CHAPTER FOUR

Childhood, Psychological, and Emotional Factors

People who suffer from self-injury are usually struggling with other psychological and emotional conditions as well. Sometimes, the resulting emotions from past history of childhood physical or sexual abuse, emotional abuse, or neglect, rape, or other trauma are just too overwhelming.

The relationship between commonly associated, psychologically based clinical and personality disorders are described and discussed in this chapter. Often, self-injurers are not diagnosed at all, incorrectly diagnosed, or correctly but incompletely diagnosed. For example, they may be clinically depressed, but there is more to the depression. Not all depressed people self-injure. And not all self-injurers are clinically depressed. At present, there is no diagnostic criteria for self-injury or established guidelines that are used by mental health professionals or medical doctors. There should be, and in chapter 2 of this book, this has been proposed.

The most common clinical and personality diagnoses among self-injurers are post-traumatic stress disorder; dissociative disorders; mood disorders (which cover depression and bipolar disorder, formerly known as manic-depression); anxiety disorders; impulse-control disorders; and borderline personality disorder.

Additionally, self-injurers often have problems with interpersonal relationships. These may include, for example, codependency; adult children of alcoholics issues; abusive romantic relationships, domestic violence, and the battered wife syndrome; and other problems with relating to other people (for example, due to fear, lack of trust, abandonment issues, inability to emotionally bond with others, and isolation).

Childhood Physical Abuse, Sexual Abuse, Neglect, and Trauma

The clinical and research literature suggest a number of conditions that might predispose an individual to self-injurious behavior. These include loss of a parent, childhood illness or surgery, childhood sexual or physical abuse, alcoholism in the family, witnessing family violence, peer conflict, intimacy problems, body alienation, and impulse-control disorders (Walsh and Rosen 1988). Recently, the association between trauma and self-destructive behavior has been enhanced by reports of self-mutilation starting after rape and after war trauma. Of these predisposing factors, recent research has focused on childhood sexual and physical abuse as being associated most powerfully with the development of self-injurious behaviors.

Green (1978) found that 41 percent of a group of physically and sexually abused children engaged in head banging, biting, burning, and cutting. This researcher concluded that the self-injurious behavior, which is often enhanced by the ego deficits and impaired impulse control of the abused children, seemed to represent a *learned pattern* originating from early painful traumatic experiences with hostile primary persons. Briere and Gil (1998) found that self-mutilation, ex-

amined in samples of the general population, clinical groups, and self-identified self-mutilators, was reported by 4 percent of the general and 21 percent of the clinical sample, and was equally prevalent among males and females. Childhood sexual abuse was associated with self-mutilation in both clinical and nonclinical samples. Results of this research suggest that the self-injury behavior is used to decrease dissociation, emotional distress, and posttraumatic symptoms.

A study by Lipschitz et al. (1999) found that childhood sexual abuse and emotional neglect were significantly associated with adolescent self-mutilation and suicidal ideation. The finding that emotional neglect was more strongly associated with suicidal ideation and self-mutilation than physical abuse was somewhat unexpected.

Clinical reports suggest that many adults who engage in self-destructive behavior have histories of trauma in childhood as well as disrupted parental care. Van der Kolk, Perry, and Herman (1991) conducted a study of young adults ages eighteen to thirty-nine to examine how histories of childhood trauma and disruptions in parental caregiving are related to suicide, self-injurious behavior, eating disorders, and dissociation. The study participants were gathered from clinical settings at Cambridge Hospital, from advertisements in local Boston area newspapers, and from the local probation department. Findings were that histories of childhood sexual and physical abuse were highly significant predictors of self-cutting and suicide attempts. On follow-up, the adults with the most severe histories of separation and neglect, and those with past sexual abuse, *continued* being self-destructive. The authors of this study conclude that "Childhood trauma contributes to the initiation of self-destructive behavior, but lack of secure attachments helps maintain it. Patients who repetitively attempt suicide or engage in

chronic self-cutting are prone to react to current stresses as a return of childhood trauma, neglect, and abandonment. Experiences related to interpersonal safety, anger, and emotional needs may precipitate dissociative episodes and self-destructive behavior."

There is some controversy among researchers and clinicians in the mental health field as to the effects of childhood neglect. Some maintain that the effects of physical abuse and sexual abuse are far worse, as these result in bodily injury. Broken bones, lacerations, and burns are immediately visible and more readily accepted as evidence that something bad has occurred, and thus tend to be seen as more traumatic.

How can a "nonevent" such as childhood neglect be "traumatic"? The following case study will help you to understand.

Children at Risk: Reena and Jeremiah

Reena and Jeremiah were cute. Six-year-old Reena was referred for a psychoeducational evaluation at her elementary school, for possible attention deficit hyperactivity disorder and severe emotional disturbance. Her five-year-old brother, Jeremiah, had already been placed in a special day class for children with multiple psychological problems and learning disabilities by the time he was in kindergarten.

The brother and sister were taken in by a caring single foster mother, along with her own young children. This was already their third placement, after having been removed from the care of their own mother, who was currently in the women's state prison for prostitution and selling drugs. The mother was a known crack addict herself. There was some question by authorities as to whether one or both of the chil-

dren were "drug babies." The kids had different fathers, who were nowhere to be found, and no other known relatives.

Court records indicated no reported physical or sexual abuse, but did indicate a severe case of neglect. Reena and Jeremiah were left alone in a cold, dark, roach- and rodent-infested basement room, with no heat in the winter, and nothing to eat, sometimes for days at a time, when their mother went "out." Feelings of extreme fear, terror, anxiety, and abandonment, and not knowing when—or if—Mom, or somebody, would come back to get them went on and on. And on . . .

Even two years later, with a lot of love and attention from the foster mother and her family, the school, the ever-involved (and ever-changing) social workers from the county court system, and some outside therapy at a community mental health center, both children looked permanently terrorized. Their eyes were always wide open, as if they had just seen a horror movie, but the picture never went away. Both children were always on the alert, were easily startled, said they had scary dreams (but they could not say about what), and were emotionally closed down. When asked about their mother or what happened, they did not say a word to anyone and looked as if they were far away.

Both children had behavior problems at school and at home. In addition to not paying attention in class, being disruptive, and not being able to focus on her schoolwork, the little girl was flirtatious and highly sexualized, like a young teenager. She sometimes bit her nails and would suck her thumb until it was red and raw. Both children, especially the boy, hit, kicked, bit, and punched their classmates and were intensely disliked by most of their peers. The boy broke a lot of things at school.

Like many other children who have been severely abused

and/or neglected, Reena and Jeremiah were much more "accident prone" than other children. They would tend to get a lot of playground-type scrapes and bruises from running, jumping, falling, and general clumsiness. Sometimes they did not even notice their own scraped knees and elbows and minor bleeding. Most kids would at least ask for a bandage.

One day the foster mother came in and told the school principal, "I had to call the county. They're taking the kids to another foster placement; I don't know where. The boy sleepwalks, and he starts fires. He almost burned my house down. I couldn't take it anymore, and I was afraid for the safety of my own family. Reena and Jeremiah won't be coming to this school anymore."

Children who have been so severely abused or neglected and traumatized, and at such a young age, are at very high risk for ongoing psychological problems. If the original trauma is not resolved and put to rest for good, addictions of various types, especially alcohol or drug addiction or self-injury, are most likely to surface in teenage years. It is hoped that the many children out there like Reena and Jeremiah will receive the best therapeutic interventions possible, and as early as possible, to prevent further damage. A stable, warm, loving, and safe home, one that is a permanent security base with consistent parental caregiving, is also needed.

Associated Clinical and Personality Disorders

People with a serious problem of self-injury who come to the attention of mental health clinicians are usually given a clinical diagnosis when they get into treatment. This helps clinicians to categorize the symptoms, for example, of depression or anxiety, and to be able to make better decisions for treatment planning and recommendations according to what has helped other people with similar symptoms in the past. This is also useful for medical doctors and psychiatrists to make decisions regarding the possible use of prescription medications. Additionally, most medical insurance companies require a diagnosis to bill for treatment.

Self-injury is seen among three categories of psychological disorders: (1) organic mental disorders, (2) psychotic disorders, and (3) neurotic disorders. While the type of self-injury we discuss in this book is strictly of the "neurotic disorder" category, a short definition of the other two categories of psychological disorders will be given here.

In terms of organic mental disorders, self-mutilation is a widespread problem among some people with severe mental retardation. It is also seen in other developmental disorders beginning in early childhood such as Lesch-Nyhan syndrome, and in certain neurological conditions such as Tourette's syndrome in which mental retardation does not occur. Self-mutilation has also been described in association with temporal lobe dysfunction. The cause of the behavior is organic and the self-injury is of an impulsive, repetitive nature without deliberate intent to hurt oneself.

Psychotic people differ in that they injure themselves in response to profound disorders of thought or perception. They do not realize the irrationality of their actions. The self-injury is not of a stereotyped, repetitive variety, but rather one or more discrete acts, which are usually bizarre or drastic in their form and have some sort of symbolic meaning. Sometimes the psychotic person maintains that he was under the control of an "outside force" (for example, hearing voices) or that he was acting in accordance with a biblical command (for example, castration or gouging out

his eye because it caused him to sin). The self-injury may be a response to command hallucinations or delusions, particularly with religious themes.

People with neurotic disorders who have the problem of self-injury are seen as "normal" functioning people with depressive, anxious, or obsessive-compulsive symptoms. Here we are talking about, for example, the teenage self-injurer in high school who has an irresistible impulse to cut herself and experiences an intolerable building up of tension if this behavior is not continued. These individuals are well aware of the irrationality of the injury caused by the behavior and often try very hard to stop. As early as 1951, Zaidens theorized that "early fears and unexpressed rage toward a punitive and prohibitive parent lead to guilt and self-punishment in the form of neurotic self-mutilation."

The self-injurer may be given any of a number of clinical diagnoses, including those that address concurrent problems such as anorexia, bulimia, and substance-related disorders for alcohol and/or drugs. Because self-injurers frequently have a relevant history of child abuse, the *DSM-IV* "V-Code" diagnoses for physical abuse of child, sexual abuse of child, or neglect of child may be given. Child abuse and neglect are frequently a focus of clinical attention among children and teenagers who come to the attention of mental health professionals.

Both clinical and personality disorders are possible diagnoses for the self-injurer, either alone or concurrently. Clinical disorders involve anxiety, mood, and thought, whereas personality disorders involve characteristic dysfunctional personality traits and behaviors. According to the *DSM-IV*, in order to give the person a particular diagnosis, "the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning."

I. Clinical Disorders Common in Self-Injurers

Post-Traumatic Stress Disorder

Post-traumatic stress disorder, commonly known as PTSD, is a syndrome defined by the intrusive reexperiencing of a trauma, avoidance of traumatic reminders, and persistent physiological arousal. PTSD is a diagnosis that describes symptoms experienced after the occurrence of an extreme traumatic event. Such traumatic events are defined as those that involve actual or threatened death or serious injury, or other threat to one's physical integrity.

The diagnosis of PTSD was first used to describe the severe and often disabling symptoms seen in Vietnam War veterans. The diagnostic label has been expanded over the years to include numerous other traumatic events besides war. Most frequently cited in the literature are childhood physical and sexual abuse, rape, and physical attacks such as robbing, mugging, torture, and kidnapping. The traumatic event may be experienced directly or witnessed or learned about in regard to another person. For example, one may witness severe domestic violence toward a parent or the death of a person in a car accident.

Because many self-injurers were physically and/or sexually abused as children or raped as adults and often have the characteristic symptoms of post-traumatic stress disorder, they are frequently given this diagnosis. Characteristic symptoms of PTSD include recurrent and intrusive recollections (memories) of the event that cause distress; recurrent dreams and nightmares; dissociative flashbacks; emotional numbing; feelings of detachment from others; and sense of a foreshortened future. This may lead to feelings of depression and hopelessness, and an overall impairment in one's ability to function. In PTSD, there are also persistent symptoms of increased arousal, such as hypervigilence,

exaggerated startle response, difficulty sleeping, and difficulty concentrating.

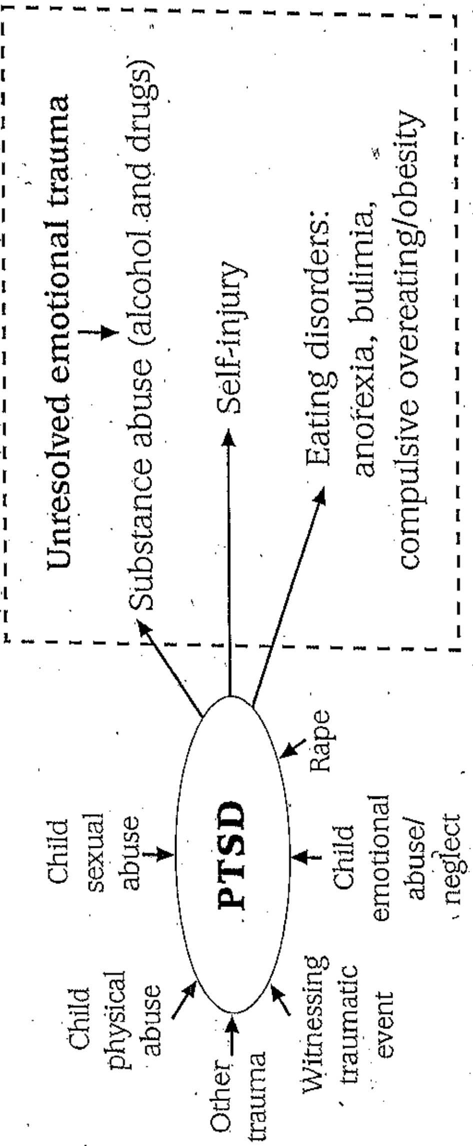
As mentioned in the *DSM-IV*, post-traumatic stress disorder may be especially severe or long lasting when the stressor is of human design (for example, torture or rape). Research has shown that one's understanding of what the trauma is matters. If someone intentionally hurts you, it adds a huge amount to the trauma. As the intensity of and physical proximity to the stressor increases, the likelihood of developing the disorder increases. Thus, children who were "trapped" in the homes of their abusers (for example, the abusive parent), over a period of time, and especially if the abuse was severe and occurred or began at a young age, are at especially high risk of developing PTSD.

Dissociation is a process associated with trauma in which the person is able to emotionally "numb out" and feel nothing. He or she feels as if the mind leaves the body and the immediate situation. This has been described by some people as "floating above the body," "not being there," and "spacing out." The mind is able to do internal cognitive tricks to escape. Dissociation is a rather sophisticated, higher-order defense mechanism. This subconscious process happens seemingly automatically and can become a learned experience. However, states of emotional numbing and dissociation often become extremely uncomfortable, if not intolerable, and may lead to impairment in functioning. For example, it is hard to concentrate on the task at hand, be it walking down the street, learning in the classroom, or having a conversation with another person, if one is feeling spaced out and not really there. Such states can be very difficult to snap out of. Other avoidant strategies (that is, to avoid facing the traumatic event) may also be developed, such as self-injury and alcohol and drug use. For trauma victims, the good news about dissociation, self-injury, and

drinking and using drugs is that it keeps one going. The bad news is that unless these avoidant strategies are given up, one never recovers.

Connors (1996) proposes in the clinical article "Self-Injury in Trauma Survivors: Functions and Meanings" that self-injury serves a number of functions that help childhood trauma survivors cope with posttraumatic events. First, self-injury is a reenactment of the original trauma, which can serve as an attempt to manage a previously unmanageable situation. ("This time, I'm in control of what happens; I'll be in charge of the pain and decide when it's too much.") It may also feel like the only way to retrieve nonverbal memories of past abuse, or to communicate to oneself and others about what happened. Second, the self-injury can serve as a vehicle for the expression of feelings and needs. Uncomfortable or forbidden feelings such as rage, frustration, guilt, shame, sexual arousal, sadness, and emotional longing are commonly released during a self-injuring episode. Another purpose of the self-injury is to express the depth of emotional pain that one is in (to oneself and/or to others) and to communicate one's needs for comfort and containment. A third purpose of the self-injury is to reorganize the self, to regain physiological and emotional balance. Connors states that many trauma survivors describe the calm that follows an act of self-injury. For example, cutting or gouging the skin may feel soothing, and tension is released or significantly reduced. The trauma survivor therefore regains a sense of homeostasis (balance). Fourth, self-injury is a way of managing the dissociative process. For some survivors of trauma, self-injury may serve as a "toggle switch" for the dissociative process: It may prevent one from dissociating or switching to an altered state (that is, the pain serves as an anchor to the present and allows one to avoid "going away"), or it may facilitate a switch into an altered state of

FIGURE 6. TRAUMATIC EVENTS THAT LEAD TO POST-TRAUMATIC STRESS DISORDER



mind (for example, when one desires to disconnect from current distress). Some self-injurers describe both experiences.

Connors concludes: "Self-injury is an adaptive coping mechanism that makes a great deal of sense from the interior experience of the (childhood trauma) survivor. It is a method born of necessity and a child's perspective of the world. Early acts of self-injury may be reinforced by their effectiveness and become habitual, or manifested as compulsive behavior interlaced with substance or sexual addictions. This repetition may add another layer to the complexity surrounding the survivor's efforts to resist or change the behavior."

As illustrated in figure 6 on page 98, traumatic events such as child sexual abuse, child physical abuse, or rape may lead to post-traumatic stress disorder. If the emotional trauma remains unresolved, it may in turn lead to addictive disorders, such as alcohol or drug abuse, eating disorders, or self-injury.

Post-traumatic stress disorder and high-risk factors for addiction are listed in the following table.

PTSD and High-Risk Factors for Addiction

1. Isolation/lack of social support
2. Trauma occurred at young age (infancy/early childhood)
3. Long duration of or multiple episodes of traumatic event (for example, repeated childhood sexual abuse)
4. Pattern of repeated victimization (for example, abused as child; mean and abusive boyfriends as teenager; battered wife as adult)
5. Not able or not willing to talk about (to "vent" and verbalize) and *process* the traumatic experience

6. Unresolved/suppressed emotional issues resulting from the trauma (for example, anxiety, fear, terror)
7. Dissociative symptoms
8. Adolescent
9. Female (especially at risk for eating disorders and self-injury)
10. Confinement (for example, living in residential/ group home/ psychiatric/prison setting, or inner-city or war zone)

Anxiety Disorders

Post-traumatic stress disorder, as described above, is categorized as one of the *anxiety disorders.* Of all the anxiety disorders, this particular diagnosis has many specific features consistent with the background experiences and reactions of self-injurers. Other anxiety disorders especially prevalent in self-injurers include generalized anxiety disorder, panic attack, and obsessive-compulsive disorder.

According to *DSM-IV* criteria, the essential feature of *generalized anxiety disorder* is excessive anxiety and worry (apprehensive expectation, for example, waiting for something bad to happen; feelings of impending doom). Symptoms may include restlessness, feeling "on edge," irritability, difficulty sleeping, and difficulty concentrating or mind going blank. Some people with anxiety also have somatic complaints; that is, a lot of headaches, stomachaches, and other aches and pains. There may or may not be an actual medical basis for these complaints (for example, sometimes the doctor does not find any reason for the stomachaches, like an ulcer).

Children and teenagers with anxiety may be excessively

worried about their performance, may be perfectionistic, and may do the same task over and over to try to get it right. They may be constantly seeking approval and reassurance, especially from adults, that everything is okay. They may have difficulty concentrating on their schoolwork. They may be constantly worried about unlikely catastrophic events, such as earthquakes, tornadoes, or war, or their house burning down, or their parents suddenly dying in a car crash every time they go out.

Panic attack, according to the *DSM-IV,* is an extreme anxious reaction with sudden onset that involves intense fear and feelings of doom and an urgent desire to "escape." This involves emotional escalation, and is usually over in about ten minutes. Many times self-injurers receive this clinical diagnosis because panic attacks resemble the "escalation/de-escalation" phase, as described in text and graphics in chapter 2. Other symptoms experienced during a panic attack may include racing heart, difficulty breathing (hyperventilating), sweating and shaking, and feelings of unreality or being detached from oneself.

According to *DSM-IV* criteria, *obsessive-compulsive disorder* involves recurrent thoughts, impulses, or images, along with repetitive behaviors (for example, compulsive handwashing or counting) to attempt to alleviate the anxiety and distress. The thoughts and behaviors are intrusive and inappropriate, and take up a lot of time and energy from one's day. The obsessions or the compulsions may interfere with other activities and obligations, such as office work for adults or learning in the classroom for children and teenagers.

For self-injurers, the "to cut or not to cut, to cut or not to cut, to cut or not to cut" phase, as described in chapter 2, is an example of an obsession. The repetitive behavior of actual cutting or burning, time and time again, is an example

of a compulsion. Many times self-injurers are given the diagnosis of obsessive-compulsive disorder (OCD) by mental health professionals because of these features.

A research study by Simeon et al. (1992) found that self-mutilators had significantly more anxiety than those who do not self-mutilate, as measured by the Schedule for Interviewing Borderlines and the Hamilton Depression Scale. Chronic somatic anxiety was significantly associated with the *degree* of self-mutilation. These researchers state, "Mounting anxiety has been clinically described as an important predictor in the escalating phase of self-mutilation. Mounting anxiety may be either a direct precipitant of self-mutilation, or the final common pathway to a variety of thoughts, affects, and experiences that trigger self-mutilating behavior." Relief of anxiety has been found in as many as 86 percent of self-mutilators in other research studies (Gardner and Gardner 1975).

Impulse-Control Disorders

Self-injurers are often described as highly impulsive in general. The self-mutilating behavior can at times be described as an impulsive reaction to stress, especially when one is extremely anxious, agitated, or angry.

The *DSM-IV* states that the main feature of *impulse-control disorders* is the "failure to resist an impulse, drive, or temptation to perform an act that is harmful to the person or to others." With most disorders of impulse control, the person feels an increasing sense of tension before committing the act. Afterward, one experiences a sense of gratification or "relief."

Impulse-control disorders described in the *DSM-IV* include but are not limited to kleptomania (stealing) and pyromania (fire setting). One of these impulse-control disorders, trichotillomania (the recurrent pulling out of one's own hair

for the relief of tension, which produces noticeable hair loss) has at times been described in the clinical and research literature as a specific type of self-mutilating behavior.

However, there is no diagnosis specifically for self-injury. Self-injurers are sometimes given the *DSM-IV* diagnosis of "Impulse-Control Disorder NOS" (not otherwise specified). Researchers Simeon et al. (1992) propose that "self-mutilation might be best viewed as a distinct (DSM) Axis I impulse control disorder."

Dissociative Disorders

According to *DSM-IV* criteria, the essential feature of *dissociative disorders* is "a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment." Feelings of dissociation and depersonalization are often described by self-injurers. Dissociation, depersonalization, and emotional numbing are especially prevalent in people who are also suffering with PTSD. There is a wide range of dissociative disorders, mostly depending on the severity and on the specific symptoms.

At the lower end of the spectrum is *depersonalization disorder*, characterized by a persistent or recurrent feeling of being "detached" from one's mental processes or body. At the higher (more severe) end of the spectrum is *dissociative identity disorder* (DID), which was formerly known as *multiple personality disorder* (MPD). However, this is an extremely controversial diagnosis; many clinical and medical professionals do not believe that this disorder exists. Furthermore, people who exhibit the clinical symptoms described in the diagnostic manual and in other literature (for example, that a person has two or more separate, distinct personalities, like in the infamous 1970s novel and movie *Sybil*) are extremely rare. Unfortunately, many people, including victims of severe child abuse and self-injurers, have

been incorrectly diagnosed with multiple personality disorder or dissociative identity disorder.

Mood Disorders

Mood disorders include but are not limited to depression and bipolar disorder. What is now called bipolar disorder used to be known as manic-depression. According to the *DSM-IV*, the predominant feature across all mood disorders is a disturbance in mood. There are a range of clinical diagnostic terms under the category of mood disorders, depending on the particular symptoms and the frequency and severity of the symptoms.

Major depressive disorder is a severe form of depression. *Dysthymic disorder* is a less severe type of depression and is often (but not exclusively) used in diagnosing children and adolescents. Depressive symptoms may include feelings of sadness; worthlessness; hopelessness; lack of interest or pleasure in all or almost all activities, even those that one usually enjoys; thoughts of death or suicide; and problems with (that is, too much or too little) eating or sleeping. Some people who are depressed may have difficulty concentrating or fatigue or loss of energy. In children and adolescents, the depression may present itself as an irritable, agitated mood.

Bipolar disorder involves both depression and one or more manic episodes. People who have bipolar disorder are often described by others as extremely "moody" or as having mood swings. Manic episodes are a distinct period(s) of time in which the person's mood is notably elevated or irritable, and there is an increase in physical goal-directed activity. The person in a manic phase may present with nonstop talking, flighty ideas, racing thoughts, and a decreased need for sleep.

Research findings about self-injury and depression have been mixed. Most of the literature supports that depression is one of the most common underlying symptoms and clinical diagnoses among self-injurers. Researchers Dulit et al. (1994) found that *frequent* self-mutilators were significantly more likely to receive diagnoses of current major depression.

The researchers Simeon et al. (1992) found that self-injurers did *not* suffer from more depression than control (non-self-injuring) subjects on the Beck Depression Inventory. They also did not suffer from greater hopelessness. These researchers speculated that "the significant negative correlation between the degree of self-mutilation and hopelessness lends to the conceptualization as an act of self-healing through the transient restoration of more hopeful affect."

Many times the self-injurer does not look or act "depressed." She may not know it herself that depression is there, deep down, because she is masking these difficult feelings by her acting-out (self-injuring) behavior. As a matter of fact, she can often fly high above any painful emotion because of her self-inflicted physical pain. That is her goal.

Therefore, the self-injurer often goes unnoticed or at least the depth of her difficulties go unnoticed for a long, long time. Sometimes, not until the cutting/burning becomes a full-blown addictive disorder.

On standardized tests that measure depression and other symptoms (for example, the Beck Depression Inventory, the Hamilton Depression Scale, the Children's Depression Inventory, the Deveraux Behavior Scales, the Burkes' Behavior Scales) scores may even come up as "normal" (that is, not significantly depressed), according to the self-injurer's own perceptions as well as the perceptions of others in her life such as parents and teachers.

"It's the Quiet Kids I Worry About"

Experienced teachers and other school personnel will often say that it's the kids who are too quiet, are well behaved, and seem to get "lost in the shuffle" that they worry about the most. That is because they seem to be doing so well—despite having been through horrible trauma such as child sexual abuse. However, these are often the ones who are suffering the most, and the ones who need the most help.

Sophia, a quiet, rather nondescript ten-year-old girl, was in a special day class for children with learning disabilities. She did not show up with significant scores on the social-emotional part of her psychoeducational testing, but further observation and diagnosis over time revealed that she was in fact clinically depressed. Sophia had been repeatedly sexually abused by a teenage boy in her neighborhood when she was very young. Not able to concentrate on her schoolwork, she was having difficulties with reading and learning in general, but otherwise appeared as the role-model student in a class full of behaviorally acting-out, aggressive children (mostly boys) who were always getting into trouble. Except for occasionally appearing to "zone out" in the classroom when she was supposed to be doing her work, according to her seasoned, well-aware teacher, "She looked too good for what she had been through." Sophia was in a lot of emotional pain, quietly suffering in silence, occasionally lightly scratching her arm with a paper clip or a pencil . . .

Because of early counseling and intervention (that is, counseling by the school counselor; intensive therapy at a community mental health center; becoming involved in self-esteem-building activities that she liked and did well in, such as the school chorus) Sophia fared well. She was very soon also able to mainstream into the general education classroom because her reading and academic learning improved significantly.

II. Common Personality Disorders in Self-Injurers

Borderline personality disorder is one of the most common diagnoses given to self-injurers, as is post-traumatic stress disorder. Many times, there is also a concurrent clinical disorder, such as PTSD, an anxiety disorder, or a mood disorder (for example, major depression), which typically demands more immediate therapeutic intervention. Borderline personality disorder is certainly the most common one in self-injurers among the *DSM-IV* Axis II Personality Disorders and the only personality disorder with a significant amount of clinical and research literature regarding the connection to self-injury.

Borderline Personality Disorder

Borderline personality disorder is a complex personality disorder marked by mood swings, high-drama behaviors, emotional (especially angry) outbursts, serious problems with close interpersonal relationships, and an intense fear of abandonment. Other symptoms include a high degree of impulsivity (for example, reckless driving, sex, spending, substance abuse) and an instable self-image (for example, internal conflicts about sexual orientation, long-term goals, values). Behaviors toward others frequently include boundary violations, giving mixed messages, approach-avoidance conflicts, manipulation, anger provocation, and at first idealizing and then turning against another person. The title of a popular psychology book on this subject, *I Hate You, Don't Leave Me* (Kriesman and Straus 1991) is a good example of something that a borderline patient would be likely to say to someone (whether it is her significant other or her therapist) that effectively summarizes her painful internal chaos.

One of the possible nine indicators of borderline personality disorder, according to the *DSM-IV*, is "recurrent suicidal

behavior, gestures, or threats, or self-mutilating behavior." The self-injurer must have at least five or more other symptoms or traits in order to make the diagnosis, which should be done with careful thought and caution. Although there is a very significant correlation, not all self-injurers have borderline personality disorder. And not all borderline patients have a problem with self-injury. Some may, or may not, have self-injured one or a couple of times as a form of manipulation and attention-seeking.

As previously mentioned, clinical literature and research results have shown a strong association between self-injury and a history of childhood abuse. Research results also demonstrate a strong association between diagnosis of borderline personality disorder and a history of childhood abuse. Herman, Perry, and van der Kolk (1989) found that significantly more (81 percent) borderline subjects than nonborderline subjects gave histories of childhood trauma, including physical abuse (71 percent), sexual abuse (68 percent), and witnessing serious domestic violence (62 percent).

A number of studies have shown an association between self-injury and reported histories of childhood sexual abuse in patients with borderline personality disorder. One study by van der Kolk, Perry, and Herman (1991) systematically explored how both childhood abuse and neglect relate to the development of self-destructive behavior. These researchers, using both historical and prospective data for people with personality disorders or bipolar II disorder, found that histories of childhood trauma, particularly sexual abuse, and histories of childhood neglect were highly significant predictors of chronic suicide attempts, cutting, and other self-injurious behavior. In this study, the borderline diagnosis was the only diagnosis significantly associated with physically self-destructive behavior.

Problems with Relationships

Most older adolescent and adult self-injurers will tell you that they have had a "difficult childhood," to say the least. Many were severely abused, sometimes by their own parent, stepparent, or other family member, or were not safe and protected by and within their own families. Many were neglected or emotionally and verbally ripped to shreds by adults in their lives who were supposed to nurture and care. Many had parents who were alcoholics or drug addicts. Many had a parent or parents who were in one way or another not there.

It is thus difficult for the struggling self-injurer, especially while in the throes of her addiction, to trust other people or to develop healthy, close interpersonal relationships with others. Self-injurers tend to spend a lot of time alone, sometimes to indulge in the cutting/burning behavior, and sometimes just because isolation seems preferable to being around other people and the possibility of getting hurt, again. As with other types of addicts, her primary relationship will be with the addictive substance or behavior of choice, and with herself.

The self-injurer coming from such a traumatic childhood background may inadvertently seem to choose negative people as friends or romantic partners. For example, she may have an alcoholic boyfriend or a husband who batters her. Something may seem to draw the self-injury addict in to the unhealthy, the destructive, in others . . . maybe because it feels familiar, it reminds her of home; and deep down, she does not feel that she deserves anything better and that life will always be this bad.

It is quite common for problems of domestic violence, alcoholism, drug addiction, child abuse, and psychological problems to go on from generation to generation, and

around and around in a vicious cycle, if not addressed, understood, and effectively dealt with.

Therapy can help the self-injurer to develop understanding, to change her negative and self-destructive ways of thinking, and to help build self-esteem and self-confidence. The recovering self-injurer may also attend Twelve Step groups that are relevant to her, such as Adult Children of Alcoholics, Al-Anon, or Codependents Anonymous, to address relationship issues. In these groups, she can learn how to have a healthy, functional relationship first with herself and then with other people.