Women and Healthy Living in Canada

Fact Sheet Number 8 Fall 2012

SELF-INJURY

"I think all, every woman, our feelings all stem from the same. It's hurt. It's a loss of control. It's hopelessness. And however you self-injure, it's all just coping mechanisms"
(Study participant)

Non-suicidal self-injury (NSSI) refers to bodily injury without the purpose of suicide, but results in tissue damage [1]. According to the Canadian Institute for Health Information (CIHI), the primary mode of NSSI is poisoning (85%), followed by cutting/piercing (10%), and suffocation/strangulation (2%) [2]. Small scale studies continue to identify cutting, scratching and burning as common forms of NSSI [3]. In Canada, in 2009/2010, approximately 140 women per 100,000 were hospitalized for NSSI [2]. Although these rates appear to have decreased over the last decade by about 15% [4], hospitalization rates do not record those who are not admitted to hospital for their injuries. It is estimated that NSSI data may be underestimated by about 60% as emergency department data is often coded as "un-determined" [5].

Sex-and gender-based analysis

Sex–and gender-based analysis (SGBA) begins with four core concepts: sex, gender, diversity and equity.

1. ***Sex*** refers to the biological characteristics that distinguish male from female bodies. Sex differences include different chromosomal patterns, reproductive organs, hormones and proportions of fat to muscle.

2. ***Gender*** refers to socially constructed roles, relationships, attitudes, behaviours, relative power, etc., that shape and describe what it means to be male or to be female in a society.

3. ***Diversity*** can be identified as variations in culture, ethnicity, sex, gender, age and ability that affect our values, beliefs and behaviours, influencing all aspects of our lives.

4. ***Equity*** is achieved when there are no unfair differences within and among populations that lead to differences in health status. Social systems and policies should ensure that everyone has access to the resources, opportunities, power and responsibilities they need to ensure their full, healthy potential [6].

Sex issues

The onset for self-injury among females is typically between the age of 14 and 24 years [3]. According to hospitalization data from 2009-2010, 58% of self-injury hospitalizations were for females [2]. Self-injury among women is more likely to result in inpatient hospitalizations and emergency department visits than for men [2, 7]. Women are more likely to engage in self-injury, whereas men are more likely to complete suicide [2]. The rate of self-injury among those with mental illness co-morbidities is common [2], however, some researchers have identified the importance of viewing self-injury as a coping response to certain social contexts rather than as symptom of any particular disorder [8].

Gender issues

Emergency department visits for cutting/piercing or poisoning injury are more likely to be coded as self-injury in women compared to men of the same age group (under 65 years) [5]. Between the ages of 12 and 17 years, the number of self-injury cases among females was more than four times (1,536) the number of male cases (368).

In addition to a history of mental health issues, self-injury may be the result of stressful life events, an environment characterized by abuse or low self-esteem, family or friends' suicides or self-harming, and/or difficulty with interpersonal relationships (e.g., social isolation) [9, 10].

A history of abuse or other invalidating experiences may result in low self-esteem and

RETHINKING WOMEN AND HEALTHY LIVING

Rethinking Women and Healthy Living in Canada: Challenging the Discourse, Evidence and Practice examines the sex, gender, diversity and equity dimensions of healthy living among women in Canada by conducting sex-and gender-based analyses of the healthy living discourse, key healthy living topics and selected healthy living strategies.

Fact sheets on women and healthy living have been prepared on physical activity, sedentary behaviour, self-injury, food insecurity, sodium, tobacco, alcohol, sexual behaviour and condom use.

Learn more at www.womenshealthdata.ca

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self-loathing for women, which have been identified as important factors in self-injury.

As a result of feeling powerless, women may engage in self-injury to gain a sense of control. Women have talked about self-inflicted injury as a way to cope in a life over which they otherwise have little equality [9].

Diversity issues

Adolescence is a particularly sensitive period during which self-injury may begin due to societal pressures to fit in with peers and/or general difficulties with family, friends or school [7, 8].

Rates of self-injury vary from province to province, with lower provincial rates in 2009/2010 in Prince Edward Island (55 per 100,000) and Ontario and Manitoba (58) compared to New Brunswick and Newfoundland and Labrador (81). Compared to the provinces, self-injury rates were substantially higher in the Yukon (192) and Nunavut (379) [4].

According to data from CIHI, individuals from less affluent neighbourhoods have twice the rates of self-injury compared to individuals from affluent neighbourhoods [2].

New forms of social media may provide a manner for women to communicate and compare their self-injuries via blogs and videoblogs [11] which may glamorize the behaviour(s). In one study, 15% of participants stated that their self-injury was motivated because of television and/ or movies [3].

Equity issues

Self-inflicted physical pain may give women a sense of power in light of the powerlessness they feel in the rest of their lives. A history of sexual or physical abuse is common among women who engage in self-injury. Engaging in self-injury may help women cope with the stress and emotional pain of past or present distressing or oppressive conditions in their lives. Punitive methods and approaches to women who engage in self-injury may further exacerbate the women's distress levels and lead to additional self-harming behaviour.

Women from low income neighbourhoods may exhibit high rates of self-injury due to additional stressors, such as violence and family poverty, which may also contribute to women's overall feelings of powerlessness [2].

Critique

The National Ambulatory Care Reporting System (NACRS), which tracks emergency department data and can provide useful information on self-injury, has not been implemented across Canada. Further, Canada does not have a national strategy to address self-injury [2]. Implementation of such a strategy and using the NACRS would help identify and track self-injury related behaviour more effectively and help improve the existing research and subsequent prevention education on self-injury in Canada. In particular, additional education and awareness is needed for various health care professionals (e.g., family physicians) as women often seek out health services prior to presenting for acute medical care as a result of self-injury.

FOR MORE INFORMATION

BC Centre of Excellence for Women's Health:
www.bccewh.bc.ca

Atlantic Centre of Excellence for Women's Health:
www.acewh.dal.ca

Prairie Women's Health Centre of Excellence:
www.pwhce.ca

The Source:
www.womenshealthdata.ca

La Source:
www.lasourcesantedesfemmes.ca

SGBA e-learning resource:
www.sgba-resource.ca

References

[1] O'Donovan A. (2007). Pragmatism rules: the intervention and prevention strategies used by psychiatric nurses working with non-suicidal self-harming individuals. Journal of Psychiatric and Mental Health Nursing, 14(1);64-71.

[2] Canadian Institute for Health Information. Health Indicators 2011.

[3] Nixon MK, Cloutier PF & Jansson SM. (2008). Nonsuicidal self-harm in youth: a population-based survey. Canadian Medical Association Journal, 178(3);306-312.

[4] Collier R. (2001). Self-injury rates indicate Canadian mental health services are inadequate. Canadian Medical Association Journal, 183(10);15-16.

[5] Rhodes AE, Bethell J, Spence J, Links PS, Streiner DL & Jaakkimainen RL. (2008). Age-sex differences in medicinal self-poisonings: a population-based study of deliberate intent and medical severity. Social Psychiatry and Psychiatric Epidemiology, 43(8):642-652.

[6] Atlantic Centre of Excellence for Women's Health, British Columbia Centre of Excellence for Women's Health & Prairie Women's Health Centre of Excellence. SGBA e-Learning Resource: Rising to the Challenge. http://sgba-resource.ca/en/

[7] Hawton KF & Harriss L. (2008). Deliberate self-harm by under-15-year-olds: characteristics, trends and outcome. Journal of Child Psychology and Psychiatry, and Allied Disciplines, 49(4);441-448.

[8] Alexander N & Clare L. (2004). You still feel different: the experience and meaning of women's self-injury in the context of a lesbian or bisexual identity. Journal of Community & Applied Social Psychology, 14(2);70-84.

[9] Skegg K. (2005). Self-harm. The Lancet, 366(9495);1471-1483.

[10] Olfson M, Gameroff, MJ, Marcus SC, Greenberg TF & Shaffer D. (2005). National trends in hospitalization of youth with intentional self-inflicted injuries. American Journal of Psychiatry, 162(7);1328-1335.

[11] Craigen LM & Milliken TF. (2010). The self-injury experiences of young adult women: Implications for counseling. Journal of Humanistic Counseling, Education & Development, 49(1);112-126.

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