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## Self-mutilation : using pain to cope

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## Self-mutilation : using pain to cope

### Abstract

Self-mutilation is a serious mental and physical health problem that is often under-reported and misdiagnosed. The mutilation is a reaction to negative internal feelings, such as despair, anxiety, anger, or cognitive constriction. The goal of the self-mutilation is relief from emotional pain by using physical pain. The self-mutilator has low self-esteem, bouts of depression, difficulty forming intimate relationships, and usually suffered some type of trauma such as physical or sexual abuse. Pharmacological treatment for the self-mutilator has been experimental but has not been well researched. However, research seemed to indicate that individual and group therapy, specifically cognitive-behavioral therapy, is helpful for the person to learn alternative coping.

SELF-MUTILATION: USING PAIN TO COPE

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In Partial fulfillment

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Master of Arts

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by

Wendy S. Cook

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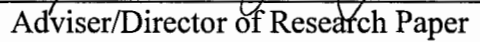
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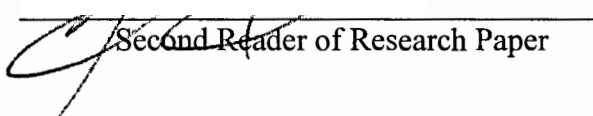
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## Abstract

Self-mutilation is a serious mental and physical health problem that is often underreported and misdiagnosed. The mutilation is a reaction to negative internal feelings; such as despair, anxiety, anger, or cognitive constriction, the person has. The goal of the self-mutilation is relief from emotional pain by using physical pain. The self-mutilator has low self-esteem, bouts of depression, difficulty forming intimate relationships, and usually suffered some type of trauma such as physical or sexual abuse. Pharmacological treatment for the self-mutilator has been experimental but has not been well researched. However, research seemed to indicate that individual and group therapy, specifically cognitive-behavioral therapy, is helpful for the person to learn alternative coping.

In the last few years, self-mutilation has become a serious mental and physical health problem (Conterio & Lader, 1998). Currently, self-mutilation is grossly underreported and misdiagnosed. Conterio and Lader (1998) provided the best estimate figures that 1,400 out of every 100,000 individuals suffer from self-mutilation. They recently conducted a survey on a college campus and found 12 percent of students admitted to having injured themselves (Conterio & Lader, 1998).

Self-mutilation is a difficult behavior for the non-mutilator to understand. According to Haines and Williams (1997), self-mutilation could best be understood as a coping strategy. The self-mutilator intentionally harms oneself due to emotional pains he or she is experiencing. This infliction of physical pain brings a temporary emotional relief to the person. Self-mutilation is any self-destructive behavior that may include; skin carving, wrist cutting, biting, burning and/or skin ulceration (Conterio & Lader, 1998; Haines, Williams, Brain & Wilson, 1995; and Pattison & Kahan, 1983). However, the injuring of the body is not an attempt to commit suicide, on the contrary, the person is using the self-mutilation as a life-sustaining act. The self-mutilation assists the person in coping with stress or helps him or her express feelings he or she has not been able to express (Conterio & Lader, 1998).

Many different factors lead to a person turning to self-mutilation. The Diagnostic and Statistical Manual of Mental Disorders (DSM) does not currently

have criteria for self-harming behavior as a separate disorder. Self-mutilation is mentioned in other disorders such as Borderline Personality Disorder, however, many argue a separate disorder should be listed in future revisions of the DSM. There have been attempts to develop a rating system of self-mutilation to standardize the classification (Conterio & Lader, 1998; Pattison & Kahan, 1983; Levenkron, 1998).

Self-mutilators are seen across geographic, cultural and socioeconomic boundaries. While the self-mutilator may be male or female, the typical self-mutilator is a white middle class female. For this reason, through out the paper, the self-mutilator will be referred to as female. Successful treatment for self-mutilation has not been adequately researched. The majority of the research has been conducted on the mentally challenged population. The research completed has found some benefit with using pharmacological therapies and/or cognitive-behavioral therapies (Levenkron, 1998).

This paper will first define what behaviors are classified as self-mutilation. Next is an outline of the “typical” self-mutilator and common characteristics of self-injurers. Family characteristics and home environments that may be present for the development of the behavior will also be examined, as well as the effectiveness of individual and group therapy for the self-mutilator and her family.

## Defining Self-Mutilation

Self-mutilation has been defined as damage done to the skin that is rarely life-threatening. Instead, self-mutilation temporarily relieves the person of negative emotions she is experiencing. The reduction of the negative emotions reinforces the behaviors (Bennun, 1984). The self-mutilator often experienced a variety of negative feelings before committing the mutilation. There are many different factors that lead to these negative feelings: interpersonal conflict, rejection, separation, or abandonment to name just a few (Feldman, 1988).

The amount of damage that is done to the body ranges from nicks to gouges. Some individuals need medical attention while other attempts do not even need a Band-Aid. Cutting and burning are the most common types of self-mutilation. The cutter will scratch or carve at the tissues of the body using anything that could cause damage. Some of the items used to cause damage to the body include razor blades, knives, glass or ingesting sharp or toxic objects (Conterio & Lader, 1998). The self-mutilator may also scrap the skin with an abrasive material such as scissors or bottle caps or she may burn the skin with matches, detergent or other irritating chemicals (Levenkron, 1998). Some individuals will carve words into the body to show how they feel about themselves such as “fat” and “ugly” (Conterio & Lader, 1998).

The majority of the wounds are superficial wounds with damage only to the skin and is usually hidden from others. Due to only the skin being damaged, there



is not any long-term harm to the body outside of scarring. The mutilation often occurs when the person is in a trance state. The person is seeking the pain and the blood to help them forget something that is emotionally painful (Levenkron, 1998). As the person relies on the cutting to assist her in dealing with her negative emotions, the cutting begins to have less of an effect on her being able to control the feelings. It is at this point that the person begins inflicting more physical pain to mask the emotional pain. Individuals will use sharper items or chemicals that burn more. Others brake bones to achieve the emotional release they are seeking. Seventy-five percent of self-mutilators use more than one method to obtain the emotional relief they need (Conterio & Lader, 1998).

The self-mutilator is a private person who does not have any real emotional connections, so she turns inward and closes herself off from others. Even if she would like to express her pain, she does not know how to communicate her feelings and does not feel anyone would care she is hurting (Levenkron, 1998).

### Diagnosing Self-Mutilation

Self-mutilation is not officially recognized as a disorder in the DSM. Some attempts have been made to define self-mutilation as a disorder. Research has found self-harming behavior generally has an onset during late adolescence. The person has also had multiple episodes of self-harm that continue over several years. The impulse to harm oneself is difficult to resist and the mutilator feels she is in the middle of “an intolerable situation which she can neither cope with nor

control" (Pattison & Kahan, 1983, p. 867). The person uses a variety of methods to harm herself, but the methods usually have a low lethality. The self-mutilator lacks social support and have one of four psychological symptoms: despair, anxiety, anger, or cognitive constriction (Pattison & Kahan, 1983).

Pattison and Kahan (1983) felt self-harm should have been included in the DSM-IV as an axis I diagnosis and be classified under the 312.00 code (disorders of impulse control not elsewhere classified). They felt this classification would be best because individuals who mutilate are unable to resist the impulse to harm themselves. They also felt there was an increase in tension before the mutilation began and the person experienced a release when she committed the act.

Favazza and Conterio (1988) agreed a specific self-harm syndrome needed to be identified because no current diagnosis in the DSM-IV was able to describe the disorder. The self-injurer usually has a combination of depressive and anxiety disorders that range from near normal to malignant. Individuals who self-mutilate feel they are unable to express their feelings and have very little physical and emotional security in their lives.

### Self-Mutilation and Other Disorders

Various researchers agree there is a connection between self-mutilation and some personality disorders, especially borderline personality disorder. This connection was made because one of the criteria for borderline personality is self-mutilation. However, Ross and McKay (as cited in Pattison & Kahan, 1983)

examined self-mutilations and personality disorders and found there was no clear association between self-mutilation and any personality disorder. Instead, Pattison and Kahan (1983) found self-mutilation was more likely to appear in borderline or histrionic personality disorders, but the self-mutilator did not have to have either disorder.

Several authors found self-mutilation can be seen in connection with other disorders beside borderline personality disorder. Dulit, Fyer, Leon, Brodsky, and Fances (1994) suggested there were many correlates that included eating disorders and childhood abuse. For many individuals, eating disorders and self-mutilation occur simultaneously or the person will alternate between the two behaviors. Both, the injuring and the eating disorder, are seen as a way to demonstrate some sense of control in her life. Walsh and Rosen (1988) studied the connection between self-mutilation and several other traumatic experiences including the loss of a parent, childhood illness, physical or sexual abuse, and domestic violence. The study found the strongest connection when the self-mutilator also had a history of abuse and witnessed domestic violence.

### Types of Self-Mutilation

Just as there was no official diagnosis in the DSM-IV, there was no criterion for rating the different injuries. Rosen and Heard (1995) felt it would be beneficial to rate different levels of self-harm, so they developed a system to distinguish the severity of injuries. Rating the behavior allows therapists and

researchers to standardize the behavior and target the type of needed treatment. The rating system also assists in being able to assess what areas regarding self-mutilation still need to be researched.

Rosen and Heard's (1995) rating system had four levels. The larger the number, the more serious the damage that has been done to the body. In level one, the injuries were superficial and the damage was only to the first layer of the skin. No medical attention was needed. In the second level, the skin was broken and minor bleeding occurred. Again, no medical attention was needed, but the person generally needed to apply a Band-Aid. The third level resulted in significant bleeding and it was necessary to either get stitches or some other closure device to stop the bleeding. These individuals are usually seen at the doctors' office or emergency rooms. Finally, level four wounds were serious and required multiple stitches. The wounds were potential disfiguring or life threatening (Rosen & Heard, 1995).

### Goals of Mutilation

As mentioned previously, the self-mutilator uses the self-injury as a coping skill. The self-mutilator intentionally harms herself in order to mask the emotional pain. The mutilation is a reaction of the internal feelings she has built up inside of her. Searching for some security, she turns to physical pain and bleeding in order to have power over her feelings. The self-mutilator often is angry about her life and does not have the voice to discuss the anger. She may

also be afraid to express anger because the anger is usually directed toward someone she loves (Levenkron, 1998).

The goal of the self-mutilation is the relief of emotional pain by using physical pain to calm herself. The pain and mutilation brings temporary relief to the individuals. As the cutting occurs, she begins to feel a sense of safety and security. The inflicting pain allows the individual to be in charge of the physical pain that she is feeling because she cannot be in control of the emotional pain. She is trading one type of pain for another type of pain (Levenkron, 1998).

Another reason the mutilator turns to cutting is due to her being unable to express her feelings. The self-mutilator has never learned how to express her feelings and feels discussing feelings, especially negative feelings, is not acceptable. Therefore, instead of talking she begins the cutting. However, according to Levenkron (1998), the cutting did not offer a sense of relief, instead it was a substitution.

The self-injurer is often angry about events in her life and is not sure how to express her feelings. The self-mutilator turns to self-injury as a way of coping with the emotional pain she is feeling. There are common characteristics of individuals who self-mutilate and these similarities will be explored next.

### Characteristics of the Self-Mutilator

Self-mutilation knows no geographic, cultural or socioeconomic boundaries. In recent years, there has been an increase in the number of men reporting these

problems as well. However, the typical self-mutilator is a white middle class female. The self-injurer generally is above average intelligence and began the mutilation during adolescence. The self-mutilator has low self-esteem and has bouts of depression. Due to these difficulties, cutters also have difficulty with forming intimate relationships with others (Conterio & Lader, 1998).

Generally, a person who is a self-mutilator feels she is powerless to events happening in her life. She may appear to be outgoing, but is often fearful and lonely. She has difficulty forming and maintaining significant relationships and feels she has no support and has difficulty trusting. The self-mutilator is a high achiever, but ignores areas that do not interest her. She is apologetic, even if she did not do anything wrong (Levenkron, 1998).

Often a person who mutilates has suffered some type of trauma. The trauma may be subtle such as being overlooked and/or neglected, being raised in a broken family, or separated from her family. Alternatively, the trauma may be more severe such as physical or sexual abuse (Levenkron, 1998). Especially for the persons who are victims of child abuse, the self-mutilation offers them a sense of control over their bodies they did not have when they were being abuse. When they are injuring themselves, they are able to control the "abuse," because they decide when it will start and when it will end (Conterio & Lader, 1998).

### Lack of Attachment

Attachment is defined as the joining or binding by personal ties and is necessary for all relationships. When a person is able to form healthy attachments, it means she is able to trust and develops dependencies with others. If a person does not form attachments, she is at a high risk for suffering emotional depletion or becoming obsessive. Individuals who do not form attachments are also more likely to develop phobias, depression, and eating disorders (Levenkron, 1998).

The self-mutilator is unable to form personal attachments. She does not trust others due to being fearful others will let her down. While the self-mutilator lacks the ability to form attachments, she has qualities that encourage others to attach to her; i.e. she is a good listener and nurturing. The mutilating helps to fill the void left by the lack of interpersonal relationships and serves as a replacement to the attachments (Levenkron, 1998).

### Abandonment Issues

Another reason a person begins to mutilate her body is due to abandonment issues. Abandonment is one of the biggest fears for a child or adult. If a person has a bad experience as a child, she accepts pain will be a part of her life. Her parents, as well as her life, have shown her to expected disappointment. She then begins to assume her parents' behaviors are "normal" and she is to blame for not adjusting to the parent's behaviors. The self-mutilator does not have significant

trusting relationships and has not learned how to communicate her feelings. Due to her lacking significant relationships, the person will look for ways to cope with her pain (Levenkron, 1998).

### Self-esteem Issues

The self-mutilator has a sense of “inner badness,” worthlessness, and a sense of being “toxic” to others. She blames herself for things happening outside of her control. However, at the same time, she does not take responsibility for what she has done (Conterio & Lader, 1998).

The person also has low self-esteem due to the cutting she is doing to her body. The shame and guilt begin due to the cutting and then spread to a general shame about oneself. Having low self-esteem also has a direct impact on how a person develops attachments with others. A person with low self-esteem is inclined to form attachments with individuals who are abusive or have greater emotional needs than herself. This, in turn, causes the person to have even lower self-esteem (Levenkron, 1998). There are common characteristics of self-mutilators. The person often is unable to form attachments to others, has fears of abandonment, and has low self-esteem.

### Family Characteristics

The self-mutilators come from similar family backgrounds. While some self-mutilators come from a relatively healthy home life, the majority grew up in unhealthy home environments. One common theme among self-mutilators is a



lack of emotional bonds or connections with her early caregivers. The self-mutilator often has parents who ignored her and her basic needs. In later childhood, the individual was often criticized by her parents and felt she was never able to please them. Self-mutilators are also likely to be children of alcoholics and mentally ill parents. However, many individuals grow up in families with alcoholics and mentally ill parents that do not become self-mutilators. The difference between the two groups is that the self-mutilators also come from an emotionally fragile home and never feel they received the support they needed (Conterio & Lader, 1998).

Another common characteristic is the rigidness of the self-injurers' home. As a child, the self-mutilator was not allowed to express emotions, be creative, or be a child. Within the family, the roles and responsibilities were confusing and chaotic. She was left to parent younger siblings and care for the physical, sexual or emotional needs of one or both of her parents. The mutilator's parents were unable to relate and respond to their own emotional needs, much less support to their children. The individual was not shown any encouragement or affection that helps with the development of self-esteem (Conterio & Lader, 1998).

While most self-mutilators come from an emotional detached family some come from the other extreme. Instead of not given any attention, one of the parents gave the child too much attention and was very controlling of her behaviors. In this case, the person has never been given the opportunity to think

for herself. Instead, the parent was often “hovering” over her. This in turn causes her to react by being overly secretive and withdrawn (Conterio & Lader, 1998).

There are many similarities regarding the characteristics of the person who develops self-mutilation. Once the behavior has been identified, it is important to have the person begin therapy to assist them in learning new coping skills.

### Therapeutic Interventions

There are several predictors of whether or not therapy will be helpful for the self-mutilator. One factor is the number of significant people who are involved in the treatment process. The more people who are involved in the therapy process, especially those important to the person, the greater the chance of success. This is due to the person feeling like there are reasons to get better. Another factor is the age and frequency of the abuse; a child neglected as an infant will adjust to the lack of attention, by lowering her expectations of care. If a child is sexually abused early on she will expect the same type of relationship with all caretakers or authority figures (Levenkron, 1998). Next, pharmacological therapies for self-mutilators will be introduced.

### Pharmacological Therapies

Pharmacological treatment for self-mutilation has not been completely studied. The majority of the research conducted was completed using samples from the mentally challenged population. The limited research completed found some benefit with using pharmacological therapies (Winchel & Stanely, 1991).

For example, Favazza (1996) found selective serotonin reuptake inhibitors (SSRIs) like Prozac, Paxil, Zoloft, and Luvox enhanced the serotonin in the brain. The serotonin then decreased or in some case eliminated the self-mutilating behaviors. Favazza (1996) discussed the use of neuroleptics and benzodiazepines. However, he reported these types of medication were found not effective in reducing the cutting behavior.

Markovitz, Calabrese, Schulz, and Meltzer's (1991) research also supported the use of pharmacological therapies. Markovitz et al. followed 12 subjects for 12 weeks who were given 80 mg of Fluoxetine (usual dosage is 20 to 40 mg). The study found Fluoxetine reduced self-mutilation by 97 percent. At the end of the study, only two of the patients were still cutting themselves and their cutting incidents had been reduced. The study also found Fluoxetine reduced impulsivity and compulsivity of the patients. However, in a follow up to the study, all of the patients had returned to cutting. It is important to note that medication reduced the incidents of cutting. While there is some evidence to support the use of medication, caution should be used because few studies have examined the effectiveness of using medication to reduce self-mutilation.

### Individual Therapy

Successful therapy of self-mutilators requires behavioral changes occur within a trusting treatment alliance. A self-mutilator will need to attend individual therapy to help her learn ways to change the expectations of

relationships. Individual therapy helps the person change her expectations regarding relationships by being involved in a positive relationship with the therapist. During the session, the therapist should not give her any negative or harmful verbal or physical responses. Instead, it is important that the person feels she is able to talk openly, trusts her therapist and begins to form a healthy attachment. The therapist will have to dispute with the cutter the negative views she has about herself (Levenkron, 1998).

The therapist needs to convey to the client he or she understands why the client is resorting to the cutting in order to relieve psychological pain. The therapist will need to form a connection with the client that allows her to feel secure. Only after the person feels there is a connection will she be able to replace the pain and cutting with discussing her feelings (Levenkron, 1998).

The therapist working with a person who is a self-mutilator must be able to differentiate between behavior that would put the person's life in danger and cuts that are more superficial. The therapist also needs to be confident in his or her abilities to work with this population. If the client sees any signs that the therapist is uncomfortable, she will feel the therapist is not able to provide the assistance needed. The therapist will also need to be very empathic, understanding, and nurturing toward the client. Finally, the therapist needs to demonstrate that he or she has a knowledge of the disease and is optimistic about the clients ability to overcome the disorder (Levenkron, 1998).

The therapist will have to be comfortable inquiring about any new cuts made since the last session. Specific questions will need to be asked to the client about the cutting. According to Levenkron (1998), if the client confirmed she had been self-mutilating, the new wounds should be examined. Looking at the new wounds will decrease the privacy the cutter has and will reduce future cutting. The therapist should help the client begin to learn how to communicate feelings by discussing her thoughts and feeling before and after the wounds were made. In addition, as the person stops mutilating herself, she will be forced to examine the emotional pain she was previously trying to avoid (Levenkron, 1998).

### Group and Family Therapy

According to Conterio and Lader (1998), group therapy was helpful because the self-mutilator learned alternative coping skills and adaptation techniques from group members. The group also allows the person to feel she is a part of a group and others have the same problem she has. Unfortunately, very few groups are offered that deal only with individuals who self-mutilate, due to the therapist not having enough individuals who are willing to participate in the group. Instead, the self-injurers attend groups with individuals who are suffering from depression or are sexual abuse survivors.

The therapist will also have to work with the family in ensuring that new ways to parent the self-mutilator are learned. The parents have not been able to provide the self-mutilator with an environment that she felt comfortable with

expressing feelings. The parents will have to learn how to foster an environment that allows the client to open up and begin to discuss her feelings instead of resorting to the mutilation (Levenkron, 1998).

### Other Therapeutic Interventions

Haines and Williams (1997) found cognitive-behavioral therapies would be beneficial to use with this population. One helpful technique is role-playing. Role-playing helps the person learn how to handle conflict and how to express her feelings (Levenkron, 1998).

Additionally, Walsh and Rosen (1988) felt cognitive-behavioral techniques would be useful to help dispute the distorted thinking that often lead to the self-mutilation. Most of the distorted thinking falls into one of four categories: 1) that self-harm is permissible; 2) her body is disgusting and she deserves to be punished; 3) something needs to be done to decrease the negative feelings; and 4) this is the only way to communicate her feelings. Pawlicki and Gaumer (as cited in Kehrberg, 1997) used cognitive behavioral techniques in therapy groups to assist the self-mutilator to see the connection between the thoughts and the self-mutilating behavior. The group stresses it is all right to have intense feelings and communicate these feelings without having to resort to self-mutilation.

Conterio and Lader (1998) used other techniques at their inpatient clinic called Self-Abuse Finally Ends (SAFE). One technique used at SAFE was having the person enter a no harm contract with the therapist. The no harm contract

sends the message to the client she can be in control of the behavior and she can find alternative ways to deal with her feelings besides cutting. The client is also encouraged to speak in the first person. If the person speaks in the first person, she is taking more responsibility for her actions, otherwise she will feel that she is "divorced from her own experience" (p. 216).

The SAFE clinic also gives writing assignments to assist the clients in beginning to identify and communicate their feelings. The first writing assignment is to write her life story. The SAFE center feels writing the life story helps her better understand her feelings and begin to put the feelings into perspective. The SAFE clinic also feels journaling may assist the person in making connections she has not been able to make in the past. Other writing assignments the SAFE clinic uses include identifying strengths and weakness, emotions surrounding the self-injury, ways to nurture yourself, and identifying the person she would like to be (Conterio & Lader, 1998).

Another important component to the treatment at the SAFE clinic is having the client keep an Impulse Control Log. The log is a record of any urges the person might have to self-injure. The person should identify what events triggered her feelings to self-injure and then identify what outcomes would have occur if she had injured herself. Finally, with the help of the therapist, the client is empowered and has will identify alternatives to cutting (Conterio & Lader, 1998).

## Conclusion

Self-mutilation is a disorder that both puzzles and scares some individuals and therapists. Therapists often do not know the best approach to treating individuals who rely on self-mutilation as a coping skill. There are a limited number of therapists or groups a self-mutilator can turn to assist her with her problem. It is surprising such a complicated behavior has little information written about it, has not been given its own category in the DSM, and little research completed regarding effectiveness of interventions.

In order to get a better understanding of the self-mutilator, a set of criteria needs to be developed and placed in the next revision of the DSM. Giving the behavior a listing in the DSM may help take away some of the secrecy and uncertainty regarding the behavior and make the disorder something more acknowledged in the general population. It will only be after self-mutilation is recognized as a disorder that additional research will be completed on the behavior. Any future research needs to address the effectiveness of medication used with this population. Research should also explore how this behavior can be effectively dealt with in therapy and which techniques are most beneficial to the client.



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