first episode of self-harm for those who were still harming during the time they filled in the survey.

Table 7.

Time since first episode of self-harm	N = 532
Year or less	17%, n = 88
Between 2 and 5 years	37%, n = 197
Between 6 and 10 years	20%, n = 107
Between 11 and 20 years	20%, n = 104
More than 20 years	7%, n = 36

Table 8. shows motivations and their prevalence in driving first acts of self-harm among our study participants. But how do people come to think of self-harm as the method to fulfil these motives? Interestingly, the power of self-harm to regulate emotion, the most prevalent motivation, was often discovered as a welcome side-effect of self-harm. This could come about in a number of ways:

1. Through accidental injury, e.g. “It was an accident. I dropped something on my hand and it was like a light coming on. I felt something at last. It felt really refreshing, like I had learnt something new and important.”
2. During a suicide attempt, e.g. “I was intending to commit suicide but found relief from just one cut”.
3. In the context of self-harm aimed at eliciting a response from others: e.g. “The first time I self-injured was a different situation to those which followed. I self-injured in order to avoid a (violent) punishment.”
4. When the primary motivation for harm was self-punishment or expression of self-loathing, e.g. “First I did it to punish myself for not doing well in exams, then I did it because I wanted everything to stop”.

We also observed the following contrast in participants’ stories about their first acts of self-harm:

1. When faced with intolerable distress, some had harmed *instinctively*, e.g. “I felt as though I was bursting through my skin. All of this agony was building up inside and if I didn’t let it out somehow it would kill me. I don’t remember actually doing it. I only remember looking down and seeing the blood and thinking ‘oh my God, what have I done?’”, or “The first time, it just somehow happened, but afterwards, I felt less numb than I had before”.
2. Some had experimented, based on what they had *learned* from others, e.g. “I had heard about other people doing this when they were depressed and wanted to see how it would make me feel” or had simply been *copying* the behaviour of others, e.g. “The first time I self-harmed was in a mental hospital so everyone else around me was doing it... so I kinda picked up the habit off them... I think I did it for attention”.



The figures in Table 8 should be interpreted bearing in mind that the FIRST time refers to one episode only and the RECENT reasons may refer to many episodes of self-harm. That said, it does look as if some motivations become more prevalent as self-harm continues over months or years while the relative importance of others wanes.

Table 8.

Motivation	<i>First instances of self-harm (N=827)</i>	<i>Recent instances of self-harm (N=769)</i>
Relieve mental pain	56.6% (n = 468)	62.7% (n = 482)
Self-hate	39.3% (n = 325)	42.5% (n = 327)
Punish myself	38.3% (n = 317)	44.9% (n = 345)
Feel in control	31.3% (n = 259)	39.1% (n = 301)
Show how feel inside	28.1% (n = 232)	28.2% (n = 217)
Feel something	27.1% (n = 224)	34.3% (n = 264)
Felt compelled to harm	26.1% (n = 216)	32.4% (n = 249)
Focus pain in one place	23.9% (n = 198)	26.9% (n = 207)
Unaware of reasons	20.2% (n = 167)	16.4% (n = 126)
Feel more normal/real	19.1% (n = 158)	24.7% (n = 190)
Make others notice/care	12.9% (n = 107)	8.6% (n = 66)
Avoid being violent to others	11.7% (n = 97)	13.9% (n = 107)
Belong to myself	6.8% (n = 56)	10.9% (n = 84)
Make body unattractive	6.4% (n = 53)	9.5% (n = 73)
Re-enact past experiences	2.8% (n = 23)	6.0% (n = 46)
Feel special	2.8% (n = 23)	2.5% (n = 19)

Self-harm in the long term

Although nearly half of participants stated explicitly that their motives for harming had evolved over time, the development didn't appear to be systematic between individuals. Despite the fact that e.g. 'derealisation', 'wanting to feel something' and 'feeling compelled' are named more frequently as motives for more recent episodes (see Table 8), further examinations of this trend yielded no significant results. For example, those who had been harming for longer (e.g. for 11+ years compared with less than a year)

were no more likely to report recent harming in order to combat derealisation or to feel something, or because they felt a compelled to do so. It seems, then, that none of these experiences are a candidate for a possible *effect* of self-harm, even prolonged self-harm. Rather, it seems that people who self-harm tend to have a number of distressing experiences, which, although they seem unrelated at first, are discovered at a later date to be connected by the fact that self-harm brings relief from all of them.

Surprisingly many reported not always knowing why they harm even during more recent episodes. In part this, as well as the increasing prevalence of feeling of compulsion to harm could be explained by the phenomenon of ‘harming without reason’ discussed in the next section.

Harming without reason: is self-harm an addiction?

Many participants had at some time, in some sense harmed ‘without reason’. Sometimes this meant engaging in pre-emptive harming, for example harming in response to a situation *before* the anticipated negative feelings could take hold. Some had experimented with new tools or methods, and some participants had harmed in order to prove to themselves they would still be able to do it if they needed to, to reassure themselves that it would still be effective. Most commonly, however, ‘harming without reason’ was a case of self-harm having become habitual, routine (n=54), e.g. “after a while it just feels like routine and a way to keep your mind in check”. Some participants went as far as conceptualising their self-harm as an addiction (n=15): “When I was self-harming numerous times a day, I think I became addicted to the feeling of harming more than anything else”. It was also common to simply feel an impulse to harm (n=42) without having clear reasons for wanting to do so, such as relieving distress, e.g. “sometimes it just comes out of the blue when I’ve been feeling calm”. This impulse was often described in terms such as “my body craves cutting” and “sometimes my body just wants me to harm it”. Although many participants’ accounts bore marks of possible addictive craving such as cue/belief dependence (craving induced by exposure to circumstances favourable to harm), this impulse to harm was often *not* related to habitual harming and could constitute the perceived trigger for someone’s very first episode of harm. In other words, while some wrote about an impulse to harm being triggered by an opportunity to harm (such as finding privacy), suggesting addictive craving, there were also descriptions such as “when it first started I just knew it was an overwhelming compulsion, like a physical need... it was scary but purely physical” where the impulse, although a “physical need”, was clearly deriving neither from underlying addiction nor from a cognised need to achieve something particular by the harm. Rather, sometimes there just seemed to be a need to harm, an instinctive desire to “deal with whatever is wrong with me. Something is just wrong”.

The researchers found an inherent difficulty in determining whether any particular participant could usefully be thought of as being addicted to self-harm. Three factors were identified as potential sources of complication in this respect:

1. It is very difficult to differentiate between addictive dependency and dependency on a coping method that is hard to do without.

2. Distinguishing emotional dissonance that arises from addictive craving from that arising from other psychological or physiological sources is problematic.
3. An addictive compulsion to harm (persistent thoughts of self-harm, or an impulse to harm) is qualitatively very similar to the sort of instinctive self-harm impulse described above.

That said, many of the elements that are commonly considered to be definitive of addiction are clearly present in self-harm¹: regular cravings or urges to harm, feelings of relief when one does so, tension and dysphoria when abstaining, wanting to cease harming but being unable to do so, struggle for self-control, cue dependence (being 'triggered' by sight of sharp objects etc.), belief dependence (i.e. urge to harm whenever opportunity arises), and 'crowding out' – the inability to think about anything else when feeling the urge to harm. Whether, and to what degree these experiences indicate addiction is an open question, but they are without a doubt a part of everyday life for many people who self-harm regularly.

¹ Elster, J. (1999) Strong feelings: emotion, addiction and human behaviour. London: MIT Press

▪ The Secret Self

As reported in the section 'Function of self-harm', participants were finding self-harm helpful in controlling their behaviour. Most commonly the behaviour that needed to be curbed was suicidal behaviour, but some participants thought that harming prevented them from acts of violence against others and generally made them able to behave in a way that was more acceptable (than e.g. arguing). Often this 'more acceptable behaviour' entailed limiting expression of emotion, hiding how one truly thinks and feels: "It keeps me happy in front of others. It has stopped my depression spilling out." This theme of inhibiting expressions of negative emotion within interpersonal relationships was repeated over and over again in participants' answers. One participant described her first episode of self-harm: "The first time I was incredibly angry but was not allowed to express any emotion or my own opinion so harming myself seemed like the only avenue for my extreme emotion – my anger/hurt/sadness was completely overwhelming and I couldn't make any sense of it or get rid of it."

Participants worried about "being found out" to be someone who hates herself, is angry, anxious or depressed. There was a sense of a 'secret self', which needed to be kept hidden at any cost, a feeling of discrepancy between outer self and inner self: "When others find me attractive or pretty or socially appealing I harm a lot more, because I know that they are wrong and I am right; I have a dark, rotten core." That this felt desire or a need to keep their inner life hidden is characteristic of those who self-harm in particular, is suggested by another finding. Participants were asked to what degree they agreed with the following statement: "Some of the feelings I experience and beliefs I hold would not be accepted by my family or friends". They were also asked how much of the time this statement applied to them: "I have to behave as if my feelings, beliefs and thoughts are different from what they actually are". Participants who had at some time self-harmed showed significantly more agreement with the first statement when compared to those who hadn't harmed². Whether the participants were current harmers also seemed to make a difference; those with a history of self-harm showed less agreement with the statement than those whose self-harm was ongoing³, but they were more in agreement with it than those who had never harmed⁴. Similarly, those who had at some point harmed felt less able to manifest their thoughts and feelings in behaviour than those who had never harmed⁵, and current harmers felt less able than those whose harming was now in the past⁶, although the latter group were still hiding their inner lives to a greater extent than those who had never harmed⁷. Both of these factors were also related to frequency of self-harm, so that frequent harmers tended to find their inner lives less acceptable to others⁸ and they tended to hide their true thoughts and feelings to a greater extent than

² (Mann-Whitney U test: $z = -7.028$; $p < .001$)

³ (Mann-Whitney U test: $z = -4.199$; $p < .001$)

⁴ (Mann-Whitney U test: $z = -4.521$; $p < .001$)

⁵ (Mann-Whitney U test: $z = -7.721$; $p < .001$)

⁶ (Mann-Whitney U test: $z = -6.379$; $p < .001$),

⁷ (Mann-Whitney U test: $z = -4.135$; $p < .001$)

⁸ (Mann-Whitney U test: $z = -2.199$; $p < .05$)

infrequent harmers⁹. For definitions of these groups and further discussion of frequency of harm please refer to the section 'Frequency of harm'.

⁹ (Mann-Whitney U test: $z = -3.447$; $p < .01$)

▪ **Frequency of harm**

Tables 9. and 10. show details of the participants' self-harming behaviour in the six months leading up to their filling in the survey.

Table 9.

N=827 (all who had at some point harmed)

Number of times harmed	Percentage/number of participants
Once	7.9% (n=65)
2-10 times	29.7% (n=246)
11-20	11.6% (n=96)
More than 20 times	29.0% (n=240)
Have not harmed in the last six months	21.8% (n=180)

Table 10.

N=568 (current self-harmers)

Frequency of harm	Percentage/number of participants
Daily	20.4% (n=116)
Weekly	29.6% (n=168)
Every couple of weeks	27.3% (n=155)
Every couple of months	19.4% (n=110)
I have only harmed once	1.8% (n=10)
No response	1.6% (n=9)

What factors might be associated with how frequently someone harms? To find this out, two groups of participants were compared to each other. The first group, named Frequent Harmers, were harming daily or weekly and the second, Infrequent Harmers, were harming every few weeks or months. Both groups had harmed in the six months leading to their participation and their self-harming was an established pattern rather than something that had only happened once.

The groups differed in their motive profiles. Frequent harmers were significantly more likely to harm out of self-hate¹⁰ or a desire to punish themselves¹¹. They were also more likely to harm in order to deliberately make their body unattractive¹².

Frequent harmers were also more likely to be looking for a sense of control through harming¹³. This association may be explained by another: Frequent harmers were more likely to elaborate the function of self-harm in their lives as a way to control a suicidal impulse¹⁴. Other aspects of gaining control appeared not to be related to harming

¹⁰ $X^2=13.690$; $p < .001$

¹¹ $X^2=4.611$; $p < .05$

¹² $X^2=7.784$; $p < .01$

¹³ $X^2=6.308$; $p < .05$

¹⁴ $X^2=6.294$; $p < .05$

frequently: Frequent harmers were no more likely to describe the function of self-harm as behavioural control (other than suicidal behaviour), nor were they more likely to identify achieving a sense control as a benefit of self-harm when the question was open-ended and they were able to give a more exact answer.

As could be expected, those who were Frequent harmers were more likely to feel compelled to harm. They were also more likely to harm 'without reason'; that is, they would harm in circumstances where they were not having the experiences that had originally motivated their harm¹⁵ (see section "Harming without reason..." above).

Those who harmed *less* frequently were more likely to cite 'wanting to feel something'¹⁶ or 'wanting to feel real'¹⁷ as a reason for their harm. Both groups were equally likely to experience overwhelming emotions before they harmed – there was no difference in this respect.

¹⁵ $\chi^2=14.072$; $p < .001$

¹⁶ $\chi^2=3.838$; $p < .05$

¹⁷ $\chi^2=8.910$; $p < .01$

▪ **Disclosing self-harm**

Information on whether and why participants hid their self-harming behaviour from significant others was collected separately for family and friends in order to reveal any notable differences in barriers to disclosing to the two groups. Overall, participants were more likely to hide their self-harm from their family (83.7%, n=692) than they were to hide it from their friends (66.4% n=549). This result may in part be explained by the youth of the sample: age appeared to make a difference to whether self-harm was disclosed to family or friends. Among those who were harming at the time of responding to the survey, those who disclosed to friends tended to be younger than those who didn't¹⁸, whereas those who disclosed self-harm to their family tended to be older than those who sought to hide it¹⁹.

Reasons for hiding self-harm

Of the reasons given for not disclosing self-harm to family by those who sought to hide it, by far the most common was to avoid the perceived emotional impact that disclosure would have, i.e. being a burden, hurting or frightening them or leading them to feel guilty or responsible in some way (38.2%, n=264). Feeling that the family wouldn't understand was the second most commonly given reason (26.3%, n=182). These were also the most frequently cited reasons for hiding their self-harming from friends, expected lack of understanding being the most common this time (21.9%, n=120), followed closely by a concern about a possible negative emotional impact (21.3%, n=117). In other words, fear of being misunderstood and concern about the impact of self-harm on others were the most significant barriers to disclosing self-harm, but the latter was much more of a factor in the context of family life than it was among friends.

Fear that disclosure will lead to rejection; will be perceived as attention seeking; will result in gossip or disclosure to others and wanting to protect self-harm as a personal, secret or private matter were all more frequently given as reasons for hiding self-harm from friends than they were for hiding it from family. By contrast, anticipation of receiving an angry or punishing response; of causing interpersonal friction; of causing others to feel ashamed of them were more common obstacles to participants' disclosure to family.

Other reasons for withholding disclosure to both friends and family included feeling too ashamed or embarrassed admit to self-harming, fear of being condemned or judged personally because of it, feeling that the behaviour itself will be condemned, not wanting to explain or answer questions about self-harm and fear of disappointing or failing expectations in some other way. In many cases the expectation that the participant was specifically worried about failing related to stopping self-harm; having once disclosed self-harm and publicly overcome it, participants were reluctant to tell family and friends that they had relapsed.

¹⁸ Mann-Whitney U test, significant at: $z = -2.333$; $p < .05$

¹⁹ Mann-Whitney U test, near significant at: $z = -1.932$; $p = .053$

Less common reasons for hiding self-harm were wanting to avoid any interference with the behaviour by others (such as enlisting professional help) or other attention/“fuss”; feeling that disclosure will result in a worsening of the self-harm; not feeling close enough to be able to tell family/friends and believing that the disclosure will not be taken seriously. Past experience of a negative reaction from others in response to a disclosure was also a relatively common reason given for later non-disclosure.

Anticipated and actual reactions to disclosure

A number of participants wrote about being surprised, often positively, about how their friends or family reacted when they found out about their self-harm, e.g. “Before I told anyone, I thought they would be disgusted by me, but actually they have been really kind.” We compared potential reactions from family and friends, anticipated by those who were keeping their self-harm hidden, to actual reactions experienced by those who had disclosed their behaviour. While participants who hid their self-harm most frequently expected their families to respond with anger (30.5%, n=211), upset (21.4%, n=148) or shock/horror/fear (15.9%, n=110) to a disclosure, and 9.1% (n=63) expected some kind of strong intervention aimed at stopping them from harming themselves, these reactions had been met relatively rarely by those who had disclosed their harm. Only 7.2% (n=12) had experienced an angry reaction and the same number had been met with shock/horror/fear. The families of only 5.4 % (n=9) were reported to have sought intervention in a way that was found intrusive. Although many families were upset in the face of their member’s self-harm, this response was less prevalent than might have been expected (15.1%, n=25).

The most prominent feature of how family members related to disclosures of self-harm was inability to understand (42.2%, n=70) rather than any negative emotional reaction such as anger or fear. Encouragingly, 29.5% (n=49) had found support within the family after disclosing, and a further 15.1% (n=25) recognised that although the family did not understand or know how to be supportive, they were at least trying. That in itself was found helpful. On the other hand, 18.1% (n=30) reported that despite having been told about self-harm their family were choosing to ignore it, e.g. “a couple of days afterwards it seemed like it was all forgotten about” or “they refuse to discuss it so it is not spoken about”. That such a reaction may have come as a surprise is suggested by the fact that only 8.7% (n=56) of those who were keeping their self-harm hidden expected to be ignored.

Participants who were hiding self-harm from their friends tended to expect a disclosure to be met with shock/horror/fear (23.9%, n=110), while those who had disclosed self-harm to their friends had experienced such a reaction relatively rarely (5.7%, n=16). Many feared rejection to be a consequence if they told their friends about their self-harm (12.8%, n=59) but those who had, had only seldom been rejected (2.5%, n=7).

To sum up: in some instances participants who had previously hidden their self-harm on disclosing it, had had their negative expectations disproved. In addition, some differences were noted between what those who have not disclosed their harm tend to expect of their friends and family, and the actual reactions reported by those who have told their friends

and family about their harming. This second finding could be explained in two ways: first possibility is that family members and peers tend to react differently than expected, when told about self-harm. The second is that the social environment of those who keep hiding their self-harm really is very different to that of those who have been able to come forth with it, and the negative expectations regarding family/friends' reactions, which no doubt make trouble for disclosing harm, are in fact accurate. In reality, both explanations are likely to be correct to some extent.

Friends were generally found to be supportive (47.7%, n=134), understanding (33.5%, n=94) and/or trying to be (14.6%, n=41) when being told about self-harm, much more so than families. In describing how their friends related to disclosures of self-harm participants introduced a new concept, one that did not appear in the context of the family; it was said that friends were able to *accept* their self-harm without necessarily understanding it, e.g. "They seem to accept that its what I have to do when things get really difficult" or "They don't judge me but recognise that its what I needed to do even if they never could". Another issue that featured strongly in participant characterisations of friends' ability to relate to self-harm was personal experience of self-harm; 22.8% (n=64) of those who had disclosed to their friends reported having friends who understood because they had themselves harmed.

Failing to disclose to supportive friends

Interestingly, one in five participants who were not disclosing self-harm to their friends thought that were they to do so, the friends would be supportive (20.6%, n=113). Below is a collection of quotes from participants to illustrate reasons for this:

1. *"They would support me but as most of my friends have mental health problems, I take their problems and it helps me cope, they don't need to know mine."*
2. *"They would support me thinking: 'yeah, I knew she was crazy all along'."*
3. *"I expect they would give me sympathy, which would make the feelings worse."*
4. *"They would probably be kind about it but I would feel judged and different around them. Self-harming is something so very personal."*
5. *"They'd be understanding, but I don't want them involved – this is private to me. They would want to talk about it which would be triggering for me."*
6. *"They'd react supportively, but they would find it hard to deal with and I would feel bad about that."*
7. *"They would be supportive but not know what to do."*
8. *"I think they would feel out of their depth and seek external help but they would be supportive."*

9. *"They would be supportive and try to make me stop."*
10. *"They'd be sympathetic for a short while."*
11. *"I would have to admit to a lot of lies about scars/burns/plasters etc... [my friends] would have a problem with the deceit that has gone with keeping my harming from them."*

The first three quotes gesture at the difficulty of admitting to having mental health problems; for those whose perceived role in the peer group is 'the strong one' (quote 1), or for those who resent the idea of being thought of as 'crazy' (quote 2). Quote 3 illustrates how sympathy can be difficult to receive in itself, perhaps because of its close proximity to pity, which can have a deleterious effect on self-image. Quote 4 raises two issues: the relative unimportance of how others react to you compared with how you evaluate yourself *as if* 'through the eyes of others', and the inherently private nature of self-harm. *Feeling* judged does not require *being* judged by those around you, and feeling different, isolated, apart from others can arise from within, irrespective of the behaviour of those around you. Quote 5 returns to the theme of privacy and introduces an element of individualism, the desire to get by without involving others. It also recognises how others knowing about self-harm may lead to unnecessary reminders about it, which can bring about further episodes. Quote 6 illustrates one possible motivation for individualism: guilt about the disclosure's detrimental effect on the lives of others. Other participants wrote about supportive attitude tinged with shock or concern being difficult to face, possibly for similar reasons. Quotes 7 and 8 refer to the feeling that peers would feel helpless when confronted with self-harm, and the latter quote connects this with another reason why self-harm might not be disclosed even to friends who are thought to be supportive: the possibility of broken confidentiality leading to strong-armed intervention. Quote 9 shows how support that is too focused on discontinuing self-harm can in itself be unwelcome. Quote 10 betrays the worry that friends' sympathy would be short-lived, that the stamina required for supporting someone with serious problems cannot be found within the peer group. Finally, quote 11 addresses the damage the secretive nature of self-harm can do to relationships through sense of betrayal experienced by those close enough to care, who may feel that they have been kept in the dark.

Veiled reasons, unseen motives

During the survey, participants wrote about their reasons for self-harm being inner phenomena such as overwhelming emotional pain, sadness, anger, self-hate, suicidal thoughts, not feeling real and/or feeling numb. Yet when they were asked what their family or friends might think their reasons were, only 10.0% of participants (n=69) expected their family to recognise emotional distress or other inner events as the reason for their harm and 15.1% (n=83) assumed their friends to do so. Instead of family or friends referring to inner experience of the participant, they were expected to assume self-harm to be either a manipulative act - attention seeking (22.0%, n=152 and 19.1%, n=105 respectively) or a way to impose on others in some other way (2.5%, n=17 and 0.2%, n=1) - or a symptom of mental illness (18.8%, n=130 and 25.3%, n=139). Other anticipated explanations of self-harm were character faults such as stupidity, weakness,



childishness, selfishness or weirdness, and external factors such as relationships, work, substance misuse and past events. Some expected self-harm to be thought of as a phase or a fad, and some believed that their reasons would be dismissed as an overreaction. Relatively few assumed that their family or friends would interpret their self-harm as a suicide attempt. Family, but not friends were expected to blame themselves for the participant's behaviour (6.6%, n=46).

▪ Stopping self-harm

Just over a quarter of participants with a history of self-harm (26.6%, n=220) stated that they had stopped harming. They were invited to say more about the experience and most chose to talk about the driving force behind their stopping. Most commonly it was social pressure (20.1%, n=44), often in the absence of a sense of personal desire to cease harming, e.g. "I still miss it, and would continue if the scars were not so hard to hide and long in fading". For many, the perceived pressure to stop was related to their understanding of their role as a parent, an employee, a wife or a husband. A related reason for success in stopping harm, also given frequently, was the perceived impact on loved ones (12.8%, n=28), e.g. "My parents found out and made me feel bad about it... I'm glad I don't do it anymore but only because I don't want to upset anyone."

For some, ability to stop was connected to development - of coping skills (16.9%, n=37) or self-knowledge in the form of insight into the reasons behind their self-harm (6.4%, n=14). Many wrote about a sense of becoming a more integrated person being relevant to discontinuing self-harm (11.4%, n=25), e.g. "when I started to become my own person it all changed and I just stopped". It was relatively common for people to talk about simply 'growing out of self-harming', mentioning increase in confidence, stability, self-knowledge and control over life as particularly relevant factors in the maturational process.

In some cases a simple change in circumstances lead to self-harm no longer being necessary, and stopping could be quite effortless (16.0%, n=35). Sometimes what helped was finding an alternative release in a physical form (5.9%, n=13), for example one participant was able to replace cutting her feet by massaging them and taking part in sport performed barefoot. Medication had helped 14 participants (6.4%) to stop harming while counselling had helped 26 (11.9%).

Strategies that were perceived as coercive were found to be of assistance by only three people, one of whom wrote: "I did stop for over a year. I have to have a stable mind to have some surgery. I was told that if I did self harm I wouldn't be able to have it! I now have to hide it from my doctor too!" The other two participants who had felt coerced out of harming talked about not self-harming in order to avoid being admitted to hospital under a section. Notably, and by contrast, six people reported that it was pivotal to the success of their attempt to discontinue harming that a choice to harm is retained as a possibility. Here one of the participants describes how permissiveness of a treatment provider helped her to stop harming: "After I'd been in hospital, I went to the college nurse and told her I had been self harming. She told me that there was nothing wrong with doing it and that I should continue if I wanted to, and booked me into a counsellor. By telling me that I could do it, it took the guilt out of the cycle and I slowly began to stop. I finally realised that what I was doing wasn't 'bad' or 'wrong', it was just my way of coping." That this "taking the guilt out of the cycle" may be an important element in successful treatment of those who self-harm is suggested by other findings of this study: following the usual feelings of relief/release (46.5%, n=379) and/or calm (23.8%, n=194) and the less often mentioned sense of control (7.7%, n=63), a large proportion (25% n=205) of participants felt guilt/shame/embarrassment and 12.3% (n=100) self-loathing after an episode of self-

harm. Given that these emotions were also precipitants of self-harm with 24.4% (n=202) experiencing disturbing memories of their own actions and 31.7% (n=262) of other events (potential occasions for guilt/shame/embarrassment) and 55.0% (n = 455) feeling self-hate prior to harming, it is easy to see how self-harm behaviour can feed itself in a vicious circular dynamic – but only insofar as it is interpreted as wrong or loathsome rather than simply a fact about what one does. On the other hand, for 6.4% (n=14) of participants who had stopped harming, the fact that they found self-harm shameful helped them to make the decision to stop.

There were also those who had stopped through beginning to think of self-harm as ineffective (particularly in the long term) or pointless (10.0%, n=22) or otherwise reappraising self-harm negatively (10.5%, n=23). The damaging nature of self-harm was the driving concern of those whose decision to stop harming was influenced by the recognition that it can be addictive (4.1%, n=9) as well as those who were concerned that they would end up causing permanent damage or accidentally killing themselves (3.2%, n=7).

▪ Summary & Discussion ('Short Report')

Nearly a thousand people, 827 of whom had first hand experience of self-harm, took part in SANE's self-harm study, which started in 2005. Over five hundred participants were still harming at the time of filling in the survey. The most commonly reported method was cutting/scratching (93%) or burning (28%) the skin and the most frequently targeted body parts were arms (83%) and thighs/legs (50%). A fifth had overdosed on medicines. It seemed to us that majority of participants, when answering further questions about self-harm, were thinking mainly of cutting/scratching or burning. The functions and motives of overdosing seemed to differ slightly from those associated with cutting and burning. **Have you got a view on this? Please write in and tell us.**

Despite being thought of as something that teenagers and young adults do, the results from our survey show that self-harm affects people of all ages. The age range of those who were still harming at the time they took part was 12-59 years of age, and while some people were reporting that they had first started self-harming as young as four, others had not harmed until they were in their late fifties. Although the majority were female, just over a hundred men who had at some time harmed themselves took part in the survey (this made up 12% of all participants who had harmed). It is still unclear whether self-harm really is that much more in common in girls/women than in boys/men, or whether the former are just more willing to talk about it and seek help.

What motivates self-harm – and what does self-harm do?

Our survey results showed that each individual act of harm can have a number of meanings and motivations, and these may evolve as years go by.

Self-loathing and need for punishment

Key findings:

- 55% of participants reported experiencing self-hate prior to harming
- 43% reported self-hate being a motive for self-harm
- 45% reported harming in order to punish themselves
- Those who harmed more frequently (daily or weekly, rather than every few weeks or months) were significantly more likely to be motivated by self-loathing or a need to punish themselves than those who harmed less frequently
- One in four participants reported feeling guilty, ashamed or embarrassed after an episode of self-harm

Self-loathing and a need to punish oneself were found to be significant factors in motivating self-harm right from the start; each was identified by well over a third of the

participants as a contributing motive for their first act of self-harm and the proportion of participants reporting these motivations increased to 43% and 45% respectively for more recent acts. We also found that those who harmed most frequently (daily or weekly, rather than every few weeks or months) tended to report these motives for their recent acts of self-harm more often. The reason for this? We think it has to do with the fact that many participants tended to have a very negative view of their self-harm (not a surprise, given how stigmatised the behaviour is). One in four reported feeling one of the negative social emotions of guilt, shame or embarrassment after acts of self-harm, and one in eight felt hateful towards, angry or disgusted with themselves afterwards. It is easy to see how this process can feed itself in a cycle of harm and self-recrimination, fuelled by stigmatisation and ill-informed prejudices of others. As counter-intuitive as it may seem, in many cases (and, as our findings suggest, especially for those who harm frequently) the best way to help someone to reduce their self-harm may be to help them to feel alright about it. **Write to us and tell us what you think!**

Feeling too little or too much

Key findings:

- When asked how self-harm had helped them, 39% of participants wrote that it helped them regulate or release emotion
- 62% experienced overwhelming emotions before harming and 63% had harmed to relieve mental pain.
- 34% had harmed in order to feel something
- 42% of participants felt detached or unreal before harming
- After harming, the positive effects felt most commonly were relief/release (47%) and sense of calm and peace (24%)
- Those who harmed *less* frequently were more likely to cite 'wanting to feel something' or 'wanting to feel real' as a reason for their harm.

One way of helping someone come to terms with their self-harm is to engage with their reasons and motivations for doing it. This is not always easy; many of our participants wrote about hiding their self-harm so that they wouldn't have to explain it to others, and the second most often cited reason for hiding self-harm was that family and friends would not understand. When it comes to the most frequently reported function of self-harm, emotion regulation, there seems to be an inherent difficulty in putting the experiences into words. This difficulty seemed to arise in two main kinds of experience. First, emotions are felt and recognised as, for example, sadness, anger, anxiety and so on – but the way in which emotions are felt is different: they are overwhelming, out of control, physically uncomfortable or confused. Alternatively, the person feels nothing, empty, dead, disconnected from the world and other people, and they feel as though they are struggling to maintain a coherent sense of self. These ways of feeling are very hard to find language for, and the person who harms is often left with a feeling that only those who share such experiences (i.e. others who self-harm) can understand why they do it.

There are many aspects of this function of self-harm that are a mystery: it isn't known, for a start, why it should be that self-harm is capable of releasing anger, lifting depression and alleviating anxiety in some people. There is even a sense in which the function of self-harm is paradoxical; it appears that whilst self-harm can help someone to feel *less*, it can at other times help them to feel *more*. **We are working on this question at the moment and hope to publish our findings soon.** The last finding presented in the box above is also curious: why should it be that those who harm less frequently are more likely to do it in order to feel something, or to feel more real? **Can you help us to explain this result? Please write to us.**

Secret self

Key findings:

- Feeling that your thoughts and feelings, if known by others, would be unacceptable to them was found to be associated with both current self-harm and a history of self-harm (and more strongly with the former)
- Feeling unable to let your thoughts and feelings manifest in your behaviour was found to be associated with both current self-harm and a history of self-harm (and more strongly with the former)
- Out of participants who were harming at the time of filling in the survey, those who thought their inner lives least acceptable and most in need of hiding tended to be those who harmed most frequently.

Recognising that there was something *different* about their emotive experience, participants often expressed that there was something *wrong* about how they were feeling. This sense of inner life (feelings, thoughts, beliefs) being something incongruent with what is acceptable, something to feel bad about and to hide from others, was present in many guises throughout the participants' responses. When participants talked about the function of self-harm in their lives, they often mentioned that it helped them to keep their real feelings under wraps, to stop their anger or sadness "spilling out". There was a 'secret self' that had become separated from the 'social self', and participants worried about "being found out" as someone who hates herself, is angry, anxious or depressed. This tendency to think of one's inner thoughts and feelings as unacceptable to others and as something to avoid showing in behaviour was found to be associated with a history of self-harm among the participants, and even more strongly, with current self-harm. Those who thought their inner lives least acceptable and most in need of hiding, also tended to be those who harmed most frequently. Given that the thoughts and feelings of the 'secret self' are not allowed to manifest in the physical, interpersonal world of expression and behaviour, it is little wonder that the fourth most frequently named function of self-harm was its ability to give mental distress a physical form, to make it tangible rather than the elusive experience it can be when it is refused its natural ground for playing itself out.

What makes emotions tangible? Is it possible that people who find themselves having to resort to self-harm experience emotions in a way that makes them somehow unusually intangible? Write to us to tell us what you think.

Control

Key statistics:

- One in three participants had at some point harmed in order to feel in control
- 17% used self-harm to control (rather than just release) emotions
- 28% used self-harm to control their behaviour

The concept of 'control' is often mentioned in the context of self-harm. Over a third of our participants reported having harmed in order to feel in control. One of its possible meanings has been discussed above: emotion control. Another, behaviour control, was mentioned in the context of suppressing expression of thoughts and emotions in behaviour. Another form of behaviour control was also very important to the participants: over a hundred participants wrote about using self-harm to prevent suicide. This subject is discussed in more detail below, under the heading: 'Common misperceptions'.

In addition to the abovementioned meanings for 'control', it seems that there is also something like a 'sense of control' that goes beyond emotion control and behaviour control, something that is part of our taken-for-granted experience, something nobody thinks about until it is suddenly gone. Self-harm can restore this feeling of being in control. Some participants connected this feeling with being able to function and focus, e.g. "It helps me regain a sense of control and so enables me to get on with everyday things again." **Can you describe this feeling of control, and what it feels like when you don't have it? Write to us!**

Common misperceptions regarding motivations behind acts of self-harm

Key findings:

- Most of self-harm is hidden from others and motivated by private therapeutic needs rather than performed to achieve social or manipulative ends.
- Although those who self-harm often *feel* suicidal when they harm, their intention is to seek relief from those feelings rather than to die. Self-harm is more an act of self-preservation, than it is an act of self-destruction.

Sometimes self-harm can be used to take control of a situation – for example, one participant wrote about using self-harm to avoid physical punishment. However, our

results suggest that these and other manipulative motivations for self-harm are rare. It has been a widespread misunderstanding about self-harm that its primary motivation is a manipulative one, e.g. attention-seeking. Several of the findings presented in this report indicate to the contrary: for one thing, the majority of those who self-harm apparently seek to hide it from their family (84%, n=692) and friends (66%, n=549). For another, the most important criterion for choosing a particular body part to harm was found to be ease of hiding the damage – this consideration often overrode a preference based on efficacy, for example. Further, only one in eight reported their first act of self-harm having been motivated by a desire to make others take notice or care, and this proportion fell to one in twelve for more recent acts.

Another common misperception about self-harm such as cutting or overdosing has been its identification with a failed suicide attempt. That self-harm is a risk factor for suicide is a well-documented fact to the point of being incontestable; Hawton *et al.* (2005) report that 25-50% of adolescents committing suicide have previously either engaged in self-harm or attempted suicide²⁰, and increased suicide risk has been shown in those who self-harm repeatedly²¹. There is no doubt, then, that self-harmers experience more suicidal thoughts and feelings than those who do not harm. But this does not mean that when someone self-harms they *intend* to commit suicide. On the contrary: for most of the time the majority of self-harmers do *not* want to die. Rather, they have persistent thoughts about death or suicide and the feelings associated with those thoughts, and they use self-harm to do away with them. Support for this claim comes from our study: over a hundred participants stated that self-harm helped them prevent suicide. Once it is more widely known and understood that self-harm is primarily an act of self-preservation rather than destruction, and that self-harm plays a role in emotion regulation, this mistake is likely to be made less frequently.

²⁰ Hawton, K; James, A; Viner, R (2005) Suicide and deliberate self-harm in young people. *British Medical Journal* 330(7): 891-894

²¹ Zahl, DL; Hawton, K (2004) Repetition of deliberate self-harm and subsequent suicide risk: Long-term follow-up study of 11,583 patients. *British Journal of Psychiatry* Vol. 185(1): 70-75

Self-harm from onset to termination

Key findings:

- Reported age of onset for self-harm ranged from 4 to 58 years. The mean age of onset was 17
- Of participants who were still harming at the time of taking part in the survey, 47% had been harming for longer than five years
- Some participants had learned the behaviour from others, but others' first act of self-harm was an instinctive response to emotional distress
- 44% of participants had identified a change in their motives for harming over time
- When participants had found themselves harming without having the usual motives of e.g. wanting to release emotion, it was most often a case of self-harm having become routine or habitual, but not necessarily an addiction.
- Just over a quarter of participants to the survey with a history of self-harm reported having ceased to harm themselves. The most common reason for stopping was social pressure (20% of those who had stopped), arising from e.g. the participant's understanding of their role as a parent, an employee, a wife or a husband.

Onset of self-harm

Participants reported having first harmed as early as four years of age and as late as fifty-eight. That self-harm is able to change one's emotional state was often discovered by chance in the context of accidental injury, suicide attempt, self-punishment or while harming to elicit a response from others. In addition, participants reported that their first episode of harm was an instinctive response to distress, or a trial of a coping strategy learned from others.

Evolving motives and harming without reason: is self-harm an addiction?

It appears that self-harm is something that, once begun, tends to go on for quite some time. Of those who were still harming when they filled in our survey, nearly half had been harming for longer than five years and a quarter for longer than eleven years. Nearly half of participants had noticed a change in their motives to harm over the years, and many found that they were now, or recently, applying self-harm as a remedy more widely, than they had when they had first started. Quite often this seemed to be the result of the individual learning more about the effect of self-harm and how it can help with a variety of uncomfortable experiences that had previously seemed unconnected. However, a significant proportion of participants said that they had at some point harmed without clear motivation such as emotion regulation, self-punishment, suicide prevention and so on. Sometimes this meant engaging in pre-emptive or experimental harming, and some

participants had harmed in order to prove to themselves that self-harm would still be an effective option if emotions became intolerable. Most commonly, however, ‘harming without reason’ was a case of self-harm having become habitual or routine (n=54), and some participants went as far as conceptualising their self-harm as an addiction.

References are made to the idea that self-harm is addictive in academic literature²², on internet sites and chat rooms dedicated to self-harm²³, and in the media, which recount real-life stories with titles such as “I was addicted to self-harm” (e.g. <http://www.bbc.co.uk/slink/iloveme/reallifestory/cutting.shtml>²⁴). Self-harm behaviour certainly exhibits many of the characteristics that define addictive behaviour (from Elster, 1999²⁵): regular cravings or urges to harm, feelings of relief when one does so, tension and dysphoria when abstaining, wanting to cease harming but being unable to do so, struggle for self-control, cue dependence (being ‘triggered’ by sight of sharp objects etc.), belief dependence (i.e. urge to harm whenever opportunity arises), and ‘crowding out’ – the inability to think about anything else when feeling the urge to harm. Some participants had noticed an increase across time in the severity and frequency of their harm, suggesting a build up of tolerance, and frequent harming was found to be associated with feeling compelled to harm. However, we also learned from our participants about how very difficult it is to make a clear distinction between someone harming habitually or routinely because it has become part of his/her regular strategy for processing emotions, and someone being addicted to harm. Nor is it clear when a craving is addictive and when it is simply an impulse to cut in order to put some un-nameable wrong to rights. It is also very difficult to say whether the tension and dysphoria experienced by someone prior to harming is addictive withdrawal, or whether it is emotional distress deriving from some other source. Conceptualising a behaviour as an addiction may not always be helpful to the person in question, if s/he takes it to imply that s/he is not in control of his/her actions – this can create a feeling of helplessness. In addition, explanation of a behaviour *purely* in terms of addiction tends to ignore the personal reasons and experiences that the individual feels are driving it. Perhaps the best option would be to think of self-harm as motivated behaviour with a long-term function in a person’s life, whilst being alert to its apparent addictive qualities. **What do you think? Please write to us.**

Discontinuing self-harm

Just over a quarter of participants with a history of self-harm (26.6%, n=220) stated that they had stopped harming. The most commonly identified driving force behind stopping was social pressure (20.1%, n=44), often in the absence of a sense of personal desire to cease harming, e.g. “I still miss it, and would continue if the scars were not so hard to hide and long in fading”. For many, the perceived pressure to stop was related to their

²² Tantam, D; Whittaker, J (1992) Personality disorder and self-wounding. *British Journal of Psychiatry* 161: 451-64

Nixon, MK; Cloutier, PF; Aggarwal, S (2002) Affect regulation and addictive aspects of repetitive self-injury in hospitalized adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry* 41(11): 1333-1341

²³ Whitlock, JL; Powers, JL; Eckenrode, J (2006) The virtual cutting edge: The internet and adolescent self-injury. *Developmental Psychology* 42(30): 407-417

²⁴ Last checked 10 March 2008

²⁵ Elster, J. (1999) *Strong feelings: emotion, addiction and human behaviour*. London: MIT Press

understanding of their role as a parent, an employee, a wife or a husband. A related reason for success in stopping harm, also given frequently, was the perceived impact on loved ones (12.8%, n=28), e.g. “My parents found out and made me feel bad about it... I’m glad I don’t do it anymore but only because I don’t want to upset anyone.” In this case again, the reason to stop seems to be purely social. **Families, friends, carers... What do you think about this? Please tell us.**

Other important factors enabling participants to stop harming included self-development, sometimes in the form of insight into reasons for harming gained through counselling, other times simply through growing older and benefiting from the increase in confidence, stability, self-knowledge and control over life associated with that. Counselling was reported to have been helpful by about twice as many participants as medication. On this subject, quite a few of our participants reported (without having been asked about it) that some medications (in particular, some tranquillisers and anti-depressants) had *increased* their self-harm, either in frequency or severity, or both. More precisely, it increased the type of self-harm that is motivated by intolerable emotional numbness, i.e. feeling too little. **Have you had this experience? Please discuss it with your doctor, and if you’d like to, write to us to describe what you felt like.**

As discussed in an earlier section of this summary (‘Self-loathing and the need for self-punishment’), helping someone to stop self-harming may require the radical step of adopting a permissive approach towards it. Why would this help? Because radical acceptance by another person may pave the way towards the person letting go of the guilt, shame and self-recrimination related to self-harm, which may previously have helped to fuel it. The opposite strategy, prohibition, may serve only to drive the person to secrecy, making open discussion of harming, its precipitants and effects impossible.

Disclosing self-harm

Key findings:

- 84% of participants sought to hide their self-harm from their family, and 66% sought to hide it from their friends
- Young age was associated with disclosing to friends
- The most common reason given for hiding self-harm from family was to avoid the negative emotional impact a disclosure was expected to have on them (38% of non-disclosers). This was also the second most commonly given reason for hiding self-harm from friends (21%).
- Lack of understanding on behalf of family (26%) or friends (22%) was cited second-to-most often as a reason for hiding self-harm.
- Participants who sought to hide their self-harm from their families most often expected them to react with anger (31%), upset (21%) or shock/horror/fear (16%).
- Participants who sought to hide their self-harm from their friends anticipated shock/horror/fear reactions (20%) to disclosure, or their friends being confused or bewildered about it (13%).
- One in five participants who sought to hide their self-harm from their friends did so despite anticipating that the friends would be supportive if they were told about it.
- Only 10-15% of participants who sought to hide their self-harm expected their family and friends to recognise mental distress as the main reason for self-harm.
- Most commonly, participants who sought to hide their self-harm expected family and friends to think that they were seeking attention (22% and 19%) or mentally ill (19% and 25%).

Fear of being misunderstood and concern about the impact of disclosure on others were identified by the participants as the most significant barriers to telling family or friends about self-harm, followed by being ashamed, guilty or embarrassed about harming and fearing condemnation as a consequence of disclosure. However, other barriers were suggested by participants' answers to questions about anticipated reactions to disclosure from family and friends, and about what they expected their family and friends to think their reasons for self-harm to be.

As previously discussed, we found that participants felt unable to express their inner lives, were prone to self-recrimination and self-loathing, and assumed that their thoughts and feelings are out of line with what their family and friends would find acceptable. These findings can help us understand some of the participants' responses to questions about disclosing self-harm. First, we found that only 10-15% of participants who hid their harm

anticipated that their family or friends would recognise the fact that their self-harm is a response to emotional distress. It seems that their inner lives, carefully hidden, are expected to be invisible to others. That in turn makes understanding self-harm difficult – if understanding a behaviour requires knowledge of the reasons and feelings behind it (we think it does). This goes some way towards explaining the prevalence among participants of the idea that family and friends would not understand their self-harm. **Has your son/daughter/friend/sister/brother told you that they self-harm? Or did you find out some other way? What did you think and feel, how did you react? What happened then? Please tell us your experiences and add another perspective to our report!**

Second, participants expected family and friends to explain self-harm by mental illness. This may present a barrier to disclosing self-harm in at least two ways, the first of which is the obvious and often cited stigmatisation of mental health problems. The second is one that links with the fear of being misunderstood. Explaining self-harm by reference to a mental illness can in some cases be used to cut across and devalue or even invalidate explanations that refer to the reasons and feelings of the individual who harms. Yet for the most part, self-harm is intentional, motivated behaviour, goal directed and even when impulsive, governed to some extent by the person's reasons and beliefs. This came across very clearly during this survey. To substitute all this with a view of self-harm that treats it as a simple symptom of a medical condition is a misunderstanding of the worst kind, insofar as it negates the whole domain of discourse within which understanding could take place.

One important qualification is needed here. Some of our participants wrote that they *never* harmed *deliberately*, that is, in every instance their self-harm was an automatic action over which they had no conscious control, even if they were conscious of it while it was going on. These participants felt that self-harm is something that *happens to them*, rather than something that *they do*, and consequently, their self-harm might be more appropriately thought of as a symptom of illness. **Or what do you think? Please write to us to tell us whether you think that self-harm is a symptom of illness, or something else. And how deliberate is 'Deliberate Self Harm' (DSH), as it is called in the academic literature?**

Earlier, we described how there appeared to be a 'secret self', and how it could be separated from the 'social self'. The third and fourth most common reasons for hiding self-harm could also be related to this split; participants were worried about being condemned if truth of their self-harm came out, and they felt ashamed about it. These feelings and concerns both reflect and are likely to feed into the separation of selves. Self-harm becomes yet another shameful secret, to be kept for fear of being judged, even rejected (this was a concern with respect to disclosing to friends). However, to feel shame it is not necessary to expect condemnation. We found that one in five participants who hid their harm from their friends, did so despite expecting them to be supportive if they were told about it. We discussed some reasons for this in the 'Full Report', including fears of being pitied or thought of as mentally ill, which can engender shame, and the (also shame-related) feeling of standing out as different to, and therefore separate from others.

Interestingly, several people who were unwilling to disclose self-harm despite anticipating supportive reactions talked about their role as “the strong one” in their peer group. In other words, they felt that distress and its expressions were inconsistent with their ‘social self’. Equivalent concerns were expressed with respect to the familial context also: participants were concerned not to disappoint, not to fail expectations. It is as if the ‘social self’ has been created to meet these perceived expectations (e.g. “I can't live up to any of their expectations, so I hide most of me”), and disclosure of self-harm would reveal the ‘more than meets the eye’: “[My family] might look at me as though I am a different person than the one they know. They might know it's not just self harm but because of the stuff going on in my head.” **We wonder where these perceived expectations of perfect health and happiness are coming from? What do you think?**

Final thoughts

A certain kind of social sensitivity characterises many of the answers given by participants to a number of questions in the survey. For example, well over a third of those who hid their self-harm from their family did so because they worried about the potential emotional impact of disclosure on their families (the equivalent proportion for friends was a fifth). A fifth of participants who had stopped harming by the time they filled in the survey had done so because they felt that harming ran counter to their social responsibilities or the opinions of others, and 13% had stopped because they felt bad about the perceived hurt that their self-harm was causing others. In addition, roughly one in five participants who were hiding self-harm named shame, guilt or embarrassment (the emotions that express our connection with our social environment) as the reason for it, and a quarter experienced those feelings following an act of self-harm. **What is the relationship between social sensitivity and the ‘secret self’/‘social self’ split? What do you think? Please write in to tell us!**

There is ample ground for further research and discussion in relating all the different findings discussed in this report to each other. How, for example, do the social aspects of self-harm such as the ‘secret self’/‘social self’ split and social sensitivity relate to emotion regulation? SANE is by no means satisfied that we now know enough about self-harm. We, the researchers at SANE are continuing to consult with those who harm and the families and friends of those who harm, to speak with clinicians and other researchers, and to write and think about this topic. In the same spirit, this report is intended to be an organically growing piece of work which will be regularly updated based on feedback, new findings and novel ways of thinking about those findings.

Therefore, if you, the reader, have any thoughts on what you have read, any experiences that perhaps run counter to something we've said or if you just want to comment on a particular point we've made, please email us on: **SelfHarmStudy@sane.org.uk** or if you prefer, send us a letter to Research Department, SANE, 1st Floor Cityside House, 40 Adler Street, London E1 1EE.



Your contribution will be anonymised: any names and other identifying information will be removed. Your email and email address will be deleted or your letter shredded within 4 weeks, once its text has been added to our password protected database. Emails are stored on a password protected computer and letters in a locked cabinet. If you would like to be credited on our list of contributors, tell us what name or nick name to use in your email/letter.

You'll have noticed that we've flagged some areas we're particularly interested in receiving input on, but you're welcome to comment on anything. We don't promise to respond to your email/letter or to incorporate your idea explicitly, but we will read what you write with interest and think about it in the context of what others have said. Your voice will be added to the voices of many, and it will contribute to increasing the knowledge base on this misunderstood and stigmatised behaviour.

Box 1: What can I do if I self-harm and want to stop?

Get talking

You could try to **talk to your friends/family**. If you're worried about them misunderstanding or judging you, why not test the waters with a casual: "You know, I've been feeling quite unhappy/angry/worried lately" and see how responsive they are to hearing about your thoughts and feelings. If you find it difficult to open up or to find the words you need to express what you are really feeling, don't be put off. It may take some time and practice so be patient with yourself and don't worry if you don't get it right first time. You might also need to be patient with the person you are talking to as it might be very unfamiliar and difficult for them too. They may feel upset or angry about what they're hearing but this doesn't necessarily mean that they won't want to help. Try to allow them their emotions without feeling responsible for them or taking their reaction personally. If you can't or don't want to talk to the people around you, you could always...**call a helpline**: just talking to someone anonymously about how you are feeling can help you organise your own thoughts and feelings, and alleviate the loneliness that can come from being troubled. SANE's helpline **SANEline is open every evening from 6pm until 11pm, call 0845 767 8000** to talk to a trained volunteer. If you prefer writing, you can always write your thoughts and experiences down and **email a SANEmail volunteer (sanemail@sane.org.uk)**. Writing is also a good way to **express your thoughts and feelings**. Expressing is important because it makes thinking easier and helps to acknowledge your feelings. Having an audience can be great, but it's not necessary! If you would like to express to someone, you could **find other people who have self-harmed and share your experiences with them**. There are **support groups** for self-harm, some of them local ones who facilitate **face-to-face** meetings and others that use the **Internet** to connect people with experience of self-harm. For example, **Bristol Crisis Service for Women** has a list of local support groups on their website, and **First Signs, National Self Harm Network** and **SIARI** host message boards and forums specifically for people who self-harm. Watch out for negative effects though! While helping others can be very therapeutic, people who self-harm may be vulnerable to excessive sense of responsibility ("I don't really feel up to it but I *have to* visit my forum because such-and-such depends on me") and feelings of guilt ("Such-and-such is self-harming, maybe it's my fault because I said ... in my last message."). If you notice that your involvement with an Internet support group is causing you stress, withdraw for a while. You won't help anyone by making yourself ill.

Learn how to manage the urge to harm

If you catch yourself early, it is often possible to **distract** yourself before the need to harm becomes overwhelming. Concerted effort to focus on some pleasant activity can help some. If you find that you're too far into the state that leads you to self-harm normally, it can still be possible to **substitute** another activity for self-harm. If you think it might be the sight of blood that makes self-harm work for you, you could emulate it by melting ice cubes made with red juice on your skin; if pain is important, maybe the pain caused by eating a hot chilli will do? (These two suggestions are taken from **an information leaflet produced by the Royal College of Psychiatrists.**)

Get professional help

Some people who have sought help from professionals for self-harm have not been treated with the kind of compassion they deserve. But health care providers are increasingly aware of what self-harm is all about and your GP might be able to refer you to a helpful talking therapy, such as **cognitive-behavioural therapy (CBT)** or **psychotherapy**. You could also ask them about **mindfulness-based therapies** such as **dialectical behaviour therapy (DBT)** and **mindfulness-based cognitive behaviour therapy (MBCBT)**. Mindfulness training focuses on awareness of the present moment, and on paying attention to thoughts, emotions and sensations in a non-judgmental way. In this way, mindfulness training can also help you to...

Get inquisitive

Try to become interested (rather than just scared or distressed) about what is going on with you. Ask yourself what self-harm is doing for you, and see if you can work out what kinds of situations or thoughts typically lead to you feeling the need to harm. While you're thinking about this, try to think about yourself with kind curiosity rather than worrying about how 'wrong' you feel. And when you discover something new, see if you can use this new knowledge to help yourself. And if you think your insight would make this report better, tell us about it!

Box 2: What can I do if I self-harm and I don't feel ready to stop?

Self-harm safely

There are things you can do to minimise the damage you do yourself whilst harming, especially by cutting or burning, which can have potentially serious consequences for mobility of your limbs and carry a risk of long-term scarring. Arm yourself with **information about anatomy and physiology** relevant to your methods and sites of harm; learn to **recognise the symptoms of infection**; teach yourself **wound care**. For example, when cutting on your arm, cut **slowly** and **look at what you're doing: avoid tendons and major blood vessels**. There's a whole book on self-harm and harm minimisation called "Cutting The Risk", you can get it from **The National Self Harm Network**.

Learn about self-harm and what it is doing for you

Take advantage of the calm and clear moments after self-harm to reflect on what is going on with you. If you start feeling ashamed or guilty, acknowledge those feelings but try to let them pass and direct your thoughts back to thinking creatively about yourself and your situation.

Combine self-harm with other forms of help

As a solution, self-harm tends to be temporary, and a crisis measure. Therapies, talking to professionals and family members or friends, art and exercise might offer longer term solutions and help you on your way to never feeling so bad that you want to self-harm in the first place. It's worth experimenting.

Box 3: What can I do if I know someone who self-harms?

Try to create a calm space in which thoughts and feelings can be expressed freely and self-harm can be talked about in a non-judgemental atmosphere

This may require some pretty challenging emotion control from your part. You might be angry or sad about what you're hearing, but getting swept away by the force of those emotions into reacting strongly will not help the person who is opening up to you. So you need to be able to contain your own feelings sufficiently so that you can focus on them and their feelings. This isn't the same as hiding or suppressing your feelings! **It is perfectly natural to feel distress, disgust or anger when faced with self-harm.** You can admit self-harm is emotionally difficult to face, and then show that you can cope with those emotions; that no permanent damage has occurred to you through the person confiding in you. **This is only possible if you remember to look after yourself and your feelings!** You too will need to be supported by someone. **SANEline (6pm-11pm every day, 0845 767 8000)** is there for friends and families as much as for those who self-harm, and there are local support groups you might want to access (see <http://www.mentalhealthcare.org.uk/carersupport/> or <http://www.carersuk.org/Information/Findinghelp/LocalOrganisations> for lists of local organisations).

Give the person some privacy!

When a family member or a close friend is known to self-harm, there is a great temptation to keep a constant eye on them. It IS good to try and be aware of how they are feeling and what is going on in their lives. But it ISN'T good to forget that they are as entitled as anyone else to have secrets and time for themselves, during which they do things you don't know anything about.

Acknowledge self-harm, but don't let it become a focal point

It's all too easy to start using self-harm as a measure of distress, substituting "have you harmed today?" for "how are you today?" That someone self-harms isn't the most important thing to know about them, and although the topic shouldn't be avoided, it shouldn't become the centre of all conversations.

Remember that self-harm has a function that is not easily fulfilled by other means, and for that reason, it is not reasonable to expect someone to stop harming overnight

Making someone promise they'll never harm again ("or else...") or devising no-self-harm contracts may contribute to feelings of guilt and lead to an increase in harm and in hiding it.

Help them to get help

Negotiating the health system is not always an easy task. You could help with getting an appointment and offer a lift or just your company when they go and see health care professionals – but always keep in mind that seeking help is their choice. There is that fine line between encouraging and pressuring, try to stay on the good side of it!

Get involved in a joint project of trying to understand self-harm

Reading this report together might be a good start. Help them to question what they learn as well as absorb it: not all information applies to everyone. Debating e.g. research findings in the light of their own experience may be a good way to acknowledge their expertise and give them the confidence to begin healing themselves.

Finally: learn about methods, anatomy and first aid

Some self-harm is lethal and some can lead to permanent damage, so it is important to get an idea when it would be appropriate to go to the A&E. Most cuts and burns can be dealt with at home, especially with help from another person. The more you know, the more you'll be able to help to prevent scarring, infections and unwanted long-term painfulness. You might also be able to help the person to shift towards less dangerous methods. (See Box 1 on 'Safe Self-harm'.)