THE POWER OF SELF HARM

CONSIDERING THE PSYCHODYNAMICS

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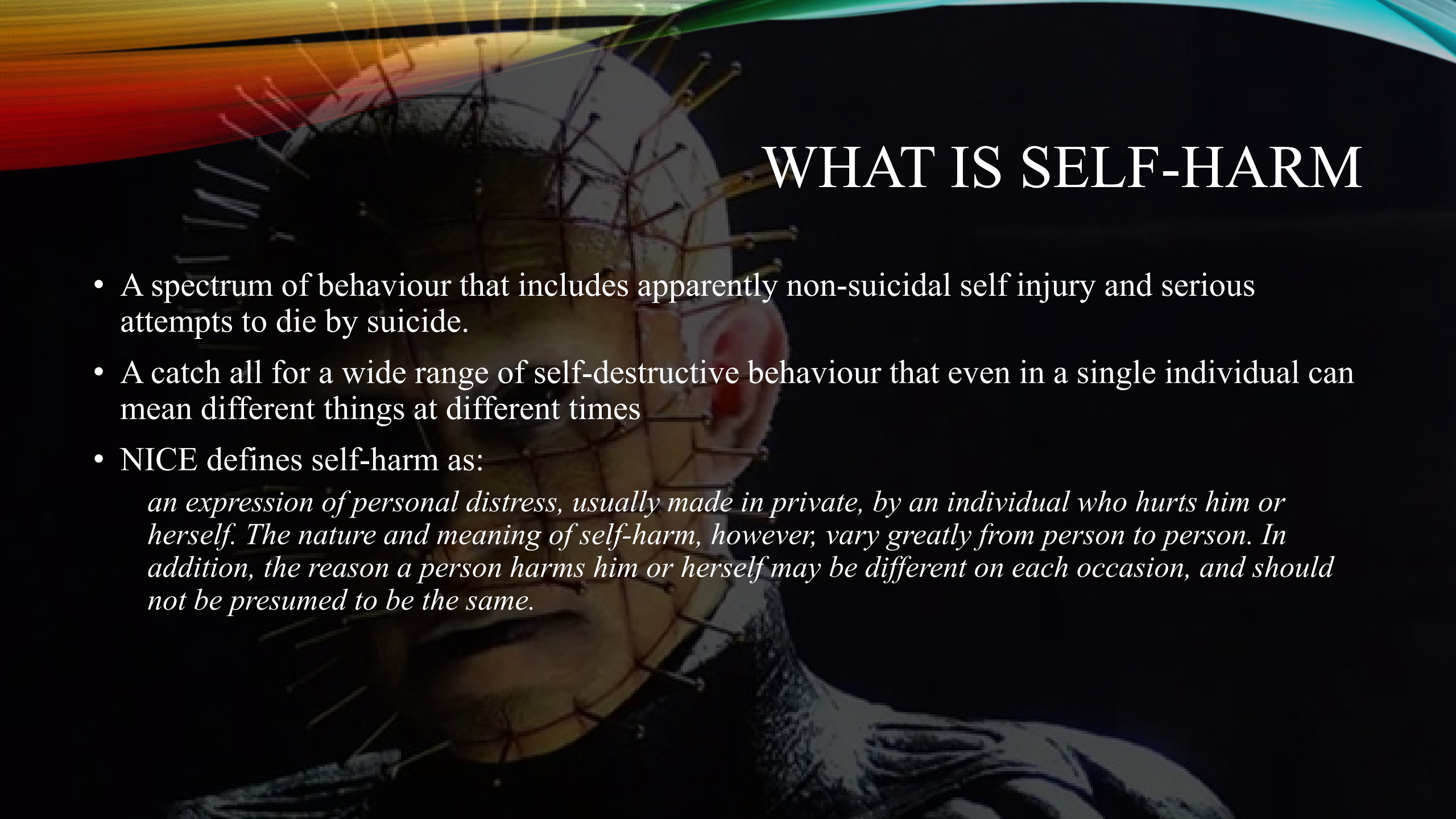
Painting Sonya Shmyk

- *He remembered the sensation, the satisfying slam of his body against the wall, the awful pleasure of hurling himself against something so immovable. . . .*
- *. . . he soon grew to appreciate the secrecy, the control of the cuts. . . . When he did it, it was as if he was draining away the poison, the filth, the rage inside him.*

- *Hanif Kureishi – A Little Life [1]*

SUMMARY

- What is self harm
- Types and methods
- Epidemiology
- Motivation
- Theoretical understanding
- Countertransference, individual and environmental
- Management



WHAT IS SELF-HARM

- A spectrum of behaviour that includes apparently non-suicidal self injury and serious attempts to die by suicide.
- A catch all for a wide range of self-destructive behaviour that even in a single individual can mean different things at different times
- NICE defines self-harm as:

  an expression of personal distress, usually made in private, by an individual who hurts him or herself. The nature and meaning of self-harm, however, vary greatly from person to person. In addition, the reason a person harms him or herself may be different on each occasion, and should not be presumed to be the same.

TYPES AND METHODS

- Self-harm encompasses a wide range of activities:
  - less acutely dangerous and habitual
  - The severe and bizarre
  - The clearly life-threatening and suicidal
- The method used will have an unconscious meaning for the patient.
- Self-cutting and self-poisoning with medication are among the most common methods of self-harm in high income countries such as the UK

EPIDEMIOLOGY

- Self-harm largely occurs in the community
- 10 to 20 percent of people worldwide report having self-harmed at least once
- Three times more common in women than men.
- There is evidence over recent years of a threefold increase in reported self-harm across the population of young people in general, and women in particular.

THE STRONGEST INDICATOR FOR FUTURE DEATH BY SUICIDE

- The risk of dying by suicide in the 12 months following a presentation of self-harm is around 30 times higher than the expected rate in the general population.
- Almost half of those who end their life by suicide have previously harmed themselves
- the more violent the method of self-harm, the greater the chance of suicide

MOTIVATION

- A means of communicating

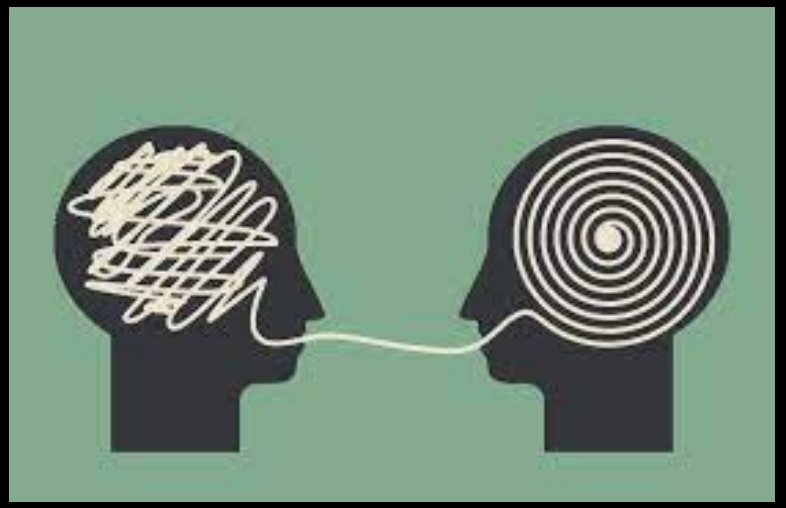
  Alan was admitted to a psychiatric ward after presenting to A&E. He had taken a life-threatening overdose after an argument with his partner. He was a young man who seemed very composed and articulate. He shocked the team by coming into his first ward round in a T-shirt exposing bright red cuts and old scars interweaving up both arms.

MOTIVATION CONT:

- To regulate overwhelming emotions and regain a sense of control
- To contain traumatic memories
- Maintaining coherence
- A dysfunctional method of eliciting care
- As an addictive behaviour
- Protection both of the self and others
- Defence against intimacy

THEORETICAL UNDERSTANDING: NEUROSCIENCE

- Early trauma has been found to affect the development of the brain
- The right side, active from birth, functions in a less developmentally mature way. It is responsible for emotional and sensory memory.
- The left side, responsible for language and temporal memory, develops around the age of three and it is only after this time that memories can be stored linguistically and sequenced in time
- When overwhelmed in the here and now, the more mature left hemisphere of the brain shuts down leaving the more primitive right side of the brain to respond.
- There is a reliving of childhood memories in the present as a bodily experience.
- Those traumatised have an emotional system which, when triggered, responds to stimuli with greater speed and strength than in those who have not been traumatised .
- Self-harm on hand to acutely manage this psychological pain.



THEORETICAL UNDERSTANDING: ATTACHMENT

- 70–75 per cent of those who self-harm has an insecure attachment style compared to 15–20 per cent in the group that do not
- The quality of early childhood attachment is vital for the later capacity to mentalise and regulate emotions.
- Language development depends on having an attuned carer who can recognise and put into words the child's emotional experience. These words can then be learned by the child and used to store this experience in memory. Difficulties in this primary relationship can lead to an incapacity to put feelings into words.
- This inability to mentalise is related to insecure attachment.

'. . . at highest intensity, when distressed and anxious, nothing but a prolonged cuddle will do' Bowlby

Attachment System Activation

- For those with insecure attachment objectively minor events in the present can elicit strong emotionally dysregulated responses. These 'trigger' events elicit unconscious memories of past trauma and therefore may be perceived as overly abandoning or rejecting. A delayed reply to an email or text can be the spark that lights an emotional fire and causes activation of the attachment system.
- When stimulated, the attachment system generates a powerful drive to seek care and closeness to the primary attachment figure
- …proximity can be sought to the source of the maltreatment.
- In later life clinging, controlling (perceived manipulative) or panicked behaviour can elicit re-enactments of the original trauma and a vicious cycle ensues.

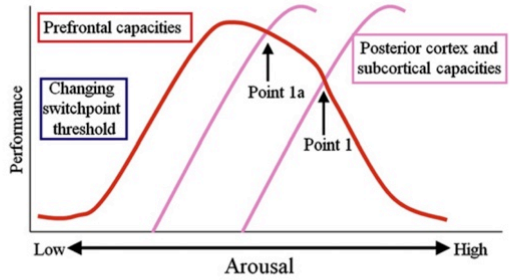


Fig. 5. Mayes' (2000)[129] adaptation of Arnsten's dual arousal systems model: implication of the hyperactivation of attachment. (*Adapted from* Mayes L. A developmental perspective on the regulation of arousal states. Semin Perinatol 2000;24:267–79; with permission.)

CASE EXAMPLE ATTACHMENT ACTIVATION

Ellen had been seriously neglected as a child, and was removed from her mother's care and placed with foster parents. She had a history of self-harm and had recently been referred to her local mental health team for depression.

She met for the first time with her new keyworker, Claudia, who had little experience of self-harming behaviour. She found Ellen appealing and during this meeting Ellen felt especially understood and cared for. Ellen found it very difficult to leave the appointment and go home to an empty flat. She felt anxious and abandoned. She tried phoning Claudia to seek reassurance. When Claudia did not answer her calls, Ellen's emotions overwhelmed her. She cut her arms very deeply and sought care for these wounds at the A&E department. Claudia had thought that she had a good session with Ellen and was surprised to get a call from the mental health team in A&E. She felt confused, let down and angry.

She did not want to talk to Ellen next time she called and gradually withdrew from contact.

Ellen felt rejected and abandoned, her self-harm increased and she had a brief hospital admission.

THEORETICAL UNDERSTANDING: PSYCHOANALYTIC THEORY

- Persecutory Superego, Underdeveloped Ego and Primitive Defences
  - The weak ego is divided, and the part identified with the hated abandoning object gets located in the body, and then attacked. The violence serves two functions, to punish the abandoning, and therefore, hated other, and to provide a self-punishment for the hatred and cruelty. A vicious circle then can occur. The more attacks, the more guilt for the attacks, the more punishment needed and so on
- The Role of the Skin
  - Esther Bick, the importance of the skin as the physical and psychic container of the self. She described how problems with separation and individuation can be expressed by and on the skin. Bell emphasises that the skin itself may be concretely felt to be the prison where the ego is trapped and tortured relentlessly by the persecutory superego.

IMPORTANCE OF UNDERSTANDING THE COUNTERTRANSFERENCE

‘. . .The diagnosis “borderline” describes an enmeshed clinical dyad in which at least the inner experience of both participants can begin to meet the criteria for the disorder’ Vallient.

COUNTERTRANSFERENCE RESPONSES

- **The promise of omnipotent mothering:** the projection of early infantile distress by those who self-harm communicates powerfully and primitively and can reciprocally activate the attachment system of the professional.

'*Borderline patients take the promise of mothering as seriously as they do the promise of a magic pill'. Groves*

- **Helplessness, confusion and uncertainty:** a need to 'do' something. It can also lead to an inappropriate certainty about diagnosis and treatment.
- **Repulsion:** undigested abusive boundary violation through projection
- **Hatred:** To deny this can lead to reciprocal disavowed violence.
- **Frustration and anger:** self-harm can be a communication of a complaint about the care provided. Taking this personally is a mistake
- **Pain and fear:** Powerful identification can occur with the projection of early separation anxiety, loss, and the fear of disintegration

PROFOUND EFFECT ON THE ENVIRONMENT

- Enactment of the Internal World
- Relationships between those that self-harm and the providers of their care can break down and instead of improvement there can be a decline in the mental health of all involved.

CASE EXAMPLE BREAKDOWN ON WARD

Chloe was admitted to an adolescent mental health unit because her parents were struggling to cope with their anxiety, after a shocking and unexpected overdose where she nearly died. They felt they could not trust her to stay alive.

In the adolescent unit Chloe would say she was fine, and then when she was given some independence would overdose. The restrictions increased and the self-harming behaviour also increased. Chloe started putting shoelaces and belts around her neck repeatedly.

The team that had been caring for her seemed exhausted and had lost all confidence in her capacity to improve. They became focussed only on trying to prevent Chloe from self-harming, neglecting other patients. They became very frightened of Chloe. What would happen to them if she died? They were sure they would be held responsible and punished.

Chloe's level of observation and restriction increased and she was transferred to a secure adult inpatient facility

DAVID BELL QUOTE

Such situations can result in a particularly deadly scenario. The patient recruits more and more people to become responsible for his own life. But the more individuals allow themselves to feel so responsible, the more the patient dissociates himself from the wish to live, now located in others. Further, as the patient becomes increasingly taken over by the cruel inner organisation, the sanity and concern now located in external others becomes the object of scorn and derision

MANAGEMENT

BASIC MANAGEMENT PRINCIPLES

- Have time and space to think about what the self-harming means for this patient at this particular time. Accept the self-harm and help the patient to think through the consequences of their actions
- Recognise and validate the patient's pain
- Maintain separateness and agree to disagree
- Avoid confrontation and consider oneself as a travelling companion who is trying to view the world from a similar vantage point
- Work within a group or a team, ensuring decisions are not taken in isolation
- Ensure there are regular structured reflective spaces including supervision and case discussion groups
- Develop alternative means of recognising and managing distress
- Develop a safety plan with the patient

CLINICAL ROLE AND REALISTIC RESPONSIBILITY

- If someone has capacity and is going to harm themselves, this is unlikely to be controlled and prevented by others in a coercive manner. It is important to work together with the patient and to see them as an equal and responsible adult in the development of their management plan.
- Talk from your adult and help recover mentalizing capacity
- Endings and transitions

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CONCLUSION

- Patients who have self-harmed need to be treated with compassion.
- This is not always easy because of the intense countertransference responses that self-harm elicits.
- Those who have recently self-harmed are in a vulnerable emotional state and are particularly sensitive to accepting or rejecting responses from professionals.
- To meet those who self-harm with an open heart requires: an understanding of the nature of the act, thoughtful and containing team structures, a therapeutic model that includes reflective spaces, and thoughtful compassionate leadership.
- When these conditions are met clinicians have greater confidence and less fear and uncertainty when approaching those who express their distress in this way.