THE DESTRUCTION OF LIFE:

SELF-INJURIOUS BEHAVIORS

by

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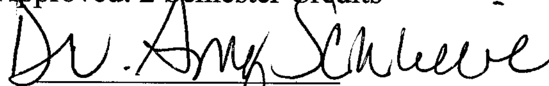

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ABSTRACT

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The purpose of this paper was to provide information regarding self-injury, primarily of young females, to the public. This paper addressed several aspects of self-injury. The function of self-injury which may include control or vengeance was discussed. Several characteristics of those who self-injure including impulsivity and low self-concept was included in this paper. Contributing factors of self-injury such as abuse was addressed. The three different types of self-injury, major, stereotypic, and superficial self-injury were all discussed in this paper. Some diagnoses associated with self-injury such as depression and personality disorders was included. Possible treatments of self-injury including medication, therapy, and inpatient programs were also addressed in this

paper. Also included in the paper are a summary of the research used in this literature review and recommendations for future research. One recommendation was to get reactions from those close to the self-injurer. Another recommendation was to monitor the success of those who completed treatment as part of a longitudinal study. The final recommendation was to use proactive measures to educate adolescents on self-injurious behaviors which may lower the high number of people who use this as a means of communication. Since self-injury is so prevalent in today's society, the need to be knowledgeable has become necessary, especially for those who work with self-injurers.

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CHAPTER I: INTRODUCTION

"How will you know I'm hurting if you cannot see my pain? To wear it on my body tells what words cannot explain"(foreword). This insight by C. Blount in Conterio & Lader (1998) offers insight into the distorted thoughts of a person who has self-injured. The introduction of Conterio and Lader (1998) explains that human beings have used skin to communicate identity, status and culture from the beginning of existence. More recently, tattoos, body piercing and body art have been the way to communicate one's affiliation, beliefs or stance. Self-mutilators often say that their scars tell their life's history. Each scar represents a particular event that they don't want to or can't forget.

Today, these life stories are more prevalent than ever before. According to Luftman and Marciano (2003), in the video *Emotion and pain: Understanding self -injury*, currently there are approximately two million persons who self-injure each year. Even famous people such as Johnny Depp, Angelina Jolie, Christina Ricci, Roseanne, and Diana, Princess of Wales have been linked to self- mutilation. More recent estimates (Briere & Gil, cited in Kress & E., 2003) indicate that approximately 4 percent of the general population and 21 percent of the clinical populations without mental retardation or a developmental disability engage in self-injurious behavior (SIB). Strong (1998) believes there are more than two million Americans, and even more people around the world, who regularly injure themselves intentionally or compulsively.

There are many who self-injure just as there are many names associated with self-injury. Ng (1998) states that self-mutilation is known by many names, including self-injury, self-harm, and self-abuse. Since self-injury is referred to differently by different researchers, the term self-injury will be used throughout this paper for consistency.

Just as self-injury has many names, there are also many methods of hurting oneself. A study conducted in 1989 by Conterio and Favazza (cited in Ng, 1998) found 72 percent of self-injurers to be cutters. The remaining methods were burning at 35 percent, self-hitting at 30 percent, interfering with the body's healing process at 22 percent, hair-pulling at 10 percent, bone breaking at 8 percent, and a combination of methods at 78 percent. Conterio & Lader (1998) state "many people progress from cutting to burning, finding that they need to wound themselves more severely to get the same relief, the same high from the pain. Some people vary their cutting, and some rely on a single tool" (p. 17).

Self-injury, research indicates, is more prevalent in females than males. At the conclusion of a 6 month long study of psychiatric hospital admissions, Graff and Mallin (cited in Strong, 1998), defined a typical cutter as being a young, highly intelligent woman who is prone to alcohol and drug abuse and has great difficulty in relationships. They also found that most of these women had suffered painful childhoods with cold, rejecting mothers, and distant, hypercritical fathers. Conterio and Lader (1998) also found the vast majority of self-injurers are women, "In our thirteen years of running S.A.F.E.(Self-Abuse Finally Ends treatment facility), we have had scarcely more than twenty male patients, compared to thousands of female patients"(p. 23). Ng (1998) believes that this may arise from many women thinking negatively about their bodies. The ideal body in today's society is tall, thin, and beautiful, which seems impossible to reach for many women. They may feel that their worth as a person depends upon their physical attractiveness and their bodies. Sometimes these women's bodies become their enemies and the target of their self-violence. Another possible reason is that some parents teach their daughters that some emotions, such as anger, are not appropriate to express. They may

hide their emotions and release the emotions by hurting their bodies (Ng, 1998). The focus of this paper will be on female self-injurers since the research on males who self-injure is limited.

Throughout the research literature commonalities in those who self-injure have been noted. The vast majority of self-injurers grew up under disturbing circumstances (Conterio & Lader, 1998). Many were physically, sexually, or emotionally abused or who had parents who ignored their basic needs. Many are children of alcoholics or those with mental illness, perhaps parents who neglected or tormented them. Most grew up in households where emotions were not allowed to be expressed and where religion and/or military-type discipline was very strong. In addition, a lack of supervision or parental guidance/support was present. Similarly, Strong (1998) says "most self-injurers come from families in which values are horribly twisted, where a backhand means discipline, where inappropriate sexual attention means love" (preface p. xix). These common circumstances can lead to self-mutilation in hopes of solving emotional dilemmas (Levenkron, 1998).

Although the self-injurer may look like they are trying to commit suicide, in fact that is a common misconception. In the video, *Emotion & pain: Understanding self injury* (Luftman & Marciano, (2003), Dr. Wendy Lader emphasizes that self-injury is a coping mechanism to help the person cope and live, not die. The self-abuser is not attempting suicide. The goals of self-injury are first to feel better and second as a communication tool to ask for help (Lader, cited in Luftman & Marciano, 2003).

Levenkron (1998) describes self-injury as "the act of damaging seriously by cutting off, or altering an essential part". In most cases, the essential part is one's skin. The damage is rarely life threatening, however, long-term harm is usually restricted to scarring (p.22).

Similarly, Ng (1998) says that self-mutilation is defined by experts as the act of intentionally harming one's body for emotional relief. When death occurs, it is usually because the person has cut too deep or cut an artery. On the contrary, Conterio & Lader (1998) state that "Self-injury is a distinctly different activity from a suicide attempt, but the boundaries often seem murky, and many self-injurers do have suicidal thoughts or have committed acts aimed at ending their lives" (p. 29).

To sustain the covertness of the act, people who self-injure tend to do it secretly. They don't call for help and don't get the medical help they may need. People who cut or burn themselves are at risk for developing dangerous infections (Ng, 1998). People are not only affected physically but emotionally as well. As a person self-injures, he/she is not dealing with his/her unresolved emotional problems. The self-injury is a way to avoid dealing with emotional pain (Ng, 1998), which is a difficult concept to understand.

Statement of the Problem

This literature review was undertaken to gain a better understanding of current research regarding self-injury, a life-sustaining act primarily in females, through a thorough review of the available literature.

Purpose of the Study

The purpose for the literature review was to increase knowledge and awareness of self-injury and the individuals who self-injure.

Definition of Terms

Self-injury, is defined in Conterio & Lader (1998) 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. It can include cutting the skin or burning it, or bruising oneself through a premeditated accident. It can mean scratching the skin until it bleeds, or interfering with the healing of wounds. In more extreme cases, self-injurers break their own bones, amputate their own digits, eat harmful substances, or inject their body with toxins (p.16).

S.A.F.E.: Self-Abuse Finally Ends, a treatment facility located in Illinois.

SIB: Self-injurious behaviors

Limitations of the Study

One limitation of this study is that not all forms of self-injury were discussed. Alcohol and/or drug abuse, eating disorders, and self-injury of those with cognitive abilities were not included in this paper. Another limitation was that this literature review was limited in comparison to the vast amount of the available literature on this topic.

CHAPTER II: LITERATURE REVIEW

Introduction

This chapter includes the function of self-injury which may be control, vengeance or a means of communication. Factors, such as culture or abuse that may lead to self-injury as well as diagnoses associated with self-injury were discussed in this chapter. The remainder of the chapter focused on forms of treatment for those who self injure.

Function of the behavior

The motives behind self-injury are numerous and complex. Some are similar to more socially acceptable forms of stress management, like smoking or drinking alcohol. Some overlap with other compulsions, like binge eating or drug addictions (Conterio & Lader, 1998). Self-injury serves many purposes for its practitioners. The purposes fall into two major categories of analgesic or palliative aims and communicative aims.

Analgesic or palliative aims are when the person feels a physical calming while self-injuring. Self-injury makes people think they are in control, and this feeling temporarily boosts their morale. Self-injury also helps people feel cleansed as they are ridding themselves of emotional toxins inside of them (Conterio & Lader, 1998). Susan L., a patient (cited in Conterio & Lader), states "During the cutting I feel calm, I feel powerful, and I feel focused. After self-injury I feel so much relief. I feel very calm. My inside pain and feelings are gone" (p. 63). After self-injuring, one usually feels a strange sense of calm, usually tinged with remorse and guilt. Many self-injurers descriptions confirm this analgesic function of self-injury, in which the injuring act produces a calming, soothing sensation (Conterio & Lader).

The second aim is communicative in which people use self-injury to depict their

emotional state and express wishes, needs, and desires. They use it to communicate with themselves and with other people. Self-injury can represent an act of vengeance, a reenactment of earlier abuse, or a desperate cry for help and compassion (Conterio & Lader, 1998). Even though self-injury is done in private and often kept hidden, self-injury clearly has a strong agenda. It can be a disguised way of showing aggression against others, or a desperate way to get caring responses from others (Conterio & Lader).

Extending from the two main purposes are other reasons that self-injury fulfill. First, self-injurers usually have faulty connections between their physical and emotional selves. They feel disconnected from their senses and body. For self-injurers who feel distanced from reality, isolated, or dehumanized, the sight of their own blood can jolt them back to reality. It reassures them that they are alive, intact, and have personal boundaries (Conterio & Lader, 1998). Many injurers feel chronically unaware of physical pain. Self-injury is the remedy that "brings the skin alive"(p. 65), connecting the physical self to the emotional self (Conterio & Lader).

Another function is the control the self-injurer feels over his/her body. Those who experienced abuse as children were victimized. The self-injurer now is able to replay the abuse, however; this time she is in control of the beginning, middle, and end of the physical manipulation (Conterio & Lader, 1998). Other self-injurers may have experienced boundary issues with parents which included enforced responsibilities. For example, perhaps a child with alcoholic parents was responsible for caring for the younger siblings as well as cleaning duties in the home. They struggle with those interpersonal boundaries not knowing which role they play, the child or the caregiver. Self-injury is sometimes described as a way of establishing a boundary between the injurer and the parent they identified with (Conterio & Lader).

Self-injury also serves another fantasized purpose, that of cleansing or purifying. Many self-injurers feel that they are "bad" or "dirty" (Conterio & Lader, 1998, p. 66). This type of message may have been conveyed to them as a child by abusive or neglectful parents. Self-injury, to some, is a way to let emotions out of their body. In addition to cleansing, self-injury, which often takes the form of flagellation, can act as a self-imposed punishment. Self-injurers say they are trying to make-up for their sinful selves or for individual transgressions (Conterio & Lader).

Many people who self-injure relay that they cannot express their emotions in words. They usually have difficulties identifying and communicating emotional states, wishes, and needs. Some say they were never able to develop the language of feeling, or they lost their ability to use it (Conterio & Lader, 1998). Self-injurers say their harmful acts show how much pain they are suffering in a way that language cannot. Self-injurers use their behavior to communicate feelings not only to themselves but to others. This communicative tool clearly has an interpersonal agenda. Jared T., a patient (cited in Conterio & Lader) called self-injury "the tangible face to my intangible pain-see my pain"! (p. 67)

The last function that the behavior of self-injury serves is vengeance. Many self-injurers seek vengeance on the people who have caused them pain, though they may not actually act on this thought. Since sufferers are frequently unable to put into words their feelings of anger and maltreatment, their rage takes a diffuse form; it simmers internally as a mass of painful feelings. Self-injury becomes a concrete outlet for the expression of this confusion (Conterio & Lader, 1998). According to Conterio & Lader (1998):

> One of the writing assignments we give at S.A.F.E. asks patients to identify the people who have wronged them, create a "fantasy" of revenge, and then imagine what actual

> apologies, punishments, or retribution might reasonably occur. Needless to say, it's a popular assignment, though it does tend to stir many strong and difficult feelings, as people recall the abuse they have suffered at the hands of people whom they love and who were often responsible for their primary care (p. 70-71).

This difficult assignment helps patients put words and feelings instead of actions to their frustration and anger. The self-injurer always has a function or purpose for the self-destructive behavior. The more one is able to understand the underlying message of SIB, the more likely a true sense of control and mastery will be gained in a non-destructive manner (Conterio & Lader).

Factors

Since self-injury is so prevalent, it leads one to wonder if society's culture plays a role in fostering this. Conterio & Lader (1998) share some observations about today's society. First, society is becoming increasingly disenfranchised. Extended families are not available for support or to help parents care for their children. People tend to move more frequently, causing transient relationships with neighbors and friends. Similarly, the extended family has collapsed which gives individuals less confidants. Children are reluctant to communicate verbally and rely on actions or technology to tell their story. Another cultural difference in today's society is immediate gratification. Everything, fast-food, instant messaging, medication, gives that "quick fix" (p. 9) that is desired. The fourth cultural force is addictions. In the last two decades many addictions such as compulsive gambling, shopping, and self-injury have statistically risen. The fifth factor is self-expression in which body image and appearance is everything. The focus on fitness, tanning booths, and cosmetic surgery is heightened by the media. The sixth cultural force is the persistent gender bias towards women which drives some to severe emotional extremes. Some girls use self-injury as a way to express their frustration and anger with gender

bias. The last force is the increased numbers of latchkey children. Many homes have both parents working or a single parent working, leaving childcare to daycare providers as opposed to family members. As children approach adolescence, they may be caring for themselves and looking to peers for guidance. There are people, however, who have experienced all of these cultural forces and have never self-injured. Resilient people are successful despite their surroundings.

Similarities exist between those who self-injure. There is no way to profile the typical self-injurer, or to say that all self-injurers have the same experiences. There are, however, some common characteristics exhibited by those who self-injure. Some identify with all of the characteristics while others only a few. Conterio & Lader (1998) address eight characteristics. The first characteristic is one who has difficulties with impulse control. This person may also have problems with eating behaviors and/or substance abuse in addition to self-injury. The second is history of childhood illness, severe illness, or disability of a family member. Thirdly, a low or incapacity to form stable relationships. Self-injurers tend to lack or have poor social skills. Another characteristic is the fear of change. This could mean everyday changes with environment, people or events. It could also mean changing a behavior. The inability or unwillingness to take adequate care of oneself is the fifth characteristic. Many self-mutilators ignore basic needs such as diet, sleep and hygiene. Also, the basic need of safety is often times not acknowledged. The sixth characteristic is that those who self-injure tend to have low self-esteem or self-image, but a powerful desire to be loved and accepted by others. The individual with low self-esteem is prone to forming attachments with persons who are abusive to her or needier than she is (Levenkron, 1998). Many people who self-injure tend to meet their need of being accepted by owning a pet and/or careers in a helping profession. The seventh

characteristic is childhood history of trauma or parenting deficits which may lead to difficulties in positive nurturing. The final characteristic is a rigid, all-or-nothing thought process. The self-abuser thinks "Nobody understands me" or "Nothing will ever change" (p. 140). Sometimes this thinking can lead to one who strives for perfectionism or, the opposite, withdrawal.

Many of those who self-injure have been abused in some way, shape or form. According to Constantinou (1997), 98 percent of all cutters have been sexually abused. Many self-injurers were abused by their parents emotionally, sexually, physically, or through neglect (Conterio & Lader, 1998). "Healthy parenting does not produce a self-mutilating child. Parenting has its greatest effect on a child during the formative years of his/her personality development (birth to six years of age)" (Levenkron, 1998, p. 47).

Experts believe that children who were abused are at greater risk for SIB. Many teens who hurt themselves have a history of abuse in their families. There are, however, those who have no history of abuse in their lives and may still self-injure (Ng, 1998). Child abuse is in many ways the most readily understandable explanation for someone's decision to self-injure. Many abuse or incest survivors said they felt continuously endangered and victimized. The body is seen as an object, which causes much pain and suffering (Conterio & Lader, 1998). The child's boundaries were not respected, therefore, the recognition and/or appreciation of those boundaries was not developed normally (Conterio & Lader). A person who was abused as a child and begins to hurt himself/herself is reenacting the abuse. When pain is inflicted on the body, all roles of an abusive relationship are played out. The person becomes the abuser, the victim, and even the soother that takes care of him/her afterward (Kaplan, cited in Ng, 1998). Many times the problem of abuse by a caregiver is compounded by the fact that another primary caregiver is "permitting" or enabling the abuse to continue.

According to Strong (1998), children are totally dependent on their parents for survival; they cannot bear to believe their parents are malicious. In reaction to the abuse, they internalize the perceived bad parts of themselves which may be their body or emotions that were damaged in the past. Actually, some parents tell their children that they are bad and deserve the abuse they are receiving. Children who are blamed for their own abuse also have great difficulty trusting their perceptions. As Frankel (cited in Strong) states "When adults say 'It didn't happen', or 'You wanted it'-those kind of comments really eat away at a kid's sense of reality" (p. 74). Therefore, "cutting grounds you, the pain is real. In that light, self-mutilation can be an effort to avoid a state of disorganization where you don't really know what reality is" (Frankel, cited in Strong, p. 74). As children grow older, they turn to self-mutilation to punish themselves for sins they have committed. Eliana Gil, psychologist, stated "Cutting can be viewed as a way to let the demons out in the form of "bad blood." Abused children sometimes believe they are bad inside and out, they want to destroy their bodies and souls" (cited in Strong, p. 72). Lisa Cross, psychotherapist, also shares "When you are abused, the natural thing to do is take yourself out of your body. Your body becomes the bad part of you that's being punished" (cited in Ng, 1998, p. 26).

Sexual abuse is the ultimate boundary violation. "The one thing that is really ours and that we have boundaries on is our body" (Lader; cited in Strong, 1998, p. 65). Cutting is a way of marking the body's boundaries, of proving what's inside and what's outside the body. Tamara, a thirty-year-old schoolteacher, recalls in Strong (1998), "When I decided the sexual abuse was too overwhelming and I wasn't going to feel it anymore, I shut everything off...It was always about the hurt and seeing the blood, when I saw the blood it made me feel alive"(p. 68). The video, *Can you see my pain ?* (2000), communicates Lader's belief that some self-injurers

feel numb and like a piece of wood, whereas the blood allows them to feel alive. According to Ng (1998), "For other people, self-injuring behavior becomes a way to release their emotions. They are substituting intense physical pain for emotional pain. They are reducing the level of their mental distress by experiencing physical distress. For them, physical pain is easier to handle than overwhelming emotions" (p. 30).

Self-injury is categorized by severity. According to Strong (1998), there are three main types of self-injury. The first is major self-injury which refers to infrequent or isolated acts such as eye enucleation, castration, and limb amputation. This type is usually associated with psychotic features such as schizophrenia. Major SIB can be the result of hallucinations and/or delusions (Kress & E., 2003). The next type is stereotypic self-injury which refers to monotonously repetitive or rhythmic acts like head-banging, hitting or biting. This tends to occur with those with moderate or severe mental retardation, possibly with Autism or Tourette's syndrome. In these cases, SIB tends to be organically based and biologically driven (Kress & E.). The third and most common type is moderate/superficial self-injury. This can be either compulsive, such as skin-scratching, hair-pulling or nail-biting, or episodic, which is skin-cutting, burning or bone-breaking. A majority of people who self-injure tend to be compulsive or episodic in their destruction.

Diagnoses

Self-injury does not fit into any one single diagnosis or category. "It may be helpful to think of self-injury as being 'nested' within a number of different psychological or psychiatric syndromes" (Conterio & Lader, 1998, p. 170). To qualify as a disorder, a behavior pattern must, according to the *Diagnostic and Statistical Manual of Mental Disorders (fourth edition),* be "rigid" and "inflexible", and lead to "distress and major impairment in several areas of the

person's life: social, familial, and occupational" (cited in Conterio & Lader, p. 172). Self-injury may fall into one of two groups; clinical disorders or personality disorders.

Clinical disorders are those that pertain to mood, anxiety, and thought. They include depression, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, and dissociative disorder. (Conterio & Lader, 1998). When one thinks of mood disorders, depression typically comes to mind. Many self-injurers suffer from frequent bouts of very severe depression. Major depression can be described as unipolar because the problems tend to revolve around a single mood. Bipolar disorder (BPD), on the other hand, is when periods of depression alternate with periods of elation or mania (Conterio & Lader). A bipolar self-injurer will harm during the manic phase in order to regulate the state of mind. Many times, people who self-injure are misdiagnosed with BPD because they have difficulties in maintaining their emotional state. (Conterio & Lader). A recent study of participants in an inpatient hospital setting found that only 48 percent of the sample met the DSM-IV-TR criteria for BPD, and when self-injury was excluded as a factor, only 28 percent of the sample met the criteria (Herpertz, Sass, & Favazza, cited in Kress & E., 2003).

Those who self-injure often suffer from anxiety disorders, which can produce extreme tension and agitation, and episodes of disorganized panic. Some self-injurers describe times when they are out of touch with reality, they may hallucinate or hear voices that tell them to harm themselves. These thought disorders can be mild or severe like schizophrenia.

A less common diagnosis among self-injurers is obsessive-compulsive disorder (OCD), in which the sufferer experiences anxiety and distress because of recurring, unwanted thoughts or mental images (Conterio & Lader, 1998). For some people the urge to self-injure may take on the qualities of OCD. Post-traumatic stress disorder (PTSD) is also a diagnosis that

encompasses those who self-injure. Some self-injurers who were severely abused may have been given this diagnosis. Dusty Miller (cited in Conterio & Lader) states that "applying the PTSD diagnosis to self-injurers with trauma histories is a step forward. It acknowledges the source of some of the trouble self-injurers have with emotions and memories" (p. 176).

Self-injurers may also be diagnosed as suffering from dissociative disorders which makes people feel numb, separated from their bodies and thought processes. Most self-injurers diagnosed with this tend to depersonalize themselves as a way of blocking the experience of pain (Conterio & Lader, 1998). An extreme form of a dissociative disorder is multiple personality disorder, which is when a person has more than one distinct identity.

People who self-injure may fall into the personality disorders classification. The disorder most frequently linked to patients who self-harm is borderline personality disorder. One of the indicators of the disorder is to have a history of suicidal gestures or self-mutilating behaviors (APA, cited in Kress & E., 2003). Other personality disorders that encompass those who self-injure are people with a dependent personality, helpless and unable to take care of themselves. People who are passive-aggressive tend not to express anger directly and their needs are met indirectly. A paranoid person is someone who is secretive and guarded, being the victim constantly. A narcissistic person is one who needs the attention and takes everything to the extreme. The last personality disorder is histrionic, which is when emotions are in excess and instant gratification is desired. (Conterio & Lader, 1998).

Although those who self-injure typically do carry a diagnosis, Conterio & Lader (1998), founders of the first treatment program in the nation, specifically for those who physically harm themselves, state:

> We do not view the diagnosis of personality disorder as a way to pigeonhole people.

> Rather, we see it as a way to describe the patient's style of relating to people. The purpose of any diagnostic description should be to help therapists intervene more effectively, not to label people in a condescending way. We emphasize as often as we can that the person who self-injures is much more than an "illness" or a "diagnosis"; he or she is a person whose problem does not define his or her identity (p.178).

Treatment

There is no single therapeutic approach that works with all self-injurers. Successful treatment generally involves a combination of medication, psychotherapy, and cognitive-behavioral techniques, staged and individualized to the patient's particular needs (Strong, 1998). This section will focus on the different types of treatment, including medication, and inpatient and outpatient treatment facilities.

Medication can be important in the treatment process. However, medications are primarily used in treating the accompanying symptoms which tend to disrupt the therapeutic process (Conterio & Lader, 1998). "With properly-tailored medications, patients find it easier to manage self-injury urges and tolerate therapy work"(p. 171) Conterio & Lader (1998).

People who suffer from mood disorders may benefit from mood-stabilizing medications such as Lithium, Depakote, Neurontin, or Tegretol. Antidepressants, like Prozac, increase serotonin in the brain and have been successful in reducing and sometimes stopping chronic, repetitive cutting by alleviating the impulsivity and compulsivity that underlie the behavior (Strong, 1998). Other antidepressants, monoamine oxidase inhibitors, help with related symptoms such as depression, anxiety, mood swings, and racing thoughts (Strong, 1998).

Self-injurers who suffer from anxiety disorders may be prescribed anti-anxiety agents

called anxiolytics, or minor tranquilizers, to block out their feelings. However, those that self-injure may be at risk to overuse or abuse the medication since they typically are trying to block out unwanted feelings. One study of Xanax, one of the anxiolytics typically prescribed, found that it produced an increase in self-destructive and impulsive behaviors (Conterio & Lader, 1998).

People suffering from thought disorders may be prescribed antipsychotic drugs, such as Thorazine, to help ease and clear the person's thought process. Self-injurers can use these drugs for relatively short periods of time, weaning from them as therapy progresses (Conterio & Lader, 1998). Those that suffer from post-traumatic stress disorder are generally prescribed medications for their specific symptoms. They may take antidepressants, anxiolytics, sleeping medications or a combination depending on the trauma and it's effects. Self-injurers who also suffer from dissociative disorders tend to take themselves out of their body or have several identities. Naltrexone, which blocks the release of endorphins causing the person to feel the pain during self-harm may be prescribed (Conterio & Lader). Naltrexone, which is also used in the treatment of alcoholism and drug addiction has been successful in controlling the cutting by taking away the euphoric high caused by endorphin release (Strong, 1998).

Since self-injury is so complex, medication responses may vary. In one double-blind study done by Rex Cowdry and David Gardner at the National Institute of Mental Health, four medications were given to patients to treat for self-injury along with other problems such as impulse control. Each patient took the same medications at the same time, first an antipsychotic drug, then an antianxiety drug, third an antidepressant, and finally an anticonvulsant. The most significant improvement occurred while the patients were taking Carbamazepine, the antiseizure

medication known as Tegretol. All of the patients responded and did not self-injure during the Tegretol trial period (Strong, 1998). "I suspect the reason for this variability in response is that there are a number of different routes to this complex behavior. You can treat different components of the problem with different agents" (p. 164), says Cowdry (cited in Strong, 1998).

In most cases, medication alone will not cure the self-injurer. This in accordance with programs and/or therapies can/will lead the person to be successful with treatment. Conterio & Lader (1998) share their view on working with those who self-injure "encountering a patient who self-injures can be frightening indeed. Many therapists shun working with patients who are aggressive or self-injurious. Self-destructiveness as an umbrella concept stirs concerns for many health care professionals in our day and age when litigation and malpractice is at an all-time high" (p. 180). Given the growing population of people who exhibit this behavior, it is increasingly likely that a psychotherapist will encounter someone with the problem during his/her career (Conterio & Lader).

One approach that has proven successful for some focuses on self-injury as a behavior. Strong (1998) believes that from a cognitive-behavioral point of view cutting is a learned behavior which is driven by self-destructive thoughts and beliefs maintained by both positive and negative reinforcement. Therefore, treatment needs to focus on unlearning the behavior. A form of treatment, dialectical behavior therapy (DBT), was developed by University of Washington psychologist Marsha Linehan. She states "This program is a manualized outpatient program that consists of one hour per week of individual therapy and two and a half hours of group therapy for one year" (cited in Strong, p. 173). The focus is on the patient's current life to identify what events, thoughts, behaviors, and emotions trigger self-injury, and to devise

strategies and alternatives to prevent giving in to the behavior (Strong, 1998). Patients learn how to resist thinking about self-injury and to release feelings and emotions through their words rather than actions. Some patients develop a coping plan for intense feelings and all are expected to sign a contract to try alternatives before self-harming (Strong, 1998). This program was specifically designed to treat patients diagnosed with borderline personality disorder and those that engage in parasuicidal behaviors. A year long study on the success of DBT was conducted with the conclusion that patients had fewer and less severe incidents of parasuicide, less hospitalizations and were more likely to stay in treatment for the full year. A follow-up study a year later, however, found some decline in the effectiveness and a gain in parasuicidal behavior and anger (Strong, 1998).

Another form of therapy is trauma resolution. Bessel van der Kolk (cited in Strong, 1998) states "Treatment must help patients regain a sense of safety in their bodies and complete the unfinished past" (p. 166). Patients need to reclaim their lives so they are no longer haunted by the terror of the past. They learn to view their traumatic experiences as an unfortunate part of their history but not an ongoing threat to which they constantly react (Strong, 1998). One of the first tasks they learn is to gain control over dissociative states. They are taught grounding techniques to bring them back to reality and differentiate between the past and present. Identifying feelings, reacting appropriately, and anxiety management are also part of trauma resolution. Patients are encouraged to get involved in the community as well as develop social supports (Strong, 1998).

Along with individual therapies, inpatient programs are deemed successful. However, as Carla (cited in Strong, 1998) states "No treatment for self-injury will be successful unless the

patient truly wants to stop cutting. It takes an enormous amount of faith, courage, and commitment to endure the pain of the past and embrace a future without the very thing that has kept one alive, that has seemed as necessary as breathing" (p. 179). One inpatient treatment facility was formed at the Bethlem Maudsley Hospital in London, England in 1992, "mainly for those who repeatedly cut or burn themselves but also for those who repeatedly take overdoses or use blood-letting as their form of self-harm" (Crowe & Bunclark, 2000, p. 48). Dr. Michael Crowe's therapeutic aim is to "enable individuals to develop alternative, more healthy ways of coping and of gaining a better understanding of themselves"(p.48). Crowe believes the two strategies that are central to self-understanding are retention of responsibility, which allows choice by the patient as opposed to the staff, and therapeutic risk-taking, which is apparent as the patient retains his/her responsibility. Referred individuals are assessed to determine level of risk, willingness to change, and psychological ability to engage in therapy (Crowe & Bunclark, 2000). Admission is planned to last for six months. Patients are involved in both individual and group therapy as well as weekly coping skills groups such as tolerance, assertiveness, and change and reflection. Many who self-injure have difficulties with verbal communication, therefore a range of alternative means of expression is provided. These include creative writing, creative art, drama therapy and projective art. (Crowe & Bunclark, 2000). The unit is a living learning environment where the staff and patients use problem solving as a community when issues are encountered. The unit also has elements of a psychosocial model as an attempt to view patients holistically, addressing interpersonal, group, familial, and social levels (Crowe & Bunclark, 2000). Since self-injury, especially in the early months of treatment, is difficult to extinguish, a negotiated approach is based on harm minimization rather than abstinence. The

first step is that a person who self-injures waits and possibly finds an alternative as opposed to an impulsive decision to cut. In the later stages of treatment, family therapy is encouraged if applicable to the patient (Crowe & Bunclark, 2000).

Another inpatient treatment program is the S.A.F.E. Alternatives program located in Illinois (Conterio & Lader, 1998). The program has expanded to offer inpatient, outpatient, and day hospital programs depending on the severity and needs of the self-injurer (Ng, 1998). The emphasis of S.A.F.E. is on treating clients with respect and empathy and placing the responsibility for recovery squarely on their shoulders. Conterio & Lader (1998) state "Our patients must face up to the fact that they are the only ones who can keep themselves safe" (p. 213). The voluntary admission is planned ahead of time and rarely takes place during a crisis. Since the program is voluntary, the patient may end their involvement at anytime. The typical length of stay is approximately thirty days. During the initial screening, the patient must demonstrate an internal motivation to stop self-injuring. Upon admission, patients are asked to sign a "No Harm Contract" while they are at S.A.F.E., which states they will not self-harm while they are in the program but rather find an alternative way to manage the emotions and urges (Conterio & Lader, 1998). A culture of safety is created in which the patients and staff maintain a relationship contingent upon patients being injury free (Conterio & Lader, 1998).

Patients are discouraged from showing scars, discussing methods of self-injuring or describing the mechanics of self-injury while they are in the program. Another rule while participating in S.A.F.E. is that patients and staff refer to the behavior as self-injury as opposed to cutting or burning. Self-injury puts all patients on the same level and takes away the uniqueness of SIB. (Conterio & Lader, 1998). Another technique utilized by S.A.F.E. therapists

is writing assignments that help patients identify, express, and tolerate feelings on paper. They also require patients to maintain an Impulse Control Log in which each urge to self-injure is recorded along with the identified trigger (Conterio & Lader, 1998). The staff share the understanding of the patient's SIB while giving them the goal to try alternatives that may serve the same function for them. Dr. Latza (cited in Conterio & Lader, 1998) said in a speech to fellow psychologists:

> Once the patient feels understood, she can begin to take the necessary steps, and risks toward change. When patients find the words to express the inexpressible, their agony is lessened. When the self-injurer's world becomes a less chaotic morass, and becomes governed by logical and rational explanations, her suffering is more manageable (p. 217).

By the time most patients leave the program they have come to believe that self-injury is a choice, that it is a behavior they should be able to control. The S.A.F.E. program has not done any follow-up studies to measure success, they only have anecdotal evidence and many referrals from former patients (Strong, 1998). Christine Roberts (cited in Ginty, 1999) recalls her treatment at S.A.F.E.:

> We learned to record our feelings in books called impulse logs. We would write down an impulse, the feelings behind it, and what would happen if we followed the impulse. We also had group and individual therapy. It took some time for me to feel comfortable enough to open up to everyone and talk... the big breakthrough came when I was able to talk about being abused. When I got to S.A.F.E., I could barely admit it happened...after I learned to talk about it, I started to feel less guilty. I don't think I'll ever injure myself

again, but I have scars that remind me of it everyday (p. 104).

As the research indicates, self-injury is complex. The functions of self-injury vary from person to person. Self-injury may be used as means of control or a means of communication for some, while others use self-injury as a way to cleanse their bodily toxins. Factors of self-injury can include societal factors such as the lack of support from extended families or the need for immediate gratification. Other factors of self-injury are seen in some common characteristics of self-injurers. People who self-injure have difficulties with impulse control, the inability to form healthy relationships, a low self-esteem, and they ignore the basic need of safety. Self-injury does not fit a single diagnosis but tends to part of several diagnoses. Self-injury may be seen as a mood disorder like depression or post-traumatic stress disorder Self-injurers have also been diagnosed with bipolar disorder or obsessive-compulsive disorder. Treatment for self-injury is usually a combination of different methods. These methods may include, but aren't limited to, medications to treat symptoms that may interfere with the treatment process, behavior therapy, trauma resolution therapy, or inpatient therapy programs. The success of treatment is dependent on the individual and the efforts of examining this complex behavior.

CHAPTER III: SUMMARY AND RECOMMENDATIONS

This chapter will summarize the research findings from the previous chapters. The chapter will conclude with recommendations to improve research and provide ideas for future research.

Summary

As learned through research, self-injury affects approximately two million people each year. This behavior has many names including self-mutilation, self-harm or self-abuse. Along with the interchangeable names, many methods of self-injury are used. The preferred method, according to a Conterio and Favazza (cited in Ng, 1998) was cutting, followed by burning, self-hitting, interfering with the bodies healing process, hair-pulling, bone-breaking, and finally a combination of the methods being used.

Research also indicates that self-injury is more prevalent in females than in males for several reasons. Women tend to think negatively about their bodies, citing the ideal as impossible to achieve. Another reason is that women, in general, are taught not to express their negative emotions, such as anger and frustration. They may hide their emotions and release it by harming their own bodies (Ng, 1998). The typical cutter is a young, intelligent woman who is prone to drug and alcohol abuse and had difficulties maintaining relationships (Strong, 1998).

Many who self-injure have similar backgrounds. A majority have grown up in disturbing circumstances (Conterio & Lader, 1998). Most were physically, sexually or emotionally abused as children. They also were children of alcoholics or those with mental illness. They came from homes where they were not allowed to share emotions or were never shown how to express

emotions. Many of the households lacked parental support, supervision and guidance.

The behavior of self-injury serves a purpose for those who engage in it. These motives are different for each self-injurer. Some say they use self-injury as a calming agent. The person is calm and in control during the behavior and feels cleansed of the feelings, emotions, and pain immediately after. Others say they use self-injury as a vengeance on others. They reenact their abuse during the act, however this time are in control of the abuse they suffered as a child as opposed to being the victim (Conterio & Lader, 1998). They feel an immense amount of control throughout the replay of their childhood abuse. Some say they feel alive when they see their own blood, it's a jolt back into reality. They are now in touch with themselves and their bodies allowing for connection. Some self-injurers report that they aren't able to express themselves through language. Self-injury allows them to identify and communicate their thoughts, feelings and emotions (Conterio & Lader). Sometimes, self-injury is a way to communicate to others. Even though the action is private, the wounds are present and sometimes visible to those who are intended to notice.

Reasons for self-injury are diverse as are the possible factors that contribute to this behavior. Many self-injurers come from highly dysfunctional homes. Single parent homes, working parent homes or relocating families may cause a lack of stability and support for children. Children aren't able to communicate comfortably or adults may not be available to communicate with. Society, in general, lacks the family values that were once so prevalent.

Many people who self-injure have similar characteristics. Conterio & Lader (1998) discuss eight characteristics common to those who self-injure. First, they typically are very impulsive, they don't think through actions or consequences before they act. Another is they

sometimes have a history of childhood illness or their parents may have had an illness or disability. Third, they have difficulties forming stable relationships. They usually have poor social skills or social concept. Another characteristic is the fear of change. Changes in environment, schedule, or changing a behavior seems impossible for one who self-injures. An unwillingness to take care of oneself is another characteristic. One may not get adequate sleep, they may have a poor diet and poor hygiene which leads to poor self-image and concept. Those who injure themselves obviously ignore the basic need of safety. They are not protected from their worst enemy, themself. Some self-injurers had poor childhoods filled with trauma and/or poor parenting which may have affected the nurturing process. The final characteristic is when the thought process is an all-or-nothing process which means "nobody likes me" or "no one cares about me"(Levenkron, 1998, p. 140).

A major factor contributing to SIB is abuse. Many who self-injure have been abused in some way; physically, sexually, emotionally, or through neglect. Experts believe that children who were abused are at greater risk for SIB (Ng, 1998). When abused, the child's boundaries were ignored therefore causing him/her to have a poor concept of boundaries. He/she isn't sure what is acceptable and the role he/she is playing is unclear as well. This person is constantly feeling victimized and endangered.

Since children are virtually dependent on their parents for survival, it is difficult for them to understand their involvement. A parent that is aware of the abuse, or is the abuser, may blame the child for the abuse. The child is then confused because not only is he/she unprotected but may be told what to feel as well, not being allowed to form his/her own feelings. The child may feel as though he/she is bad and takes the frustration out on his/her body later in life, to get rid of

the bad parts physically and emotionally (Strong, 1998). Sexual abuse is the ultimate boundary violation. Their bodies are unreal to them, an object without feelings. Many self-injurers report that their body is not alive and that seeing the blood, during self-injury, makes them realize they in fact are alive (Strong, 1998).

The three main types of self-injury, according to Strong (1998), are categorized by severity. The first, and most severe, is major self-injury which refers to isolated acts such as limb amputation. This tends to be associated with those who have severe psychosis. The second type is stereotypic self-injury which is monotonously repetitive or rhythmic acts such as head-banging or hitting. People with moderate or severe mental retardation tend to fall into this category. The final, and most common, type is moderate self-injury which can be either compulsive such as hair-pulling or nail-biting, or episodic such as skin-cutting or burning.

Self-injury, in itself, does not carry a diagnosis or category. Rather it falls within the two groups of diagnoses, clinical disorders and personality disorders (Conterio & Lader, 1998). Those that self-injure many times have mood disorders such as depression, post-traumatic stress disorder, or dissociative disorder. Many self-injurers are not able to express their emotions or feelings therefore having difficulties maintaining their emotional state which can lead to a bi-polar diagnosis. Some self-injurers, in fact, are out of touch with reality and believe voices are telling them to hurt themselves. Since childhood abuse is so prevalent in those who self-injure, they may be diagnosed with post-traumatic stress disorder because of the abuse trauma. One way for self-injurers to cope with their pain is to take themselves out of their body or their thoughts, leading to a diagnosis of dissociative disorder. They may also have multiple personalities or one distinct personality that does the self-harming. Borderline personality

disorder is another common diagnosis given to those who self-injure since one of the indicators of the disorder is having a history of suicidal gestures (Conterio & Lader, 1998).

Treatment for those who self-injure varies and is usually a combination of methods to ensure success (Strong, 1998). Medication can be important in the treatment process. People take medication based on their symptoms and diagnosis. Those that suffer from mood disorders take drugs that stabilize their mood and emotions. People with thought disorders need an antipsychotic drug to stabilize their thought process. Antidepressants may be prescribed for those that suffer from PTSD or depression (Strong, 1998).

In most cases, medication alone will not cure SIB. Therapy combined with medication may be successful. One form of therapy used with those who self-injure is from a cognitive-behavioral viewpoint with the belief that self-injury is a learned behavior and the treatment focus is to unlearn the behavior (Strong, 1998). DBT focuses on the patient's current life to identify events, thoughts, behaviors, and emotions that trigger the act of self-injury. Patients are taught how to release feelings and emotions through words rather than actions and resist the thought of self-injury. A year long study confirmed that patients using DBT had fewer and less severe incidents of parasuicide, less hospitalizations, and were more likely to complete the one year of treatment (Strong, 1998).

Another therapy used in the treatment of SIB is trauma resolution. Patients learn to regain a sense of safety in their bodies which was destroyed through the trauma of abuse (Strong, 1998). They see the trauma as something in the past, something they no longer control. They differentiate between the past and present and learn to identify and share feelings and emotions appropriately in the present and future.

Inpatient treatment facilities can also be effective, possibly in conjunction with medication. One facility, Bethlem Maudsley Hospital, in England was established in 1992 to allow self-injurious patients to develop alternative ways to cope. The focus is on the patient taking and retaining responsibility and taking therapeutic risks such as sharing personal information (Crowe & Bunclark, 2000). The sixth month stay is intense. Patients attend individual and group therapy sessions as well as weekly coping skills groups on topics such as assertiveness or reflection. Patients are encouraged to broaden their communication skills through alternative means such as creative writing or drama therapy. The living unit is a learning environment where psychosocial needs are addressed. The focus of self-injury during treatment is on minimization rather than abstinence. Patients set the goal to find an alternative in order to cope and use wait time in order to lessen their impulsive action of self-injury (Crowe & Bunclark, 2000).

Another inpatient program is the S.A.F.E. program located in Illinois. This facility also offers outpatient and day hospital programs to meet the needs of their patients (Ng, 1998). This voluntary program focuses on placing the responsibility on the patient's shoulders. Abstinence from SIB is encouraged. The patients are asked to sign a No Harm Contract stating that they will refrain from SIB while in treatment (Conterio & Lader, 1998). The typical length of stay in the S.A.F.E. facility is thirty days. Patients are not allowed to show scars while in treatment and must refer to the behavior as self-injury in order for all patients to keep the same level and take away the uniqueness of the behavior (Conterio & Lader, 1998). Patients also must complete writing assignments to help identify, express, and tolerate their own feelings on paper. They write in an Impulse Control Log to identify urges to self-injure and triggers of that behavior

(Conterio & Lader, 1998). As people leave the S.A.F.E. program, they believe that self-injury is a choice and a behavior they can control.

Recommendations

One recommendation for future research is to include reactions from self-injurer's family members, peers, etc. It may be interesting to get their perspective on thoughts and feelings they have of the self-injurer. It may be helpful to know how they found out, if there were any warning signs, how they offered support, was it accepted, as well as what they are doing now for the self-injurer. If in fact the person who self-injured was abused, it would be interesting to see how the abuser would react to seeing the cutting, burns, etc. and the pain they caused. One would assume that it would be ignored, denied, or blamed again.

Another recommendation is to look at the success rates of those who completed treatment. As part of a longitudinal study with checks in six months, one year, etc. to check for relapses, coping skills, or support group attendance. It would also be helpful to know how success is measured for those who once self-injured. It would be an ongoing process and struggle, since they would be reminded of it daily by seeing the scars.

The final recommendation is to implement proactive measures in the schools to help prevent SIB. Then comparisons could be made to see if this is effective in reducing the high numbers of those who self-injure. As the research indicates, those who self-injure aren't able to communicate appropriately because of past circumstances. Perhaps different means of delivering such programs in schools would allow some to make changes in their behaviors. Since SIB is growing, any proactive measures taken may reduce the numbers.

Several recommendations have been given to aid in the future research of self-injurious

behaviors. This complex and complicated behavior is expanding to include younger adolescents. The need for more research and proactive measures is necessary to educate those who need it, self-injurers, those that work with self-injurers, families and friends of those who self-injure and potential self-injurers.

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