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## Secret pain : understanding and treating self-injurious behaviors in women

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## Secret pain : understanding and treating self-injurious behaviors in women

### Abstract

This paper is an attempt to raise awareness of the presence of self-injury in Western societies. Causes, symptoms, related diagnoses, and treatment of self-injurious behaviors will be discussed. Most importantly, however, this paper is meant to challenge and, ultimately, decrease the stigma surrounding SD and increase empathy and compassion for the self-injuring person.

Due to constraints of this research paper, the author focuses on female self-injurers and excludes information on self-injury in mentally retarded individuals and prisoners.

SECRET PAIN--UNDERSTANDING AND TREATING SELF-INJURIOUS BEHAVIORS IN  
WOMEN

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Eva Schoen

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The late eighties brought an increase in eating disorders, the early nineties an increase in attention deficit disorders, and at the end of the century in the mental health field, a surge of patients who injure themselves without fatal intentions is increasingly common. Self-injury (SI), also called self-harm, deliberate self-harm, Deliberate Self-Harm Syndrome (DSH) ( Favazza, 1987), and Trauma Re-enactment Syndrome (Miller, 1994) is not a new phenomenon. Menninger (1938) described a case of a female self-injurer as early as in the 1930s, instigating an interest in SI as a symptom of schizophrenia and psychosis. During the eighties and nineties, the focus of psychology and psychiatry has shifted from treating severely psychologically disturbed patients who self-injure to patients who are either presenting with SI as the primary diagnosis or whose self-injury is associated with more common disorders such as bulimia or anorexia nervosa. SI is also a common symptom in people who have been sexually abused (Miller, 1994).

It is curious, though, that in this decade of affluence and materialistic wealth, so many of the clients seen by psychologists, counselors, and social workers are showing symptoms of self-injury. Conterio and Lader (1998) have speculated on the reasons for the increase in self-injury. The three most convincing ones in these authors' opinion appear to be the individualization and disenfranchisement in and of Western society, the increase in addictions, a "quick-fix" mentality (p. 9), and the negative attention given to body size and

body shape. Since self-injurious behavior usually takes place in secrecy (Levenkron, 1998), the actual number of people who are intentionally hurting themselves might be even higher than the current estimates of about 750 per 100,000 (Favazza, 1987).

It is surprising and disturbing that, in comparison to other mental illnesses and psychological disturbances, self-injury is one of the least researched expressions of emotional pain (Miller, 1994). Clinicians treating mental health patients may not be aware of self-injurious behaviors in patients, they may be hesitant to ask for fear of possibly suggesting those behaviors to clients, or they may decide to ignore the problem. Therapists frequently experience strong reactions to the injuries of their patients, mostly in the realm of compassion but also anger and frustration (Levenkron, 1998). One might ask what it is that drives people to cut or burn their skin, pull out their own hair, or ingest poisonous fluids.

#### Statement of Purpose

Self-harming behaviors seem to be so contrary to the human instinct of self-preservation and well-being that many lay people, some of them directly affected by self-injurious behaviors that they observe in others, respond with fear, terror, disgust, or open rejection of the self-injuring person. Those responses, though common and understandable, will not help human beings whose self-hatred appears to be so strong that they violate their own bodies

without any regrets. This paper, therefore, is an attempt to raise awareness of the presence of self-injury in Western societies. Causes, symptoms, related diagnoses, and treatment of self-injurious behaviors will be discussed. Most importantly, however, this paper is meant to challenge and, ultimately, decrease the stigma surrounding SD and increase empathy and compassion for the self-injuring person.

The author of this paper contends that self-injury should be regarded as a coping response similar to fleeing into alcohol or drugs when feelings and emotions become too overwhelming. This contention is supported by recent findings by Miller (1994) and Levenkron (1998). Self-injurious clients show their pain, anger, and aggression by hurting themselves rather than communicating feelings and emotions verbally or in less "painful" ways. In a similar fashion as eating-disordered patients communicate through their body size and shape, SI patients express themselves via hurting their skin or their organs. It will be shown that SI serves a variety of functions for a client, and treatment programs will have to address the whole person in order to allow a client to give up self-injury. Due to constraints of this research paper, the author focuses on female self-injurers and excludes information on self-injury in mentally retarded individuals and prisoners. Since the majority of self-mutilators seem to be females (Connors, 1996), the author refers to "she" and

“her” when talking about patients who self-injure. Readers should be aware, however, that SI is also being increasingly diagnosed in males.

### Definition

The phenomenon of deliberate self-injury poses problems for finding one cohesive explanation for the syndrome. Self-injury appears in cultural rites (Hewitt, 1997); in healing ceremonies; in everyday habits like nail biting; in shamamism, myths, and religion (Favazza, 1987); and in its most damaging form as suicide (Farberow, 1980). However, the term “self-injury” used in this paper might be best defined as an intentional action against one's own body, skin, and organs. Conterio and Lader (1998) described it as "the deliberate mutilation of the body or a body part, not with the intent to commit suicide but as a way of managing emotions that seem too painful for words to express" (p. 16). The words "deliberate" and "not with the intent to commit suicide" point to the fact that most self-injurers, except for patients with dissociative identity disorder (Martinson, 1998), are aware of what they are doing to themselves and decide when to stop so self-injury does not turn into suicide. Having said that, there is evidence by research that many self-injurers are not fully aware of their actions when they engage in self-harming behaviors (Levenkron, 1998).

### Population of Self-Injurers

According to Ross and McKay (1979), the population of self-injurers most commonly is comprised of children and adolescents, prisoners, and young



females. Even though the authors dedicated their book to the treatment of female teenage self-injurers in a training school, the information presented was found to be significant for female self-injurers of any age. Miller (1994) supported the diagnosis as a mainly "female" diagnose because she made a connection between trauma, abuse, and self-injurious behaviors. Favazza's studies (as cited in Conterio & Lader, 1998) brought forth the following percentages of patients who also engage in SI: Bulimics (40.5%), Anorexics (35.0%), patients with multiple personality disorder (34%), prisoners with personality disorders (34.0%), and mentally retarded people in institutions (13.6%).

These figures, together with a list of possible personality characteristics compiled by Martinson (1998), show that self-injurious behaviors are actually a reality for a high percentage of psychologically disturbed individuals. Martinson also found in non-scientific surveys that the female-to-male ratio in self-injury was 85/15, and other research supported that figure (Favazza, 1987; Miller, 1994). SI evidently is a phenomenon that is much more common than previously thought of by clinicians, and thus it is definitely an increasing concern for therapists.

#### Who Should Know about Self-Injury?

Fairly recently, the media reports on SD have increased, both in national television broadcasts (20/20), and lifestyle magazines like Allure and

New York Times Magazine (as cited in Conterio & Lader, 1998). This means that the general public is becoming aware of the population of self-injuring individuals. Even though statistics probably underestimate the prevalence of SI in society, chances are that many "healthy" individuals have met somebody who self-injures, but because the disorder is kept secret by the sufferers, it takes keen observers to tell if somebody is at risk for self-injury or not.

Although self-injury is increasingly discussed in the mental health professional literature, it is still not regarded as a legitimate diagnosis (Favazza, 1998). However, since SI can be regarded as both a separate disorder (Favazza, 1987) and a feature of another psychological disorder like depression or an eating disorder, it is imperative that mental health professionals are knowledgeable enough about SI to become aware of self-injurious behaviors in their patients. They also need to be able to come to an accurate diagnosis (SI as either primary or secondary symptom) and address SI in therapy. Clients are not recovered yet if they continue to secretly carve, cut, burn, or poison themselves, and therapists should suspect SI with the above mentioned diagnoses and include questions about self-injurious behaviors in their assessment routine. As Levenkron (1998) pointed out:

The mental health profession will have to get comfortable talking with patients, in detail, about cutting and burning oneself. They will have to get used to demanding that their patients show them the damage done,

inspect this damage, and determine whether or not a physician needs to treat them. All of this must become a natural and comfortable part of the therapist's treatment repertoire. (p. 10)

### Literature Review

The literature on self-injury is scarce but growing. It can be divided into two distinct categories: literature exclusively about SI as a primary diagnosis and writings on SI as a symptom connected to a specific diagnosis other than SI. The diagnoses linked to SI include mental retardation, eating disorders, and traumatization.

Professional interest has increased in the area of SI as a primary diagnosis. The earliest scientific accounts of SI as a diagnosis were given in the 1970s by authors such as Ross and McKay (1979). They addressed various forms of self-mutilation, etiology, and treatment. Shortly thereafter, in 1980, Farberow included a well-written synthesis on the subject of SI in his book on suicide. Throughout the 1980s and 1990s, Favazza and Favazza (1987; 1998) worked on studying SI and published numerous articles and books on self-injurious behaviors. They could be regarded as pioneers in the field in terms of making the diagnosis public. Their work included the book Bodies under Siege (1987) and the article "The Coming of Age of Self-Mutilation" (1998). Their book became a classic, tracing the roots of self-mutilation in religion, anthropology, and psychiatry. Similarly, Hewitt's book (1997) on self-

mutilation provided readers with an overview of the cultural significance of body mutilation. Another important milestone in the 1990s for the study of SI was Miller's (1994) book on the connection between traumatic experiences and self-injury.

Most recently, Conterio and Lader (1998), directors of the S.A.F.E. ("Self-Abuse Finally Ends") program which specializes in treatment of self-injurious behaviors wrote a comprehensive book on etiology, diagnosis, and the treatment methods they developed for female self-injurers. Levenkron (1998), a well-known researcher on anorexia nervosa, seemed to regard self-injury as an addiction which requires a process of recovery. The Internet is also an excellent source for current information and research on self-injury, in particular the web site by Martinson (1998) and the Internet resources provided by the S.A.F.E. centers and programs (1999) in the United States and Canada.

In contrast to the view of self-injury as a primary diagnosis, SI has long been seen by clinicians in conjunction with other psychological disorders. Thus, SI was described as a secondary symptom in other primary disorders such as eating disorders (Favaro & Santonastaso, 1996; Favaro & Santonastaso, 1998; Klayman Farber, 1997; Vanderlinden & Vandereycken, 1997; Yaryura-Tobias, Neziroglu, & Kaplan, 1995); depression (Martinson, 1998); trauma (Connors, 1996; Dubo, Zanarini, Lewis, & Williams, 1997; Romans, Martin, Anderson, Herbison, & Mullen, 1995; Zlotnick, Shea, Recupero, Bidadi,

Pearlstein, & Brown, 1997); borderline personality disorder (Sabo, Gunderson, Najavits, Chauncey, & Kisiel, 1995; Shearer, 1994); impulse-control disorder NOS (Martinson, 1998); obsessive-compulsive disorder (Yaryura-Tobias & Neziroglu, 1997); dissociative identity disorder (Martinson, 1998); suicide attempts (Safer, 1997), and substance abuse (Zlotnick, Shea, Recupero, Bidadi, Pearlstein, & Brown, 1997).

The fourth edition of the Diagnostic and Statistical Manual for Mental Disorders by the American Psychiatric Association (APA) (DSM-IV) (1994) does not include self-injury as a separate diagnosis, but lists self-injurious behaviors as characteristic for the borderline personality disorder. Levenkron (1998) rightfully criticized the omission of SI as a separate diagnosis.

Since there is no generally acknowledged and recognized definition for self-injury like the DSM-IV (APA, 1994) provided in the case of other psychological disorders, authors on SI have offered an array of explanations, studies, theories, and treatment programs that cannot distinctly be classified. More detailed studies on the etiology of SI found psychometric and biological causes for SI (Herpertz, Sass, & Favazza, 1997); difficulties communicating feelings (Solomon & Farrand, 1996); and contagion of self-injurious behaviors, especially among adolescents (Taiminen, Kallio-Soukaninen, Nokso-Koivist, Kaljonen, & Helenius, 1998). In a few years, hopefully mental health researchers will have found ways to diagnose and explain SI more cohesively.

An important step on this path would be the inclusion of the primary diagnosis of SI in a revision of the DSM-IV.

### Explaining Self-Injury

Since there is no officially recognized categorization for self-injurious behaviors in psychological reference books, researchers and writers currently studying SI are compiling important information on the syndrome that will be invaluable for establishing diagnostic criteria in the future. In the following section of this paper, specific characteristics and forms as well as etiology and dynamics of SI will be addressed. A brief case example will show how SI may become an issue for a woman. An overview of SI in relation to specific disorders will conclude this section.

### Characteristics and Forms of Self-Injury

Depending on the classification system one wants to use, self-injury comes in different shapes and forms, for example, cutting one's skin, carving, burning, eye enucleation, inserting strange objects, and hitting oneself (Ross & McKay, 1979). Ross and McKay called these behaviors "direct self-injurious behavior or self-mutilation" (p. 16) and distinguished them from indirectly self-injurious behaviors like alcohol and tobacco consumption and obesity.

According to Kahan and Pattison (1984) (as cited in Favazza, 1987), SI might be called "Deliberate Self-Harm Syndrome" (DSH). Kahan and Pattison established the following criteria for this syndrome:

1. A sudden, irresistible impulse to harm oneself physically; 2. A psychological experience of existing in an intolerable, uncontrollable situation from which one cannot escape; 3. Mounting anxiety, agitation, and anger in response to the perceived situation; 4. Perceptual and cognitive constriction resulting in a narrowed perspective of the situation and of alternatives to action; 5. Self-inflicted destruction or alteration of body tissue done in a private setting; 6. A rapid, temporary feeling of relief following the act of self-harm. (p. 205)

Levenkron (1998) contended from his therapeutic experience that he "consistently encounter(s) two characteristics in all self-mutilators: 1. A feeling of mental disintegration, of inability to think; and 2. A rage that can't be expressed, or even consciously perceived, toward a powerful figure (or figures) in their life, usually a parent" (p. 44).

Self-injury could thus be a learned response to overwhelming feelings and emotions, control issues, family disruption, self-hatred, low self-esteem, negative body image, and other psychological disturbances. In any case, DSH or SI has to be viewed as a coping "skill" which is used by the client to the best of her abilities. According to the literature (Conterio & Lader, 1998; Levenkron, 1998), a "typical" way of acquiring this coping response might be the following: A now seventeen-year old female grew up in an abusive household (sexual, verbal, physical, or emotional). She is intelligent and an

introvert, but she has poor social skills and problems with her sexual identity. Due to an environment that is rejecting of her as a person, the teenager has learned to hate herself from a very early age. One day she accidentally cuts herself when working in the kitchen and suddenly, the view and feel of blood calm her down physically and emotionally. The next time she is in the kitchen, she tries to scratch her skin just a little bit in order to see if it will bleed. Thus, a habit is born which may be linked in the client's brain to a calming of tension.

As the example illustrates, self-mutilators may have numerous psychological issues, one of them being a habit of self-injurious behaviors. Unfortunately, there might not be a way to really explain SI to somebody who does not know about the background of the self-injuring person or who does not understand the influence of a non-supportive or even traumatic environment on a potential self-injurer. For somebody who does not have past experiences that lead to SI or who does not have the propensities to engage in it, self-injurious behaviors might be as inconceivable as alcohol abuse for somebody without an addictive personality. Therapists working with self-mutilators know that it takes a certain mind set, a certain level of self-hatred, self-loathing, and anger to actually lay hands on oneself. In the example mentioned above, the teenager is learning a habit by accident. However, if the habit did not coincide with her self-hatred and self-loathing, she probably would not continually



engage in this habit. Unfortunately, in this case, the person has stumbled onto to a coping skill that fits with what she believes about herself and thus she may repeat the behavior. In the case of the wrist-cutting syndrome, Farberow (1980) noted that the precipitants for self-mutilation included a lack of attention, a lack of mechanisms for controlling aggression, or loss and abandonment experiences, to mention only a few.

#### Etiology and Dynamics of SI

Self-injury cannot be understood without taking into consideration the fact that various theorists and clinicians have found rather divergent causes for the same self-destructive symptoms. In fact, just as there are numerous different forms of self-mutilation, there are numerous theories attempting to explain them. Therapists are clearly dealing with a multifactorial symptom, which means that more than just one factor might cause a woman to self-injure. Some proponents, like Miller (1994) and Vanderlinden and Vandereycken (1997), saw a strong link between sexual and emotional abuse in childhood and subsequent self-injurious behaviors. Dubo et al. (1997) reported that both "parental sexual abuse and emotional neglect were significantly related to self-mutilation" (p. 63) in the borderline personality disorder cases that they investigated.

Farberow (1980) and Levenkron (1998) put more emphasis on possible secondary gains driving the self-harm. They discussed such gains as getting

attention from others, symbolic revenge, or, the shock factor. The latter is an important factor in adolescent self-mutilation. Women certainly might engage in SI for all the secondary gains mentioned, but still, the trauma connection seems to be at the root of the problem and the strongest indicator for self-harm. Farberow (1980) cited dissociation and depersonalization as other processes linked to trauma and as possible causes for self-harm. Reasons for self-injury might also be the attempt "to remedy internal and external flaws" (Favazza, 1987, p. 197) or a "cathartic release of anger" (p. 194).

Traumatic experiences and resulting self-hatred are not the end of the given explanations for SI. Farberow (1980), along with Levenkron (1998), suggested that unsuccessful attachment in childhood may lead to fear of loss and abandonment, which in turn may cause a woman to use self-injury as a coping response. Attachment and abandonment issues interestingly enough are also found in borderline personality disorder clients. Conterio and Lader (1998) spoke of a "hypersensitivity" (p. 85) present in many female self-injurers; they tend to take other people's reactions personally and overreact in certain situations. Conterio and Lader, the founders of the S.A.F.E. ("Self-Abuse Finally Ends") treatment program for self-injury, also noted an association between a person's struggle with sexual identity and the prevalence of SI. In a similar vein, Hewitt (1997) stated that SI aids in the cultural process of gaining an identity.

Among the sheer myriad of predisposing factors for SI, family of origin "disruption such as divorce or separation" (Favazza, 1987, p. 206), inflexible values or beliefs, a lack of stability, and switched family roles (with children in parental roles) (Conterio & Lader, 1998) should not be forgotten. Therapists also need to take into consideration personality characteristics of self-injurers, such as "difficulties in various areas of impulse control, low capacity to form and sustain stable relationships, fear of change, an inability or unwillingness to take adequate care of themselves, and rigid, all-or-nothing thinking" (ibid., p. 139f). Miller (1994), as well as Conterio and Lader (1998), emphasized the influence of body image and low self-esteem on self-mutilative tendencies, and several authors have supported the notion that there might also be a biological aspect involved in the development of self-injurious behaviors (Farberow, 1980; Favazza, 1998).

Since there is no single, cohesive explanation for why and how people engage in self-injurious behaviors, the clinician will have to carefully assess the patient's history and possible other symptoms before he or she attempts to explain the causality. What is important to keep in the diagnostic mind is that, for whatever reason, a particular client chose to use self-mutilation rather than any other available coping mechanism in order to express herself. The most important aspect of the question of etiology is that clinician and client should

jointly search for the underlying causes of SI, so as not to assume that one clinical picture fits every client who self-mutilates.

### Diagnoses Associated with Self-Injury in Women

The diagnoses associated with self-injurious behaviors are varied, ranging from eating disorders and mood disorders to posttraumatic stress disorder, and from dissociative identity disorder to the personality disorders. The primary diagnosis of SI needs to be considered when DSH is the major concern and the patient uses SI on a habitual basis (Levenkron, 1998). Oftentimes, however, clinicians may find out about SI while treating clients for other disorders. Self-injury usually is not a phenomenon clients freely describe when they first enter therapy. Therefore, because research has shown that the following disorders also sometimes include a self-injurious component, therapists should assess for self-injury in situations where the primary disorder oftentimes includes self-injury as one of the deviant behavioral symptoms.

Self-injury as primary diagnosis. SI as the primary diagnosis could be regarded as either an addiction or a misdirected coping response (Favazza, 1987; Levenkron, 1998). The addictive qualities of self-injury can be explained by changes in the brain chemistry of chronic, habitual self-mutilators that may lead to withdrawal effects such as "agitation, irritability, fear, hallucinations, and paranoia" (Favazza, 1987, p. 207). Farberow (1980) listed the strong analgesic effects of self-induced pain, as well as the seemingly

tension-reducing sight of blood that increases the draw to self-mutilative behaviors. Distinguishing between SI as a primary diagnosis and as a symptom associated with another psychological illness is not an easy task because so far guidelines for establishing a diagnosis of SI or DSH have been lacking in standard psychological works. It might be deduced from the information on SI, however, that the more chronic, habitual, and severe the self-injurious behaviors become, and the less a person is able to cope in any healthier way with her life, the more the symptoms require a primary diagnosis of SI and a focused effort on the part of the therapist to address the underlying issues of SI.

Self-injury and eating disorders. Two of the diagnoses with a strong link to self-injury are anorexia nervosa and bulimia nervosa (Vanderlinden & Vandereycken, 1997). In fact, "the starving anorectic and the purging bulimic may be viewed as people who deliberately harm their bodies" (p. 48), but the authors also found a high incidence of self-injurious behaviors like cutting and scratching when they did a study on the connection between eating disorders and SI. When looking for the maladaptive functions of self-mutilation, Vanderlinden and Vandereycken found the following to be true for their eating-disordered patients (in order from most "positive" to least "positive" function): relaxation, attention, stimulation, punishment, and self-destructiveness (p. 54). All of these functions fit with the view of SI as a coping response. In the case

of patients with eating disorders, SI might help deal with a negative body image and self-hatred. Hewitt (1997) dedicated an entire chapter of her book to the connection between anorexia and self-mutilation and made a strong case for the existing self-hatred in both of the disorders. Vanderlinden and Vandereycken's claim that bulimics tended to engage in SI more frequently than anorexics was supported by Klayman Farber (1997), who added an interesting viewpoint from a psychodynamic perspective. She regarded bulimic and self-mutilating behaviors as "psychosomatic processes" and a form of "self-medication" which serve "ego-compensatory needs in the absence of the adequate ability to regulate and modulate emotions, moods, and tensions" (p. 87).

Yaryura-Tobias et al. (1995) studied self-mutilation and the switch from anorectic to bulimic behaviors. Again, SI was associated more strongly with bulimic behaviors than with starvation. Their findings also point toward an impulsivity component in self-injurious patients whose primary reason for SI might be to help relieve tension and aggression. Favaro and Santonastaso (1998) regarded SI in bulimic patients as a form of "self-punishment" (p. 157) and found in an earlier study (1996) that "self-injurious behaviors were significantly fewer in the anorexic and bulimic nonpurging groups compared to purging groups" (p. 102), which would indicate that purging and SI can both be used to cope with overwhelming emotions. Levenkron (1998) mentioned a

non-scientific finding from his practice: "As someone reduces or eliminates cutting, in the case of the anorexic, she then begins to lose weight. In the case of the bulimic, she increases or resumes her bingeing and vomiting" (p. 212).

Self-injury and depression. Not surprisingly, researchers have found yet another connection between eating disorders and self-mutilation, and that is over the presence or absence of depression. Self-injurious behaviors have been linked to the feelings of helplessness, powerlessness, and hopelessness, and most women who meet criteria for depression are also prone to experience self-destructive tendencies (Favazza, 1998; Hewitt, 1997). Conterio and Lader (1998) described SI in cases with major depression and bipolar disorder. Especially in manic phases, patients seem to be at higher risk for self-injury, or, "in clinical terms, most self-injurers are highly labile, meaning they are unstable and intensely moody" (p. 173). Even though the connection between depression and self-mutilation has been made, that connection has less research support than the link between eating disorders and depression. More research has to be done on how both depression and anxiety disorders relate to self-injurious behaviors (Conterio & Lader, 1998).

Self-injury and trauma-related disorders. Similarly, research evidence on Dissociative Identity Disorder (DID) and SI does not seem conclusive. *Historically, DID has been tied to traumatic and abusive experience in childhood, but recently, the validity of a DID diagnosis has been doubted by*

authors such as Spanos (1985). No matter which research seems more convincing to the reader, there is ample reason to believe that people suffering from a fragmented personality, in the DSM-VI (APA, 1994) called DID, also oftentimes self-injure (Martinson, 1998). DID clients experience altered states of consciousness, which sometimes are presupposed for the occurrence of self-injury. Another disorder linked to trauma which features self-injurious behaviors is Post-Traumatic Stress Disorder (Martinson, 1998). Again, as with eating disorders, several functions of SI can be pointed out, such as tension relief, relaxation, or self-punishment. However, all of these functions are primarily meant for coping with disturbing memories.

Self-injury and personality disorders. Personality disorders, mainly antisocial, narcissistic, histrionic, and borderline (Farberow, 1980; Favazza, 1987) are sometimes indicated in self-injurers. The diagnosis most typically associated with SI is certainly Borderline Personality Disorder, as Favazza cited: "Borderline personality disorder is the only mental illness in which, according to the official psychiatric nomenclature, the occurrence of physically self-damaging acts is a major diagnostic criterion" (p. 84). However, he also stated that "while some chronic self-mutilators may have this disorder [borderline personality disorder], many do not" (p. 236). It is not a coincidence that a host of other symptoms of borderline personality disorder, for instance, depression, high impulsivity (Sabo et al., 1995), past traumatic



experiences (Shearer, 1994), an inability to cope with feelings and emotions, and an addictive personality (Martinson, 1998) have previously been linked to self-injurious behaviors in other disorders such as anorexia and bulimia.

It seems that SI appears together with numerous other symptoms, and it might be impossible even in specific cases to disentangle the symptomatic system and find linear causality. What matters more is that self-injury is regarded as a cry for help, a self-soothing coping mechanism and the best method a patient has found to cope. As Conterio and Lader (1998) stated: "The borderline diagnosis captures the quality and tenor of some self-injurers' relationships: they are full of mistrust, fear, vulnerability, and unpredictability" (p. 178). From the information given on the link between personality disorders and SI, it should not be deduced that self-mutilators are also suffering from a personality disorder. Automatically doing this would do a disfavor to clients who self-injurer for the various other reasons mentioned above.

Many (but not all) patients suffering from eating disorders, Dissociative Identity Disorder, or Borderline Personality Disorder have had traumatic experiences in childhood and adolescence (Conterio & Lader, 1998). Zlotnick et al. (1997) reported that "among 85 substance abusing or dependent inpatients they found that those with histories of distressing traumatic events reported more self-mutilative acts, higher levels of dissociation, and a greater degree of impulsivity than did patients without such histories" (p. 650). Romans et al.

(1995) studied sexual abuse in childhood and deliberate self-harm. They concluded that the more serious and frequent the abuse was, the more self-injurious behaviors were present in a patient.

For somebody without traumatic experiences, it seems almost illogical that a person who had to bear abuse by others would add to that by abusing herself. Connors (1996) provided a very logical answer to this question: "The fundamental construct is that self-injury helps survivors to cope with the aftermath of trauma" (p. 197). The four ways Connors sees as to how SI might help are as a "re-enactment of the trauma" (p. 202), an "expression of feelings and needs" (p. 203), help with "organizing the self, regaining homeostasis" (p. 203), and "management of the dissociative process" (p. 205). Clinicians who know about possible functions of SI will be more inclined to encounter the self-injurious patient in an empathic, compassionate manner, driven by understanding of the underlying causes of SI and the desire to help find more adaptive coping responses.

### Assessment of SI

Two kinds of assessment modes are available for investigating SI. First of all, there is the clinical interview with a client. For mental health professionals, it is not a common assessment method to ask people to show their wrists, arms, and stomach. However, in the case of suspected self-injurious behaviors, the therapist might decide to ask questions about self-injury

and then request to see the arms of a person (Levenkron, 1998), especially when the client is wearing wrist-wraps or long-sleeves even in the summertime. If the patient is also under the care of a physician, the therapist might ask the physician to routinely examine the patient for signs of self-injury. It certainly takes caution, therapeutic concern, and sensitivity for the self-injuring patient in order for a therapist to pose relevant and non-threatening questions about SI.

Secondly, clinical interviews and standardized tests, for instance, for Borderline Personality Disorder or eating disorders are another way of assessing for SI. Vanderlinden and Vandereycken (1997) developed a Self - Injury Questionnaire (SIQ) for their study on eating disorders and SI. They also pointed out that impulsivity checklists (like the Impulsiveness Scale, IS) and the Dissociation Questionnaire (DIS-Q) (as cited in Vanderlinden & Vandereycken, 1997) might be very useful to get closer to secretive behavior patterns oftentimes associated with SI. Ross and McKay (1979), in addition to employing the MMPI, used body charts so patients could draw where and how they had injured themselves. Questionnaires such as the Self-Harm Questionnaire , an unpublished instrument developed by Sansone (Sansone et al., 1995) which asks about suicidal ideation, might be beneficial to the therapist.

## Treatment Options

This section focuses on the different treatment modalities used with self-injuring patients, including both conventional approaches and more recent developments in treating women with SI. An integration of approaches will be attempted.

Conventional approaches. As difficult as it might be, a correct assessment and diagnosis of SI in patients is just the beginning of treatment for that population. The more difficult part, according to the literature, seems to be the choice and availability of treatment programs and modalities. It should have become evident from the discussion about etiology and characteristics of SI that this is a complex, multifaceted symptom which still defies a single explanation. Needless to say, treatment for the condition used to be mainly of behavioral and psychopharmacological nature, especially with those diagnosed as having schizophrenia or mental retardation. Now that a new self-injuring population of women with average or above average IQs has come forward, available treatment models needed to be expanded to address their issues. A brief look at conventional treatment modalities for SI reveals the following options: behavioral approaches, cognitive-behavioral therapy (like Rational-Emotive Behavior Therapy, REBT), psychodynamic therapy, and psychopharmacological treatment. Another option is to view SI as an addictive

behavior and work out of an addiction model or a Twelve-Step model (Favazza, 1987).

Behavioral treatments are based on the notion that SI is a learned behavior (Conterio & Lader, 1998) that can be modified through therapeutic steps, for instance, through behavior modification programs. Ross and McKay (1979) operated out of the behavioral model in the study with adolescent females at a training school and recognized that their token economy was not as successful in eliminating carving among the patients because the gain of attention the girls received for carving was enough to blot out the significance of the token rewards. Behavioral models have proven to work sufficiently well with a mentally retarded population (Wells & Stuart, 1981), but there is no data available that would justify a purely behavioral model with the population dealt with in this paper, female self-injurers.

Cognitive-behavioral methods like Rational-Emotive Therapy by Albert Ellis, Dialectical Behavioral Therapy for Borderline patients by Linehan (as cited by Martinson, 1998), or the model by Vanderlinden and Vandereycken (1997) have been used successfully to reduce deliberate self-harm. Since the latter is not as well known as the other two models, it shall be presented here in more detail. Vanderlinden and Vandereycken called their model "contract management," which means that "a clear agreement is made about what each party (patient and therapist) can expect from the other in case of self-injury"

(p. 87). According to the contract, the therapist will nurse the wounds or make sure a physician checks on the patient. The main goal during that step is that the therapist does not overreact and does not respond to the feelings underlying the self-injurious behaviors. Later on, the therapist is supposed to address the incident in the therapy session in order to allow the client the time and space to calm down and work on adhering to her part of the contract. The patient agrees to engage in the following self-monitoring behaviors: jot down notes about difficult situations; prevent her own self-destructive actions by finding a safe place; go into time-out, or engage in alternative abreaction activities like physical activity. The objective behind this model seems to be to teach clients how to identify triggers for self-injury and find coping skills other than hurtful behaviors.

Psychopharmacological interventions have not been well-researched with self-injury as the primary diagnosis. The only two authors among those reviewed who mentioned treatment with serotonin-re-uptake-inhibitors (SSRIs) were Favazza (1998) and Bystritsky and Strausser (1996), who reported successful treatment of an obsessive-compulsive cutter with naltrexone. Nevertheless, antidepressant and anti-anxiety medications have certainly proven beneficial in the treatment of eating disordered patients, patients with Borderline Personality Disorder, and clients suffering from Dissociative Identity Disorder (Martinson, 1998). Research on neurochemical influences on

impulsivity and self-harm is not strong enough yet to support prescribing a psychopharmacological agent without another primary diagnosis that warrants the medication.

The S.A.F.E. treatment model. Since cognitive-behavioral and behavioral treatment programs are usually geared towards a primary diagnosis other than SI, self-mutilation is only one aspect dealt with in therapy. Other aspects might take prevalence, like an eating disorder, depression, or Dissociative Identity Disorder. However, if the self-injurious behaviors have gotten out of control and now have to be regarded as the primary diagnosis, the best treatment model appears to be the inpatient S.A.F.E. Alternatives program, founded in 1985 by Conterio and Lader (1998). The main difference between conventional treatment programs and S.A.F.E. seems to be that the conventional programs try to keep the patients safe by taking away their responsibility and all sharp weapons, whereas the S.A.F.E. program is based on the client's learning how to take responsibility for herself. Conterio and Lader suggested that trying to "rescue" patients just plays into the mechanisms of self-injury, but that "an effective inpatient milieu for the self-injurer focuses on the expectation that patients will take responsibility for their actions, to learn to *keep themselves safe*" (p. 211).

According to Conterio and Lader (1998), the premises of S.A.F.E which differ from most of the conventional understandings of SI include: clients are

not victims; clients need to be ready and commit to their own recovery; SI is not an addiction, and clients should not revert to symptom substitution such as hitting an inanimate object instead of oneself. The idea behind these premises is that the only ones who can help clients are the clients themselves. Staff is supportive and available around the clock in the residential treatment centers to assist clients in struggling through difficult times. The main focus of the four-week long inpatient therapy is to teach clients to communicate verbally about their feelings rather than using their "bodies as paper" and their "blood as ink," so to speak. Conterio and Lader, the founders of the S.A.F.E. programs in the United States and Canada, have thus far not proven statistically that their program is successful, but reports from former patients sound promising, and the program seems to be based on a sound foundation.

Integrating approaches. In specialized treatment programs like S.A.F.E., the self-injurious patient is the norm. For most therapists working in mental health settings, however, SI in patients is not the primary focus but rather yet another symptom to be taken into consideration when dealing with a primary diagnosis other than SI. In these cases, SI needs to be treated within the context of the primary disorder, and an integration of approaches linked to the main concerns of the patient (like an eating disorder) and self-mutilative symptoms should be attempted. Like with any other symptom, therapists are probably asking for the functions of SI for a particular client. Depending on



the primary diagnosis, SI might fulfill different functions for clients. When the clinician knows about the functions, he or she can help the client understand SI as a coping response to emotional pain. The next step is to work with the client on learning how to communicate about and share feelings and emotions in a safe therapeutic setting. This learning might then be transferred to the client's life in the outside world. Self-injurious behaviors, as painful as they might look to an outsider, fulfill a positive function for the sufferer. It is the therapist's task to understand the person behind the symptom and to help reframe the person's existing coping skills and beliefs about the world.

Even if it is kept a secret, SI almost always influences therapy in one way or another, and it might become more of a therapeutic issue in the future the more acceptable the behaviors become to the public. Favazza (1998) admitted that treatment for self-mutilators is a long-term process and "still problematic" (p. 267), but he also left room for hope by saying that "medication and new psychological approaches are helpful" (p. 267). One thing that makes therapists and clients dealing with self-injurious behaviors in treatment seem alike: the need for hope, hope, and hope that there are other ways to cope with pain than hurting one's own flesh.

#### Conclusion: Understanding Self-Injury

Self-injury seems to be one of the most misunderstood symptoms of psychological distress. Granted, people who cut, burn, carve, or disfigure

themselves are seriously disturbed, but they deserve compassion and empathy, because they are harming themselves more than they can harm anybody else through their actions. Connors (1996) so aptly stated: "Self-injury is a fundamentally adaptive and life-preserving coping mechanism. It enables people struggling with overwhelming and often undifferentiated affect, intense psychological arousal, intrusive memories, and dissociative states to regulate their experiences and stay alive" (p. 199). In reality, however, the long-term effects of repeated self-injurious acts are harmful to the client's psychological well-being because SI oftentimes replaces other, more adaptive coping mechanisms.

Farberow's statement in his 1980 book on suicide that self-mutilation has "long-term, cumulative, serious, harmful effects--physical, psychological, and social" (p. 277) is certainly correct. Still, there is reason for hope. Treatment programs like S.A.F.E. have had respectable success in helping women end their self-injurious behaviors by learning how to take responsibility for themselves and their emotions. There can be an end to secret pain by calling it forth, out in the open, and addressing it with the help of a knowledgeable, compassionate therapist who is dedicated to the client's long-term recovery.

There is much to learn and understand about self-injurious behaviors. One thing, however, will always remain the same, no matter how serious and

disturbing the self-harm has become: One is dealing with a person who is in extreme emotional pain with no other way of coping than to hurt herself physically. It is this author's sincere wish that in the future, the women who had to secretly relieve themselves of their pain by cutting, burning, biting, or hitting will get the help from medical and mental health professionals that they deserve. Self-mutilators need advocates for their pain. They need therapists who will stay with them through the process even if the SI gets worse for a while. They need others to see that they are hurting and to respond to them in accepting ways. They need safe places to uncover their arms and thighs and show their scars. They need to share their stories of self-abuse and, through other people's empathy for them, learn how to become more empathic with themselves.

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