Risk Factors for Self-Harming Behavior

Carina H. Dick

University of Alaska Fairbanks

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Self-mutilation, deliberate self-harm, self-inflicted bodily-harm, and self-injurious behavior are all terms that have been used to describe harm inflicted on one's own body. Though there is considerable variation on the definition of self-harm in the literature, self-harm may be defined as damage to one's own body tissues in the absence of suicidal intent (Castille et al., 2007). In addition, self-harm is usually distinguished from acts of self-injury that may occur in cases of a cognitive disability, a developmental disorder, or psychosis (Gratz, 2006; Mangall & Yurkovich, 2008). Knowledge of self-harm raises questions about what could cause a person to express his or her emotional and mental pain in such a tangible way. The purpose of this paper is to explore some of the risk factors for self-harm.

Self-harm affects children, adolescents, and adults (Mangall & Yurkovich, 2008). Though prevalence for self-harm among the general population is about 1% (Sansone, Chu, & Wiederman, 2007), other populations are reported to have higher rates. For example, studies have indicated that 4% of military recruits, up to 35% of college psychology students, and 24% of high school students have experienced self-harm (Gratz, 2006). Prevalence of self-harming also varies depending on diagnosis of psychopathology. According to Sansone et al. 80% of people with borderline personality disorder, up to 35% of individuals with eating disorders, and 25% of women who are treated for substance abuse exhibit self-harming behaviors.

Levenkron (1998) describes self-harmers as primarily young women, though he acknowledges that self-harm affects males as well. Contrary to Levenkron, Marchetto (2006), whose own research on skin-cutting indicated no gender differences among self-harmers, claims that women have been overrepresented in the literature on self-harm. Marchetto attributes this overrepresentation to factors such as the use of female-only samples and the focus on studying

cutting within populations in which women have higher prevalence rates, such as eating disorders.

It appears that self-harm serves several functions for the self-harmer. In a study on self-harmers' perceptions of the meaning of their self-harm, Warm, Murray, and Fox (2003) found that nearly all participants agreed that self harm is a way to maintain control, to release anger, express emotional pain, and to cope. Harming also serves to release tension and actually facilitates a physiological reduction in stress (Mangall & Yurkovich, 2008).

Self-harm is inflicted in a variety of ways. In a study containing 243 participants from 15 countries, Warm et al. (2003) found that cutting was the most common self-harming behavior, with 96% of participants reporting this behavior. Over half of the participants reported scratching and hitting themselves, and less common acts of harm included overdosing, burning, and scalding. Gratz (2006) found that those who self-harm often use more than one method, and nearly one third of the participants in her study indicated that they had used at least 4 different forms of self-harm.

There are many environmental, emotional, and cognitive factors that can contribute to the development of self-harm. A primary factor associated with self-harm is the experience of childhood abuse, especially sexual abuse (Gratz, 2006). There is also evidence that physical abuse is linked to self-harm. In a study of self-harmers conducted by Marchetto (2006), it was found that 56% of participants had experienced either sexual or physical abuse. In addition, 84% of participants indicated their first incident of self-harm occurred after a traumatic experience. Many of the participants in Marchetto's study who self-harmed and did not report childhood abuse reported other types of trauma, such as death of a loved one, rape, or divorce.

In the absence of childhood trauma, other factors, such as parental bonding, are believed to influence the development of self-harm (Marchetto, 2006). Insufficient parental care and inappropriate overprotection and control have been suggested as primary parental factors that may contribute to pathology. Research also indicates that childhood emotional neglect may be linked to self-harm in adults (Gratz, 2006). Levenkron (1998) identified lack of warmth and lack of attentiveness toward a child as parental factors that may contribute to the development of self-harming in their child. Also, a parent who, rather than supporting his or her child, depends upon the child may place the child in a position of having no safe place to express feelings, which can increase the risk of self-harm.

Abuse received as an adult is also a risk factor in self- harm (Sansone et al., 2007). Sansone et al. conducted a study to assess the relationship between self-harm and the experience of intimate-partner violence. Participants of the study included 113 adult women who completed questionnaires pertaining to a self-harm behavior and intimate-partner violence. Sansone et al. found a significant link between the experience of intimate-partner violence and self-harming behavior. Sansone et al. suggest that it is important for helpers who assist women who are victims of intimate-partner violence to be aware of the additional possibility of self- harm.

A variety of emotional factors have been linked to self-harm. According to Mangnall and Yurkovich (2008), the buildup of emotional tension is usually present directly before an act of self-harm. In addition, depression and anxiety are frequently experienced by those who self harm. Marchetto (2006) found that among self-harmers, after personality disorders, depression was the second most common diagnosis. The degree of anxiety an individual experiences has been found to be related to degree and form of self harm (Mangall & Yurkovich, 2008). For example, self-cutters report more anxiety than do self-harmers who use other means.

Levenkron (1998) went so far as to claim that anyone who self-harms is experiencing a combination of an anxiety disorder and a depressive disorder and that the experienced feelings of anxiety and depression may range from mild to severe. Levenkron also believes that these disorders are hereditary, and the nurturing of a child has a great deal to do with whether not a more naturally anxious child will develop self-harming behaviors.

Mangall and Yurkovich (2008) indicated that hostility and impulsivity are also risk factors for incidents of self harm, as are emotional characteristics such as guilt, resentfulness, self-dislike, and cynicism. Dissociative episodes, which encompass feelings of unreality or depersonalization, have also been linked to self harm. Research has found that the incapacity to verbally articulate feelings is linked to self-harm (Gratz, 2006). These findings were complemented by a study of 249 female college students in which Gratz found that the frequency of self-harm was connected to lower positive affect and to emotional inexpressivity.

Other emotional factors that research has linked to self-harm include anger, lack of confidence, and feelings of inadequacy (Castille et al., 2007). According to Levenkron (1998), self-harmers experience feelings of fear and loneliness, and they may feel disconnected from others. The self-harmer feels powerless and different from his or her peers.

Levenkron's descriptions of self-harmers are supported by the research of Castille et al. (2007) who found four main ways of thinking that distinguished self-harmers from non-self-harmers. Castille et al. explain that those who self-harm feel emotionally deprived and believe that there is no one who will provide them with emotional support. Feelings of loneliness are associated with the belief that one is different from others. A third belief of self-harmers, which is associated with feelings of mistrust, is that others will hurt, humiliate, or abuse them. Finally, self-harmers are distinguished by the belief that they lack self-control.

There is also evidence that self-objectification can play a role in the development of self-harm. According to research conducted by Muehlenkamp, Swanson, and Brausch (2005) self-objectification was found to be directly linked to negative body regard, which in turn was linked to symptoms of depression, which was connected with self-harm. Though Muehlenkamp et al. did not find self-objectification to be a direct risk factor it does appear to add to the risk of the development of self-harm.

Some believe that women experience body objectification by the overall culture, especially Western culture, and that society itself can act as a risk factor for self-harm (Muehlenkamp et al., 2005). Other factors that have been associated with self-harm in the research are risk-taking behaviors, body detachment, and negative attitudes about one's body.

Conclusion

The factors that contribute to self-harming behavior are many and complex. Understanding the risk factors can help prevent self-harming behavior as well as contribute to the development of effective treatments. Other benefits to research on self-harm include improved understanding, which may help dismiss myths that may currently exist in the literature (Warm et al., 2003). As Warm et al. point out, understanding the self-harmer's own perceptions of the meaning of his or her behavior can be an important part of developing an effective therapeutic relationship. Much of the literature reviewed focused primarily the self-harming behaviors of women. As endorsed by Marchetto (2006), this is an area that needs further research in order to ensure that both men and women receive the necessary treatment to relieve them of the need to self-harm.

References

Castille, K., Prout, M., Marczyk, G., Shmidheiser, M., Yoder, S., & Howlett, B. (2007). The early maladaptive schemas of self-mutilators: Implications for therapy. *Journal of Cognitive Psychotherapy: An International Quarterly, 21*(1), 58-71. Retrieved September 29, 2008, from Academic Search Premier database.

Gratz, K. (2006). Risk factors for deliberate self-harm among female college students: The role and interaction of childhood maltreatment, emotional inexpressivity, and affect intensity/reactivity. *American Journal of Orthopsychiatry, 76*, 238-250. Retrieved September 29, 2008, from Academic Search Premier database.

Levenkron, S. (1998). *Cutting: Understanding and overcoming self-mutilation*. New York: W. W. Norton and Company.

Mangall, J., & Yurkovich, E. (2008). A literature review of deliberate self-harm. *Perspectives in Psychiatric Care, 44*, 175-184. Retrieved September 29, 2008, from Academic Search Premier database.

Marchetto, M. J. (2006). Repetitive skin-cutting: Parental bonding, personality and gender. *Psychology and Psychotherapy: Theory, Research and Practice, 79*, 445-459. Retrieved September 29, 2008, from Academic Search Premier database.

Muehlenkamp, J. J., Swanson, J. D., & Brausch, A. M. (2005). Self-objectification, risk taking, and self-harm in college women. *Psychology of Women Quarterly, 29*, 24-32. Retrieved September 29, 2008, from Academic Search Premier database.

Sansone, R. A., Chu, J., & Wiederman, M. W. (2007). Self-inflicted bodily harm among victims of intimate-partner violence. *Clinical Psychology and Psychotherapy, 14*, 352-357. Retrieved September 29, 2008, from Academic Search Premier database.

Warm, A., Murray, C., & Fox, J. (2003). Why do people self-harm? *Psychology, Health & Medicine, 8*(1), 71-79. Retrieved September 29, 2008, from Academic Search Premier database.