FACT SHEET

Self-Harm Among Criminalized Women

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This fact sheet examines the issue of self-harm among criminalized [a] women [b] in Canada. It was prepared by Dr. Colleen Anne Dell, Senior Research Associate, Canadian Centre on Substance Abuse (CCSA), and Tara Beauchamp, Research Assistant. It was reviewed by Dr. Cathy Fillmore and members of the Manitoba Intersectoral Committee on Self-harm.

Defining Self-Harm

- There is no single definition of self-harm. Terms used interchangeably with self-harm include self-injury, self-defeating coping strategies, self-damaging behaviours, self-mutilation and self-abuse.
- Traditional definitions of self-harm focus on physical injuries such as cutting and slashing the skin. Recent research has challenged this, and has included any behaviour, be it physical, emotional, social or spiritual, that a woman commits with the intention of causing herself harm. This ranges from physical injury to self-destructive behaviours, including substance abuse and sexual risk taking[1].

Reasons for Self-Harm

- Research suggests that women who self-harm have frequently experienced family disruption and trauma in their lives. This includes, but is not limited to, family alcoholism/drug abuse, dysfunctional family relationships, parental death, financial instability and partner violence.[2] The onset of self-harm typically occurs in adolescence and is often linked with childhood abuse and violence (including, emotional, physical and sexual abuse, neglect and bullying).[3]
- For incarcerated women, the "pains of imprisonment" are a major contributing factor to self-harm. This includes the fear of loss of child custody, negative relations with staff and other prisoners, confinement in segregation, stressful living conditions, and rigid and arbitrary rule enforcement.[4]

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[a] The term "criminalized women" refers to women whose behaviour has been criminally sanctioned by law (e.g., prison sentence). Race, class, gender and sexuality affect the process of criminalization in complex ways, causing marginalized groups to be more negatively impacted. In this fact sheet, the term "criminalized women" also refers to women who are at risk of criminalization (e.g., a woman shoplifting food for her family and is not apprehended). The term "criminalized women" has commonly replaced "women in conflict with the law". For further discussion, see Balfour, G. & Comack, E. (eds.) (2006). *Criminalizing Women: Gender and (In)Justice in Neo-Liberal Times*. Halifax: Fernwood Publishing.

[b] This fact sheet is specific to females, particularly adult women, although males also engage in self-harm. For males, it is reportedly different in nature and frequency. Studies suggest that males more typically direct their feelings of emotional pain and anger externally (e.g., violence and abuse of others) while females direct their harm internally.

- Material and social deprivations are common in the lives of criminalized women (e.g., housing, nutrition, child-care). A criminalized woman is typically young, a mother, poorly educated, unemployed or under-employed, single or involved in an unstable relationship, and a survivor of childhood and/or adult violence. A disproportionate number of criminalized women in Canada are Aboriginal.[c]

Self-Harm as a Coping Mechanism

- Self-harm is generally identified as a coping and survival mechanism for dealing with emotional pain and distress, isolation and oppressive conditions in women's lives, including violence.[5] Although unhealthy, self-harm provides women with identifiable coping responses, including a sense of release/cleansing, a means to feel, a sense of control, and a way to communicate internal pain.[6]
- Substance abuse is identified as a form of self-harm. Research has shown that some women's use of substances is in response to coping with chronic pain, gynecological difficulties, stress and depression. There is also a link to experiences of victimization.[7] Research as well shows that substance abuse commonly occurs alongside physical forms of self-harm, such as cutting.
- Self-harm and addiction share similar characteristics, although the literature is not clear on whether self-harm is addictive. For example, alcohol use and self-inflicted cutting are both reported to provide a sense of relief, can be uncontrollable for individuals, and may have neurological aspects that lead to the release of certain chemicals in the brain.[8] More research is needed.

Self-Harm is Not Suicide

- Current research disputes the common perception that self-harm and suicide attempts are the same. Research suggests that self-harm and suicide attempts have different intents, etiologies, bodily harms, frequency and methods.[9] Suicidal acts are oriented toward ending pain and suffering through the ending of life, while self-harm is viewed as a method of coping.[10] People who self-harm may still, however, be at risk of suicide.[11]
- Some studies report higher rates of suicide after deliberate self-harm.[12] It is also important to recognize that self-harming behaviour may unintentionally result in death (e.g., drug overdose). Self-harm has been identified by some criminalized women as "an installment plan for suicide".[13] Further research is necessary to explore the relationship between self-harm and suicide.

Prevalence of Self-Harm

- It is difficult to estimate the prevalence of self-harm among criminalized women in either the community or in correctional institutions. Problems include (1) the lack of a universal definition of self-harm, which makes comparability across studies difficult; (2) the absence of systematic data collection methods; (3) the stigma and shame associated with self-harm prevents women from disclosing; and (4) it is often a behaviour that occurs in isolation.[14]
- In correctional institutions, women's reluctance to disclose their self-harm is compounded by the fear of punitive responses, such as segregation, as well as being assigned a higher risk assessment score, which may result in their being housed within a higher security level.[15] Research has also suggested that self-harm is more common in correctional institutions than

[c] In addition to the social structures that oppress women generally in Canada (e.g., class, sexual orientation), Aboriginal women face the devastating historical impact of colonial government policies and practices, such as residential schooling and the Indian Act.

in the general community.[16] A 2000 report specific to incarcerated Aboriginal women in Canada found that the experiences of incarceration, especially segregation, led to increases in self-harming behaviours.[17]

- Some Canadian studies have attempted to define self-harm and identify the prevalence rate among specific research populations of criminalized women.
  - A 2005 study of agencies that work with adult women in correctional institutions identified an increase in four types of self-harm over the previous two years: physical injury, alcohol and drug abuse, sexual risk taking and involvement in destructive relationships.[18]
  - A 2001 qualitative study of criminalized women who self-harmed in prison and the community concluded that self-harming behaviours were common and widespread.[19]
  - A 1999 study of 26 patients admitted to the Intensive Healing Program at the Prairie Regional Psychiatric Centre in Saskatchewan found that 73% of women engaged in self-injurious behaviour prior to their admittance and 50% continued afterwards.[20]
  - A 1989 study at the Kingston Prison for Women reported that at minimum 59% of the federally sentenced women interviewed had engaged in self-harm on their bodies, such as cutting.[21]

Peer Influence

- Research suggests that peer influence (in terms of a modelling or copy-cat effect) is a factor in women's and youth's self-harm, especially in institutional environments (e.g., correctional facility, residential substance abuse treatment program).[22] However, in a recent study of community and residential service providers working with women and girls who self-harm, uncertainty was expressed over the role of peer influence, although it was noted that the impact of close living quarters could not be ignored.[23]

Responding to Self-Harm

- The literature [d] suggests the following recommendations for improving policy and practice concerning self-harm. Confusion, judgmental attitudes and inappropriate responses on the part of community and correctional service providers surround criminalized women's self-harm. This results in further stigmatization and decreases women's likelihood of seeking required medical and therapeutic attention.

  Community Services

  - Provide an integrated approach to care that offers criminalized women support, advocacy and access to a range of appropriate community resources (e.g., shelters, transportation, Elders). This is particularly important for women with multiple vulnerabilities.
  - Increase health care services for Aboriginal women. This requires attention to developing and utilizing existing appropriate culturally-specific healing approaches, programs, supports and services (e.g., sweat lodges, full moon ceremonies, sun dances). These interventions need to be designed, developed, implemented and evaluated by Aboriginal women.[24]
  - Establish a referral system between professionals, including medical and psychiatric practitioners, and community service providers for out-patient care and follow-up. This is especially important for women leaving correctional facilities and hospitals.
  - Offer crisis intervention services (e.g., mobile crisis unit).

[d] Not all literature drawn on is specific to criminalized women, but it is applicable.

Education

- Improve public understanding about self-harm as a serious health issue to decrease the negative effects of stigma in women's lives (e.g., not accessing treatment).[25] This includes educating women who themselves self-harm.
- Increase educational opportunities and training on self-harm for community service providers, hospital personnel, and correctional staff.[26] Particular attention should be paid to debunking the myths that self-harm is strictly a form of manipulation or indicative of suicidal intention. Emphasis should also be placed on increasing understanding about the underlying issues associated with self-harm.

Policy

- Do not respond to self-harm with a suicide intervention policy/protocol because suicide and self-harm are different.
- Develop policy and guidelines that focus on the underlying causes of self-harm rather than the behaviour(s). The Addictions Foundation of Manitoba has such a policy in development.
- Provide opportunities for service providers to learn about their agency's self-harm policy, guidelines or common practices.
- Adopt a women-centred policy in correctional facilities that would not "isolate[e] women during [a] crisis and would strive to recognize the voices of the individual women to secure a more individualized approach to 'intervention' ".[27] Once again, the need for a culturally-sensitive response is necessary, particularly for Aboriginal women who are disproportionately represented in Canada's correctional system.

Research

- Design and conduct studies that examine the prevalence of self-harm among criminalized women, and women and girls generally. Both qualitative and quantitative studies need to focus on the extent and forms of self-harm in both the community and institutional settings.
- Conduct research that evaluates self-harm treatment and healing approaches, interventions, programs, supports, policies and services.
- Pay particular attention in research studies to the role of trauma and violence in the lives of criminalized women, as well as its specific role for women in the sex trade.

Treatment

- Recognize potential negative consequences for women when they access treatment (e.g., custody issues, lack of child care support, job loss, anger from spouse, loss of friends).[28]
- Adopt multi-disciplinary therapeutic approaches that identify self-harm as a sign of emotional distress and contextualize the client as a trauma survivor.
- Employ women-centred therapies that recognize the connections between women's experiences of marginalization and disenfranchisement (e.g., poverty, abuse, sexism, history of colonialism/colonization and racism) and how these relate to women's criminalization and self-harm. The empowerment of women is central.
- Increase women's access to holistic and alternative programming and resources, such as art mentorship projects in correctional institutions and the community. Research suggests that art projects can serve as an alternative means of communication, a form of empowerment and as a positive coping mechanism for women who self-harm.[29] There is considerable empirical support for the benefits of the creative arts for personal healing in correctional facilities,

including women prisoners who self-harm.[30] Peer support programs have also been identified as viable healing approaches, including in the prison atmosphere.[31]

Non-punitive responses

- Promote acceptance, understanding, compassion, care and respect among service providers for criminalized women who self-harm. These are necessary qualities for effective staff-patient relationships.[32]
- Avoid punitive responses in an attempt to control self-harm (e.g., requiring clients to enter into rigid contracts, using physical restraints, withholding privileges, placement in segregation). Responding in ways that are "intrusive, dehumanizing and infantilizing" replicates the stigmatization, marginalization and disempowerment the women already face, and adds to their emotional distress.[33]
- Identify individualized triggers and healthy coping strategies (e.g., tension release exercises, participation in a hobby) for criminalized women who self-harm.[34]
- Explore a harm-reduction approach to self-harm. Research has shown that completely removing a women's means of coping may result in more serious forms of harm.[35] For example, a pilot study at St. George's Hospital in Stafford, UK has shown that allowing patients to keep their blades to physically harm themselves, in the context of a care plan, can reduce a patient's dependence.[36] Harm reduction strategies can include a range of possibilities, such as the use of clean cutting instruments, minimizing substance use, proper care of wounds, and adopting alternative and healthier coping strategies.
- Ensure the judicial use of medications. Some research suggests that the use of drug treatments does not have any direct effect on the tendency to self-harm,[37] while others maintain that they may in fact produce untoward outcomes, such as "feelings of unreality, confusion and inability to cope", which in turn leads to more self-harming behaviours.[38]

Endnotes

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