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Deliberate Self-Harm in Clinical and Non-Clinical Populations

Approximately 4% of the general population and 14% of college students have engaged or currently engage in deliberate self-harm. The purpose of the Literature Review is to assess similarities and differences of demographic information, gender, age, frequency, prevalence rates, methods, and reasons of self-harm in both clinical and non-clinical samples. Definitions and alternate names of self-harm were presented, common misconceptions regarding gender were discussed, and frequency and prevalence rates in clinical and non-clinical samples were compared.

Self-harm is a common ritual in many of the world's cultures. However, the difference between ancient tattooing and piercing and deliberate self-harm is intent. Deliberate self-harm, often referred to as DSH, is a growing concern in all cultures. DSH is a relatively neglected issue such that many people are unaware how many people actually do harm themselves in order to relieve pain, stress, and negative emotions. Empirical research and public acknowledgement of self-harm began with the book, *Bodies Under Siege: Self-Mutilation in Culture and Psychiatry*, by Dr. Armando Favazza in 1987. Favazza brought the concern for DSH to the public, spawning much research relating to self-harm.

However, due to the relatively minimal empirical research on self-harm (hundreds of articles rather than thousands) there are numer-

ous inconsistencies in terms of gender, prevalence rates, frequencies, methods, and reasons for DSH, all of which appear to depend on the definition of DSH used in the research and the sample the researchers chose for their research (Nock & Prinstein, 2005).

Favazza defined DSH as "the deliberate, direct destruction or alteration of body tissue without conscious suicidal intent" (Favazza, 1998, p. 260), and some researchers use this definition (e.g. Nock & Prinstein, 2004, 2005). According to Favazza (1998), "deliberate" is the crux of the definition of self-harm; someone who accidentally harms himself is not considered a self-harmer.

One difficulty with Favazza's definition is that he includes tattooing and piercing as alternate forms of self-harm. However, the intent

behind tattooing and piercing tends to be more for aesthetic reasons than self-harm. Conterio, Lader, and Bloom (as cited in White, Trepal-Wollenzier, & Nolan, 2002) proposed several questions that could separate DSH from other acts: “(a) Is there a compulsive need to engage in the behavior? (b) Is the self-injury a result of artistic self-expression or does the person feel a ‘high’ from the behavior? (c) Does the behavior consume the person’s thoughts or interfere with daily functioning? (d) Could the person realistically stop the behavior?” (p. 105-106). Depending on the answers to the questions, the action is either labeled as self-harm or not.

Krietman (as cited in Clarke et al., 2001) included the ingestion of substances in excess of the therapeutic dose with Favazza’s definition. Whereas, Harriss, Hawton, and Zahl (2005) define self-poisoning “as the intentional self-administration of more than the prescribed dose of any drug, and includes poisoning with non-ingestible substances, overdoses of recreational drugs and severe alcohol intoxication where clinical staff consider such cases to be acts of self-harm” (p. 60). Gratz (2001) and Gratz, Conrad, and Roemer (2002) claim that the resulting injury must cause tissue damage to classify an act as DSH.

Many terms have been associated with self-harm throughout the literature including (a) attempted suicide, (b) suicidal behavior (Skegg, Nada-Raja, Dickson, Paul, & Williams, 2003), (c) deliberate self-harm (Favazza, 1998), (d) self-mutilation (Stanley, Gameroff, Michalsen, & Mann, 2001), (e) self-injurious behavior (Paul, Schroeter, Dahme, & Nutzinger, 2002; Warm, Murray, & Fox, 2003), (f) direct self-injury (Deiter, Nicholls, & Pearlman, 2000), and (g) near-fatal deliberate self-harm (NFDSH) (Douglas et al., 2004). The plethora of different terms used by researchers to describe DSH complicates the literature. Some studies exclude extreme cases of DSH and other studies include only extreme cases.

Prior to Favazza’s *Bodies Under Siege*, DSH had been relatively unnoticed for nearly 150 years. According to Favazza, the first published

article on DSH was written by Bergmann (as cited in Favazza, 1998) and was about a 48-year-old female who had removed her own eye and asked a doctor to amputate her legs and arms in the name of God. However, it was not until much later in the 1960s that DSH became a more common interest of psychologists and psychiatrists. During the 1960s self-cutting became the common understanding of self-harm rather than the medieval castration and amputation that had been previously reported (Favazza, 1998). From the 1960s until the publication of *Bodies Under Siege*, few cases of DSH were addressed in mainstream psychiatry. However, since 1987, hundreds of thousands of cases of DSH have been recorded, but still very few researched. Nearly 14% of the general population has harmed themselves at least once according to Favazza (as cited in Gratz, 2001) and Ross and Heath (2002). Considering the number of presented cases of DSH, the literature concerning DSH is lacking direction and continuity.

If the current literature could be assessed as a whole and a consensus could be made, then individuals who deliberately harm themselves could benefit from researchers and psychiatrists having a clearer understanding of their reasons for and methods of self-harm. This literature review attempts to organize the methods, reasons, and demographics of deliberate self-harmers from clinical and non-clinical samples. Researchers have often disagreed on the image of the deliberate self-harmer, methods of DSH, and reasons for and correlates of DSH. The disagreement surrounding the image of the self-harmer is usually based on the common age of onset of DSH, prevalence rates, frequencies, gender, and sexual orientation. Methods of DSH are often a problem within the research due to the different methods chosen by the researchers. Some researchers include some methods and others exclude certain methods. The most agreement in the literature is found in the reasons for and correlates of DSH. There are unanimous underlying correlates of self-harm, but there are also some additional possible correlates of DSH found by some researchers.

Image of the Self-Harmer

Researchers have examined many different demographic features to describe the individuals who use self-harm. However, the literature tends to vary in descriptions of age of onset, prevalence, frequency, gender, sexual orientation, and reported abuse of individuals who self-harm in clinical and non-clinical samples (Deiter et al., 2000; Favazza, 1998; Gratz et al., 2002; Hawton, Harriss, Simkin, Bale, & Bond, 2004; Nada-Raja, Skegg, Langley, Morrison, Sowerby, 2004; Nock & Prinstein, 2004, 2005; Ross & Heath, 2002; Skegg et al., 2003). In fact, characteristics of clinical and non-clinical samples tend to be very different.

One notable area of agreement in clinical and non-clinical samples is age of onset for self-harm. According to Favazza (1998), the typical age of onset for repetitive self-harm is adolescence with a typical course lasting 10 to 15 years. In 1998, Favazza described the "typical" self-harmer as a 38-year-old white woman who has harmed herself on at least 50 occasions since the age of 14 and uses self-cutting, self-burning, and self-hitting as her methods of self-harm. The current literature has maintained relatively the same image of a self-harmer. Ross and Heath (2002) found that the common age of onset for DSH in a non-clinical sample was grade 7 or 8, supporting Favazza's assertion of self-harm generally starting at or around age 13. However, the age of onset could be around 11 or 12, according to Ross and Heath who found that 24.6% of individuals in the non-clinical sample said they began harming themselves prior to the sixth grade. Nock and Prinstein (2004) found similar results in a clinical sample with most individuals reporting their first self-harm incident at age 12.8.

In a study by Briere and Gil (as cited in Nock & Prinstein, 2004, 2005), prevalence rates of self-harm range widely from 4% in non-clinical samples to 82.4% in clinical samples. Nada-Raja et al. (2004) discovered that nearly 16% of women and 11% of men had engaged in self-harm in their lifetime in a non-clinical popula-

tion. The highest prevalence of self-harm in non-clinical populations may come from Gratz (2001) who reported that 35% of a college sample reported a history of DSH. Gratz used "a history of self harm" to describe both individuals who have had a single incidence of self-harm and individuals who repeatedly self-harm, whereas researchers using clinical samples also deal with repetitive self-harmers. Nock and Prinstein (2004) found that only 7% of clinical samples engaged in only a single episode of self-harm. Nock and Prinstein (2005) found that 82.1% of individuals reported self-harm among their friends in a clinical sample. Nock and Prinstein claim that the high prevalence rate of DSH between friends may be a sign of social modeling. In summary, prevalence rates of self-harm seem to average about 13.9% according to Ross and Heath (2002), which is consistent with Favazza (as cited in Gratz, 2001) who found an average of 14% of adolescents reporting self-harm. As is the case with all factors relating to self-harm, the source of the sample is pertinent to the prevalence of self-harm. Non-clinical samples have seen rates of self-harm between 4% and 36%, which is drastically different from the 80% to 90% found in clinical samples (Nock & Prinstein, 2004, 2005).

The frequency of self-harm seems to be inconsistent across the literature as well. However, Gratz (2001) and Gratz et al. (2002) found very similar frequencies of self-harm in their studies. Of the individuals who repeatedly self-harm, 15% of them reported DSH more than 10 times and 9% of them reported having harmed themselves at least 100 times (Gratz, 2001). Gratz et al. (2002) similarly found that 18% of individuals who self-harm have done so more than 10 times and 10% of them have harmed themselves more than 100 times. In contrast, Ross and Heath (2002) found that 27% of those who harm themselves do so a couple of times a week, and 19.6% harm themselves a couple of times a month. The frequencies of Ross and Heath seem to contradict those of Gratz (2001) and Gratz et al. (2002) with much higher numbers for those injuring themselves more often

and lower numbers for those injuring themselves less often. The difference in frequency may be due to the way the questions were presented to the subjects. Gratz (2001) and Gratz et al. (2002) assessed individuals' frequencies based on cut-offs (e.g. less than or more than 10 times and less than or more than 100 times), whereas Ross and Heath were asking individuals how many times they self-harmed on a weekly and monthly basis. Seemingly, a self-harmer who has harmed himself over a hundred times would also have a high average weekly frequency rate of DSH. However, the self-harmer may harm himself more than a hundred times, but may not be the same person that harms himself on a weekly basis; individuals may harm themselves multiple times for only certain dilemmas. Nock and Prinstein (2004) found 80 incidents to be the average number of times individuals self-harmed within the last year in a clinical sample. As with every other descriptor of self-harm, the frequency of self-harm will depend on the methods that are used in the research and the sample studied. Studies including more typical methods of self-harm (e.g., cutting, burning, and hitting) will have higher frequencies than the studies using more serious methods of self-harm (e.g., amputation and castration) as defined by Favazza (1998).

The most inconsistency across the literature concerning DSH is found in the prevalence rates of male and female self-harmers. Researchers have often thought that self-harm was primarily a female problem (Gratz et al., 2002). However, some of the current research has been unable to show a significant gender difference in rates of DSH (Gratz et al., 2002; Nock & Prinstein, 2004), and according to Ross and Heath (2002), males are more likely to self-harm than females. Gender appears to yield different rates when different definitions and/or methods are used in defining self-harm as seen in the current literature comparing self-poisoning with self-cutting (e.g. males and females in clinical samples are prone to use different methods of self-harm). Males are more prone to self-cut whereas females are more prone to poison themselves

(Hawton, Fagg, Simkin, Bale, & Bond, 2000; Hawton et al., 2004). The inconsistencies within the literature may be due to the way self-harm is defined by researchers and the samples studied, which could confound the results of the study (Ross & Heath, 2002).

Prior research has shown differences in rates of suicide among individuals with different sexual orientations; however, few have correlated DSH with sexual orientation. Skegg et al. (2003) found significant differences in sexual orientation among individuals who self-harm in non-clinical samples. More specifically, Skegg et al. found differences among groups of self-harmers who have only opposite sex attraction (7%), minor same-sex attraction (29%), and major same-sex attraction (38%). This research shows that there is a strong correlation between those who are exclusively homosexual and those who self-harm. According to Skegg et al. the same applies to suicidal ideation and the number of suicide attempts. According to the current research, the definition of the typical self-harmer as identified by Favazza (1998) may benefit from including information regarding sexual orientation as well. Also, due to the growing "known" number of homosexuals, they may benefit from some public attention regarding the issue.

Several studies (Deiter et al., 2000; Dohm et al., 2002; Favazza, 1998; Gratz et al., 2002; Paul et al., 2002; Warm et al., 2003) have found significant correlations between self-harm and a history of childhood abuse. Deiter et al. (2000) found that individuals who scored highest on the Inner Experience Questionnaire (IEQ) were significantly more likely to have a history of both self-harm and abuse with a significant correlation between childhood abuse and self-harm. Favazza and Conterio (as cited in Favazza, 1998) found that 62% of self-cutters reported a history of childhood abuse. Contrary to Favazza and Conterio (as cited in Favazza, 1998), Gratz et al. (2002) found that only 26% of individuals who self-harm have experienced physical abuse and 25% of individuals have experienced sexual abuse as children. Additionally, Warm et al.

(2003) discovered that nearly 36.2% of individuals who self-harm were victims of sexual abuse and 33.3% of physical abuse. Paul et al. (2002) further found that 16.8% of individuals who self-harm had also been sexually abused prior to the age of 13, and 20.7% of individuals had reported sexual abuse after this age. On the other hand Dohm et al. (2002) discovered that 70.7% of individuals who self-harm were either physically or sexually abused. While none of the prior research looked at eating disorders and their relation to self-harm, both Paul et al. (2002) and Dohm et al. (2002) studied samples including only individuals with eating disorders, which may account for the inconsistencies found within the literature. Sample type, clinical versus non-clinical, did not seem to play a part in the differences of individuals reporting a history of abuse. Nevertheless, a history of childhood physical and sexual abuse seems to be strongly correlated with DSH.

Methods of Deliberate Self-Harm

Methods of DSH appear to differ drastically across the literature depending on the subjects measured and time of the study. Methods of self-harm have included, but are not limited to, overdosing, self-poisoning (Hawton et al., 2004), self-stabbing, self-gassing, self-shooting, jumping, trying to hang, self-drowning, self-electrocution, crashing a vehicle on purpose, self-battery, excessive exercise, denying oneself necessities, self-biting (Favazza, 1998), skin picking, erasing skin, and inserting objects under the skin (Keuthen, Wilhelm, Fraim, & O'Sullivan, 2000). Favazza (1998) has sorted these methods of DSH with regards to severity into the following categories: *major self-mutilation* (e.g., castration and limb amputation), *stereotypic self-mutilation* (e.g., head banging, throat and eye gouging, tooth extraction, and joint dislocation), and *superficial or moderate self-mutilation* (e.g., skin-cutting, skin-carving, skin-burning, trichotillomania, nail biting, self-scratching, and needle sticking).

Researchers tend to use different selection/

exclusion criteria when researching methods of DSH. Certain studies exclude individuals who have a history of suicide attempts (e.g., Klonsky, Oltmanns, & Turkheimer, 2003) whereas other studies embrace these cases (e.g., Cooper et al., 2005; Fanous, Prescott, & Kendler, 2004; Guertin, Lloyd-Richardson, Spirito, Donaldson, & Boergers, 2001; Harriss & Hawton, 2005; Haw, Hawton, Houston, & Townsend, 2003; Stanley et al., 2001). Additionally, some of the literature eliminates self-harm cases that have resulted from excessive alcohol or illicit drugs (e.g., Clarke et al., 2001). However the research is conducted, the lack of a standardized set of methods of self-harm will continue to confound the results of each study, leading to inconsistencies across the literature.

According to Favazza (1998), self-cutting and burning are the most common methods of self-harm in non-clinical samples. The literature yields different results when considering clinical versus non-clinical samples, and individuals who self-harm and admit themselves to hospitals versus individuals who self-harm but do not admit themselves to hospitals. This is where the inconsistencies within the literature concerning methods of DSH arise. Several studies (Hawton et al., 2000; Hawton et al., 2004) have shown that one of the fastest growing methods of self-harm is self-poisoning among those admitted to a general hospital. Hawton et al. (2000) found that 88.7% of self-harm episodes involved self-poisoning, whereas only 7.5% of episodes involved self-injury, which was defined as any injury that was deliberately self-inflicted according to medical staff. Hawton et al. (2000) also found significant differences between males' and females' chosen methods of self-harm. DSH was found to be more common among males (13.2%) than females (2.6%), whereas self-poisoning was found to be more common among females (91.2%) than males (82.5%) for individuals admitting themselves to general hospitals. Hawton et al. (2004) also found significant gender differences with regards to methods of DSH in individuals who entered a general hospital. Hawton et al. (2004) found the same

results that they had previously uncovered in their prior research: 86.8% of individuals who self-harm chose poisoning as their method whereas only 8.4% of individuals chose self-cutting. Fifty-seven percent of self-cutters were male whereas only 42.8% of self-cutters were female; however, females (65.3%) were much more likely to poison themselves than their male counterparts were (34.7%), at least for patients admitting themselves to general hospitals. Nada-Raja et al., (2004) also verified gender differences with regards to methods in hospital populations. Nada-Raja et al. found differences between males who self-cut (9.1%) and females who self-cut (6.2%) and the comparison of females (83.3%) and males (89.1%) who self-poison. Gender plays an important role in distinguishing between likely methods of self-harm in individuals. However, all of the three aforementioned studies' data were obtained through clinical or hospital samples, which may limit the results to only clinical and hospital samples rather than the *typical* teenage cutter.

Gratz et al. (2002) found drastically different results when consulting a non-clinical college-student sample. Gratz et al. found that the most frequent forms of self-harm were needle sticking (16%), self-cutting (15%), and scratching (14%) with no relevant significance of self-poisoning. Guertin et al. (2001) also found carving in the skin (33%) to be the most common form of self-harm followed closely by skin picking at wounds (31%) in non-clinical samples. Cutting was also found to be the primary method of self-harm by Ross and Heath (2002). They found that skin-cutting was chosen by 41% of their sample followed by self-hitting, which occurred in 32.8% of the sample. Paul et al. (2002) discovered that nearly 46.2% of individuals who self-harm chose self-cutting as their method and Warm et al. (2003) found that nearly 96.7% of their sample chose self-cutting as their preferred method of self-harm. As seen above self-poisoning seems to range anywhere from 0.0% to 86.8% of a sample, whereas self-cutting ranges from 7.5% to 96.7% of individuals depending on the sample chosen for the study. Often in non-

clinical samples, self-poisoning is not introduced as a method of DSH because the repetitive self-harmer so rarely chooses it, whereas for clinical samples the results are often completely contradictory. These variations in sampling cause a great deal of inconsistency and contradictory findings within the literature (Nock & Prinstein, 2005).

Researchers have also found variability within specific methods of self-harm. Nada-Raja et al. (2004) found significant differences between individuals who self-cut their wrists (7.4%) and individuals who self-cut elsewhere (1.0%). Keuthen et al. (2000) found a significant difference between individuals who self-pick with and without self-injurious intentions with regards to location of the body of where they pick. According to Keuthen et al. most skin-pickers with self-injurious intentions tend to pick at more locations on the body (self-pickers with self-injurious intentions: 11.58 body locations; non-self-injurious self-pickers: 3.96 body locations). Keuthen et al. also found that self-injurious skin-pickers will pick at healthy skin, scabs, and mosquito bites more frequently than will non-self-injurious skin-pickers. With regards to self-poisoning Hawton et al. (2000) found a sharp increase in the use of paracetamol, a popular painkiller, from 38.4% of overdoses in 1985 to 65.1% in 1995. Hawton et al. (2004) also found a decrease in the use of minor tranquilizers and other drugs, but little change in the usage of antidepressants.

Reasons for and Correlates of Deliberate Self-Harm

DSH as a Coping Strategy

Researchers have been investigating reasons for and correlates of self-harm for nearly 25 years, and only recently have they come to a consensus across both clinical and non-clinical samples about why individuals self-harm (Haines & Williams, 2003). Many researchers have found depressive and anxiety symptoms as leading factors for deliberate self-harm in both clinical and non-clinical populations (Guertin et

al., 2001; Hawton, Kinsbury, Steinhardt, James, & Fagg, 1999; Ross & Heath, 2002; Ross & Heath, 2003). Evans, Hawton, and Rodham (2005) investigated the differences in feelings of individuals that deliberately self-harm and those who do not self-harm. They found that individuals that deliberately self-harm are more likely to identify themselves as having serious personal, emotional, behavioral and/or mental health problems than individuals who do not self-harm. Evans et al. further found that self-harmers are often more likely to feel the need for help, but not try to get any help than those who do not self-harm. This coincides with Guertin et al.'s (2001) understanding of deliberate self-harm as a vicious cycle of individuals seeking to be alone rather than seeking help from others.

Evans et al. (2005) assessed the communication efforts and trends of deliberate self-harmers. They found that only 46.7% of deliberate self-harmers looked for help prior to harming themselves and only half of those seeking help actually received help after harming themselves. This is very important when considering the prevalence of self-harm in that nearly half of the individuals who self-harm are not searching for or receiving help before or after harming themselves according to Evans et al. In terms of gender differences, females were more likely than males to get help before, but not after episodes of self-harm. Deliberate self-harmers told their friends about their self-harm prior to harming themselves in 72.4% of cases and 25% of self-harmers told someone in their immediate family according to Evans et al. According to Evans et al., 25% of individuals who deliberately harm themselves do not tell anyone before-hand, and of those who do tell somebody they often confide in their friends rather than their family members.

Harris (2000) found that for many self-harmers the notion of making their interior pain visible on the exterior of their body is a common motive in self-harming behavior. As illogical as self-harm appears to be, according to Harris, self-harm makes perfect logical sense to the individual. Individuals who self-harm often

describe a feeling of relief after self-harming. Most self-harmers feel the necessity to harm themselves in order to bear life, but hold no intentions of dying from the harm they are inflicting upon themselves; in fact they call self-harm "damage limitation" because for them, self-harm preserves their life (Harris, 2000). According to Harris, self-harm can be a way of limiting the potential damage to the self. Simpson (as cited in Favazza, 1998) went as far as to call self-harm "an act of antisuicide, for the cutting is used as a direct, reliable, and rapidly effective way of coming back from the dead unreal preceding state" (p. 261). Both Simpson and Harris claim that DSH is not the individual's way of trying to end his life, but rather his own way of preserving his life.

Most research has shown significant correlations between pain and self-harm, whether physical, social, or psychological pain (Haines & Williams, 2003; Theodoulou, Harriss, Hawton, and Bass, 2005). Theodoulou et al. (2005) found that 28% of individuals who admitted themselves to a general hospital for deliberate self-harm had current problems with physical health and/or physical illness and 17% deliberately harmed themselves as a result of their ongoing physical pain and/or illness. McBeth and Silman (as cited in Theodoulou et al., 2005) concluded that there is a strong correlation between physical pain and depression, which is often an underlying factor of DSH. Significant correlations have been found between depression and DSH in both clinical and non-clinical populations (Guertin et al., 2001; Hawton et al., 1999; Ross & Heath, 2002, 2003), which may explain the large number of cases of self-harm among patients with chronic pain.

As discussed previously, there is also a strong correlation between childhood sexual and/or physical abuse and self-harm (Deiter et al., 2000; Dohm et al., 2002; Favazza, 1998; Gratz et al., 2002; Paul et al., 2002; Warm et al., 2003). Ayton, Rasool, and Cottrell (2003) found that self-harm is significantly correlated with social deprivation. Ross and Heath (2003) found that nearly 78.7% of individuals deliberately self-

harm in order to relieve feelings of anxiety and hostility. However, in their non-clinical sample Ross and Heath found that 11.5% of the sample reported no feelings of anxiety or hostility, but rather feelings of sadness and loneliness prior to harming themselves. Guertin et al. (2001) concluded that individuals who self-harm reported greater levels of loneliness and anger expression than individuals who did not self-harm in a non-clinical sample. Ross and Heath also found that 62.3% of individuals deliberately harmed themselves in order to express their anger toward others. Guertin et al. found loneliness to be the only significant cognitive predictor of deliberate self-harm. They found that self-harming adolescents who were classified as clinically lonely were 5 times more likely than adolescents in the general population to deliberately harm themselves.

Several studies offer possible explanations for the strong correlation between social deprivation/loneliness and deliberate self-harm. Guertin et al. (2001) describe the connection between self-harm and loneliness as a viscous cycle. They claim that self-harmers may often isolate themselves from others in order to self-harm, which in turn leads to loneliness. They then deliberately harm themselves in an attempt to escape their loneliness, which creates a vicious never-ending cycle. Whether the pain is defined as hostility, depression, or anxiety it all relates to emotional pain, which Ross and Heath (2003) found to be the main reason for DSH for 67.2% of a non-clinical sample.

Suicide and DSH

There has been an ongoing debate within the literature about the inclusion of suicidal intent in measuring DSH. Various studies (Cooper et al., 2005; Douglas et al., 2004; Fanous et al., 2004; Harriss & Hawton, 2005; Haw et al., 2003; Nada-Raja et al., 2004; Stanley et al., 2001; Suominen, Isometsa, Haukka, & Lonnqvist, 2004) have specifically assessed suicidal intent in individuals who deliberately self-harm whereas some studies have eliminated cases of self-harm that involve past suicide attempts and/

or suicidal intent (Klonsky et al., 2003; Paul et al., 2002). More than a presence of suicidal ideation at the time of self-harm, there is also a strong correlation between DSH and future suicide attempts (Fanous et al., 2004; Hawton et al., 2003). Klonsky et al. claim that in order to assess a true self-harming population, individuals that deliberately self-harm with suicidal intent should not be included in analyses of data concerning self-harming samples. Deliberate self-harm has often been defined as parasuicide, which is a common misconception within the current literature. Contrary to the current literature, Douglas et al. (2004) did find a significant correlation between DSH and a desire to die as they had defined it. Douglas et al. used their own definition of self-harm and defined it as "near-fatal" deliberate self-harm, which includes only the most severe of deliberate self-harm cases in a clinical setting, which may have skewed the results. According to Nada-Raja et al. (2004) it is important to study and understand deliberate self-harm both with and without suicidal intent in order to understand the full range of self-harm. According to Suominen et al. (2004) deliberate self-harmers are at a 40-fold risk of eventual suicide compared to the general population, which is why research is necessary regarding individuals without as well as with suicidal intentions. Cooper et al. (2005) found a 30-fold increase in the risk of eventual suicide in deliberate self-harmers.

Most of the literature concerning deliberate self-harm with suicidal intent often assesses clinical samples rather than non-clinical samples due to the common presentation of suicidal attempts showing up more in general hospitals (Douglas et al., 2004; Harriss & Hawton, 2005; Harriss et al., 2005). Harriss and Hawton found that 21% of non-suicidal male deliberate self-harmers have at least a 5% probability of committing suicide in the future, 52% have a probability between 1-5%, and 27% of males have a probability of less than 1%. They further found that 5% of female deliberate self-harmers have a 5% probability of committing suicide in the future. Of the 555 deliberate self-harmers

Harriss and Hawton assessed, 4% (22) of the clinical sample committed suicide. Suominen et al. (2004) also ran an ongoing study with a 5-year follow-up in which 5% (57) of their sample had committed suicide since their presentation to a general hospital for DSH. Cooper et al. (2005) followed a group of 7,968 deliberate self-harmers and found the risk of suicide in the first year after their admittance to hospital to be 0.5%, which is much less than previous findings.

Haw et al. (2003) looked specifically at the potential lethality of self-harm episodes of individuals presenting themselves to a general hospital. They found that in 64.7% of deliberate self-harm cases, death is unlikely to result from their self-harm; however, they found death as a probable outcome in 18% of cases. They were unable to find any significant correlations between previous neither deliberate self-harm nor repeated self-harm and lethality. One of the individuals in whom the self-harm was defined as death-unlikely committed suicide during the follow-up period according to Haw et al. Their scores for lethality were verified by correlating subjects' lethality scores with their Suicidal Intent Scores in which they found a strong, but expected correlation.

Eating Disorders and DSH

Self-harm has become a noticeable symptom of many psychological disorders including antisocial, dissociative, and borderline personality disorder (Paul et al., 2002). In particular, self-harm has often been correlated with eating disorders because individuals who self-harm often have lower self-esteem than normal populations as do many individuals with eating disorders (Hawton et al., 1999). Dohm et al. (2002) found no differences between deliberate self-harmers with bulimia nervosa and self-harmers with binge eating disorders. They found a 10% prevalence rate of self-harm among individuals with eating disorders. Paul et al. (2002) found a 34.6% prevalence rate among individuals with eating disorders. Forty-nine percent of the patients with eating disorders began harming themselves after the onset of the

eating disorder, which correlates the two. Paul et al. further found that deliberate self-harmers had significantly higher scores on the Self-Harm Behavior Survey, which tends to point to a more severe eating disorder than individuals who do not deliberately harm themselves according to Paul et al.

Psychiatric Disorders and DSH

As previously stated, inconsistencies in the literature are often due to the sample studied, either clinical or non-clinical. Clinical samples included individuals who were currently inpatients at psychiatric hospitals at the time of the studies as well as individuals who had been diagnosed or treated for a psychiatric disorder in the past. Studies that include clinical samples tend to reveal the most information about psychological causes and/or correlates of self-harm. Sampson, Mukherjee, Ukoumunne, Mullan, and Bullock (2004) found that clinical patients who self-harm were significantly more likely to experience depressive symptoms. Sampson et al. used the Montgomery-Asberg Depression Rating Scale (MADRS) and found that inpatient self-harmers had higher depression and mood fluctuation scores than those individuals who do not harm themselves. This was also found to be the case in the studies by Ross and Heath (2002, 2003).

Skegg, Nada-Raja, and Moffitt (2004) further found a high prevalence of psychiatric disorders among self-harmers compared to those who do not self-harm. They included selected psychiatric disorders from the DSM-IV, rather than all disorders, which makes the results difficult to discuss because the individuals could have had a personality disorder, which was not included in the current study. The study conducted by Klonsky et al. (2003) goes one step further than Skegg et al. They included specific psychiatric and personality disorders rather than lumping them all together as one. They found that individuals who self-harm were significantly more likely to be diagnosed with personality disorders including Paranoid, Schizoid, Schizotypal, Antisocial, Borderline, Histrionic, Narcissistic,

Avoidant, and Dependent. Many of the possible personality disorder correlations found by Klonsky et al. coincide with what has been found in prior research in both clinical and non-clinical samples. As mentioned previously, self-harmers are often more depressed than non-self-harmers, as well as more antisocial and avoidant. Self-harmers tend to avoid or escape the problem at hand and wish to find a quick fix (i.e. self-harm). They tend to be more antisocial and have less friends and family members they feel they can relate or talk to as concluded by Evans et al. (2005).

Although inconsistencies within the literature depend on the sample chosen by the researchers, ignoring either clinical or non-clinical samples would be devastating to the understanding of self-harm in the general population due to the high correlation between psychiatric disorders and DSH. Many self-harmers show signs of various disorders, which makes it very difficult to eliminate psychiatric patients from the current literature because they play such a prominent role in our understanding of DSH. The current literature must be looked at simultaneously as two different categories: 1) deliberate self-harmers without psychiatric disorders, and 2) deliberate self-harmers with psychiatric disorders. Each category is important in its own right, but comparing the two leads to very different findings.

Future Research and Conclusions

Research regarding DSH is still in its infancy. Due to the relative lack of empirical research on self-harm there is a lot of inconsistency regarding prevalence rates, frequency, methods, and reasons for self-harm. Studies using only non-clinical samples will differ drastically on results from studies using only clinical samples. However, there are some instances and information where the literature appears to be unanimous.

The main focus of the current literature review was to assess the current literature studying both clinical and non-clinical samples and come to a consensus as to who is the self-harmer.

Roughly 14% (3 in 20) of the general population has harmed themselves at least once according to Favazza (as cited in Gratz, 2001) and Ross and Heath (2002). Self-harm is a widespread problem and a growing epidemic. Eating disorders were virtually unheard of in the early 1980s, but by the early 1990s, adolescents with eating disorders were thrust into mainstream media. This is the same type of publicity that needs to happen for DSH. Many adolescents who injure themselves feel as if they are alone in the world or have no one to turn to, which is the same way many adolescents felt during the early 80s with eating disorders (Favazza, 1998). However, after the issue hit the mainstream media they were able to find and receive reasonable help.

One issue that has yet to be looked at by researchers is the possible influence of culture on DSH. If some cultures are more susceptible to depression and isolation, and both depression and isolation are correlated with DSH, then perhaps certain cultures are more likely to self-harm than others. Mackay and Barrowclough (2005) claim that considering 50% of all suicides have harmed themselves prior to taking their own life, that by treating self-harm more effectively suicide rates may decline.

DSH is often thought of as a grotesque form of self-punishment misunderstood by so many, which only perpetuates the problem of troubled adolescents and inconsistent literature. Favazza (1998) claims that DSH reigns supreme among the group of "difficult patients [including] alcoholics, substance abusers, compulsive gamblers, borderlines, masochists, [and] pedophiles" (p. 259). It is difficult to assess issues concerning self-harm when many of the deliberate self-harmers are afraid to ask for help in fear of being labeled "crazy" or being forced into hospitals, which has led to numerous inconsistencies within the literature due to inadequate sampling. Until DSH is accepted as a common problem, and not "brushed-off," researchers will be unable to come to a consensus regarding the issue.

DSH has often been looked at as a female problem; however, Gratz et al. (2002) and Nock

and Prinstein (2004) have shown that there is no gender difference in prevalence rates. In contrast to prior understanding, Ross and Heath (2002) found that males were more likely to self-harm than females. This is a very important aspect of the current literature review in that psychologists and psychiatrists need to pay as much attention to males as females with regards to DSH. As concluded by Hawton et al. (2002, 2004), self-poisoning is a growing method of self-harm as seen in individuals presenting themselves to a general hospital. Self-poisoning is quite possibly a more lethal method than self-cutting, which is why future research concerning methods of self-harm is necessary due to the growing number of self-poisoners.

Forming a consensus on factors, causes, and correlates of self-harm is nearly impossible. There are two distinct types of literature: those that include clinical samples and those that include non-clinical samples. The data from the two different groups tend to be contradictory and counterproductive to a common understanding of DSH. Future research should include a clear assessment of either clinical or non-clinical populations rather than a semi-mix of the two, which a lot of current literature has done. There is still a lot of research needed concerning the prevalence and frequency of self-harm in both clinical and non-clinical samples. However, researchers and readers must be very cautious regarding definitions of deliberate self-harm and sample selection.

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