CHAPTER FIVE

Why Now?

History and Increasing Incidence of Self-Injury

The self-mutilation syndrome has received increasing attention both theoretically and descriptively in psychiatric literature during recent years (Simpson and Porter 1981). There has also been an increase in the general public's awareness of this problem since 1997, when Princess Diana's admission of being a self-injurer on national television brought widespread attention to the problem. Even with recent media, books, and other publications, there is still a lot to be done in terms of increasing the general public's awareness as well as *understanding* of the problem of self-injury. Because of all the recent media attention to the problem of self-injury, many self-injurers and their families (for example, parents in hopes of helping their teenage daughters who are struggling with this problem) are likely to seek treatment.

Most important, there is a great need to "demystify" the disorder and to offer practical treatment options, as has been done with anorexia nervosa and bulimia over the course of the last twenty or thirty years. It is important that we (professionals, parents, and the general public) no longer cringe in fear, go into a panic, or freeze in astonished amazement when hearing about or seeing a teenage girl (or anyone else,

for that matter) who cuts or burns herself repeatedly, silently screaming for help.

Historical Overview of Self-Injury: Many Biblical/Religious Cases

Self-injury has been around for a long, long time. In the fifth century B.C., in book 6 of *History,* Herodotus describes a Spartan leader who deliberately and severely mutilated himself with a knife. Deliberate self-injury is also mentioned in the Bible: the Gospel of Mark 5:5 describes a man who "night and day would cry aloud among the tombs and cut himself with stones."

Self-mutilation resulting from religious delusions or extreme religious beliefs have occurred since before the time of Christ. They continue to occur to this day, although less frequently and only in those with severe psychosis, schizophrenia, and delusional intoxication. Documented cases of such acts demonstrate religious self-mutilation to either atone for sins (including sins of thought and sins of action) or for the purpose of appeasing one's God or gods.

A review of the existing literature on self-mutilation accompanying religious delusions shows that castration and enucleation (deliberate removal of one or both eyes) are the most common forms. Other acts include cutting off or otherwise injuring one's hand(s), slashing or burning one's flesh, and amputation of one's tongue.

Referring to biblical texts to explain acts of religious self-mutilation occurs among a number of (extreme pathological) self-mutilators. Probably the most commonly quoted passage is Matthew 5:29,30, which states, "And if thy right eye offend thee, pluck it out. And if thy right hand offend thee, cut it off." Consequently, some extreme religious self-mutilators are inclined to remove any body part that they

feel causes them to commit, or even to think of, sin. Other verses in the Bible give examples of self-mutilation. In Matthew 19:12, eunuchs castrate themselves "for the sake of the Kingdom of Heaven." I Kings 18 describes a rain-making ceremony in which the priests of Baal gashed themselves with knives and lances until blood gushed.

Sometimes, such examples from the Bible and religious stories and examples are misinterpreted. They may be interpreted literally by some extremists to mean that self-mutilation or the amputation of a particular body part is necessary to demonstrate one's faith and to free oneself from sin. One may think that, for example, after all, how could such actions be wrong if they're portrayed in the Bible as being appropriate or even honorable in certain circumstances?

Clark (1981) in his article on self-mutilation and accompanying religious delusions makes recommendations for treatment and study of such extreme cases. These are attention to previous history or evidence of self-injury; attention to preoccupation with biblical passages regarding self-injury; attention to preceding drug abuse; and attention to early loss of the father in males. Rapid tranquilization and intensive psychotherapy are advised following hospitalization.

The "Holy Anorexics"

During medieval times, a number of women in search of piety, wishing to imitate the sufferings of Christ, would deliberately starve themselves and deliberately injure themselves by such methods as self-flagellation (that is, self-punishment by whipping), scourging and disfiguring their faces, and impaling their breasts with nails. Living lives of extreme deprivation, suffering, and charitable acts toward others was encouraged and applauded by priests. Many

young girls idolized and wanted to be like these holy women, and imitated them, much like young teenage girls today imitate and dress like certain female pop stars.

One of the most famous and fully documented cases of the "Holy Anorexics" (women who starved themselves to death in pursuit of sanctity) was that of Saint Catherine of Sienna, who lived in the 1300s (Bell 1985). Her biography was a best-seller for two hundred years. When Catherine of Sienna was sixteen, her beloved older sister died, and her parents pressured her to marry her rich, older, disgusting brother-in-law. She panicked and embraced a life of radical piety and chastity. She cut off her long blonde hair, put an iron chain around her waist to ensure her virginity, wore a crude woolen shift, and limited her diet to bread, water, raw vegetables, and bitter herbs. She slept on a wooden board and indulged in self-punishment by whipping herself three times a day with the chain until she drew blood. The lack of food reduced her weight by half within months. She spent most of her time at her parents' home praying alone in a tiny cell underneath a flight of stairs, where she had visions and hallucinations (Egan 1999). No one could stop her from her chosen life of self-deprivation and self-punishment. She undertook a life of extensive charity, helping the sick and the dying. She was credited with having performed numerous miracles, such as multiplying loaves of bread to feed the poor. She attempted to organize a group of women to fast and pray for the success of the pope. When her efforts at renewing the papacy and the Church failed, she became despondent, even gave up water, and died three months later in 1380 at the age of thirty-three. She was canonized as a saint in 1460 (Bell 1985).

Other famous holy women of medieval times who endured such self-inflicted suffering and starvation include Saint Teresa of Avila, who went so far as to induce vomiting

by poking the back of her throat with an olive twig before receiving Holy Communion (Callender 1999). Bridget of Sweden poured hot wax on her flesh, and Saint Clare of Assisi slept on the cold floor in the wintertime and fasted three days each week during Lent (Egan 1999). Saint Lucia was said to have avoided sexual temptation by cutting out her eyeballs.

Historical Overview of Academic Literature on Self-Injury

Since the mid-nineteenth century, there have been numerous case-study-type articles in the medical literature about the more deviant forms of self-mutilation. These were primarily of severe psychotic individuals who engaged in isolated incidents of extreme self-mutilating behaviors (usually in response to religious delusions or hallucinations) such as the gouging out of eyeballs (enucleation) or castration. The first published article in the medical literature on self-injury, in 1846, was a case report of a forty-eight-year-old manic-depressive widow who took out both of her eyeballs. She did this because she felt that her eyes were causing her to desire men and therefore to "sin." Self-mutilation was for a long time considered a "symptom" of various mental disorders.

Other academic research and clinical literature up until the 1980s primarily covered medication trials and behavioral interventions used to treat profoundly retarded people, autistic people, and others with developmental disabilities. The focus was on individuals who engaged in the stereotypic, repetitive type of self-mutilation seen in organic disorders beginning in early childhood.

As early as 1934, Karl Menninger of the Menninger Clinic in Topeka, Kansas, wrote about self-mutilation from a psychoanalytic theoretical point of view. He believed that

self-mutilation contained three essential elements: (1) aggression turned inward, often that which is felt toward an external love-hate object, usually a parent; (2) stimulation, with either a sexual or purely physical intent; and (3) a self-punishing function that allows the person to atone for an aggressive or sexual "sin." The great paradox is that while self-mutilation is self-punishing and self-destructive, it is also an attempt at self-healing.

Menninger (1934) wrote: "In any circumstance, however, while apparently a form of attenuated suicide, self-mutilation is actually a compromise formation to avert total annihilation, that is to say, suicide. In this sense it represents victory, sometimes a Pyrrhic victory, of the life instinct over the death instinct."

The trend in the academic literature from that time on, up until the late 1980s, was to vary from an extreme to a minimalizing point of view. Self-injury was sometimes seen as a form of "para-suicide" in which the person has suicidal ideation or intent. Sometimes the whole problem of self-injury was referred to as "wrist-cutting" or, according to Pao (1969), "delicate self-cutting," thus not considering the full scope of the problem.

In 1979, Morgan (in England) described a "delicate self-harm" syndrome. This included self-mutilation as well as drug overdoses and failed suicide attempts. In 1983, Pattison and Kahan reviewed fifty-six case reports of self-harm in the existing clinical literature and developed a model for the Deliberate Self-Harm Syndrome. According to this model, the syndrome involved

1. onset in late adolescence
2. multiple episodes of self-harm
3. multiple types of self-harm
4. low lethality

5. the behavior continues over many years
6. four predominant psychological symptoms (despair; anxiety; anger; cognitive constriction)
7. predisposing factors of lack of social support; homosexuality (in men); drug and alcohol abuse and suicidal ideation (in women)
8. associated depression and psychosis

Drug overdoses and failed suicide attempts were excluded from Pattison and Kahan's model of the Deliberate Self-Harm Syndrome. The syndrome was considered by these authors to be an impulse-control disorder.

In 1986, Lacey and Evans described the connection between self-mutilation and other impulsive addictive disorders. Hence, they described the problem of self-injury and addiction substitution. They described a "multi-impulsive disorder" with interchangeable symptoms such as binge eating, substance abuse, kleptomania, and self-mutilation. These authors noted that people with this disorder tended to drift from clinic to clinic: "Thus, if alcohol abuse is addressed in the alcohol treatment unit, the patient may stop drinking but moves to food or cutting."

It has long been known that addiction substitution happens, unfortunately, more often than not. In order for an addict to *really* recover, a solemn and rigorously honest commitment to abstinence must be made. Underlying emotional issues as risk factors need to be addressed and dealt with, brought into awareness and understood.

In 1987, the groundbreaking work of Favazza highlighted the idea that self-injury is distinct from suicide. His theoretical writing and empirical research did wonders in advancing our knowledge base and understanding of self-injury. Favazza states, "A basic understanding is that a person who truly attempts suicide seeks to end all feelings

whereas a person who self-mutilates seeks to feel better." He also notes that it is important to be aware that repetitive self-cutters are at high risk for suicide, often by overdoses, secondary to demoralization over an inability to control their acts of self-harm (Favazza and Conterio 1989).

Categorizing Self-Injurious Behaviors

In his 1998 article, Favazza described a clinically useful classification of self-mutilation into three categories: major, stereotypic, and superficial/moderate. *Major* self-mutilation includes the infrequent, drastic acts such as eye removal (enucleation) and castration, which are associated with psychosis and intoxication. *Stereotypic* self-mutilation includes acts such as the head banging and self-biting often seen in individuals with Tourette's syndrome or severe mental retardation. *Superficial/moderate* self-mutilation includes compulsive acts such as skin picking and trichotillomania (the deliberate, repetitive act of pulling out one's own hair), as well as such episodic acts as skin cutting and burning, which evolve into a clinical syndrome of impulse dyscontrol with variable symptoms.

Furthermore, Favazza classified self-mutilation into three subtypes: compulsive, episodic, and repetitive. *Compulsive* self-mutilation involves a behavior that is automatic, without much thought put into it, that occurs in response to an irresistible urge and promotes relief. The most heavily researched type of compulsive self-mutilation is trichotillomania, repeatedly pulling out one's own hair. *Episodic* self-mutilating behaviors occur periodically (only every so often) as a symptom or as an associated feature in clinical disorders such as post-traumatic stress disorder, dissociative disorders, or borderline personality disorder.

Episodic self-mutilating behavior can turn into *repetitive*

self-mutilation when the self-injuring behaviors become an overwhelming preoccupation. Repetitive self-mutilators may describe themselves as "addicted to" their self-injury. At this point, the self-injury seems to run its own course.

When a person presents with the problem of self-injury, for example, when there are visible self-inflicted cut marks, or when a verbal threat to harm oneself is made, mental health professionals need to quickly and accurately assess which one of three things may be going on (A, B, or C):

A. Is the purpose of the self-injury to commit suicide?
B. Is the purpose of the self-injury to try to manipulate somebody, or to get attention?
C. Is the purpose of the self-injury to relieve intolerable feelings (such as to alleviate anxiety/anger/emotional escalation or to escape emotional numbing/dissociation), and is the self-injury of the episodic or repetitive addictive type?

Then, the best decisions for what to do in the moment as well as long-term to help the person in need can be made. It is important to remember that sometimes a combination of two or more of these things may be going on. For example, a psychologist called me for consultation about how to help an adult woman patient with borderline personality disorder who threatened to drink cleaning fluids. She was attempting to get her therapist's attention, via a rather dramatic cry for help, and had a tendency to be histrionic, acting out, and inappropriately manipulative. When assessed at the hospital clinic, the woman was not suicidal and admitted to the attempt to get attention. However, further assessment over time revealed that the patient also had a problem with self-injury of type C. She was repeatedly indulging in various self-injurious behaviors when distressed and had one day come into her therapist's office having severely bit the inside

of her mouth on both sides as well as her tongue, which was purple, swollen, and badly bruised.

Early and accurate assessment of the problem of self-injury and appropriate therapeutic intervention can help such women while the destructive behavior is merely episodic, before it becomes a full-blown addiction.

Prevalence of Self-Injury

Getting a true estimate of how often self-injury actually occurs in the general population is not possible. This is because it is a "hidden" disorder, like bulimia. It is easy to hide. Many self-injurers and the people in their lives do not even know that self-injury is a disorder, or have the words to explain it, or realize that other people have it too. Some would not admit to it, either to themselves or to anyone else, or do not think that it is a "problem" (like alcoholics or drug addicts who are in denial or who do not realize that their excessive drinking/using drugs has become a problem or an addiction).

Over the years, researchers have attempted to estimate how many people in the general population self-injure. At times the research methodology has been flawed, or biased, or both. One significant study by Briere and Gil (1998) used advertisements looking for people with a history of self-mutilation placed in popular magazines *(Good Housekeeping, Parents)* and publications for child abuse survivors *(Moving Forward, Treating Abuse Today)*, and handouts that were distributed at abuse-survivor conferences on both the East and West Coasts. Not everyone reads those particular magazines, and not everyone is interested in or attends conferences. This study in particular excludes men, teenagers, and people of lower socioeconomic and educational backgrounds. Furthermore, the researchers were unable to

tell which questionnaires that came back were from the magazine solicitations or the conference attendees. In another study reported in the same article, a national sampling service generated a stratified, random sampling of the United States, based on geographical locations of registered owners of automobiles and people with listed telephones. However, this tends to exclude teenagers (the largest proportion of self-injurers) and people who do not own cars or who do not have a telephone.

Briere and Gil's (1998) results from the aforementioned study were that self-mutilation was reported by 4 percent of the general and 21 percent of the clinical population, and it was equally prevalent in males and females. This prevalence is considerably greater than Walsh and Rosen's (1988) estimate of 14–600 cases per 100,000. Favazza (1998) writes that superficial/moderate self-mutilation (the most common form) occurs at a prevalence rate of at least 1,000 per 100,000 in the population per year. In a survey of 500 college students in America, 14 percent admitted to at least one episode of self-mutilation (Favazza, DeRosear, and Conterio 1989).

It has been somewhat easier (but still difficult) to get estimates of the prevalence of self-injurious behavior in clinical populations. Most of the studies include only those self-injurers who present for psychotherapy in clinics that serve abused children or trauma clinics, or for therapy in general, or who are in confined settings such as psychiatric hospitals, residential treatment centers, or prisons.

In reviewing the literature, Pattison and Kahan (1983) report that the vast majority of self-injury cases occur in late adolescence, particularly among violent and antisocial youth in institutional settings, with incidence rates as high as 40 percent.

In the landmark study of 240 female self-mutilators by

Favazza and Conterio (1989), child abuse was reported by 62 percent. Sixty-one percent admitted to having or having had an eating disorder in the past. There was also a significant association with alcohol and substance abuse.

As discussed in chapter 4, self-injury is strongly associated with certain clinical and personality disorders, such as post-traumatic stress disorder and borderline personality disorder. Some of the research studies over time have primarily focused on exploring the prevalence of self-injury in patients who have these specific disorders.

Is the problem of self-injury actually on the increase? There are a couple of factors that need to be considered when answering this question:

1. Self-injury has been around for a long time; it is only recently coming into the light regarding research, publications, media attention, and people who are seeking treatment, so now it is noticed and acknowledged more.
2. Self-injury is a learned behavior. There are some people who will "copy" the behaviors of others, however dysfunctional or destructive they may be. When I was living in a college dorm in the early 1980s, a group of girls on our floor were watching television in the lounge. There was a special on a late-night talk show about bulimia, which seemed to grab everyone's interest. Heidi, a severely overweight graduate student, loudly exclaimed, "I want to learn how to throw up, like that girl on TV, so I can lose weight. I'm serious, I want to become a bulimic!"

Contagious Self-Mutilation

The problem of self-mutilation as "contagious" or as an "epidemic" within treatment programs, hospitals, and especially with males in prisons has been described throughout the literature. The problem of contagion has generally been defined as "the infliction of self-injury by one individual and imitation by others in the immediate environment" (Rosen and Walsh 1989).

Episodes of contagious mutilation present a serious problem, because they generally create havoc in treatment settings or other environments in which they occur. Staff report feeling helpless and demoralized, and this behavior can certainly scare the living daylights out of other patients, residents, students, or anyone else who is in the immediate environment. Rosen and Walsh state, "Ultimately, self-mutilation contagion is likely to be best understood as an interaction of individual psychopathology with dysfunctional relationships in a given social context."

A group of consulting psychiatrists (Fenning, Carlson, and Fenning 1995) investigated an outbreak of contagious self-mutilation in a junior high school. Their observations were that the majority of adolescents involved in this behavior did *not* demonstrate any severe overt psychopathology. They had *not* been identified as "emotionally disturbed students." All of them belonged to the leading inner social circle in school. All of them excelled in their academic achievements. The behavior seemed to be contagious. Girls were more involved in the self-mutilating behavior than boys. *Isolating* the "hard core" students (those who initiated the self-mutilating behavior, with the more severe psychopathology, who "induced" the self-mutilating behavior in the more passive and less disturbed students) seemed to be the only effective means of controlling this contagious behavior.

Fenning, Carlson, and Fenning (1995) also state that self-mutilation may be more frequent in the educational systems than reported. Underreporting might be due to the

reluctance to deal with this issue openly. These authors state that it is important (for psychiatric consultants) to

1. provide more information to educational systems
2. identify populations at high risk for self-mutilation
3. guide the (school) staff in their management of this highly contagious behavior

Males Who Self-Injure

The problem of self-injury is most often reported across the clinical and research literature in females, mainly in teenage girls and young adult women. Females tend to ask for help and to seek mental health treatment services such as psychotherapy more often than males do. Favazza (1992) writes, "The majority of repetitive self-mutilators who come to the attention of psychiatrists are females in their twenties, about two-thirds of whom report childhood sexual and/or physical abuse."

Many males in our society tend to avoid emotional expression that may involve getting in touch with difficult feelings, such as deep sadness, and at all costs may want to avoid crying. Some males may be concerned about not wanting to appear "weak" or "needy," so they may be reluctant to, or do not, seek help.

Self-injury does occur in males also, but much less frequently—just as with anorexia and bulimia. Male self-injurers tend to have more severe cases, for example, to cut or self-destruct more savagely, and to have more associated psychopathology, such as antisocial personality disorder. This may be at least in part because by the time male self-injurers come to the attention of treatment professionals, their self-injurious behaviors are well advanced and very serious.

Males tend to express their anger via physical aggression toward others, whereas females tend to turn their angry feelings inward, toward themselves.

The greatest concentration of males with the problem of self-injury are found in prisons. In prison settings, especially in heavy confinement, the self-mutilation problem can be spread "contagiously" and may reach epidemic proportions (Favazza 1992).

Over the years, there have been a number of studies about self-injurers in the prison system. Jones (1986) analyzed data collected from the case records of self-mutilating prisoners and compared this with a random sample of others in prison. Findings were that three-quarters of the self-injuring incidents took place in isolation cells or on prison psychiatric units. Injuries were the result of self-inflicted cuts. Statistical analyses revealed that the self-mutilators were more likely to already have scars on their wrists or forearms upon admission and were more likely to have attempted suicide while in prison. While they were incarcerated, the self-mutilators were also charged with more assaults, convicted of more felonies, and had more severe disciplinary actions taken against them.

In 1997, Fulwiler et al. conducted a study to explore how prisoners who injured themselves without intending to die would differ clinically from prisoners who had attempted suicide. Findings were that suicide attempt was associated with adult affective disorder, whereas self-mutilation was associated with a history of childhood hyperactivity and a mixed dysthymia/anxiety syndrome that began in childhood or early adolescence. Furthermore, the self-mutilators and those who attempted suicide had very different clinical presentations and histories.

Having worked as a consulting psychologist in a residential facility for teenage boys who are on court probation, I

have seen numerous incidents of deliberate self-injury in males. A lot of the boys had scars on their forearms from cuts, and burns from cigarettes, cigarette lighters, and hot pennies. Most often, this would start off as a "dare" game, to see who was the strongest and the toughest. Sometimes it became compulsive.

Homemade tattoos have become increasingly popular over the years, with both teenage boys and girls, especially (but not only) with those who are gang affiliated. This behavior can also become compulsive and, needless to say, very dangerous in terms of getting (and spreading) infections, including HIV, from using dirty needles. At one time, two of the boys in the residential facility where I worked had even invented a homemade tattoo machine, using the cassette reels of a "boom box." It was quite an ingenious invention, albeit something negative and destructive. After the appropriate reprimands and consequences, staff encouraged these boys to put their brainpower into their schoolwork instead.

Characteristics Prevalent in Self-Injurers

Most of the literature describes characteristics of self-injury as seen in females, because they are the ones who most frequently come to treatment and who respond to surveys. Most prevalent background characteristics of self-injurers (which are discussed in detail throughout this book) are history of childhood abuse, including sexual abuse, physical abuse, and neglect; trauma, including post-traumatic stress disorder; current or past history of eating disorders; and current or past history of alcohol and/or substance abuse.

Other characteristics of self-injurers include an early history of surgical procedures or illness, accident-proneness, perfectionist tendencies, dissatisfaction with their body

shape and sexual organs, and an inability to express feelings easily (Favazza 1992).

Conterio, Lader, and Bloom (1998), in their textbook *Bodily Harm*, point out certain prevalent themes as ones that recur among the self-injurers seen in the S.A.F.E. Alternatives inpatient treatment program:

1. difficulties in various areas of impulse control, as manifested in problems with eating behaviors or substance abuse
2. history of childhood illness; or severe illness or disability in a family member
3. low capacity to form and sustain stable relationships
4. fear of change
5. an inability or unwillingness to take adequate care of themselves
6. low self-esteem, coupled with a powerful need for love and acceptance from others
7. childhood histories of trauma or with significant parenting deficits. This leads to difficulties with internalizing positive nurturing
8. rigid, all-or-nothing thinking (self-injurers often have catastrophic thinking such as "Nothing will ever change!") and/or perfectionism and workaholism

Profiles: What Does a Self-Injurer Look Like?

In their study of 240 female habitual self-mutilators, Favazza and Conterio (1989) describe a "typical" self-injurer:

> The typical subject is a 28-year-old Caucasian who first deliberately harmed herself at age 14. Skin cutting is her usual practice, but she has used other methods such as skin burning and self-hitting, and she has injured herself on at least 50 occasions. Her decision to self-mutilate is

impulsive and results in temporary relief from symptoms such as racing thoughts, depersonalization, and marked anxiety. She now has or has had an eating disorder, and may be concerned about her drinking. She has been a heavy utilizer of medical and mental health services, although treatment generally has been unsatisfactory. In desperation over her inability to control her self-mutilative behavior this typical subject has attempted suicide by a drug overdose.

I believe very strongly in early assessment and therapeutic intervention for children and adolescents, at the first sign of trouble, before problems escalate and take over a person's life, as happened to the twenty-eight-year-old self-injurer described above. For example, even a very young child who was physically or sexually abused can benefit greatly from some type of therapy, before resulting problems interfere with his or her school experience, learning, and life in general. The problem in assessing self-injury is that it is so easy to hide. Most teachers, parents, and professionals do not understand it, let alone know what to look for. In teenagers, a "typical" profile of a self-injurer may look something like this:

She is sixteen or seventeen years old; of any race or socioeconomic background; bright; attractive; does well academically; and on first impression, seems like a very "normal" teenager. She may be obsessing about her appearance and her weight, and you suspect that she may have, or may have had, problems with some type of an eating disorder such as anorexia or bulimia. She was most likely sexually or physically abused, or both, sometime in childhood. She comes from a family where there are other problems—for example, an alcoholic or drug-addicted parent; a parent or parents who are not there

for her (e.g., they may be dead or in some way emotionally unavailable). She has probably experimented with alcohol and/or drugs more than the average teenager, sometimes overdoing it. She may already have an alcohol or drug problem. She seems emotionally closed down; a bit of a loner or aloof; often "moody"—sometimes quiet and depressed, and sometimes anxious, inappropriately angry, or agitated. She has a tendency to, in general, be highly impulsive. She sometimes looks as if she's "spacey" or in a world of her own. She may be sexually promiscuous, at least in the way she dresses, or she may avoid boys and dating altogether. She may be a bit of a perfectionist, have an air of uniqueness or independence about her, and she definitely has a mind of her own. She may complain of a lot of headaches or stomachaches, and starts missing a lot of time from school. Her grades may begin to drop, and she may start to slide academically—although she is bright, she can't seem to concentrate on her schoolwork. She begins to spend more and more time alone, in isolation. She always wears long sleeves, even in the summertime.

She may be your own daughter, or if you're a teenager, your best friend; or a student in your junior high or high school classroom who looks like she daydreams too much. She needs help.

Associated Feelings and Effects of Self-Injury

Favazza (1998) writes that "SM (Self-mutilation) can best be understood as a morbid self-help effort providing rapid but temporary relief from feelings of depersonalization, guilt, rejection, and boredom as well as hallucinations, sexual preoccupations, and chaotic thoughts." Favazza also states that self-mutilating behaviors provide temporary relief from

the distressing symptoms of mounting anxiety, racing thoughts, and rapidly fluctuating emotions.

Among the effects of self-mutilating behavior are tension release; termination of depersonalization; euphoria; decreased troublesome or enhanced positive sexual feelings; release of anger; satisfaction from self-punishment; a sense of security, control, and uniqueness; manipulation of others; and relief from feelings of depression, loneliness, loss, and alienation (Favazza 1989).

Treatment: What Has Worked, Ideas for Intervention, and Future Directions

To date, most treatment approaches for self-injury have been based on theoretical notions as opposed to empirical studies that determine the efficacy of different treatment approaches. No one method or specific type of therapy seems to work better than any other for self-injury. Research on what works best and for whom, and the development of more effective therapeutic interventions, are called for.

We do know from the literature and clinical experience that behavioral therapy interventions have been used extensively and have shown some positive results in the treatment of stereotypic self-mutilation, especially for mentally retarded patients. In more severe cases, regarding all types of self-injury with its associated clinical symptoms such as depression and anxiety, the use of medication has sometimes been helpful.

Favazza (1998) points out that treatment is still problematic, especially for repetitive cutters and burners. He states that medication and new psychological approaches are helpful.

Briere and Gil (1998) state that treatment for self-injury may be most effective when it reduces painful affect and when it bolsters coping strategies. It may thus be helpful to

treat self-mutilating clients not only by discouraging the self-mutilating behavior, but also by intervening in the conditions that keep it going. Briere and Gil suggest that effective interventions may include the following:

1. Most immediately, exploration of alternate methods of reducing distress that are less injurious or shame-inducing (for example, physical exercise, distraction via telephone or reading, changing environments [by going outdoors, moving to a different room, etc.] or contacting friends or hotlines when the desire for self-mutilating behavior is intense)
2. Teaching cognitive and behavioral strategies for dealing with stressful situations and painful internal states
3. Strengthening internal affect regulation capacities and strategies (ability to control internal emotional ups and downs), so that external methods like self-mutilating behavior become less necessary
4. Ultimately, reducing the distress and dissociative symptoms that may underlie and motivate involvement in self-mutilating behavior.

—(Briere 1996; Linehan 1993; Walsh and Rosen 1988)

Much work still needs to be done in terms of advancing the understanding of self-injury as well as in developing treatment strategies that work and in conducting research studies, as has been done for alcohol and drug addiction, and more recently for anorexia and bulimia over the last several years. Favazza (1998) points out that "the undeniable truth is that acts of self-mutilation are unnerving"—to most people, including medical and mental health professionals. He further states: "The impulsivity of repetitive cutters and burners is exasperating to deal with, but no more so than that of alcoholics."