



scottishdevelopmentcentre  
for mental health

**RUHBC**  
Research Unit in Health,  
Behaviour and Change



## **WRITTEN ON THE BODY**

**A review of literature on self-cutting**

**Prepared for the National Inquiry into Self Harm among Young  
People**

**Executive Summary**

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&  
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## **SUMMARY**

### **CHAPTER ONE INTRODUCTION**

As part of the National Inquiry into Self-Harm Among Young People, the Camelot Foundation and Mental Health Foundation commissioned the Scottish Development Centre for Mental Health (SDC) and the Research Unit in Health, Behaviour and Change (RUHBC) to undertake a review of literature on self-cutting.

The remit for the review was to identify and review UK published and 'grey' literature focusing on self-cutting among young people. An initial analysis revealed: a comparatively small pool of work focusing on self-cutting; little on self-cutting among young people; and even less on self-cutting among young people in the UK. To ensure as comprehensive a review as practicable the remit was extended to include international (English language) material relating to self-cutting, or which included self-cutting as one form of self-mutilative behaviour; and studies that included, but extended beyond, young people aged 11 – 25 years.

The three core aims of the review were to inform an understanding of: patterns of prevalence and incidence of self-cutting among young people; the risk and protective factors associated with self-cutting; and preventative and therapeutic interventions.

### **CHAPTER TWO SELF-CUTTING WITHIN A WIDER SELF-HARM CONTEXT**

The wider intellectual context within which self-cutting, as one form of self-injurious behaviour, is set is marked by continued debate about terminology and definitions, particularly the relationship between acts of attempted suicide and other forms of self-harm where the intention or motivation may not be suicide. Terms used include 'attempted suicide', 'parasuicide' and 'deliberate self-harm'. A recent taxonomy distinguishes between instrumental suicide-related behaviours and suicidal acts. The method of self-harm is a further axis of differentiation. Self-poisoning and self-injury

are the two major methods of self-harm that have been recognised. Although less is known about self-injury than self-poisoning, there is evidence to suggest that the underlying motivation is not typically oriented towards suicide.

The scale of self-injury is difficult to estimate. Data from research drawing on hospital-based samples do not give a true guide to the distribution of either self-poisoning or self-injury in the population, especially among young people. Available evidence does, however, suggest that self-injury is more common than self-poisoning among young people in the UK general population.

### **CHAPTER THREE                    LITERATURE REVIEW METHOD**

To identify published and peer reviewed material a range of social science, psychological and medical bibliographic databases were consulted. ‘Grey’ literature or work in progress was identified through direct contacts with individuals and organisations working in the field of self-harm and/or with children and young people, and through websites. Appendix 1 indicates the full list of contacts.

A range of search terms were used including *self-cutting*, *self-mutilation*, *cutting*, *carving*, *wrist scratching*, *self-wounding*, *self-harm*.

The material identified was roughly divided into three groups: studies which focused solely or specifically on self-cutting; studies concerned with self-mutilation/self-mutilative behaviour; and studies which addressed deliberate self-harm. A degree of judgement was used to determine the relevance of studies in the second and third groups: the acid test was “what does this tell us specifically about self-cutting, especially among young people”. In terms of age criteria, studies were included if the samples comprised just young people aged between 11 – 25 years, or which were mixed in terms of age, or where age was not specified. The material was systematically categorised using a specially devised coding frame (Appendix 2).

In total, just over 70 relevant articles and books were included in the review. Of these, 23 focused specifically on self-cutting: 14 related solely to children and young people, of which none were undertaken in the UK.

## **CHAPTER FOUR METHODOLOGICAL FEATURES OF THE MATERIAL IDENTIFIED**

Two categories of material were identified: primary research and literature reviews. Primary research included an extensive range of quantitative studies. These included: studies of prevalence and incidence of deliberate self-harm, including self-cutting; studies aimed at establishing the physiological, psychological, social and behavioural correlates of self-cutting; studies comparing different methods of self-cutting; and surveys of professional groups. The smaller proportion of qualitative studies included those seeking to explore the meanings which those who engaged in self-cutting attributed to their experiences. These smaller scale studies also included psychotherapeutic and psychoanalytic perspectives on self-cutting. A number of literature reviews were also identified. These were often targeted at specific professional audiences such as nurses and, in the US, school counsellors.

Research methods used included: batteries of standardised psychological and psychobiological tests analysed statistically; case record analysis; clinical case studies; and semi-structured or open-ended questionnaires. Authors using quantitative approaches recognised that they were identifying associations, not causality, and further, that they were not necessarily exploring meanings or motivations. Studies relying on case records could be hampered by the poor quality of recording information. While the majority of studies included reference to having obtained ethical approval, few describe the support mechanisms in place for those taking part.

Extending the remit of the review to include international material reveals a greater focus on self-cutting, as a distinct phenomenon, in countries such as Japan, Hong Kong, the US and Australia, than in the UK.

The sample populations varied in terms of size, from one-person clinical case studies to large-scale studies of deliberate self-harm (including self-cutting) among community populations. Reflecting the review inclusion criteria, samples comprised just adolescents or young people, or mixed age groups, for example people aged

between 17 – 47 years. Studies could also be distinguished between those that drew on largely ‘clinical’ populations, i.e. in-patients or out patients, and non-clinical samples drawing from school or prison populations. Both clinical and non-clinical samples raise their own questions regarding the generalisability of the findings to broader populations.

In terms of the socio-demographic composition of samples, women tended to predominate. Even in studies including both men and women there was no attempt at a gendered analysis. Further, studies rarely addressed differences in ethnic background. The sexual orientation of people in the samples was a further blind spot, while no studies were identified which included the experiences of people with disabilities. It is suggested that a more reflective approach to sampling is required in order to understand the ways in which different social factors – gender, ethnicity, sexual orientation, disability, as well as age - may impact on self-cutting among young people.

Qualitative studies provided an opportunity for representing the perspectives of people with experience of self-cutting. Only one study, however, explored the perceptions of those closest to the young person, their family and friends. It is suggested that ethical and access issues raised by a number of these studies should not be used as barriers to hearing, or listening to, the voices of young people.

## **CHAPTER FIVE    INCIDENCE AND PREVALENCE OF SELF-CUTTING**

Only a small number of studies were identified which provided data in a form which could be used to estimate incidence and prevalence of self-cutting among young people. Based on the limited evidence available, around 4% of adolescents *in the community* cut themselves over a 12-month period. The annual incidence of *hospital treated* self-cutting is about 31% per 100,000 population aged 15 – 19 years. Data based on the English prison population suggests an annual incidence rate of cutting and scratching among males and females (all ages) of 129 per 1000 population. In community and prison populations the rates are markedly higher among women than men. In hospital treated samples women aged 15 – 19 years have a higher rate, but among those aged 20 – 24 years the rate among men is higher.

## **CHAPTER SIX RESILIENCE FACTORS**

Very little work has been undertaken on the factors protecting young people from engaging in self-cutting. Where consideration has been given to protective factors, this has tended to focus on the role of supportive family and peer relationships. It is suggested that there is scope for further research to identify not just why some young people engage in self-cutting, but the reasons why others, in similar circumstances, do not.

## **CHAPTER SEVEN RISK FACTORS**

Several commentators make the point that it is not possible to develop a unifying theory to account for self-cutting among young people. To unpack some of the dimensions the review focused on: socio-demographic factors; social, psychological and biological factors identified to suggest why some people may be more predisposed to engage in self-cutting; the reasons why someone might engage in self-cutting; the association between self-cutting and other disorders; and the contribution “*hostile care*” may make in exacerbating self-harming.

In terms of socio-demographic factors, self-cutting was seen as a predominantly female behaviour. There was little work, however, which examined the relationship between self-cutting and gender as it affected young men and young women. What is required is research which: systematically explores and compares the vulnerability factors that impact on young men and young women; compares the meanings young men and young women give to self-cutting; and explores the specific factors that may give rise to self-cutting among young men.

Nothing was found in the course of the review which examined the impact of, for example, the experience of discrimination on self-cutting among young men and women from black and minority ethnic groups, or young people who identify as lesbian, gay, bisexual or transgender. Nor has any analysis been undertaken on the meanings people from these groups may give to self-cutting. Further, little research

has been undertaken exploring the impact of being in institutional care – whether residential or custodial – on self-cutting among young people.

The vulnerability factors identified in the literature to account for why some people may be more at risk of self-cutting than others included social, psychological and biological factors.

Social factors implicated included: childhood trauma, particularly the experience of childhood sexual abuse; parenting styles; adolescence; and exposure to environments in which self-cutting can be ‘learned’.

Psychological factors identified included depression, the experience of dissociation, and poor impulse control.

Biological factors included the operation of the ‘serotonergic system’, and the ‘endorphin rush’ that self-mutilation could engender; and the impact of psychophysiological arousal patterns.

Social, psychological and biological factors may begin to account for why some people are more at risk of turning to self-cutting. From the literature the reasons proposed for why they do fall into four overlapping categories: to communicate powerful internal emotional states that cannot be expressed verbally; to release tension and provide a sense of ‘relief’; to regain control, either personal control or control over situations in which they feel powerless; and as an adaptive alternative to suicide – a way of coping that stops people from attempting suicide.

The reasons why people continued to engage in self-cutting was associated with its ‘addictive’ or habitual quality, articulated either in terms of a biological response, or for the ‘good feeling it brings’.

Self-cutting was also found to be associated with eating disorders, particularly in women. Associations were also made between self-mutilation and borderline personality disorder (also particularly in women) and with personality disorder. The

ways in which the diagnosis of personality disorder is applied, and the nature of the samples used, make it difficult to unpack or identify the nature of the association.

Studies suggested that people who engaged in self-cutting may also harm themselves in different ways at different times and for different reasons. Self-cutting could also be associated with substance misuse and sexual risk behaviours.

A number of studies point to the negative responses people who engage in self-cutting may experience when they come into contact with professional caregivers. It has been suggested that this 'hostile' response can further reinforce emotional distress, exacerbating the risk of further self-cutting.

Issues arising from the discussion of risk factors include: first, that the relationships identified are probabilistic rather than deterministic, that is, while the experience of childhood abuse may increase the likelihood that someone turns to self-cutting it does not make it a certainty; second, multiple factors, both past experiences and current stressors may influence why someone engages in self-cutting; third, self-cutting may be just one of the forms of self-injurious behaviour to which someone may turn. Focusing on this alone may risk failing to see it as one part of the whole of an individual's experience. Fourth, what the literature does not consider is the potential impact of societal risk conditions such as inequality and discrimination on self-cutting among young people.

## **CHAPTER EIGHT INTERVENTIONS**

No studies were identified which systematically evaluated the effectiveness of different interventions. The discussion of therapeutic interventions, including prevention, is therefore based on descriptive accounts only.

Data drawing on presentations to A & E departments suggest that people who engage in self-cutting may be disadvantaged in terms of access to specialist services.

No studies were found which discussed or described the range of services required for young people who engaged in self-cutting. Young people, however, described the

characteristics of the services they would like to see available, namely for services to be non-judgemental and respectful, including protecting their confidentiality and privacy.

A range of different treatment modes have been attempted with people who engage in self-cutting, reflecting the “multifaceted” nature of self-injurious behaviour. The repertoire of therapeutic options described included: psychosocial interventions, behavioural techniques, pharmacological and preventative approaches.

Psychosocial approaches aimed to enable the individual to express feelings verbally, and to teach behavioural alternatives to self-injury such as emotion regulation strategies.

Behavioural therapies included Cognitive Behavioural Therapy and, in relation to people diagnosed as having borderline personality disorder, Dialectical Behaviour Therapy. The use of *covert sensitisation* techniques was described by one group of Australian researchers. Material was not identified in the course of the review to indicate how extensively these approaches have been used in the UK for the treatment of young people who engage in self-cutting.

Several studies included within ‘clinical guidelines’, a combined approach of psychosocial and pharmacological approaches.

Prevention, targeted at at-risk populations rarely featured in the material.

In addition to specific therapeutic approaches the literature addressed the social environment within which care was delivered. On the one hand, the issue of ‘contagion’ in in-patient and school environments was considered. On the other hand, a number of studies were concerned with the impact of way in which care was delivered. For people who engaged in self-cutting the responses of caregivers, particularly in A & E departments could be experienced as, at worst, humiliating and punitive. From the point of view of professionals, self-cutting in particular, and self-injurious behaviour in general, could present personal as well as therapeutic challenges. Several commentators suggested that there was a need for caregivers to

manage their own personal reactions in order to work successfully with young people who engaged in self-injurious behaviour.

To provide a service that respects and empowers a young person may also require accepting that the person may need to engage in self-cutting, rather than attempting, as a primary goal of therapy, the cessation of self-injurious behaviour. Arguably, however, this raises its own ethical and legal dilemmas for caregivers, dilemmas not addressed in the literature.

A number of studies explored the specific implications for particular professional groups, including nursing staff, school counsellors and social workers, of self-injurious behaviour among young people. A common thread was the suggestion that the professional worked with, and empowered, the young person, providing a safe, supportive environment, in which they could articulate and address their feelings and experiences. One study also described the role of social workers in supporting the parents and peers of young people who engaged in self-cutting, enabling them to respond appropriately.

Overall, current evidence on what works or does not work with young people who engage in self-cutting is limited for four main reasons: first, there is no research or analysis of different service models; second, there are no controlled studies systematically exploring the effectiveness of interventions for this group of people; third, even descriptive accounts need to be treated with some caution because of the ways in which the study samples are constructed, both in terms of age and gender; fourth, much of the literature focuses on clinical interventions, often based on hospital populations. Little attention has been paid to social models, to the prevention of self-cutting among young people, or to the promotion of positive mental health.

## **CHAPTER NINE CONCLUSIONS**

Despite the current media and public concern with self-cutting, very little UK literature was identified of relevance to the review. Extending the remit to include international material on self-mutilation revealed many of the same problems encountered in the Inquiry's review of material on self-harming among young people:

a focus on clinical settings and clinical interventions; little specifically on young people; a lack of studies evaluating the effectiveness of evaluations; and an emphasis on quantitative studies.

A number of common themes do though emerge. These include: the gendered nature of self-cutting; the limited work being undertaken to explore resilience factors; the significance attributed to pre-disposing factors such as childhood sexual abuse; the functions of self-cutting as a tension release mechanism and as a form of communication; the distinctiveness of self-cutting from attempted suicide; the use of a range of psychosocial, behavioural and pharmacological therapies; the significance of *how* care is provided.

For service providers, the review suggests a training need to enhance the capacities of practitioners to respond to the needs of young people who engage in self-cutting. In terms of further research, there is scope to develop a better understanding of the extent and nature of self-cutting in the UK. More also needs to be understood both about the differences between different methods of self-harm and the commonalities, that is, the fundamental factors that may impel young people to engage in *any* form of self-injurious behaviour. The distinctiveness of self-cutting from attempted suicide has potential implications for policy makers in the context of current approaches targeted at suicide reduction.

What the review also reveals is a failure to incorporate or consider the impact of the wider processes of social exclusion on self-cutting among young people. For policy, practice and research there is a need to widen the field of vision so that it encompasses the broader social agenda of tackling the social causes that may render young people powerless – a powerlessness that becomes visible by being written on the body.