CHAPTER 1

Definition and Differentiation from Suicide

The most important point should be stated at the outset: Self-injury is a conundrum. In many ways it is separate and distinct from suicide, and should be managed as such. Yet self-injury is also an important risk factor for suicide attempts. In this chapter, I define self-injury and differentiate it from suicidal behavior. In the next chapter, I discuss self-injury as a risk factor for suicide attempts, with specific suggestions for how to prevent the most extreme of all self-destructive acts.

TERMINOLOGY

Since the mid-1990s, the language used to refer to such behaviors as self-inflicted cutting, scratching, burning, hitting, and excoriation of wounds has changed. These were previously referred to as "self-mutilation," but the more common and popular term has become "self-injury" or "nonsuicidal self-injury." Both self-injuring people and those who treat them have protested that "self-mutilation" is too extreme and pejorative a term (e.g., Hyman, 1999; Connors, 2000; Simeon & Favazza, 2001). These advocates have argued that most people who self-injure employ the behavior as a coping mechanism to deal with psychological distress; therefore, the behavior has adaptive features. Moreover, they have correctly stated that the large majority of self-inflicted wounds involve only modest physical damage that leaves little if any long-term scarring. The wounds do not result in a "mutilation" of the body. The *Merriam-Webster Dictionary* (1995) defines "mutilate" as "to cut up or alter radically so as to make imperfect" and "to maim,

cripple" (p. 342). I accept the contention that the term "self-mutilation" is derogatory, stigmatizing, or even sensationalistic in referring to the behavior (Simeon & Favazza, 2001), and therefore I use the term "self-injury" in this text.

FORMAL DEFINITION

In this book, self-injury is defined in the following way:

> *"Self-injury" is intentional, self-effected, low-lethality bodily harm of a socially unacceptable nature, performed to reduce and/or communicate psychological distress.*

The components of this definition require some explication. As explained above, the term "self-injury" is descriptive and nonpejorative. It is also nonexaggerative. The word "intentional" specifies that self-injury is deliberate; it is not accidental or ambiguous as to intent. Self-injury is also "self-effected." This term is chosen rather than "self-inflicted," because many individuals self-injure with the assistance of others. Not uncommonly (especially among adolescents), two or more people may take turns hurting or simultaneously hurt each other. For quite a few people, self-injury is an interpersonal experience.

The next term in the definition is "low-lethality." Self-injury, by definition, involves those forms of self-harm that do modest physical damage to the body and pose little or no risk to life. The distinction of self-injury from suicide is explicit and fundamental, as discussed in detail later in this chapter.

Self-injury is primarily about "bodily harm." The behavior alarms others because of the tissue damage. A person may present with talk or planning about self-injury, but until he or she crosses the line into actively damaging the body, there is no self-injury.

The phrase "of a socially unacceptable nature" is included in the definition to emphasize social context. Favazza (1996) has written extensively about the multifarious body modifications that occur around the world. In most cultures, body modification is symbolically meaningful and culturally endorsed. It may have profound religious significance and be part of a complex rite of passage. This is not the case for common self-injury, which, although it may have many meanings for its perpetrators, is not endorsed by the prevailing culture. Granted, self-injury can often seem to be part of an adolescent expression of angst and alienation; among teens, there may

be considerable social reinforcement for the behavior. However, there are no organized, culturally endorsed rituals that surround it. Self-injury is not connected to any socially sanctioned rite of passage.

The final phrase in the definition is "performed to reduce and/or communicate psychological distress." Self-injury is enacted primarily because of its ability to modify and reduce psychological discomfort. It is usually immediately and substantially effective, and therefore it is often repeated. The behavior is not suicidal, but it is psychologically motivated. Self-injury is a behavior that cannot be explained via biological mechanisms alone. Rather, it is a self-conscious, self-intentioned form of distress reduction behavior.

To a lesser degree, self-injury also often has interpersonal features. Self-injury frequently serves such interpersonal functions as communicating pain, influencing others to change their behavior, or demonstrating courage or toughness. As discussed later in this volume, social contagion can also play a role in the occurrence of self-injury.

DIFFERENTIATING SELF-INJURY FROM SUICIDE

This portion of the chapter discusses 11 points of distinction between self-injury and suicide. These points are provided to justify the contention that self-injury and suicide should be understood, managed, and treated differentially. All too often, self-injury is inappropriately labeled "suicidal," resulting in unnecessary psychiatric hospitalizations and other poorly designed interventions. The 11 points of distinction presented here provide a practical roadmap for determining whether a self-destructive behavior is suicidal or self-injurious. This distinction has major implications for all the assessment and treatment that follow. A concise summary of 10 of these 11 points is provided in Table 1.1. (Prevalence, the first point discussed below, is omitted from the table, since its importance is demographic rather than clinical.)

Prevalence

The prevalence for suicide versus self-injury is very different. The prevalence for completed suicides in the U.S. population is well established via ongoing epidemiological studies: Suicide occurs at a rate of 11.5 per 100,000 (American Association of Suicidology [AAS], 2008). In contrast, the prevalence rate for self-injury is unknown, in that large-sample epidemiological studies have yet to be conducted. Estimates have ranged from 400 (Pattison & Kahan, 1983) to 1,000 per 100,000 (Favazza, 1998). Even if the low estimate is correct (and this is very unlikely, given the rising prevalence in

TABLE 1.1. Differentiating Suicide Attempts from Self-Injurious Behavior

Assessment focus	Suicide attempt	Self-injury
What was the expressed and unexpressed intent of the act?	To escape pain; terminate consciousness	Relief from unpleasant affect (tension, anger, emptiness, deadness)
What was the level of physical damage and potential lethality?	Serious physical damage; lethal means of self-harm	Little physical damage; nonlethal means used
Is there a chronic, repetitive pattern of self-injurious acts?	Rarely a chronic repetition; some overdose repeatedly	Frequently a chronic, high-rate pattern
Have multiple methods of self-injury been used over time?	Usually one method	Usually more than one method over time
What is the level of psychological pain?	Unendurable, persistent	Uncomfortable, intermittent
Is there constriction of cognition?	Extreme constriction; suicide as the only way out; tunnel vision; seeking a final solution	Little or no constriction; choices available; seeking a temporary solution
Are there feelings of hopelessness and helplessness?	Hopelessness and helplessness are central	Periods of optimism and some sense of control
Was there a decrease in discomfort following the act?	No immediate improvement; treatment required for improvement	Rapid improvement; rapid return to usual cognition and affect; successful "alteration of consciousness"
Restriction of means	Important, often life-saving	Impractical, often inadvertently provocative
What is the core problem?	Depression, rage about inescapable, unendurable pain	Body alienation; exceptionally poor body image in clinical populations

community samples), the rate of self-injury is almost 40 times higher than that for completed suicide.

Intent

A fundamental place to start differentiating suicide from self-injury clinically is the topic of intent. A clinician needs to know what a person is intending to accomplish via the behavior. What are his or her goals in acting self-destructively? Some people are quite insightful and articulate in explaining the intent of their self-harming behavior. They provide clinicians with explanations of their behavior that are clear and concise. For example, some self-injuring people say, "I cut myself to feel better. I don't want to die. I just want to get the anger out." In a similar vein, suicidal individuals make their motives quite evident. They may say, "If I don't have this relationship in my life, it's not worth living. My life is over. That's why I took the overdose." In both examples, intent could not be more clear.

However, more frequently than not, clinicians find it difficult to elicit a clear articulation of intent. Self-destructive persons are emotionally overwhelmed and often very confused about their own behavior. When asked why they acted self-destructively, many individuals provide ambiguous responses, such as "I'm not sure why I took the overdose; it just seemed like the thing to do." Others speak with considerable vagueness, such as "I wouldn't cut myself now, but I had to do it then," and refuse (or are unable) to say more.

Some individuals seem to be disconnected from conscious thought processes when they hurt themselves, such as the individual who said, "At one point, I looked down at my arms, saw a lot of blood, and had no idea how it happened." Another variation is the all-too-common encounter with adolescents who, when asked why they performed some self-destructive act, reply with that classic roadblock to psychological progress: "I don't know."

Intent can be successfully elicited from both suicidal and self-injuring persons, but the process often requires a combination of profound compassion and investigative persistence.

Suicidal Intent

In his classic work *Definition of Suicide*, Shneidman (1985) identified a number of salient points that differentiate suicide from self-injury. The first of these is intent. Shneidman stated that the intent of the suicidal person is generally not so much to kill the body; rather, the intent is to "terminate consciousness." The suicidal person wants to stop the psychological pain—to escape the "psychache," as Shneidman (1993) calls it. The suicidal person will do whatever it takes to make the pain go away *permanently*.

Self-Injurious Intent

In contrast, the intent of the self-injuring person is not to *terminate* consciousness, but to *modify* it. The overwhelming majority of self-injuring individuals report that they harm themselves in order to relieve painful feelings. The type of emotional distress they want to relieve falls into two basic categories. The majority of those who self-injure report hurting themselves in order to relieve *too much* emotion (Favazza, 1987; Walsh & Rosen, 1988; Brown, 1998, 2002; Brown, Comtois, & Linehan, 2002; Klonsky, 2007, 2009; Nock, 2010). The minority report harming themselves in order to relieve either *too little* emotion or states of dissociation (e.g., Conterio & Lader, 1998; Shapiro & Dominiak, 1992; Simeon & Hollander, 2001). Those who report feeling too much emotional distress identify such feelings as these:

- Anger
- Shame or guilt
- Anxiety, tension, or panic
- Sadness
- Frustration
- Contempt

Studies differ regarding the order of these uncomfortable emotions. See Brown (2002) and Klonsky (2007) for thorough reviews of studies on emotions that precede self-injury.

A smaller proportion of self-injurers report feeling too little emotion. They state that they feel "empty," "zombie-like," "dead," or "like a robot." These individuals self-injure to alleviate this absence of feeling. As a young adult female once told me, "When I cut myself and see the blood, it's very reassuring, because I can see for myself that I'm still alive." Many of these individuals may be experiencing states of dissociation immediately prior to self-injuring.

The key point regarding intent is that a suicidal person wants to eliminate consciousness permanently; a self-injuring person wants to modify consciousness, to reduce distress, in order to live another day.

Method and Related Level of Physical Damage and Potential Lethality

Given the difficulty of eliciting clearly articulated intent from clients, clinicians often have to focus on the acts of self-harm in order to perform an accurate assessment. Fortunately, the chosen method of self-harm often tells

us a great deal about the intent of a self-destructive person. Certain behaviors convey suicidal intent; others suggest self-injurious motivation.

Suicide Methods

Research has shown repeatedly that people who die by suicide use a rather short list of high-lethality methods. For example, statistics from the Centers for Disease Control and Prevention (CDC, 2010) identify death by suicide as occurring via six basic methods: use of a firearm (50.7%); hanging (23.1%); pill or poison ingestion (18.8%); jumping from a height (1.6%); use of a sharp instrument (1.7%); and death involving motor vehicles, such as cars, trains, or buses (1.1%). Note that the most common form of self-injury (cutting or use of a sharp instrument) is reported to result in death for only 1.7% of those who die by suicide. That is to say, *98.3% of individuals who die by suicide in the United States use methods other than cutting.* Furthermore, it should be emphasized that those who die by cutting use very specific and uncommon methods: (1) severing the carotid artery or jugular vein in the neck, (2) piercing the heart, or (3) performing a massive incision to the abdomen (CDC, 2010). The most common form of self-injury, cutting the arms or legs, is not listed as a method that results in death; nor are other forms of common self-injury listed below.

Moreover, if the statistics for cause of death by suicide are reviewed for the age group of 15–24 years, the percentage of those dying by cutting becomes even lower. This is the age group in which self-injury is most common. The proportion of 15- to 24-year-olds who die by cutting/piercing is 0.6% (CDC, 2010). *Thus 99.4% of youth who die by suicide use methods other than cutting.* The methods of suicide are highly distinct from those of self-injury.

Self-Injury Methods

There are no comparable data from large samples regarding the methods of self-injury. Favazza and Conterio's (1988) study employed a convenience sample that responded to an episode of *The Phil Donahue Show* devoted to self-injury. Responding to a request to complete a mail-in questionnaire, 250 people (96% of whom were female) did so. The results indicated that respondents used the following self-injury methods: cutting (72%), burning (35%), self-hitting (30%), interference with wound healing (22%), hair pulling (trichotillomania; 10%), and bone breaking (8%).

Some additional data regarding types of self-injury are available from a small-sample study I conducted in the late 1990s (Walsh & Frost, 2005).

The study sample consisted of 70 adolescents who were receiving intensive treatment in either special education or residential programs. Of these, 34 had a history of suicide attempts and recurrent self-injury, as well as multiple forms of indirect self-harm (including risk-taking, substance abuse, and eating disorders). These youth reported that their self-injury took the following forms: cutting (82.4%), body carving (64.7%), head banging (64.7%), picking at scabs (61.8%), scratching (50%), burning (58.8%), self-hitting (58.8%), and self-piercing (apart from properly sterilized ornamental piercings) (52.9%). Other less common forms of self-injury for these youth were self-inflicted tattoos (47.1%), self-biting (44.1%), and hair pulling (38.2%). Although many of these behaviors were alarming, it is important to emphasize that none was life-threatening. Note also that when the categories of cutting, scratching, and carving were combined, body incising (91.2%) was by far the most popular method of self-injury for this sample.

Whitlock, Eckenrode, and Silverman (2006) reported somewhat different findings in their study of college students. The self-injury in their sample of over 2,800 students, 17% of whom self-injured, consisted of the following:

Severely scratched or pinched with fingernails or objects causing skin to bleed	51.6%
Punched objects to the point of bruising or bleeding	37.6%
Cut	33.7%
Punched oneself to the point of bruising or bleeding	24.5%
Ripped or tore skin	15.9%
Carved words or symbols into skin	14.9%
Interfered with the healing of wounds	13.5%
Burned skin	12.9%
Rubbed glass or sharp objects into the skin	12.0%
Engaged in trichotillomania	11.0%

Note that when cutting and carving are combined for the Whitlock et al. study, this new category is second only to scratching and pinching in frequency. What is clear is that across the literature on self-injury (e.g., Favazza, 1987; Walsh & Rosen, 1988; Alderman, 1997; Conterio & Lader, 1998; Brown, 1998; Briere & Gil, 1998; Simeon & Hollander, 2001; Klonsky, 2007; Nixon & Heath, 2009; Nock, 2010), the most common methods of self-injury are as follows:

- Cutting, scratching, and carving
- Excoriation of wounds
- Self-hitting
- Self-burning
- Head banging
- Self-inflicted tattoos
- Other (e.g., self-biting, abrading, foreign-body ingestion, inserting objects, self-inflicted piercings, hair pulling)

These are presented in the general order of frequency, although the exact order varies from study to study. Cutting is by far the most common form reported.

It is important to emphasize that none of these behaviors is likely to result in death, except in the most extreme circumstances (e.g., self-burning that takes the form of self-immolation, an exceedingly rare behavior). If cutting behaviors are unlikely to result in death—particularly the most common forms of cutting arms, wrists, and legs—it is quite reasonable to conclude that the behavior is generally about something *other than suicide*. If self-injury is generally not about trying to end one's life, then what is it about? This is the question I attempt to address in the rest of this book.

Chapter 3 discusses the broad category of direct self-harm, which can be divided into two groups: suicide and self-injury. When clients discuss plans to use (or actually employ) such methods as shooting, hanging, self-poisoning, jumping from a height, cutting the neck, stabbing through the heart, or performing massive abdominal puncture, it is appropriate to conclude that their intent is suicidal. These are high-lethality behaviors that frequently result in death. In contrast, if clients discuss performing, or actually perform, acts of cutting, excoriation, self-hitting, self-burning, or self-biting on themselves, it is appropriate generally to view the behaviors as self-injurious rather than suicidal.

Frequency of the Behavior

Another point of distinction between suicide and self-injury is the frequency with which the behaviors occur. In general, self-injury occurs at much higher rates than suicide attempts. The large majority of people who attempt suicide do not do so recurrently or frequently. The most common pattern is that people attempt suicide once or twice when they are in a particularly stressful period in their lives (Nock & Kessler, 2006). For most persons, this type of crisis period passes, and they move on with their lives. Most individuals are resilient and/or obtain professional help and are unlikely to attempt suicide again.

However, there are others—those in the minority—who attempt suicide recurrently over extended periods of time (years or even decades). These are usually persons who have a serious and persistent mental illness (e.g., major depression, bipolar disorder, borderline personality disorder [BPD]). Most frequently, it appears that those who recurrently attempt suicide employ pill overdose as their methods. These individuals appear to know how much prescribed or over-the-counter medication they can ingest and still survive. Or they may take serious, even lethal dosages, but quickly disclose their actions to others, resulting in protective intervention. However, even for these individuals, the rates of their attempts pale in comparison to rates of self-injury in many persons.

Many, probably the majority, of self-injuring persons perform the behavior frequently. A commonly reported frequency by self-injuring clients is 20–100 times over a multiple-year period (Walsh & Rosen, 1988). Even adolescents who are in their early teens describe a several-year course of self-injury, with as many as 20–30 episodes per year. For example, in my own clinical experience, I have encountered two 14-year-olds who cut themselves over 150 times in a single week! It is very common for self-injury to be a high-rate behavior.

Sometimes the frequency of self-injury can be hard even to count for some clients. Consider this example:

> Eloise's favorite form of self-injury was to cut many finely executed parallel lines on her left forearm. She would begin near her wrist and cut progressively up her forearm until she reached the inside of her elbow. On one occasion, as part of a behavioral assessment, we attempted to count the exact number of separate and distinct cuts executed during a single episode. The count was about 78. Also, several days after inflicting such self-injury, Eloise would tend to reopen the wounds by scraping a razor blade "across the grain" repeatedly. This type of self-harm defied any attempts at counting.

Many persons self-injure many (even hundreds of) times. Almost no one attempts suicide at such rates.

Multiple Methods

Another point of distinction between suicide and self-injury is whether the perpetrators use multiple methods. Research has shown that individuals who repeatedly attempt suicide tend to use the same method (Berman, Jobes, & Silverman, 2006). Although there are no precise statistics on these individuals, clinical experience suggests that most of them employ one method over time, that being overdose. In contrast, most self-injuring persons use more than one method. Note that in my small-sample study of

adolescents mentioned above, over 70% employed more than one method. In the Favazza and Conterio (1988) study cited above, 78% of 250 responders had used multiple methods. And Whitlock, Muehlenkamp, and Eckenrode (2008) also reported a rate of 78% using multiple methods in their young adult community sample.

The use of more than one method may be related to at least two factors: preference and circumstances. Many self-injuring persons state that they use different methods of self-injury because they prefer to do so. For example, some self-injuring people say that they cut when they are anxious and burn when they are enraged. Others say that they cut when dissociating but hit themselves when angry. The range of links between types of affective distress and forms of self-injury is almost infinite. An important detail in the assessment and treatment of self-injury is determining whether an individual uses more than one method and, if so, how he or she decides on a specific method at any point in time.

Sometimes the decision on method of self-harm is more related to circumstance than personal preference. For example, adolescents placed in a group home or an inpatient unit may have difficulty obtaining a razor to cut because of close staff supervision. Although cutting may be their preferred method, they may have to resort to scratching, hitting, or biting due to the unavailability of the preferred tool.

Level of Psychological Pain

Shneidman (1985) emphasized that "unendurable, persistent pain" drives the suicidal crisis. The misery of the suicidal person is so profound, deep, and excruciating that it is intolerable—unlivable. Moreover, the pain is persistent, wearing down the person and producing profound psychic fatigue. Given the phenomenological experience of this pain, it is no wonder that the suicidal person contemplates a permanent escape. For the large majority of suicidal persons, this experience of intense pain is fraught with significant cognitive and emotional distortions. Nonetheless, within the mindset of suicidal persons is a certain logic that compels them in the direction of suicide in order to escape.

In contrast, a different type of psychic distress characterizes self-injury. The pain of the self-injuring person is intense and uncomfortable, but it does not reach the level of a suicidal crisis. The psychological anguish is interruptible and intermittent, rather than permanent and unalterable. One reason for the difference is that the self-injury itself offers a method to interrupt and reduce the pain, rendering it temporary and partial.

Muehlenkamp and Gutierrez (2007) conducted a study of adolescents that compared those who self-injured with those who had attempted suicide.

They found that those who self-injured, but had not attempted suicide, had lower ratings on hopelessness, more developed reasons for living, a stronger future orientation, and more fear of suicide than those who had attempted to kill themselves. These important findings support the clinical impression that the levels of psychological pain are different for the two forms of self-harm.

Constriction of Cognition

Another key feature of a suicidal crisis is cognitive constriction. Shneidman (1985) has used several terms to explain this mindset, including "constriction," "tunnel vision," and "dichotomous thinking." They all mean essentially the same thing: In a suicidal person, life is channeled down to an all-or-nothing option. The person thinks in a radically narrow or constricted way. A particularly common example is the belief "I must have this relationship with this person, or I must die," but there are many other scenarios. Here are some other examples encountered in clinical practice:

"If I lose my fortune, I will kill myself."
"If this disease is incurable, I will end it all."
"I can't tolerate getting a bad grade. If I get a mere B, I'll overdose."
"If I can't get this job back, I'll kill my boss and myself."
"If I can't have custody of my children, no one will."

(Note that the last two are murder–suicide scenarios.) However diverse the content, all these examples have constricted thinking in common. The basic formula is "*X* must happen, or I must die."

Self-injury is not characterized by dichotomous thinking. More frequently than not, the thought process of self-injuring individuals is disorganized rather than constricted. They do not reduce their lives to an all-or-nothing predicament. Rather, they still perceive themselves to have choices in their lives and options from which to select. One of these options—and not the best one—is to self-injure. For self-injuring persons, the option to cut or burn is oddly reassuring.

Helplessness and Hopelessness

Suicide research has long identified both hopelessness and helplessness as important components of depression and suicidal behavior (Beck, Rush, Shaw, & Emery, 1979; Seligman, 1992; Milnes, Owens, & Blenkiron, 2002). "Helplessness" refers to a loss of controllability (Seligman, 1992). People who feel helpless believe that they have no real influence or control over

their situations. They are convinced there is nothing they can do to affect or improve their lives. Such cognitive pessimism is very conducive to the "giving up" that suicide entails.

"Hopelessness" is the counterpart to helplessness. When people feel hopeless, they believe that their pain is endless, permanent; they have no future. Persons in a suicidal crisis feel unendurable pain that seems infinite and over which they believe they have no control. Within such a bleakly pessimistic mindset, it is no wonder that people consider suicide as the remaining option.

Another way to describe the helpless and hopeless world view of the suicidal person is in terms of the "cognitive negative triad of depression" (Beck et al., 1979). Within this perspective, suicidal people think, "I'm no good [self], everything around me is terrible [world], and nothing will ever change [future]."

In contrast, helplessness and hopelessness do not characterize the self-injury scenario. Self-injuring persons generally do not feel that they have no control over their psychological pain. In fact, the option of self-injury provides a key sense of control. Most self-injuring people find it reassuring that cutting, burning, or some other form of self-harm is available whenever they may need it to reduce distress. The control that self-injury offers is antithetical to hopelessness. The future is not one of endless inescapable pain, because self-injury often works as a tension-reducing mechanism. Granted, self-injuring persons may be episodically pessimistic and despair that their lives include so much discomfort. But their distress lacks the sense of inescapability and permanency that is fundamental to the suicidal crisis.

Psychological Aftermath of the Self-Harm Incident

The aftermath of suicidal behaviors also differs from that of self-injury. Most people who survive a suicide attempt report feeling no better following the attempt. Instead, they often report feeling even worse. They may make bitterly self-critical comments, such as "I even screwed this up—I'm such a loser," or "I didn't even kill myself right." Other statements include "I didn't have the guts to do it, but next time I will," or "Now I feel even worse than I did before I took the pills." These are people who, despite the attempt at suicide, have in no way diminished their psychological pain and their intent to kill themselves. One case vignette conveys the tone and content of the suicidal aftermath quite well:

Erin was a 17-year-old with a history of depression and recurrent suicide attempts by overdose. Recently released from a psychiatric unit where she was deemed to be safe, Erin became enraged and despondent when her mother was critical of her. Erin walked to

a nearby bridge and jumped from a 30-foot height into frigid winter water. She survived only because an off-duty policeman saw the incident and pulled her out. Once medically cleared, Erin was immediately placed on a locked psychiatric unit.

Interviewed the next day on the ward, Erin was asked if she was feeling any better. In a bitter, sarcastic tone, she spat out her reply: "My only regret is that I didn't jump off something higher onto something harder!"

This vignette points to the common features of a suicide attempt's aftermath. The person often shows persistent, intense psychological pain and high-lethality intent even after the attempt.

The aftermath of self-injury behavior is often the *direct opposite* of the reaction following a suicide attempt. The "draw" of the self-injury episode is its effectiveness in reducing emotional distress. Moreover, the relief obtained is *immediate*. Self-injuring persons emphasize the importance of the relief obtained and the accessibility of the effect. They make such comments as these:

> "As soon as I cut, it was like all the anger was let out, and I felt so much better."
> "After cutting my arms or legs, all the tension leaves my body, and I can go to sleep."
> "Once I burn myself, I can see my rage on the outside, so I don't have to feel it inside any more."

Clinicians should be especially alert when clients report that their self-injury is no longer producing the desired outcome. When self-injury fails to provide its usual "therapeutic" effect, persons who rely on it for relief can begin to feel hopeless and helpless and may start to panic, feeling that the pain is inescapable. This loss of escape can catapult such persons into a suicidal crisis. The pain is no longer manageable and within their control. As the pain escalates and they are unable to reduce it, the conditions for a suicidal crisis may emerge, and protective intervention may be necessary. In such cases, the individuals will switch methods from those associated with self-injury to those associated with acts of suicide.

Restriction of Means

Another key distinction between suicide and self-injury has to do with restriction of means. It has long been established that restriction of means is an important, often life-saving intervention with suicidal behavior (Jacobs, Brewer, & Klein-Benheim, 1999; Berman et al., 2006). Examples include confiscating firearms and pills, erecting protective barriers on bridges, and

moving from coal gas to natural gas as a heating fuel in the United Kingdom (Kreitman, 1976). Every graduate student is taught that a basic aspect of performing a suicide assessment is to ask the client (and significant others) about access to lethal means. And if the answer is affirmative, a first course of action is to restrict those means.

In contrast, it is not at all clear that restricting means is an effective strategy in responding to self-injury. In fact, in my experience, restriction often appears to be counterproductive. There are two main problems with attempting to restrict means with those who self-injure. First, it is impractical. It is virtually impossible to remove all means of self-injury. I have often encountered staff members from inpatient units or residential programs who are intensely, even fiercely, committed to preventing self-injury. Although their intentions are good, the results are often less than effective. In consulting to workers in these settings, I often make the point: "If you are so committed to preventing self-injury, don't forget to remove your clients' fingernails, fists, and teeth. And in the environment, don't forget to remove every staple, CD case, hard floor, or wall." In other words, it is impossible to provide such safety and prevention.

A second and related problem with using coercive and intrusive methods of supervision is that they often inadvertently provoke those who self-injure. It can be immensely triggering to have one's body, room, and/or belongings searched for "sharps" or "weapons." The mere process of "preventing" self-injury can paradoxically produce it. A far more promising strategy is to emphasize the collaborative teaching of skills with clients to replace self-injury. This approach is discussed in detail in Chapter 11.

The Core Problem

The core problem for the suicidal person is usually some combination of depression, sadness, and rage about his or her primary source of unendurable pain. Maltsberger (1986) has emphasized that the despair that drives a suicidal crisis is not only about sadness, loneliness, and isolation, but also includes elements of "murderous hate." This hatred provides much of the energy for the suicidal behavior and is often directed both at the self and at others.

The challenge in assisting suicidal individuals is therefore to identify the primary source of unendurable pain and to reduce it. Shneidman (1985) stresses that if a professional can add a third term to the dichotomous thinking of a suicidal person, then suicide risk will be reduced. For example, if the constricted thinking of such an individual is "I must have this relationship, or I will die," adding a third term might mean introducing the option

of counseling with a focus on the relationship. The dichotomous scenario of "This must happen, or I will die" is expanded (and lethality simultaneously diffused) by adding a third term: "This must happen, or I will die, *or* I will address the relationship in counseling."

Finding the *specific* source of the unendurable, inescapable pain is the primary focus in working with suicidal persons. The more precisely defined the source, the more effective the work is likely to be. Moving from the global (e.g., "All of my life is terrible") to the idiosyncratic (e.g., "I'm tired of being humiliated by my boss at work") is at the heart of the therapeutic work.

In contrast, the core problem for many self-injuring persons often involves their body image. Not surprisingly, many people who repeatedly hurt their bodies often have especially negative attitudes toward their bodies (Walsh & Rosen, 1988; Alderman, 1997; Hyman, 1999). For many, a profound sense of body alienation or body hatred drives them to self-injure. Key questions that become central foci in the treatment of self-injury are "Why do you repeatedly inflict harm on your body?" and "What are the origins of this relationship with your body?" The relationship between body alienation and self-injury is discussed at length in Chapter 15.

However, one emerging group of self-injuring persons does not appear to have significant body image problems. This group appears to consist of healthier individuals from community samples (as opposed to clinical samples), who have surfaced only since the late 1990s as a self-injury phenomenon. The core problem for these individuals appears to be a combination of intense stress, inadequate self-soothing skills, self-denigrating thoughts, and peer influences that endorse self-injury. The challenges that drive these individuals to self-injure are reviewed in Chapter 4.

CONCLUSION

This chapter has set the stage for the rest of the book. A formal definition of self-injury has been provided and explained. In addition, suicide has been differentiated from self-injury in terms of 11 key characteristics:

- Prevalence
- Intent
- Level of physical damage and potential lethality
- Frequency
- Use of multiple methods
- Level of psychological pain

- Constriction of cognition
- Helplessness and hopelessness
- Psychological aftermath
- The utility of restriction of means
- The overall core problem

The next chapter deals with self-injury as a risk factor for suicide attempts.

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