CHAPTER TWO

Why an "Addiction"?

Clinical and research literature as well as popular textbooks on self-injury have at times alluded to, in a vague sort of way, the fact that self-injury is "like" an addiction. However, this theoretical framework and approach to treatment, of viewing self-injury from an addictions perspective, has not yet been fully explained or developed.

Throughout this book, self-injury is explained from an addictions perspective. Explanations, approaches to treatment, and case examples not only of self-injurers but also of alcoholics, drugs addicts, and those who are multi-addicted are woven throughout this book to illustrate the addictive process and the similarities across addictions.

This chapter contains some technical terms and complex concepts. The book is intended primarily as a resource for people who have the problem of self-injury and for the people in their lives who care, which includes medical and mental health professionals. Some readers may wish to skim or skip over the more technical sections on *DSM-IV* clinical diagnostic criteria and biochemical theories. Feel free to do so if you like, and move on to other sections of the book that you can relate to.

There is no clear-cut, simple definition of addiction that I have found to be quite satisfactory. A simplistic definition

cannot account for all of the signs and symptoms of the addictive process. However, a person can be reliably classified as an addict based on different combinations of basic characteristics. Most addicts show only certain combinations. Coupled with the addict's characteristic strong denial system, diagnosis can at times be difficult, unless the addiction is severe or obviously brought to attention.

The most meaningful conception of addiction that I have found is one that was developed by Chein and his colleagues from a study of heroin addicts in New York City. Their book *The Road to H* (1964) is considered a classic. Their description of the addictive process experienced by heroin addicts extends to other addictions as well. It supports the generality of all addictions, including that of self-injury.

As shown in the "Chein criteria" below, there are most striking similarities between heroin addicts and self-injurers. Heroin is an opioid addiction, and self-injurers produce their own internal opioids through a subconscious physiological process, to which they can become addicted. Hence, this is a highly applicable and a particularly useful conception for our purposes.

The Chein criteria are

1. physical dependency
2. craving
3. total personal involvement

Physical dependency involves a history of repeated episodes that lead to some sort of intoxication (for example, getting drunk or high). It does not apply to being intoxicated only one time. There is a need for a larger dose of the drug (or a greater intensity of the self-injurious act—for example, progressing from delicate self-cutting on to burning) as time goes by, to produce the same effect. This is called tolerance.

Connie, a twenty-five-year-old graduate student, who had

progressed from scratching and cutting to deep burning, would experience an extreme "high" from her self-injurious behavior. It scared her when a roommate (who herself was in and out of treatment for cocaine and alcohol abuse) once stated: "Girl, I've never seen anyone get as high as you do (when you hurt yourself) from no matter what kind of alcohol, drugs, cocaine, or anything else—and I've seen it all and done it all myself—you better be careful! Someday you're going to have a heart attack or stroke and die!" Still, she could not stop.

Cross-tolerance may occur and will often happen within the same class of drugs. For instance, under the sedative/hypnotic category, people may show cross-tolerance to alcohol and barbiturates. Connie, like many other self-injurers, also had an ongoing problem with substance abuse. Her drugs of choice were cocaine and uppers "to bring my mood up when I'm down."

Addicts who are not only psychologically but also physically addicted may experience physical withdrawal symptoms when not using for a critical period of time. This may include nausea, shaking, sweating, and sometimes even convulsions and hallucinations in severe cases. Because both heroin and the internal physiological changes that occur in self-injury are powerful analgesics (chemicals that cause insensitivity to pain), these types of addicts are, to varying degrees, unfamiliar with physical and emotional pain. So, they become terrified of withdrawal (and the resulting feelings that come to surface), especially during detoxification. This is why many heroin addicts move on to methadone maintenance, a much safer form of the drug that produces some of the same desired effects. These addicts may visit methadone maintenance clinics on a regular basis, sometimes indefinitely. Likewise, self-injurers sometimes choose a safer alternative, for example, medically prescribed psychotropic

medication such as antidepressants. Some addicts may decide to avoid withdrawal at all costs.

Craving is defined by Chein and his associates as (1) an "abnormal intensity of desire," (2) an extreme reaction to failure to satisfy the desire, and (3) an abnormal limitation in the modifiability of the desire.

Craving involves an all-encompassing obsession or preoccupation. Some addicts will go to any lengths to obtain a drug. Stories of addicts who steal money or hock possessions that belong to their own parents or who break into pharmacies or go directly to bars immediately after being released from jail or treatment centers are quite common. When self-injury addicts have an intense craving, they may go to any lengths to find places to hide to indulge in their self-destructive behavior. They may find things that they can hurt themselves with even in locked institutions where all dangerous objects have presumably been removed.

Clarice, a thirteen-year-old girl from Philadelphia, was taken to a small, private general psychiatric hospital by her parents. They were at wit's end with her compulsive, repetitive self-injurious behavior. She came in with her (much older and drug-involved) boyfriend's name slashed across her arm, bragging about it to the other teenagers on the young people's unit. Hospital staff searched Clarice's bags and took all sharp implements away from her upon entry, including the safety pins that she used to hold up her favorite jeans with the broken zipper. It particularly bothered her that she had to ask staff every time she needed a pencil to do her homework, which she hated doing anyway. One day when Clarice became frustrated, she managed to break and use a lightbulb in her room to cut herself. Subsequently, she was moved to the front hallway by the nurse's station, where the kids with medically complicated cases could be more closely observed. Most of the staff's attention at

the time was on the girl in the room next to her. Lisa, a seventeen-year-old beauty queen who was diabetic, had to take insulin injections every day and was detoxing from a variety of street drugs. One evening when Clarice was having an intimate conversation with one of her favorite nurses, Lisa had a medical episode. The nurse had to get up and leave the conversation and run to Lisa's aid, which made Clarice very angry. She emotionally escalated. Frantically searching around the room for something to hurt herself with, she spotted the flower arrangement her aunt had sent her, on the dresser. She managed to create a sharp enough instrument by unwrapping and twisting together several of the very thin green-paper-wrapped wires used to hold the pink carnations in place. This and another bloody arm-scratching episode all happened while sitting on the bed under a blanket, pretending to be reading an English book. When later discovered, Clarice was terminated from the hospital program.

No matter what happens, the severe addict continues to use and abuse despite the consequences of her addiction.

A pattern of *total personal involvement* with drugs characterizes the lives of many addicts, according to Chein and his associates. This also applies to alcoholics in regard to their alcohol and to self-injurers in regard to their self-destructive behaviors. Total personal involvement means that the addict's personality structure is built around his or her addiction. Drugs, alcohol, or self-injury have become essential to the personality when (1) the person feels "normal" only when under the influence or (2) certain aspects of the personality are expressed only under the influence. For example, a cocaine addict may become self-confident, socially outgoing, and flirtatious around men only when she is high.

The Self-Medication Hypothesis

A number of researchers in the field of addictions have proposed that addicts who have a difficult time managing their affect (that is, have difficulty in bringing to order their conscious subjective experience of emotions) use alcohol or drugs as a way to self-medicate.

Khantzian (1985, 1990) described addiction as "a purposeful attempt by the addict to remediate a particular dysfunction." He noted that addicts who reported depression chose addictive substances that relieved the uncomfortable sad feelings and that addicts who did not have a normal level of feeling sensitivity chose addictive substances that stimulated them.

Other researchers have also studied and substantiated Khantzian's hypothesis that *specific drugs* were selected on the basis of the drug's particular ability to reduce unacceptable feelings or to amend unwanted emotional states. Cocaine and amphetamines were selected by addicts who sought more stimulation. Alcohol and opiates were preferred by those who wished to escape from intolerable emotions.

Researchers have also tested the idea that addicts' drugs of choice were based on their *particular defensive style.* Findings included, for example, that amphetamine addicts used stimulants because they wanted to experience an inflated sense of self-worth. Narcotics were used to defend against intolerable feelings of hurt, rage, shame, and loneliness.

Self-injurers use their addiction as a way to self-medicate, as alcoholics and other addicts often do. Deliberate self-injury can be either a method of stimulation to escape depression, numbness, and feeling "dead inside" or a method to relieve anxiety and agitation. Many self-injurers have used and are at a very high risk for using and abusing alcohol and other drugs. Some self-injurers may prefer drugs

such as cocaine or amphetamines; some may prefer alcohol or heroin; and some may vary their choice of substance from time to time, depending on what uncomfortable emotional state they want to relieve.

Biochemical Theories: Trauma, Addiction, and Self-Injury

Research on biochemical theories and physiological explanations of self-injury is still in its beginning stages. There are not yet any final answers or definitive conclusions. However, we do know that self-injury involves both physiological and psychological processes. Much of the research and theorizing about the biochemical theories and physiological explanations regarding self-injury stem from the work on trauma and post-traumatic stress disorder (PTSD), because similar factors and processes are involved.

One of the common processes is stress-induced analgesia, or numbing. People with severe numbing almost always have PTSD. There is an interrelationship between trauma, particularly childhood trauma (child abuse), and self-injurious behavior and other addictions.

According to trauma expert John Briere, people with PTSD develop new avoidant strategies. These may include, for example, drugs, alcohol, self-mutilation, violence, and shoplifting. Briere explains self-mutilation as "a way to alter your affect." In an October 2000 seminar on complex psychological trauma and PTSD (in California), Briere cited a clinical example of a fourteen-year-old girl who described a "physical equivalent of cocaine" when running a paper clip over her arm and bleeding.

Cutting, burning, and other self-injurious behaviors may be a way to manage unbearable emotions by altering interpersonal conditions as well as by altering the body's biological balance. Bessel van der Kolk, M.D., and colleagues at Harvard Medical School (1991) have proposed that "the fact that both the severity of the trauma and the age at which it occurred affected the particular ways in which our subjects were self-destructive suggests that both psychological and biological maturity play a role in how experiences of abuse and neglect are managed."

There are a number of studies indicating that disruptions in early caregiving may have long-term consequences for biological self-regulating systems. The effects of trauma and early maternal and social deprivation have been extensively studied in animals. Research on nonhuman primates has demonstrated that self-mutilation is a common reaction to social isolation and fear. Experimental animals that have been exposed to inescapable stressors (for example, electric shock, fighting, and starvation) develop stress-induced analgesia (numbing). Fear activates the secretion of endogenous (internally produced) opioids, which can become highly addictive. In animals that have been severely stressed, withdrawal symptoms can be produced by stopping the stressful stimulus. (This explains from an addictions perspective why it is so difficult for severe self-mutilators to stop.)

In animals, harmful stimuli (reminders) continue to precipitate conditioned biological "emergency" responses over time, resulting in "fight, flight, or freeze" reactions. Younger, developmentally immature animals are especially vulnerable to developing these conditioned emergency responses to repeated stress. This holds true for abused children as well.

People who have endured severe trauma react, and continue to react, with extremes of underarousal or overarousal. They respond to stimuli (triggers) that remind them of the original trauma with conditioned psychological and biological stress responses. Current research on traumatized children has identified a wide range of neurobiological

abnormalities in this population; and that children who have been victims of abuse have chronic problems with affect management, which range from extremes in hyperactivity to psychic numbing.

Self-injurers are prone to experience intense physiological disorganization as a result of repeated self-inflicted trauma on top of their already existing childhood abuse or other life trauma. Thus, they may follow similar psychological and biological response patterns as do the experimental animals that have been exposed to extreme stress.

Van der Kolk, Perry, and Herman (1991) found that two decades after the original trauma, people with post-traumatic stress disorder developed opioid-mediated analgesia (numbing) in response to a stimulus resembling the original traumatic stressor, which they correlated with a secretion of endogenous opioids equivalent to 8 mg of morphine. They concluded, "Dissociation, self-destructiveness, and impulsive behavior may all prove to be hormonally mediated responses that are triggered by reminders of earlier trauma and abandonment."

An Explanation, Not an Excuse

There is convincing evidence from a biological/physiological basis to describe the connection between trauma, self-injury, and addiction. There is a predominant theoretical view that these biological and physiological factors, internal wiring, and effects on the body's central nervous system are permanent. It is an explanation, but not an excuse to react by using alcohol, drugs, or self-injury to try to "fix" the problem.

What is important is that we respond effectively to what is, instead of reacting to whatever it is in a dysfunctional way. For those who have been traumatized, and for those with chemical imbalances or who are otherwise prone to

alcoholism and other addictions (for example, due to genetic or familial factors), this can be extremely difficult. Self-medicating to get rid of the inner pain and turmoil is tempting.

The Vipassana method of meditation (*Doing Time, Doing Vipassana* 1997) is a method of reform that is widely taught and being used in the prison systems in India. Because of very positive results, it is starting to make its way to other places, including the United States. Before embarking on this voluntary educational experience, the prisoners are required to make a commitment to refrain from all use of alcohol and drugs, sexual behavior, and acts of violence, at least for the duration of the course, so that they can free themselves from external distractions. This ten-day intensive meditation course teaches people—namely, hardened criminals who have a history of violent behaviors and many of whom also have addictions—to learn to sit quietly with their emotions, flooding of memories and flashbacks, and accompanying physical sensations

The Vipassana view is that "The root to all our physical addictions and emotional reactions comes from our physical sensations within the body. And that one must learn to go inside, to sit with it, and to not react to these internal feelings."

Child physical abuse, sexual abuse, and trauma such as rape are unconscionable acts that are difficult for most anyone to comprehend. (See figure 1, page 42.) A very young child typically does not yet have the knowledge that these things *can* actually happen; it is out of her frame of reference. Being overpowered and trapped in the grip of her abuser, someone who is older and stronger, someone whom she looks up to, trusts, and is dependent on for her care and survival (for example, the abusive parent), is beyond the scope of what she can comprehend on an intellectual level, let

alone deal with on an emotional level. The resulting emotional trauma is too confusing and overwhelming, too much for her to deal with. Therefore, she becomes emotionally and physically numb, dead inside, and dissociates.

The traumatized child probably does not have the words, or may not even know enough words yet, to explain this to herself in her own mind or to anyone else. She is operating at a preverbal level, experiencing only vague floating thoughts, muffled sounds, physical sensations, and visual images. Being forced to undergo and endure violence at the hands of another person, being trapped with no way out . . . is utterly unbearable. The only place to go is within, or away.

However, the abused child's subconscious mind is hard at work during all this. The abused child who grows up to be a self-injurer makes the connection that physical pain itself is a way to escape. Not in so many words, but rather in thoughts and images, she figures out that "when pain happens, this means that I can go away. There is a way out!" This idea becomes reinforced in her mind, over and over, with the reoccurrence of the physical or sexual abuse. Verbal abuse, witnessing domestic violence, or seeing the erratic behavior of an alcoholic/addict parent, and other negative experiences that are emotionally overwhelming add to it. She can go away, or space out, or go off into dreamland anytime she becomes emotionally overwhelmed, and feel nothing instead. She learns how to become numb and to dissociate. She learns that she does not "really" have to experience anything she does not want to experience.

A newspaper article written by Tracy Weber in the *Los Angeles Times* (1998), entitled "Despair of the System Kids," spoke of one such teenage girl who had been repeatedly abused since she was a toddler. Jessica could not escape the violent environment and unfortunate circumstances that she was forced to endure. Sent back and forth

FIGURE 1.
ORIGINAL TRAUMA AND TRAUMATIC MEMORY PAIN REACTION

between her drug-involved mother's home, being placed with an aunt, and shuffled around from group home to group home, Jessica felt "trapped."

Jessica had first come to the attention of county social workers when she was three years old, after her mother's boyfriend whipped her during a drug-fueled rage. There were several other incidents of domestic violence throughout her childhood, which brought the attention of the police in response to her mother's screams. Jessica was placed with an aunt at the age of eight while her mom kicked her methamphetamine habit. She was eventually returned home, but when she was ten, the mother's boyfriend's father reportedly sexually abused her during a camping trip. Jessica fought with her mother, to no avail. By twelve, she was a chronic runaway and had been placed in a psychiatric hospital twice. Her mother eventually drove her to the county's shelter for abused children, insisting that they take her daughter. By the age of fourteen, Jessica became a "system kid," being shuffled from one group home to another . . .

The newspaper article begins:

"Jessica's childhood is etched in shiny scar tissue. Each thin slash on her forearm is a memento of another stint in the county's home for abused kids. Each lumpy burn—a smiley face seared with the metal top of a disposable cigarette lighter—another group home that didn't work out. 'Some were because I wanted to make my mom feel bad,' Jessica says, 'Some were because my life sucks.'"

The original traumatic experience becomes imprinted in the subconscious memory of a self-injurer, and in physical sensations in her body, permanently. The body remembers what the mind does not.

As time goes on and the years go by, life happens, as it will . . . emotionally difficult experiences, negative situations, and daily frustrations are inevitable, for everyone in the world. However, such experiences seem to affect the self-injurer in a more profound way and thus cause her to react in the most effective, albeit destructive, way that she knows how.

Other experiences that are difficult to deal with on an emotional level, along with the uncomfortable feelings, remind her of the past. As the self-injuring episodes continue, the idea that "physical pain is a way to escape" becomes reinforced. She learns that this idea can be applied to cope with just about anything that is difficult or uncomfortable. This includes even the minor annoyances and daily hassles of life, such as a flat tire or a squabble with her boyfriend about what toppings to get on a pizza.

The originally traumatized child who grows up to be a self-injurer has found a faulty, yet effective, way to cope with life in general. The fact that self-injury is destructive and that it can be very dangerous are secondary or not important to her at all.

Anything can be an emotional trigger—an event, a memory, a childhood flashback, or a nightmare. A triggering event or memory reminds her of the original trauma (for example, the physical or sexual abuse) and/or the resulting suppressed emotional feelings that went along with it. Sometimes feelings such as frustration, anxiety, loss of control of a situation, or entrapment in and of themselves are enough to make one remember, even if these feelings are connected to some present, seemingly irrelevant or trivial situation. And to remember that there is a way to escape.

The self-injurer realizes, albeit on a subconscious level, that physical pain equals escape and ultimate freedom. And that she can cause herself to experience physical pain (with the end goal of going away and having no feelings) by hurting herself on purpose.

Understanding and becoming fully conscious of the dynamics involved, of both the original trauma and the resultant subconsciously ingrained and well-learned defective coping mechanisms used in the present, can help to break this cycle. Becoming verbal helps.

The Deliberate Self-Harm Escalation/De-escalation Cycle

According to the clinical, medical, and biochemical research literature, there are two very different main conclusions as to the reasons "why" people self-injure:

1. to escape by becoming emotionally numb and dissociating
2. to relieve states of escalated anxiety and agitation

Clinicians and researchers have not yet come up with a single definitive answer. This is likely because some self-injurers describe having either one or the other type of experience, which is true for them. Some self-injurers describe variable feelings and experiences, which are confusing to both themselves and to outsiders. They self-injure sometimes to become numb and dissociate, and other times to relieve feelings of anxiety and agitation.

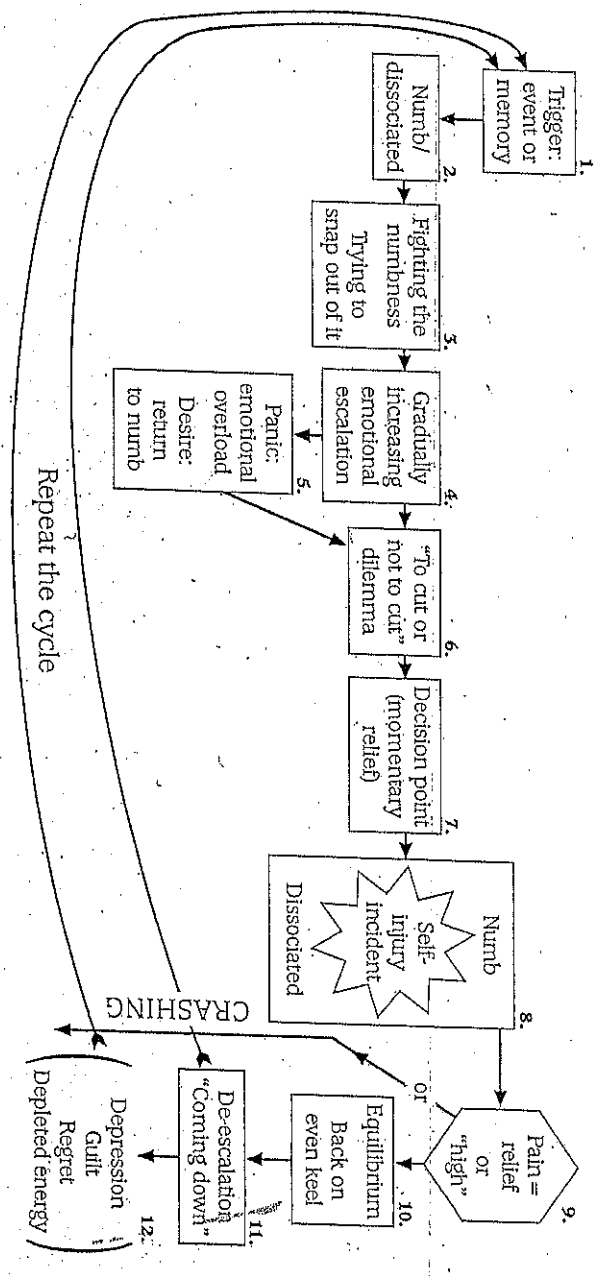
The following figures describe the two different processes (see pages 47, 52). This information has been gathered and put together over years of clinical work with and observations of self-injurers and addicts, reading the research literature and numerous case histories, talking with other self-injurers, and understanding this from my own personal experience.

Some self-injurers who read this may have slightly different perceptions in regard to their specific experience. This is, however, a composite view of what is most general.

When an event or memory occurs that on some level

FIGURE 2.

PURPOSE: TO RELIEVE AND REPRODUCE NUMBNESS/DISSOCIATION



reminds the self-injurer of the original trauma or the resulting emotions attached to it (a "trigger"), the goal is to once again become numb and dissociate, to go away. However, the one who has been traumatized in the past eventually becomes more aware of her environment, of the people around her, of the fact that this behavior is socially inappropriate and frowned upon, and that self-injury can (at least temporarily) impede her ability to function. Thus, a state of internal conflict is born.

The serious self-injurer becomes caught in an addictive cycle. A triggering event or memory happens, which causes her to automatically become numb and dissociate. However, she will most likely try to "snap out of it," to fight the numbness, much like someone pinches herself if she is getting sleepy and groggy but has to stay awake while driving a car.

Next, the self-injurer becomes briefly aware of the reality around her. A gradual sense of increasing emotional escalation occurs when thoughts and feelings begin to drift back. Eventually, the self-injurer is on emotional overload; she panics and has a desire to return to numb. This may happen in a moment or over the course of days.

Hence the dilemma: "To cut or not to cut, to cut or not to cut, to cut or not to cut." It is a horrible internal struggle of an obsessive nature. This is very similar to what an alcoholic or addict experiences when obsessing about drinking or doing drugs.

Speaking from experience, the obsessional phase was, for me, most intolerable. The thoughts of wanting and actually needing to hurt myself, knowing it was wrong, and trying futilely to talk myself out of it, became overwhelming and distracting to the point where I could not concentrate, especially when it went on too long. In the first three to five months of my recovery, I had to learn to sit with those uncomfortable thoughts, feelings, and physiological sensations continually, without even momentary relief, which was one of the hardest things I've ever had to do. I would never want to go back to that place again. There was no easy way out, but getting through it successfully made me a very strong person.

When the person reaches the decision point that she is going to hurt herself, she experiences a sense of momentary relief. However, it is only momentary. She may self-injure immediately or have a plan to do this later on, for example, after work when she has time to go to the drug store and get a six-pack of razor blades and a bottle of wine to go with it.

This sense of relief is similar to what suicidal people experience when they make the decision to kill themselves. People around them, sometimes even their therapists, think that the suicidal person is doing better now, that he or she seems a lot happier. Clinicians who work with self-injurers need to become aware of this.

Just before and throughout the self-injury incident, the self-injurer once again becomes numb and dissociated. She cannot, or will not want to, hurt herself unless she is in that state. This state comes on primarily on its own. However, she may use alcohol or drugs to help get her there faster or to intensify the experience. Mostly, she produces her own internal anesthetic within her mind and body. Then it happens.

During the self-injury incident, so much endorphin release occurs that one can get "high." There is a welcome sense of relief. Pain equals relief, or getting high. The experience of pain becomes addictive. The self-injurer comes to like pain, and she eventually craves it.

The self-injurer's mind and body then return to a state of balance, or equilibrium. She is back on an even keel, which

for her means being at least somewhat high for a while, because her most usual state is one of feeling down and depressed.

Next, the self-injurer gradually de-escalates from the high, both physically and psychologically. She experiences a comfortable, physically and emotionally tolerable, level of pain. She may pick at the scabs or wounds as she is de-escalating, or coming down, to prolong the pleasant experience or to avoid withdrawal.

Finally, the inevitable depression, guilt, and regret come along. She feels even worse than she did before. Her physical and emotional energy are depleted. "Crashing" means coming down quickly and very hard. This feeling is similar to what happens with a major dose of certain drugs such as cocaine, amphetamines, or other stimulants.

She may get back on the self-injury roller coaster again and again. She may want to escape again, or to feel good, or to get high. Eventually, the experience becomes addictive. The self-injurer typically repeats the cycle either when she is de-escalating, or coming down, or when she is feeling depressed or her physical and psychological energy are depleted. She does not do this when she is feeling good, or back on an even keel, and simply enjoying and coping with life. When de-escalating or back to her usual depressive state, a triggering event or memory happens, as it inevitably will, that sets her off. The self-injury addict repeats the vicious cycle again. She may even look for or "create" a triggering situation to avoid withdrawal, by scanning the environment for something to get upset about (one can always find something!). Or worse yet, she may subconsciously deliberately put herself in negative or dangerous situations, such as picking fights and arguments with people, or becoming caught up in abusive relationships.

Many self-injurers describe feelings of escalating anxiety and agitation, frustration, anger, and rage that are utterly intolerable. These self-injurers are more visible to both clinical professionals and to the general public. Their self-injuring episodes are typically more severe and more dramatic. The injuries are more significant, possibly even life threatening, due to their impulsive nature. These self-injurers may appear as people who are more outspoken and always angry, agitated, frustrated, argumentative, loud and hyperactive, speeding around, and with dramatic up-and-down mood swings.

The following describes what happens when one self-injures for the primary purpose of relieving anxiety and agitation (see figure 3, page 52):

A triggering event or memory happens. The person "reacts" immediately, feeling anxious and agitated. These feelings escalate rapidly. One may appear to be emotionally overwhelmed, as if she is "speeding," with racing heart and frantic mannerisms. She may be crying and hyperventilating. Depending on how fast the escalation happens, how intolerable her emotions are, and how impulsive she is, the self-injurer may go either straight to the self-injury incident or through the process of a more gradual emotional escalation and become numb and dissociated before she hurts herself. This second process is similar to what has been described in figure 2, with a few variations: The emotional escalation is much more rapid; the goal of self-inflicted pain is primarily to become calm and "comfortably numb"; and the downfall to depression is much more rapid and severe.

With impulsive self-injury, one does not have time to numb out and dissociate or to even think about what she is doing. Impulsive behavior can be extremely dangerous.

This is what happened to seventeen-year-old Denise in chapter 1, when she impulsively slashed her leg with a razor blade in her classroom, immediately without stopping to think or to breathe, because she got mad at her teacher.

With impulsive acts of self-injury, there is no great feeling of relief, maybe just a momentary but intense "high," or a brief feeling of calm. Equilibrium is not restored. The self-injurer crashes rapidly, falling down into depression-guilt-regret and exhausting her supply of energy. She may repeat the cycle when going down too low, because being emotionally escalated, anxious, and agitated is her more natural state of being. She wants to restore her status quo. However uncomfortable it may be, at least it is familiar. Or she may get back on the roller coaster when the "comfortably numb" feeling starts fading away.

Impulsive incidents of self-injury provide an answer to the frequently asked question: "Why do some self-injurers say that they feel pain and some say they don't while self-injuring?" Pure physical pain caused by an impulsive self-injury incident, that results in pure physical injury (for example, the breaking of bones or a burn) with no internally produced anesthetic, hurts like hell. It's like accidentally getting burned on an iron or a hot stove. Even with more thought-out and deliberate acts, the self-injurer may not become numb and dissociated enough to not feel the pain. It's like not having enough internally produced anesthetic to fit the experience. (See figure 4, page 54.)

However, many self-injurers, especially those whose afflictions are more severe and have been having repetitive episodes over a long period of time, have unintentionally "perfected" their ability to not feel pain. They have learned to avoid feeling acute severe physical pain in general. This can include subconsciously avoiding the beneficial physical

FIGURE 3.
PURPOSE: TO RELIEVE ANXIETY/AGITATION

pain that occurs to alert us that there is an injury to or a malfunction in the body that needs tending to. Acute, severe pain—like from a fractured leg or a burn while cooking—"shocks" the self-injurer on an emotional level. This causes an immediate subconscious recall of the over-learned way to react. The experienced self-injurer, or even some young children who have been repeatedly physically or sexually abused, can immediately and seemingly automatically become numb and dissociate. Unfortunately, sometimes the numbing and dissociation goes on too long, and the self-injurer may not realize that she is seriously hurt or ill. Needless to say, if physical injuries or illnesses are not tended to, they can become significantly worse.

Chronic or low-grade pain is different. It does not shock the system and generally does not cause one to instantaneously react by becoming numb and dissociated. In this case, the person has feeling, a normal physiological pain response. It is uncomfortable, but tolerable. Chronic and low-grade pain may result from, for example, a chronic illness such as an arthritic condition, or from minor ailments such as headaches or menstrual cramps, or from physical injuries during the healing phase.

Withdrawal from a severe, repetitive pattern of self-injury, when one is addicted, has many characteristics in common with alcohol and drug withdrawal (see figure 5, page 56).

A severe self-injury incident occurs. (The self-injurer may or may not be numb/dissociated.) After the pain, the person comes "crashing" down and is physically and emotionally exhausted.

As with withdrawal from substances such as opiates, cocaine, alcohol, or amphetamines, the withdrawing self-injurer may experience a variety of psychologically distressing symptoms. These may include, for example, extreme

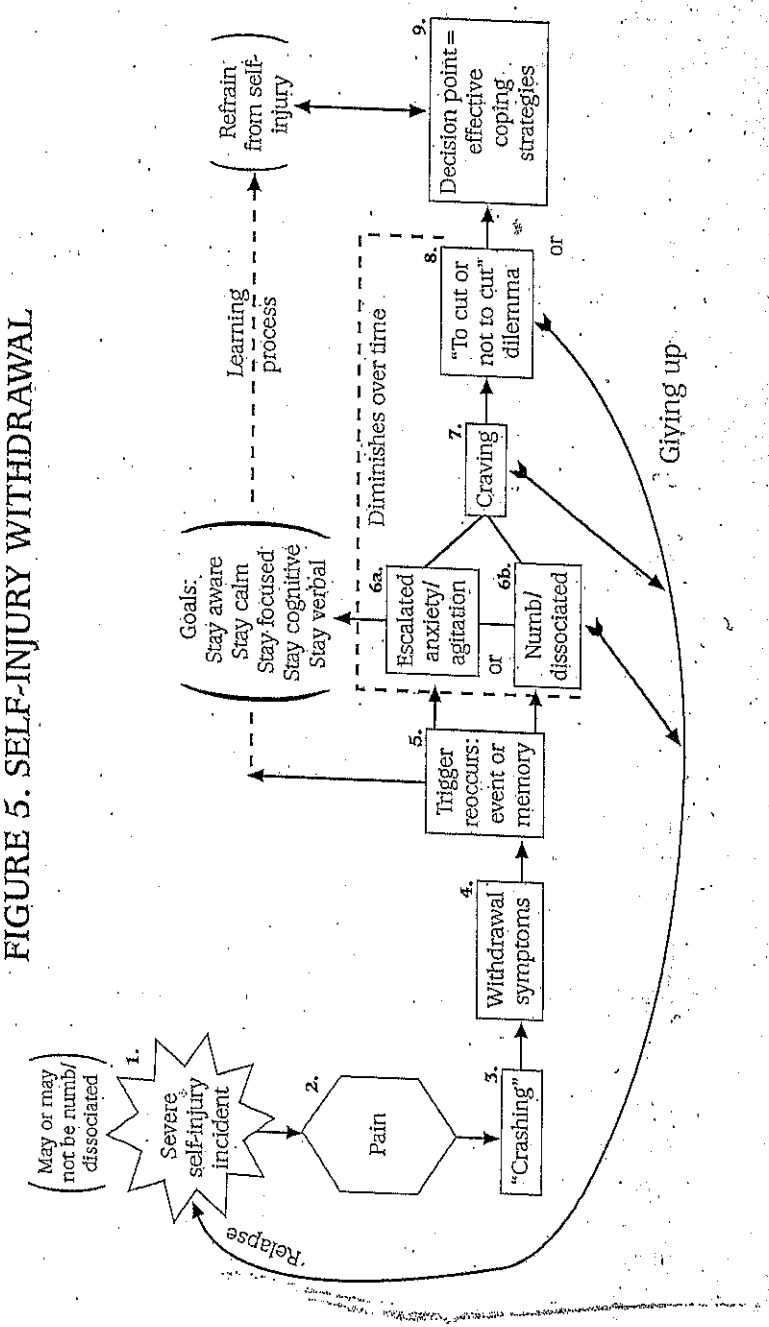
FIGURE 4. THE SELF-INJURER'S TYPICAL EXPERIENCE OF ACUTE VS. CHRONIC PAIN

depression and/or anxiety. There may also be a sense of confusion and disorientation. The self-injurer may appear "spaced out" to others. Some self-injurers report experiencing fatigue, insomnia or hypersomnia (sleeping too much), muscle aches and pains, and vivid horrifying dreams or flashbacks after stopping their behavior. These symptoms steadily diminish in severity and duration as the addictive substance (the internally produced opiates) wear off. Such unpleasant symptoms can cause significant distress and temporarily impair overall functioning.

Another triggering event or memory, in real life or in "flashbacks," occurs. The self-injurer once again reacts by becoming numb/dissociated or by becoming emotionally escalated, agitated, and anxious. The craving to self-injure comes on like a fast-moving train. The craving is not for the experience of marring up one's body, but for the experience of feeling relief by getting high or by getting calmed down and comfortably numb. Hence, the "to cut or not to cut" dilemma. If the self-injurer has hit bottom, or an ultimate low, with her self-injury addiction, she may want to stop. Now she is at a crossroads. When she reaches the decision point, she may give up and self-injure again—she can choose to relapse. Or, she can decide to try to refrain from self-injury no matter how hard it may be. She can search for more effective coping strategies instead.

The self-injurer who wants to recover must go through a relearning process. The goal is to become completely abstinent from self-injury and to learn to cope with life and all of its difficulties, experiences, and memories effectively. The anxiety/agitation and numbing/dissociative reactions to emotional triggers will diminish over time with continued abstinence. One must learn to ride it out and to tolerate the extreme psychological discomfort for a while.

FIGURE 5. SELF-INJURY WITHDRAWAL



This is similar to the relearning phase that alcoholics and addicts go through in the beginning of their recovery. The newly recovering self-injury addict often looks, acts, and feels like the newcomers who walk into the rooms of Alcoholics Anonymous and other Twelve Step meetings. It is hard to tell the difference, because there isn't much of one.

Diagnostic Research Criteria for Self-Injury DSM *Inclusion*

At the time of this writing, there is not yet a diagnostic category or listing for self-injury in the *Diagnostic and Statistical Manual of Mental Disorders* (published by the American Psychiatric Association). But there should be. The *DSM* is the book, the main reference guide, that psychiatrists, psychologists, and other mental health professionals use for making diagnoses. Self-injury is only briefly mentioned as one of the possible criteria in a long list under Diagnostic Criteria for 301.83 Borderline Personality Disorder: "(5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior."

The self-injurious behavior syndrome is a disorder of its own. It most closely fits the *DSM* criteria for and should be included as a specific Impulse-Control Disorder: Not Elsewhere Classified. As self-injury becomes increasingly addictive, it has many of the same characteristics as in the *DSM* Substance-Related Disorders category, and a few that are more specific. The following is a set of criteria, according to *DSM* system, design, and wording, that warrants further research and development for inclusion in a future edition of this manual.

✦ Research Criteria for (#XXX.X) Self-Injurious Behavior Syndrome

A pervasive pattern of deliberate mutilation of one's own body with the intent to cause injury or damage, but without suicidal intent, in order to provide relief from an intolerable emotional state, usually beginning in adolescence, and marked by the following:

(1) recurrent impulses to physically harm oneself
(2) intrusive, obsessional thoughts about self-injuring
(3) intolerable, increasing states of emotional anxiety and agitation and/or emotional numbing and dissociation
(4) feelings of both physical and psychological relief after the act of self-injury
(5) multiple episodes of self-injury
(6) low lethality
(7) impulsivity in other areas that are potentially self-destructive (e.g., alcohol or substance abuse; eating disorders; high-risk or dangerous behaviors such as reckless driving or becoming involved in abusive interpersonal relationships)
(8) a general pervasive mood of depression or anxiety

The following proposed *Diagnostic and Statistical Manual of Mental Disorders* research criteria for Self-Injury Dependence and Problematic Excessive Self-Injury (akin to Substance Abuse) are derived from much of the same criteria used to describe Substance-Related Disorders. When the problem of self-injury becomes addictive, it fits into this

same basic framework. There are remarkable similarities. Much of the same wording in the *DSM-IV* applies and is used here for descriptive purposes.

✦ Research Criteria for Self-Injury Dependence

A repetitive pattern of self-injury leading to clinically significant impairment or distress, as manifested by three or more of the following:

(1) tolerance, as defined by either of the following:
  (a) a need for markedly increased and more severe episodes of self-injury to achieve the desired effect
  (b) markedly diminished effect with continued self-injury at previous levels of intensity
(2) withdrawal, as manifested by either of the following:
  (a) increased symptoms of distress when first stopping the behavior
  (b) repeated episodes of self-injury or addiction substitution (e.g., use of a substance such as alcohol or drugs) taken to relieve or avoid withdrawal symptoms
(3) the self-injury is more severe, causes more physical damage, is more physically dangerous, or occurs over a longer time period than was *intended*
(4) there is a persistent desire or unsuccessful efforts to decrease or control the self-injury
(5) a great deal of time is spent recovering from the immediate effects of the self-injury incident (e.g., tending to serious wounds; physical exhaustion)

(6) important social, work, or recreational activities are given up or reduced *because* of the self-injury
(7) the self-injury is continued despite *knowledge* of having a persistent or recurrent physical or psychological problem that is likely to have been caused by or made worse by the self-injury (e.g., recurrent self-injury despite recognition of the resulting feelings of depression, worthlessness, and regret; continued self-injury despite recognition that the body is becoming significantly marked up or disfigured from cuts or burns)

Specify if:

With Physiological Dependence: evidence of tolerance or withdrawal (i.e., either Item 1 or 2, or both, are present)

Without Physiological Dependence: no evidence of tolerance or withdrawal (i.e., neither Item 1 or 2 is present)

✦ Research Criteria for Problematic Excessive Self-Injury (akin to Substance Abuse)

A. A repetitive pattern of self-injury leading to clinically significant impairment or distress, as manifested by the following:
  (1) recurrent self-injury resulting in failure to fulfill major responsibilities at work, school, home, or in the community (e.g., repeated school absences and/or poor academic