A CRITICAL ANALYSIS OF RESEARCH

RELATED TO THE PSYCHOLOGY OF SELF-MUTILATION

by

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ABSTRACT

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A Critical Analysis of Research Related to the Psychology of Self-Mutilation

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The purpose of this study was to look at the available research associated with the psychology of self-mutilation. Self-mutilation is not an uncommon phenomenon today. The behavior is an area of great concern for many due the complexity, the rise in incidents, the insufficient knowledge of helping professionals, and the limited amount of empirical research available.

A comprehensive literature review was conducted to examine the complexities associated with self-mutilation. The study was focused on the following areas: history of self-mutilation; prevalence of the behavior; different types of self-mutilation; purposes

that self-mutilation serves; common precursors to the behavior; commonly associated disorders; and successful therapeutic interventions when working with self-mutilators.

The multitude of research concurred that there is no definite solution to self-mutilation due to the variety of purposes it serves for individuals and the precursors that lead up to the behavior. However, there are some therapeutic interventions that are helpful to self-mutilators. It is clear that more empirical insight is necessary for optimal intervention with those who self-mutilate. This study attempted to make meaning of self-mutilative behaviors in order to assist individuals who struggle with the behavior to overcome the devastating effects.

Lastly, recommendations were made to assist professionals in the counseling field. The series of recommendations focused primarily on counselor education regarding self-mutilation.

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CHAPTER ONE: INTRODUCTION

Rachel is a sixteen-year-old female who has recently been diagnosed as Cannabis Dependent and has now been placed in a group home for constant supervision. Shortly after intake, the staff realizes that Rachel has issues with eating, where she will binge, or eat a lot at one time, and immediately go to the bathroom to purge by making herself vomit. A few days after recognizing her bingeing and purging behaviors, a staff member finds out from Rachel's roommate that she is using a razor to cut superficial gashes into her upper arms and stomach. The therapist conducts an assessment with Rachel and realizes that while she has suicidal ideations, her cutting is not an attempt at suicide but a way for her to release her emotional pain. The therapist is perplexed and appalled by Rachel's behavior and is unsure about how to treat her.

Situations such as Rachel's are not an uncommon phenomenon for therapists to deal with today. In the past two decades, self-mutilation has increased dramatically. Since the 1990's, more attention has been drawn to the issue of self-mutilation, especially in adolescents, because it is so prevalent in our society. There has been extensive research conducted on the behavior, as well as what therapists and other professionals can do to help.

According to Turner (2002), self-mutilation may be the fastest growing problem for teenagers today. Research on the behavior shows patterns that are increasing in intensity and severity. Self-mutilation is more common in adolescents and young adults than society believes because acts of self-mutilation are often underreported or misdiagnosed (Strong, 1998). This happens for a number of reasons. First, acts of self-mutilation are seldom brought to the attention of helping professionals because the act is

serving a specific purpose for the individual. The average person who engages in self-mutilative behaviors believes that their actions towards themselves are helpful rather than harmful. Furthermore, in most cases the acts of self-mutilation are not so severe as to require medical attention, consequently keeping the disorder hidden. Second, acts of self-mutilation are often misdiagnosed. The more severe forms of self-mutilation that do require medical attention are oftentimes misdiagnosed as a suicide attempt. In addition, in other reported cases of self-mutilation, the behaviors are often seen merely as symptoms of other disorders rather than a diagnostic disorder in itself.

Due to their complexity, self-injurious behaviors are not completely understood (Turner, 2002). In society today, it is commonplace to see someone with a lot of tattoos. This is not likely to be a person who self-mutilates, but rather a person who wants to be unique and in sync with current trends. In order to determine the presence of self-mutilation, it is important to look at the behaviors the person is engaging in. Signs that the behavior is self-injurious include taking the behavior to extreme measures, obsessions and compulsions related to the behavior, and striving for the experience of pain.

Since self-mutilation is a hidden disorder, it is difficult to determine how many people partake in the behavior. Studies show that the incidence of the act among adolescents and young adults is approximately 1,800 per 100,000 (Suyemoto & MacDonald, 1995). Self-mutilation seems to be less common in the general population of the United States with only four percent reporting the behavior in the last six months and less than one percent admitting to frequent self-mutilation (Briere & Gil, 1998). The incidence is significantly higher in the clinical population with twenty-one percent of clients reporting that they rely on self-mutilation as a way to cope.

Acts of self-mutilation had received attention prior to the 1980's but was most often associated with other disorders. It was most often connected to borderline personality disorder but is also present with other diagnoses, such as autism, schizophrenia, obsessive-compulsive disorders, post-traumatic stress disorder, depression, substance abuse, trichotillomania, eating disorders and other personality disorders (Suyemoto & MacDonald, 1995). Due to increased attention by popular literature – such as *Reviving Ophelia*, by Mary Pipher – adolescents and young adults who self-mutilate have received more attention and have been increasingly given a proper diagnosis in the 1990's and beyond (Zila & Kiselica, 2001).

In 1985, self-mutilation was openly discussed on a national television show. The public concern was evident due to the enormous response to the show. Over one thousand letters were received from viewers, exemplifying the need for more research and attention on the subject (Zila & Kiselica, 2001). Self-mutilation's first major debut into the public eye was in 1995 when Princess Diana announced that she practiced self-mutilation due to the strain of her marriage (Edwards, 1998). Since then, other celebrities, such as Johnny Depp, Christina Ricci, Angelina Jolie and Drew Barrymore, have admitted to performing self-mutilation.

Due to the prevalence of the behavior in the 1990's, self-mutilation has become known as the 'addiction of the 90's' (Strong, 1998). Most people who chronically self-mutilate admit that eating disorders, alcohol, drug, and sex addictions are all easier to cease than the act of self-mutilation. This happens because the ability to cope with feelings without self-mutilating decreases significantly over a period of time. Although

self-mutilation is referred to as an addiction and has many addict-like qualities, most therapists prefer to call it a habit.

The groundbreaking work on self-mutilation began in 1938 with Karl Menninger's *Man Against Himself*. This was the first piece of literature to make a distinction between self-mutilation and suicide. However, Favazza's work in 1987 clarified the distinction in a time when the behavior seemed to be increasing in the public eye (as cited in Turner, 2002). Favazza's work clarified that suicide was a means to end all feelings while self-mutilation was used to make one's self feel better.

Purpose of the Study

The purpose of this study is to examine the complexities associated with self-mutilation. This includes identifying the purposes that the self-mutilation serves for those who partake in the behavior, common precursors of the behavior, disorders that are commonly associated with the disorder, and effective treatments for the behavior. This is achieved by conducting a literature review, an analysis, and a critique of the findings related to the psychology of self-mutilation. Recommendations are provided for helping professionals.

Research Questions

The study addresses the following research questions.

1. What purposes do acts of self-mutilation serve for individuals?
2. What are common precursors to self-mutilation?
3. What disorders are commonly associated with self-mutilation?

4. What therapeutic treatments have proven to be successful regarding acts of self-mutilation?

Definition of Terms

For clarification, the following terms are defined.

1. Self-mutilation - “The deliberate, direct, nonsuicidal destruction or alteration of one’s own body tissue” (Strong, 1998, p. x).
2. Trichotillomania - The compulsive act of tearing out one’s own hair.
3. Eye enucleation - The act of extricating one’s own eyeball.

Limitations of the Study

While there is much general literature regarding self-mutilation, there is minimal statistical information available. A limitation of the study is that those who self-mutilate do not report their actions or their actions may be misdiagnosed by helping professionals, thus skewing the prevalence of the behavior.

CHAPTER TWO: LITERATURE REVIEW

Introduction

This chapter is a comprehensive review of the research and literature associated with the psychology of self-mutilation. The focus of the chapter will be on self-mutilation as it relates to the history of the behavior; prevalence of the behavior; different types of the behavior; the purposes it serves for those who engage in the behavior; the precursors to the behavior; the disorders commonly associated with the behavior; and common therapeutic treatments for the behavior.

A Concise History of Self-Mutilation

"The skin is the first, largest, and most exquisitely sensitive of all the organs of the human body" (Strong, 1998, p. 17). Human beings use skin as a communication device that can convey emotions such as pleasure, affection, and pain. Throughout history, individuals have manipulated the outer shell of their bodies by decorating, scarring, tattooing, cutting, branding, hiding, and revealing the skin. This exploitation of the body can be a nonverbal expression of prestige, power, and status for all societies, both ancient and contemporary.

Although it is now receiving the attention that it deserves, self-mutilation is not a new phenomenon. The behavior has occurred even before the time of Christ. Self-mutilation has been written about since the earliest of times (Turner, 2002). More specifically, there are numerous references of the behavior in the Bible. One such example is in the Gospel of Mark 5:5 which describes a man who "would cry aloud among the tombs and cut himself with stones" (as cited in Turner, 2002, p.112).

According to the literature, the most common forms of religious self-mutilation were castration and enucleation.

Prior to the nineteenth century, self-mutilation was practiced only as a form of religious observance (Menninger, 1938). The behavior was representative of sacrifice, practiced as part of a religious rite. Self-mutilation was commonly known as "mortification of the flesh," related to the Christian religion (Strong, 1998, p.29). Messianic delusions were occasionally reported where individuals would crucify themselves by burning, cutting, or starving (Menninger, 1938).

In the 1800's, self-mutilation was an uncommon occurrence. In the cases that were reported, the individuals were frequently diagnosed with hysteria or neuroticism. It was believed that self-mutilation was a bizarre act only to be engaged in by patients in mental institutions. Furthermore, acts of self-mutilation were looked upon from a psychoanalytic lens. Menninger (1938) wrote that genital castration was an archetype of all self-mutilative acts. Any part of the body that was annihilated was considered to be an unconscious representation of the genital organ.

According to Strong (1998), helping professionals have only begun to understand self-mutilation in the last sixty years. In addition, it has only been in these last sixty years that self-mutilation has become considered a coping mechanism rather than a symptom of hysteria. Self-mutilation was first studied in depth in the 1960's. Researchers looked for commonalities among those who self-mutilate. According to most sources, the typical person who engages in self-mutilation is a female adolescent who is single, intelligent, and from a middle to upper class family (Strong, 1998). The act usually commences in

adolescence and continues through young adulthood, although there have been incidents of self-mutilation reported in individuals as young as two and as old as ninety.

Although the act of self-mutilation is most commonly reported in female adolescents, the act is rising among young males due to increased attention to the disorder. This raises concern about what adolescents are learning from society today. There are several possible reasons why females are diagnosed with self-mutilation more often than males. One is that males are less likely to seek help. Also, males tend to avoid emotional expression and instead turn their emotions outward through violence and aggression whereas females are more likely to internalize them (Conterio & Lader, 1998). When males utilize self-mutilation they often carry out more severe forms of the behavior. These actions are more often diagnosed as accidents rather than intentional acts (Clarke & Whittaker, 1998). From the little research done on self-mutilation in adolescent boys, it is evident that self-injury is most common among boys who were sexually abused (Zila & Kiselica, 2001). Most of the research on self-mutilation focuses on females because of the prevalence and abundance of information available.

What is Self-Mutilation?

There has been a lot of uncertainty surrounding self-mutilating acts, simply because of the different terms and definitions. Although it is most commonly referred to as self-mutilation, there are many different terms for the behavior. Zila and Kiselica (2001) reported that in 1979 there were 33 terms for the behavior. Such terms included self-cutting, self-destructive behavior, self-inflicted injury, self-harm, self-wounding, parasuicide, self-injury, and deliberate self-harm (Huband & Tantam, 1999).

In addition, self-mutilation has many definitions. The English definition for the act of self-mutilation is “a non-fatal act in which an individual deliberately causes self-injury or ingests a substance in excess of the therapeutic dose” (Clarke et al., 2001, p.350). In contrast, the most comprehensive definition in the United States is “the deliberate, direct, nonsuicidal destruction or alteration of one’s own body tissue” (Strong, 1998, p. x). The discrepancy between the two definitions is that, according to the English definition, unsuccessful suicide attempts are included in the term, whereas that is not the case in the United States’ version. For the purposes of this paper, self-mutilation will refer to harming the body without the intent to commit suicide.

Much of the early literature on self-mutilation is hidden within reports and statistics on suicide. While self-mutilation and suicide are associated, they are not considered the same, as most research in the United States indicates. Menninger conducted the groundbreaking research on suicide and self-mutilation in his book, *Man Against Himself* (1938). His research was the first to distinguish a difference between two deliberate acts. Himber (1994) described that for some women, self-mutilation prevented a suicide attempt. In addition, she stated that while self-mutilative acts are not suicidal, there might still be suicidal ideation present. Suyemoto and MacDonald (1995) concurred that self-mutilation was a way to avoid suicide, offering a mastery over death or a compromise between the drives of life and death. Similarly, Menninger (1938) explained that self-injurers are working toward self-healing as opposed to death. In the United States today, the rate of self-mutilation is thirty times higher than the rate of suicide attempts and one hundred forty times the rate of completed suicides (Strong, 1998). Clearly, these two deliberate acts are not one in the same.

Self-mutilation and suicidal behavior are different in several ways. First, suicidal individuals want to end their lives, where self-mutilators do not (Zila & Kiselica, 2001). Typically, those who self-mutilate do not want to commit suicide. If they did, they could do it with a lot less effort than they put into the self-mutilating acts (Menninger, 1938). Second, attention from others reduces suicidal attempts, as opposed to acts of self-mutilation where behaviors do not diminish. Third, those who are suicidal often improve when removed from stressful environments while self-mutilators usually continue regardless of the stress level. Also, self-mutilation is considered an act of low lethality where suicide is high in lethality. Last, self-mutilation is followed by a sense of relief while there is no such relief for a person who has failed at a suicide attempt. Crowe and Bunclark (2000) agreed that the goal in self-mutilation is usually to reduce tension rather than to end life. While a strong case has been made on differentiating self-mutilation and suicide, one should not be mistaken in thinking that self-mutilation is an anti-suicide indicator (Briere & Gil, 1998). In some cases, self-mutilation may be a practice run at a suicide attempt.

Approximately fifty-five to eighty-five percent of self-mutilators have made at least one suicide attempt (Stanley, Gameroff, Michalsen, & Mann, 2001). Although these acts may seem to be primarily manipulative and attention-seeking, the self-mutilator should not be underestimated as they may misperceive the lethality of their attempt or expect to be rescued. According to the same research, self-mutilator's lives are flooded by suicidal thoughts. Groups of self-mutilators particularly at risk for attempting suicide seem to be those suffering from depression or borderline personality disorder. For example, suicide rates in individuals with borderline personality disorder who self-

mutilate are twice as high as individuals with borderline personality disorder who do not self-mutilate (Fowler, Hilsenroth, & Nolan, 2000).

For years, researchers have attempted to make sense of self-mutilation by classifying the behavior into categories. Menninger (1938) proposed that it is not so much the degree of seriousness that determines its classification but the nature of the act of self-mutilation. According to Menninger, nail biting is a form of self-injurious behavior because the individual is deliberately destructing their body.

In 1983, Pattison attempted to classify self-mutilation in terms directness of harm to the body, repetition of the behaviors, and the likelihood of lethality associated with the behavior (Pattison as cited in Strong, 1998). From these findings, Favazza and his colleagues classified self-mutilative behavior into three categories: major, stereotypic and superficial or moderate (Favazza as cited in Strong, 1998).

Major

The first, major, is usually a part of a psychotic illness where the acts are infrequent but severe, as they typically result in the loss of a limb, castration, or eye enucleation (Clarke & Whittaker, 1998). This type of self-mutilation is typically the result of a psychotic outburst or acute intoxication. Most often the self-destruction has underlying religious or sexual connotations. Individuals who partake in this extreme form of bodily harm feel little or no pain at the time of the incident and suffer little remorse for their actions. Major self-mutilation is the most rare form of self-injury.

Stereotypic

The second category, stereotypic, is most often linked to an organic etiology, as is the case with autism, Tourette's syndrome, and Lesch-Nyhan's syndrome (Clarke & Whittaker, 1998). Stereotypic self-mutilation usually consists of rhythmic and repetitive head banging, biting, hitting, and joint dislocation. The repetitive head banging has been linked to an individual's attempt to reexperience the soothing sound of the mother's heartbeat from within the womb (Strong, 1998).

Superficial or moderate

The last category, superficial or moderate self-mutilation, seems to be the least understood (Clarke & Whittaker, 1998). This category causes the greatest concern because while it is the most common form of self-mutilation, it receives little attention from researchers.

There are three subtypes within the superficial category: episodic, repetitive, and compulsive (Strong, 1998). The episodic and repetitive subtypes are the most common and include cutting, burning, interfering with wound healing, and bone breaking. The difference between the two subtypes is that repetitive self-mutilation is chronic, as the behavior becomes a significant part of the self-mutilator's life. Both episodic and repetitive self-mutilation serve similar purposes for the self-mutilator. They relieve tension, release anger, end emotional numbing, and help the person to feel a sense of control over themselves. Commonly associated psychological disorders include post-traumatic stress disorder, depression, dissociative identity disorder, and other personality disorders.

The compulsive subtype is the most repetitive and ritualistic of all subtypes. Individuals in this category engage in self-injurious behaviors in order to relieve swelling anxiety, usually related to obsessive-compulsive disorder.

Types of Self-Mutilation

Cutting and burning of the skin are the two most common forms of self-mutilation that individuals practice (Zila & Kiselica, 2001). The most common places for self-injurers to cut are their wrists and forearms; however, it is not uncommon to see cuts on the face, genitals, thighs, stomach, breasts, legs and ankles. Cutting is achieved by using a number of objects ranging from knives, needles, fingernails, razors, bones, pen caps and credit cards. By and large, burning the skin is accomplished by using cigarettes or matches. While the preferred method of self-mutilation is cutting, 75 percent of mutilators use more than one technique (Clarke & Whittaker, 1998).

Other forms of self-mutilation include: interfering with wound healing; constricting air passages or blood flow; inserting objects into the skin or into bodily orifices; biting or chafing the skin; hitting the body with objects or body parts (Zila & Kiselica, 2001); extracting an excess amount of hair; chewing lips, tongue, or fingers; eye enucleation; amputation; ingesting sharp objects, or toxic objects (Conterio & Lader, 1998); running into traffic; and strangulation (Clarke et al., 2001). Some forms of self-mutilation that are rarely painful include hair cutting, nail biting, and shaving (Menninger, 1938).

Data shows that self-mutilators can find almost any means to harm themselves. It is often difficult to interfere because they can injure themselves using only their bodies without objects. Furthermore, most studies show that self-mutilation is a persistent

behavior where individuals have scars all over their bodies. One study found an average of 93 scars per self-mutilator (Zila & Kiselica, 2001).

What Purposes do the Acts of Self-Mutilation Serve?

For many, it is hard to understand why someone would intentionally hurt themselves. Yet, self-harm has a significant purpose for those who do it. There are many reasons why people injure themselves; most of the reasons cluster around an inability to cope with emotions and express feelings or to communicate their needs to others.

Most individuals cut themselves for more than one reason. In her research, Himber (1994) found specific reasons for self-mutilation including induction of a pleasurable state, tension release, discharge of anger, communication, expiation, self-purification, self-punishment and enhancement of self-esteem. Other reasons include affect regulation, self-medication, coping mechanism, sexual gratification, religious and societal beliefs, and symbolism.

Affect regulation

The most frequently cited function of self-mutilating behavior is affect regulation. It reduces anxiety, depression, tension, loneliness, feelings of emptiness, guilt, and dissociation. Self-mutilation distracts, soothes or otherwise draws attention away from internal emotions. Haines and Williams's (1997) research shows that the act of self-mutilation has a sense of immediate and significant reduction in tension. Injuring the self is an answer to "not existing" (Strong, 1998, p. 55); it is proof that they are truly living.

Self-medication

According to Turner (2002), individuals use self-mutilation as a way to self-medicate. The purpose is to cease the inner pain and turmoil. For some, it is a means to escape feelings of depression and numbness. Creating pain helps the individual to deescalate and subsequently feel calm and relaxed. For others, it is to relieve intense feelings of tension and anxiety. These feelings mount quickly, leading the person to self-injure in order to feel calm. In the end, these individuals feel depressed or guilty over what they have done to their bodies.

Coping mechanism

Most research shows that, although detrimental, self-mutilation serves as a form of therapy for the mutilator. They see harming themselves as the only way to cope with what they are feeling. It may also be a desperate attempt to communicate to others that they need help.

Research has suggested that self-mutilation occurs because of the individual's inability to cope with difficult situations. Self-mutilation is a way for them to calm down in the absence of a better mechanism. Individuals who self-injure as a way to cope explain it as an escape from the problem and afterward report feeling better, less confused, as if they exist, and in touch with their bodies (Zila & Kiselica, 2001). Many individuals use self-mutilation as a way to escape from emotional pain. The behavior becomes reinforced for the person since it is an effective outlet for coping with the emotional pain (Turner, 2002).

A study conducted by Haines and Williams (1997) found that self-mutilators perceived themselves to have less control over their interpersonal problem solving skills

than did the control group. The reinforcement of self-mutilation as an effective coping strategy is dangerous and may evolve into an addiction or compulsion (Clarke & Whittaker, 1998). Similarly, Turner (2002) explains that self-mutilators are susceptible to physical changes after self-mutilative acts. During the event, the body releases endorphins and the individual may get a "high" from the self-mutilative experience. This experience of relief becomes habit-forming for the self-mutilator.

Sexual gratification

Self-mutilation can also be used as a form of sexual gratification. Individuals may combine sexual gratification with punishment because of an urge to self-stimulate. This most often coincides with a distorted sense of pain and pleasure and a distorted body image. However, the most common functions of self-mutilation include ritual and symbolism and tension relief.

Religious and societal beliefs

Self-injury is embedded in many societal and religious rituals. As a result, it is often difficult to distinguish between socially deviant self-injury and socially acceptable self-injury (White, Trepal-Wollenzier, & Nolan, 2002). In contemporary society, socially deviant behaviors include cutting and burning while socially acceptable behaviors include tattooing and body piercing. Ritual wounding and bleeding serve to increase and celebrate the connection between the self and others (Himber, 1994). It can serve as a function to help an individual fit in with others.

Symbolism

The skin is symbolically important because it is a barrier between the outer world and the inner world for an individual. Further, it can reveal emotions through color and tone, such as fear, rage, and embarrassment (Clarke & Whittaker, 1998). Self-mutilation helps the individual create a concrete marker when they are troubled to exemplify where the outer world ends and where they begin (Fowler et al., 2000). In *A Bright Red Scream,* Strong (1998) states that bleeding is a symbolic form of healing for many who self-mutilate. Consequently, the scars that follow also serve as a symbol, a memory of what they have experienced.

Individuals have been able to communicate through marking their skin since the beginning of human existence. Some of the most common reasons for body modification, both past and present, are to increase sexual desirability, to test strength and stamina, to ward off evil, to intimidate others, and for religious reasons.

Ancient Egyptian mummies have been found bearing tattoos and scarification. Mayan Indians traditionally pierced and tattooed all body parts. In addition, Mayan babies' heads were forced into wooden molds in order to reshape them. These modifications are signs of cultural beauty to Mayan Indians. The Chinese engaged in the custom of binding the feet by sewing the foot and forcing the bones to break so that the foot takes of the shape of a lotus flower. Until it was outlawed, this was a sign in the Chinese culture of beauty, sexuality, and status.

In modern times, body modification is generally associated with lower classes, prisoners, gangs, and sailors. For many years, the Christian church outlawed body modification. Although it was brought back to Western society much earlier, body

modification did not increase in popularity until the 1960's. The children of this time were searching for individuality and, as a result body piercing and tattooing surged.

This is still evident today as people embellish their bodies with piercings and tattoos. Modern ideas for piercing and tattooing have been taken from indigenous tribes; only the recent body modification has been taken to the extreme. This is evident in body piercings that are similar to the piercings in African, Indian, and Middle Eastern tribes. Another extreme example is the 1980's Mohawk, which is an offshoot of Indian tribal symbols.

Other purposes

According to Zila and Kiselica (2001), other possible causes for self-mutilation include: sexual acting out, regression, existential statement, manipulation, risk-taking, attention-seeking, retaliation, frustration, depression, built up tension, ineffective communication, self-punishment and low self-esteem.

What are Common Precursors to Self-Mutilation?

Many researchers speculate that shame, guilt, self-hatred, self-blame, and self-punishment are common precursors to self-mutilation. Others believe that the behavior stems from shame associated with past sexual abuse. In any case, the critic of the self-mutilator comes from within. These people learn to be hard on themselves because of the way they were treated in the past. A sense of shame and guilt is also associated with the act of self-mutilation. People will generally hide any evidence of harming themselves.

Oftentimes, people who self-mutilate also cope with other concerns like interpersonal relationship discord, codependency, abusive relationships, and alcohol and

drug issues (Turner, 2002). They may be predisposed to self-injurious behaviors because of a significant loss in childhood, illness or injury in childhood, sexual or physical abuse, familial alcoholism, peer conflict, concerns with intimacy, or impulse-control. Other common characteristics apparent in self-mutilators include perfectionism, dissatisfaction with their body, impulse-control difficulties, childhood illness, unstable relationships, fear of change, need to be accepted, low self-esteem, traumatic past experiences, and dichotomous thinking.

Typically, those who self-mutilate come from enmeshed families, where an independent identity is complex (Strong, 1998). Oftentimes, these individuals have never completely attached to a caretaker early in their life and, as a result, they live in an unvarying state of separation anxiety. The attacks upon the self are usually following a seemingly real threat of loss or abandonment. These feelings are so overwhelming that the individual is unable to deal with their feelings on an emotional level; instead they deal with these feelings on a physical level. Emotionally healthy individuals can think through and cope with what they are feeling rather than acting the emotion out through self-harm.

People who were abused as children typically begin to act out at adolescence. It is at this time that their cognitive development is sophisticated enough to begin to cope with the abuse. Unfortunately, they may choose to deal with the issues through self-injurious behaviors.

Issues with sexuality

Adolescence is a time when many extreme changes are going on within the body. It is at this time that self-mutilative behaviors usually begin to surface. Sexual identity, sexual experiences, body image, sexual abuse, and sexual assault are suddenly new issues

for the individual. Zila and Kiselica (2001) state that most adolescents who self-mutilate report feeling sexually confused. While some self-mutilators have had extensive sexual experiences, most tend to be unusually prudish.

In addition, the onset of menstruation often creates anxiety for adolescents. One study, cited by Zila and Kiselica (2001), reported that over half of the participants had negative, unhappy, or disgusted reactions to menstruation. Another study reported that girls with abnormal cycles more frequently performed self-mutilative behaviors. Yet another study reported a correlation between the onset of self-mutilation and the beginning of the menstruation cycle.

Past abuse

In the 1980's researcher Walsh inquired as to why self-mutilation develops. His research concluded that individuals who self-mutilate had some type of abuse or a significant change happen during their childhood (Walsh as cited in Strong, 1998). In 1979, Morgan hypothesized that a lack of emotional expression was a major cause for self-mutilation (Morgan as cited in Strong, 1998). Like Walsh and Morgan, Favazza found similar findings in his studies on self-mutilation (Favazza as cited in Strong, 1998). His research found that self-mutilation was often associated with the inability to deal with sexuality due to previous sexual abuse or assault. Additionally, a study cited in Zila and Kiselica (2001) discovered a strong correlation between the history of physical and sexual child abuse with self-mutilation. Oftentimes, self-mutilators act out against themselves because they are trying to reclaim their bodies from past abuse (Strong, 1998).

Childhood physical and sexual abuse applies to about fifty to sixty percent of the cases of self-mutilation (Strong, 1998). While this is a significant amount, there are still a fair number of individuals who have not been abused. Therefore, it is important not to assume abuse has occurred (Crowe & Bunclark, 2000).

Furthermore, Himber (1994) proposed that growing up abused or neglected fosters a difficulty in receiving comfort. Children who have been abused or neglected do not learn from the adults in their lives how to soothe themselves. Instead, they turn to self-mutilation to cope with issues (Strong, 1998). Most self-mutilators consider this upbringing to be normal and familiar (Turner, 2002). Self-mutilation could be a way for these individuals to keep others at a distance. Distancing others as a way of avoiding exposing wounds and scars is easier with body vandalism than without (Himber, 1994). Oftentimes, victims who fear being sexually assaulted will mutilate their genitals or disfigure their faces so that they appear unattractive to perpetrators. They may have the belief that their body is bad both inside and out, and as a result, attempt to destroy their outer core. In addition, some individuals may self-mutilate in order to draw attention to their bodies. The self-destruction is a cry for help.

When Do People Self-Mutilate?

The beginning of the week seems to be the primary time for self-mutilators to injure themselves, as reported by medical facilities (Clarke et al., 2001). In contrast, Fridays have the lowest number of cases reported to medical facilities. The peak time for receiving medical attention is ten o’clock at night. The peak months for self-mutilation are March, June, July and November, which fall between the school holidays in the United Kingdom where the study took place. This information can be beneficial to look

at because it can assist in narrowing down why the behavior is occurring. The study shows that individuals engage in self-injurious behaviors at the beginning of the week when stress levels are high. In addition, they seek medical attention at night, when alone. Self-mutilative acts also coincide with the beginning and end of semesters of school, a stressful and overwhelming time for students. In addition, this can be a time of social isolation for students where they have little interaction with others.

What Disorders are Commonly Associated with Self-Mutilation?

According to Favazza (as cited in Strong, 1998), the root of self-mutilation varies. Possible roots include childhood physical or sexual abuse, childhood illness or surgery, parental mental illness, parental alcohol or drug abuse, a negative body image, a need for perfectionism, or a serotonin imbalance in the brain.

The single most common precursor to self-mutilation is sexual abuse. At the same time, sexual abuse also commonly precedes borderline personality disorder, post-traumatic stress disorder, and other dissociative disorders. Incidentally, these disorders are the most commonly diagnosed for those who self-mutilate. Other common diagnoses of self-mutilation include anxiety disorders, mood disorders, and impulse-control disorders (Turner, 2002).

Borderline personality disorder

Today, the most frequently used diagnosis related to those who self-injure is borderline personality disorder (Strong, 1998). Self-mutilation is included in the criteria for borderline personality disorder, but is not exclusive to the disorder. In women,

borderline personality disorder is over-diagnosed. The personality disorder has become a catch all for diagnosing those who self-mutilate.

Very few clinical populations are as difficult to treat as borderline personality disorder as the disorder carries with it a stigma (Smith & Peck, 2004). When diagnosed with the disorder, it is difficult to move beyond it because it would require adapting one's personality. The disorder carries with it many ramifications as people who suffer from the disorder are lumped into the same category of the mentally ill in need of institutionalization.

Post-traumatic stress disorder

An alternative diagnosis that also seems to offer a suitable explanation for self-injurious symptoms is post-traumatic stress disorder. This diagnosis, as compared to borderline personality disorder, allows the individual to realize the possibility of healing and recovery. This is because there is no call for changing one's personality. Since abuse can have extremely distressing effects, it is important to find a connection to post-traumatic stress disorder. Three symptoms that are common in both self-mutilation and post-traumatic stress disorder are intrusive thoughts, avoidance, and dissociation.

Dissociative disorders

Prior to the 1960's, individuals who engaged in self-mutilative acts during a dissociated state were diagnosed with schizophrenia due to the bizarre nature of dissociating, which was thought to be hallucinating (Strong, 1998). Now, there are several disorders in which dissociation is a common symptom.

Dissociative disorders range on a continuum from depersonalization to dissociative identity disorder (Turner, 2002). These disorders are commonly linked to past trauma, and subsequently, self-mutilative behaviors. Dissociative symptoms are common in those suffering from post-traumatic stress disorder. Individuals who suffer from dissociation are able to separate their mind from their body in order to feel no pain. They are living in the moment and are brought back to reality either from the pain associated with the act or by the sight of blood. For some, the bleeding can be a form of crying. According to Turner, self-mutilators inadvertently learn how to instantly become numb during the act.

Many who self-mutilate have the ability to dissociate from the event (Strong, 1998). Their pain is anesthetized and they become an observer. During the dissociated state, the self-injurious behavior becomes relief from the overpowering anxiety and arousal. This relief, however, is only a temporary fix from the anxiety. Eventually, the anxiety mounts, requiring the individual to confront it once again.

Strong (1998) explained that it is common for people to dissociate at the time of a trauma. By detaching the mind and the body, these individuals are able to survive the trauma. However, this has devastating effects on both the mind and the body and is a common indicator of post-traumatic stress disorder. Van der Kolk (as cited in Strong, 1998) infers that the majority of traumatized adults and children are unable to remember what happened during the traumatic event. As a result, they reenact the trauma through self-mutilation or somatic complaints because they cannot verbally express what has happened to them. Reenacting the trauma is an attempt at self-healing. The victim of the trauma does so in order to make sense of the trauma.

Miller, a psychologist who has done extensive work with self-mutilating women, coined the term ‘trauma reenactment syndrome’ to classify women who repeatedly engage in self-mutilation in order to reenact traumatic experiences they have had in the past (Miller as cited in Strong, 1998). According to Miller, the reenactment is not a solution for the trauma and usually causes more suffering because it diverts the person from truly resolving the trauma. It is important for the person to deal with the trauma in order to cease the self-mutilative acts.

Self-mutilation relieves the overwhelming angst and agitation and the numbness felt within. Oftentimes, those who self-mutilate report feeling little or no pain associated with the act. This continues to perplex medical professionals today. Although there are no definite answers to why this is, there are several different theories about the body’s response to the mutilative acts (Strong, 1998). One theory is that a reminder of the traumatic event triggers the endorphin release of natural opiates. This release provides the analgesic effect that allows the self-mutilator to wound the body. These findings concur with other experiments conducted on animals that found the same natural painkillers released after reminders of trauma. Another study found that individuals become conditioned to the stress that releases the opiates, causing the numbing. This conditioning is similar to an addiction because the self-mutilator experiences opiate withdrawal and cravings when the stress or trauma is deficient. This creates a vicious cycle where the withdrawal is manifested by anxiety, aiding the body in releasing more natural opiates.

Anxiety disorders

Anxiety disorders are commonly linked to self-mutilation due to the fact that anxious feelings are one of the primary feelings experienced for self-mutilators prior to

inflicting harm upon themselves. Many disorders fit in this category including post-traumatic stress disorder, generalized anxiety disorder, and obsessive-compulsive disorder. People who suffer from anxiety use self-mutilation as a way to deescalate from excessive worrying (Turner, 2002).

Mood disorders

The primary mood disorders related to self-mutilation are depression and bipolar disorder. Many self-mutilators who suffer from mood disorders go unnoticed because they do not appear to be depressed (Turner, 2002). Oftentimes, the individual does not even know that they are depressed. The self-mutilating behavior often masks the depression because the physical pain creates a physiological high, concealing any emotional pain that may be present. Depression inventories even appear to be within normal limits as most are focused on self-report.

Impulse-control disorders

Self-mutilators are commonly referred to as highly impulsive (Turner, 2002). These individuals have a difficulty resisting the temptation to harm themselves as they are only thinking of the temporary relief that will result. Behaviors like these are categorized as impulse-control disorders. Trichotillomania is one such disorder that is highly impulsive, resulting in pain and a noticeable loss of hair.

What Comorbid Disorders Make Treatment Difficult?

Oftentimes, individuals who self-mutilate also partake in other self-destructive behaviors such as eating disorders and substance abuse. At times, it is difficult to distinguish whether the self-mutilative acts precede the disorder or if it is a result of the

comorbid disorder. Similarly, people in recovery from self-mutilation often use these self-destructive behaviors to replace the self-mutilative behaviors (Turner, 2002).

Eating disorders

The issue of control often associated with self-mutilation sometimes takes the form of an eating disorder (Zila & Kiselica, 2001). Both self-mutilating behavior and eating disorders have similar origins: at least one past trauma, such as abuse; a need for perfectionism; a preoccupation with the body; a distorted body image; self-directed aggression; and self-destructive behavior. The two also share some of the same functions such as managing post-traumatic symptoms, relieving overwhelming feelings, and creating the experience of a physiological high (Turner, 2002). Sometimes the two coexist in an individual and other times one behavior replaces the other.

According to Strong (1998), thirty-five to eighty percent of those who self-mutilate also endure a comorbid eating disorder. Turner (2002) suggests similar findings where forty-one percent of bulimics and thirty-five percent of anorexics participate in self-mutilative acts. As statistics show, bulimia is particularly prevalent among self-mutilators. In a sense, both behaviors are an attack on the body. According to Turner (2002), self-mutilation and eating disorders coexist so frequently that self-mutilation should be included as an associated feature under eating disorders in the Diagnostic and Statistical Manual of Mental Disorders IV-TR.

Oftentimes, everything is dichotomous to those who suffer from eating disorders and also self-mutilation (Strong, 1998). The individuals have a hard time seeing any gray areas between black and white. Those who suffer from both disorders also tend to be perfectionists and feel like they are never good enough. In the United States, both eating

disorders and self-mutilation are more common in women because society tends to judge females by their beauty, where men are judged by their strength and ability.

Substance abuse

There is a disagreement between researchers on how substance abuse and self-mutilation are related. Some believe that substance abuse is a major predisposing factor to self-mutilation, while others believe that substance abuse is just another form of self-mutilation. Being under the influence of alcohol or drugs may trigger self-mutilative behaviors due to impaired judgment, reduced pain awareness and fantasy stimulation (Zila & Kiselica, 2001).

What Therapeutic Treatments have Proven to be Successful Regarding Acts of Self-Mutilation?

There are several avenues to recovery a self-mutilator can take. For some, they are able to cease the injurious behaviors on their own. Others may move beyond the behavior after it has served a specific purpose. For others, self-mutilation concludes when they begin to utilize therapy to verbalize. Yet for some, it is much more complex and they have a more difficult time abstaining.

Treatment strategies vary significantly for each self-mutilator. There is no "cookie-cutter" treatment simply because each case is unique and the roots vary. If self-mutilation fit into a category or diagnosis, it would be much easier to treat. According to research, there is very little agreement about what works and what does not. The limited empirical information on self-mutilation can deter its proper treatment. Therefore, it is

one of the most difficult groups to treat in both inpatient and outpatient settings (Fowler et al., 2000).

Compassionate counseling is imperative when working with self-mutilators. The self-mutilators must know that the therapist understands and is there to help. A good therapeutic relationship must be established before intensive therapy begins. Many helping professionals have not received appropriate training in the treatment self-mutilative clients (White et al., 2002). Oftentimes, clinicians find it hard to understand the behavior of their clients, much like professionals did twenty to thirty years ago with the rise of eating disorders (Turner, 2002). In the past, self-mutilators have been met with disgust by doctors who do not understand their actions and find their behavior offensive (Edwards, 1998). Therapists have also misunderstood the sufferers, immediately labeling them with a disorder or labeling them suicidal. Others dismiss the self-injurers, claiming that they only want attention from their actions. Turner (2002) states that the key is to respond to the self-mutilator, rather than react to the behavior. Helping professionals must work to become desensitized to the "blood-and-guts" element of the disorder. Because individuals who self-mutilate know the harsh and unsympathetic reaction they receive from others, they sometimes admit to suicide attempts to be treated with more dignity. Because of the various causes of self-mutilation and numerous acts, there is not a consensus on how to treat it.

The major disagreement among helping professionals is whether an individual should abstain from the self-mutilating behavior before beginning treatment. Some argue that asking the self-mutilator to refrain from self-harm takes away their most effective coping mechanism (Strong, 1998). White et al. (2002) agree that attempts to force self-

mutilators to quit should be avoided in order to evade a power struggle. Asking individuals to stop takes away the control that they have over their body, something that is crucial to most self-mutilators. Others argue that it is essential that individuals refrain from self-harm for their own safety.

Another area of discord is related to the focus of the treatment. Therapists from theoretical orientations, such as cognitive-behavioral therapy, state that looking into the past may stir up the traumatic experience, creating an increase in self-mutilative behaviors. Psychoanalysts believe that focusing only on the present is treating the symptom rather than the disorder.

Himber (1994) suggests looking for the underlying issues and asking details about the acts of self-mutilation. Others recommend screening for symptoms of disorders, such as eating disorders, and also inquiring about sexual assault (Zila & Kiselica, 2001). Clarke et al. (2001) advise that the self-mutilators receive psychiatric evaluation and that the treatment be a collaborative effort between the physicians and therapists. Furthermore, it is important for the therapist to have regular supervision and a good working relationship with physicians and inpatient units (Himber 1994).

Before beginning any type of treatment, a helping professional should be sure that the self-mutilator is taking responsibility for their behavior (Himber, 1994). If they do not want to stop the self-injurious behaviors, treatment will not be successful. Similarly, if they place the blame on someone else, counseling techniques will surely fail. Verbalizing emotions is virtually impossible for the self-mutilator. The next priority when beginning to work with a client who is self-mutilating should be to help them find words – rather than destructive behavior – as an expression of emotion. Additionally, crying is an

inadequate way to cope with issues. A therapist needs to help them talk about their patterns of behavior and encourage verbal expression of feelings.

Cognitive therapy

Cognitive therapy has shown positive results in that it shows self-mutilators the connection between their thoughts and their actions (Zila & Kiselica, 2001). Self-harm is a learned behavior that is motivated by self-destructive thoughts and beliefs (Strong, 1998). It is imperative to help the individual unlearn the behaviors and replace them with healthier coping skills. The therapeutic aim should be to help individuals develop alternative ways of coping and gain a better understanding of themselves. Along with the cognitive therapy, Crowe and Bunclark (2000) believe that the self-mutilator should find alternative ways to express their emotions such as creative writing, drama, or art. Other alternative means of expression include: talking about feelings or painting feelings; postponing the behavior by going for a walk or calling a friend; making it difficult to self-mutilate by getting rid of sharp objects; and listening to prerecorded tapes of themselves telling them not to self-mutilate. Not all alternatives will work in every situation, but researchers have found that by delaying the acts, there is less probability that they will occur as frequently.

Dialectical behavior therapy

Another cognitive-behavioral approach that shows a promising result, especially in those with borderline personality disorder, is dialectical behavior therapy (Smith & Peck, 2004). Initially, this therapeutic approach was designed for women who engage in self-mutilation. Now, it is frequently used with both men and women who self-mutilate.

The dialectical behavior therapy provides a distinct combination of interventions that enables acceptance and change. This therapy targets problems, looks for alternatives, and teaches solutions. Dialectical behavior therapy is made up of several stages of treatment. Although it is structured, there is room for the therapist to be creative in their approach. This approach is very effective if completed. In order for the treatment to work, the individual needs to commit to a full year of therapy. Some of the downfalls of the therapy include the complication of implementation and the lengthiness of the treatment.

Behavior modification therapy

Behavior modification has also been used to help self-mutilators modify their behaviors, although it has been difficult to find an alternative form of tension relief. This treatment seems to be especially helpful in acute cases of self-mutilation (Strong, 1998). One suggestion, cited in Zila and Kiselica (2001), is to mimic the effects of self-mutilation without physical harm by immersing a body part into ice water. Most research shows that cathartic methods, such as hitting a pillow, are ineffective in that they reinforce that violence is an acceptable form of expression (Conterio & Lader, 1998).

Art therapy

For some therapists, art therapy has proved to be very effective when working with self-mutilating adolescents. Therapists who utilize this technique see the art as a metaphor of the skin and the art creates a protective layer. Art is a way for the self-mutilator to release feelings without harming their bodies. Milia (1998) practiced art therapy with an adolescent female and witnessed the female's reenactment of self-mutilation while using clay by layering, cutting, smoothing over and relayering the clay.

Milia also observed the girl mutilating self-representations and her tension appeared to be relieved. Throughout therapy, Milia saw recurrent themes that she believed were the female's process of recovery.

Art therapy seems to be a small step in the right direction because the self-mutilator is not forced to discuss the strong emotions immediately. Expression through artwork is the initial step and later the client and therapist can discuss what occurred in the art therapy session.

Group therapy

According to Wood et al. (2001), the results of group therapy are also promising in reducing self-mutilation in adolescents. Individuals who had sessions of group therapy had a better outcome than individuals who did not participate in group therapy. In addition, alternative forms of treatment include awareness training, modeling, assertiveness training, and reinforcing acceptable ways of expressing negative feelings.

Group therapy can also be helpful in breaking down the barriers of shame, isolation, and secrecy (Strong, 1998). In some instances, peer pressure from other group members can be quite therapeutic. Groups that have an array of individuals with diverse issues tend to be more dynamic and enhance the therapeutic quality (Turner, 2002). Alternatively, self-mutilation can also express isolation and affiliation. As a result, it may start an injurious contagion (Strong, 1998). For example, adolescents who have no history of self-injurious behaviors may begin to do so when beginning a therapeutic group. This may be completed as an attempt to fit in with others in the group.

Turner (2002) outlines a twelve step group, similar to Alcoholics Anonymous, for individuals who self-mutilate. In her work, she discusses feelings of emptiness that are

experienced by self-mutilators. These individuals tend to have a convoluted idea of God or another higher power, as a result of negative experiences in childhood.

Psychotropic medication

Favazza (as cited in Turner, 2002) states that treatment is particularly challenging for those who self-mutilate repetitively. Since the 1990's, more research is being done and new medications are available to counteract the self-mutilative behaviors.

Serotonin, a neurotransmitter in the brain, is a key component in controlling mood and aggression. According to Strong (1998), self-mutilators have less serotonin activity than the average person. This is also the case for other conditions such as depression, anxiety, obsessive-compulsive disorders, eating disorders, and some personality disorders. Selective serotonin reuptake inhibitors, like Zoloft, are a class of antidepressants that have been found to increase serotonin levels in the brain, thus decreasing self-mutilation in some individuals. This family of medications appears to be very effective in alleviating impulsive and compulsive behaviors, which are prevalent in self-mutilators. Conversely, selective serotonin reuptake inhibitors are not helpful for biologically based disorders like Tourette's syndrome or Lesch-Nyhan's syndrome.

Other psychotropic medications have been found to be especially useful in treating cases of acute self-injurious behaviors. Haldol and Thorazine, both anitpychotics, have been sufficient in decreasing symptoms of self-mutilation. Similarly, Naltrexone, a narcotic antagonist, has proven effective in blocking the release of natural opiates. Tegretol, an anti-seizure medication, has also demonstrated its effectiveness in a study summarized by Strong (1998). Although high anxiety is a common symptom for many

self-injurers, some anti-anxiety medications showed an increase in self-injurious behaviors for some individuals.

Stress hormones such as dopamine, adrenaline, and norepinephrine also play a significant role in physiological aspects of self-mutilation. It is proposed by Favazza that these hormones may activate the hyperarousal that leads individuals to self-injure (as cited in Strong, 1998). When these hormones are automatically released during traumatic flashbacks and nightmares, the trauma seems to be further engrained.

Eye movement desensitization reprocessing

Certain therapeutic techniques have been found especially helpful in treating those individuals with extreme trauma in their past. It may be important for those who dissociate to focus on the present, rather than reverting back to past experiences (Strong, 1998). Some helpful strategies to use include relaxation and eye movement desensitization reprocessing (EMDR). EMDR assists the client in processing traumatic memories that have not been processed before. This is done by stimulating the brain to reprocess thoughts without having to verbalize or recall the traumatic events from the past.

Strong's treatment approach

According to Strong (1998), the best blend of treatment includes psychotropic medication combined with cognitive-behavioral therapy. However, helping professionals need to remember that techniques that work with one client may not necessarily work with the next. Underlying issues make up a large part of the self-mutilating behavior and direct what type of treatment is necessary for the particular case. Conterio and Lader

(1998) explain that self-mutilation needs to be treated as a choice, not a disease. The self-injury is secondary. A therapist needs to look and the underlying issues that are causing the mutilative behaviors.

Individuals who self-mutilate are helped most by being taught how to express their feelings as a form of tension relief rather that to disfigure their bodies. This can be a slow process but inevitably the individual has to take the responsibility for their actions and want to change their behaviors.

It is critical for the self-mutilator to find healthy coping mechanisms to replace the self-destructive behaviors. As with other habit-forming behaviors, self-mutilators may turn to other self-destructive behaviors such as alcohol and drug abuse, eating disorders, and sex addictions in order to alleviate feelings of tension and anxiety.

Therapy should be used to help the individual build self-esteem and break down negative feelings and self-destructive ways of thinking (Turner, 2002). First, it is essential that the self-mutilator learn to have a healthy relationship with themself. Then the self-mutilator can begin to form healthy relationships with others.

In recovery, self-mutilators must learn to cope with the distressful experiences that they once rid themselves of by self-injurious behaviors (Turner, 2002). They must endure the distress in order to learn to manage the feelings rather than self-mutilate. The self-mutilator may experience symptoms of withdrawal, including depression, anxiety, fatigue, and insomnia.

Involving the family as a support system can also be very effective. The family members can work together to hold the self-injurer accountable for their actions. In

addition, the family can monitor the injurer's behavior and report back to the helping professionals involved.

Although the display of unsuccessful counseling techniques seems overwhelming, counselors are becoming more aware of what works and what does not with the self-mutilating population. Examples of ineffective treatments, as cited in Zila and Kiselica (2001), are physical restraints, hypnosis, chemotherapy, no-cutting contracts, faith healing, group psychotherapy, relaxation therapy, electroconvulsive therapy, family therapy, educational therapy and chiropractic work.

Helping professionals need to keep in mind that with any treatment option, miracles will not occur overnight. At times, therapists may feel pessimistic and helpless when working with self-mutilators (Turner, 2002). Therapists need to remember that relapse is part of the healing process. If underlying issues are left unresolved, the possibility of relapse is extremely likely. Under unusual stress, self-mutilators may not know how to manage their feelings and may revert to their old ways of coping. In that instance, the therapist needs to help the client get back on track. The therapist and client would benefit from having a strategy if relapse does occur.

Oftentimes, a struggle surfaces between the client and the therapist, which leaves the client feeling misunderstood and the therapist feeling ineffective and overwhelmed (Conterio & Lader, 1998). Again, the therapist needs to be aware of such struggles and compensate.

Conclusion

As research shows, self-mutilating behavior is a prevalent problem in our society with no indication that it is lessening. It is an immense problem, especially for females,

today and a growing problem for males. Many circumstances add to the complexity of the behavior including the purpose it serves for individuals, the precursors that lead up to the behavior, common disorders that make treatment difficult, and successful treatment strategies. Society needs to teach its members more mature coping skills to help them deal with their emotions. There are many causes, numerous underlying issues and no "cookie-cutter" method for intervention. This creates a dilemma for therapists; but it also compels them to treat each case uniquely and to understand each particular client's situation.

It is clear that additional research is needed. Unfortunately, self-mutilation is a cluster of behaviors masked in secrecy and filled with contradictions, making intervention complicated. Society is becoming more aware of this problem and self-mutilative behavior is finally getting the attention it deserves and has needed for so many years. Individuals are now beginning to get the support and treatment needed for their behaviors.

CHAPTER THREE: DISCUSSION

Introduction

This chapter presents a summary of the information obtained in the literature review. A critical analysis is included regarding the purposes that self-mutilation serves, common precursors of the behavior, commonly associated disorders, and successful therapeutic approaches to helping those who self-mutilate. Last, the chapter offers recommendations to those in the helping profession who work with self-mutilators.

Summary

In the past two decades, self-mutilation has increased dramatically. Since the 1990's, more attention has been drawn to the issue of self-mutilation, especially in adolescents because it is so prevalent in our society. In fact, self-mutilation may be the fastest growing problem for teenagers today. Self-mutilation is more common in adolescents and young adults than society believes because acts of self-mutilation are often underreported or misdiagnosed (Strong, 1998). There has been extensive research conducted on the behavior, as well as what therapists and other professionals can do to help.

Due to the complexity, self-injurious behaviors are not completely understood. Furthermore, self-mutilation is a hidden disorder and it is difficult to determine how many people partake in the behavior. Studies show that the incidence of the act among adolescents and young adults is approximately 1,800 per 100,000 (Suyemoto & MacDonald, 1995). Self-mutilation seems to be less common in the general population of the United States with only four percent reporting the behavior in the last six months and

less than one percent admitting to frequent self-mutilation (Briere & Gil, 1998). The incidence is significantly higher in the clinical population with twenty-one percent of clients reporting that they rely on self-mutilation as a way to cope.

Acts of self-mutilation had received attention prior to the 1980's but was most often associated with other disorders. It was most often connected to borderline personality disorder but is also present with other diagnoses, such as autism, schizophrenia, obsessive-compulsive disorders, post-traumatic stress disorder, depression, substance abuse, trichotillomania, eating disorders and other personality disorders (Suyemoto & MacDonald, 1995).

Due to the increased attention and prevalence of the behavior in the 1990's, self-mutilation has become known as the 'addiction of the 90's' (Strong, 1998). Although self-mutilation is referred to as an addiction and has many addict-like qualities, most therapists prefer to call it a habit.

The work on self-mutilation began in 1938 with Menninger's groundbreaking book, *Man Against Himself*. This was the first piece of literature to make a distinction between self-mutilation and suicide. Favazza's work clarified that suicide was a means to end all feelings while self-mutilation was used to make one's self feel better (Strong, 1998). Clearly, these two deliberate acts are not one in the same. Self-mutilation and suicidal behavior are different in several ways.

In order to better understand self-mutilation, Favazza and his colleagues classified self-mutilative behavior into three categories: major, stereotypic and superficial or moderate (Favazza as cited in Strong, 1998). The self-mutilative behaviors are

categorized by the severity of the self-injurious behavior and the rationale behind the behavior.

For many, it is hard to understand why someone would intentionally hurt themself. Self-harm has an immense meaning for those who do it. Most individuals cut themselves for more than one reason. In her research, Himber (1994) found nine major reasons for self-mutilation: induction of a pleasurable state, tension release, affect modulation, discharge of anger, communication, expiation, self-purification, self-punishment, and enhancement of self-esteem.

The most frequently cited function of self-mutilating behavior is affect regulation. It reduces anxiety, depression, tension, loneliness, feelings of emptiness, guilt, and dissociation (Haines & Williams, 1997). Other possible causes for self-mutilation include ritual and symbolism, sex, regression, existential statement, manipulation, risk taking, attention-seeking, retaliation, frustration, depression, tension relief, inappropriate communication, sexual gratification, self-punishment, and low self-esteem.

Many researchers speculate that shame, guilt, self-hatred, self-blame, and self-punishment are common precursors to self-mutilation. Others believe that the behavior stems from shame associated with past sexual abuse. According to Favazza (as cited in Strong, 1998), possible roots of self-mutilation include childhood physical or sexual abuse, childhood illness or surgery, parental mental illness, parental alcohol or drug abuse, a negative body image, a need for perfectionism, or a serotonin imbalance in the brain.

Often times, self-mutilation goes unnoticed as it is hidden beneath other disorders that take precedence over self-injurious behaviors. Commonly associated diagnoses

include borderline personality disorder, post-traumatic stress disorder, dissociative disorders, anxiety disorders, mood disorders, and impulse-control disorders (Turner, 2002).

Treatment strategies vary significantly for each self-mutilator. There is no "cookie-cutter" treatment, simply because each case is unique and the roots are so different. If self-mutilation fit into a category or diagnosis, it would be much easier to treat. According to various sources, it has been found that compassionate counseling, cognitive-behavioral approaches, creativity, group therapy, and medications can all be used to successfully treat self-mutilation.

Critical Analysis

There are several research questions that this study attempts to address. The following is a critical analysis of the original research questions.

1. What purposes do acts of self-mutilation serve for individuals?

The various sources that were referenced indicate that self-mutilation serves a purpose for those who engage in the behavior. Most reasons are related to an inability to cope with or express feelings. Although most individuals cut themselves for more than one reason, research shows that the most frequently cited purpose for self-mutilation is affect regulation. The behavior is used in order to decrease inner turmoil and pain or to escape from feelings of hopelessness and numbness. Engaging in self-mutilating behaviors allows the individual to deescalate quickly and subsequently feel relaxed. During these self-destructive experiences, there are physiological changes that take place within the body. The body releases endorphins in response to the pain that creates a

natural “high” for the self-mutilator. This experience may become habit forming for the individual thus leading to future episodes of self-mutilation.

For some, self-mutilation also serves a purpose through ritual and symbolism. This phenomenon has been taking place since the beginning of time. Individuals take part in self-injurious behaviors in order to connect with others or to be socially acceptable. The skin can also be utilized as a symbolic form of healing, both outside and in. Furthermore, the scars can be a visual reminder of past experiences.

2. What are common precursors to self-mutilation?

This literature review found that often times the critic of the self-mutilator comes from within the individual. They learn this coping mechanism as a result of being a part of dysfunctional life situations. Studies show that these experiences may include sexual abuse, physical abuse, alcohol or drug issues, relationship difficulties, a significant loss in childhood, or a traumatic experience in childhood. Common characteristics that ensue include guilt, shame, self-hatred, self-blame, self-punishment, low self-esteem, a need for perfectionism, and dissatisfaction with their body.

Physical and sexual abuse endured throughout childhood results in fifty to sixty percent of the reported cases of self-mutilation. Although it is not a necessary precursor, it is all too common to immediately rule out. Individuals may use self-mutilation to disfigure their bodies in order to push perpetrators away.

3. What disorders are commonly associated with self-mutilation?

Commonly diagnosed disorders associated with self-mutilative behaviors include borderline personality disorder, post-traumatic stress disorder, dissociative disorders, anxiety disorders, mood disorders, and impulse-control disorders. The most commonly

diagnosed of these disorders in relation to self-mutilators is borderline personality disorder, post-traumatic stress disorder, and dissociative disorders. Sometimes the treatment of the self-injurious behaviors becomes more difficult due to these associated disorders.

Oftentimes, self-mutilators also engage in other co-occurring behaviors that make treatment difficult. Such behaviors include eating disorders and substance abuse. These behaviors are complex, and at times, it is difficult to distinguish whether self-mutilation comes first or if the behavior is a result of the comorbid disorder.

4. What types of therapeutic treatment are successful regarding acts of self-mutilation?

Treatment strategies vary among individuals. There is no “cookie-cutter” treatment due to the varying underlying issues that make each self-mutilator unique. For this reason, there is very little agreement among helping professionals about what is successful and what is not. In addition, there is disagreement over whether a self-mutilator should abstain from self-mutilation before beginning therapy. Some helping professionals find it essential in order for therapy to be effective while others believe it is taking away their only known coping mechanism. In addition, the limited empirical information available deters its proper treatment. Despite the lack of unity among helping professionals and limited empirical evidence, some treatments have been successful with self-mutilators.

A major downfall that helping professionals come across, when working with individuals who self-injure, is a lack of education regarding the self-injurious behaviors. For many, it is difficult to empathize with a person who engages in self-destruction.

Helping professionals do agree however that a thorough assessment is necessary to identify underlying issues that precede or exacerbate the self-mutilating behaviors. Also, it is agreed upon that the self-mutilator must take responsibility for their actions in order to be successful.

Therapeutic treatments that have shown to be successful in regards to self-mutilation include cognitive-behavioral therapy, dialectical behavior therapy, behavior modification, art therapy, group therapy, 12-step groups, psychotropic medications, and eye movement desensitization reprocessing.

Along with the variety of treatments, the helping professional must assist the self-mutilator in expressing their emotions as a form of tension relief rather than using self-destruction. This is a difficult, but imperative task in ending the cycle of self-mutilation. Helping the self-mutilator to express feelings is a small part in alleviating the dangers of the behavior. Although there is no one successful therapy, it has been proven that any form of therapeutic intervention is more successful than none.

Limitations of the Study

While there is much general literature regarding self-mutilation, there is minimal statistical information available. Another limitation of the study is that those who self-mutilate do not report their actions, or their actions may be misdiagnosed by helping professionals, thus skewing the prevalence of the behavior.

Recommendations

In order to assist helping professionals in working with individuals who self-mutilate, the following recommendations are made as a result of the literature review and critique.

1. It is recommended that helpers be understanding and knowledgeable about self-mutilating behaviors.
2. It is recommended that counselor education should provide more training related to the treatment of self-mutilative behaviors.
3. It is recommended that early intervention be employed with self-mutilating clients.
4. It is recommended that abstinence from self-harm be practiced in order to be successful in recovery.
5. It is recommended that a variety of treatment strategies be employed with self-mutilators.
6. It is recommended that more research be conducted on the precursors of self-mutilation.
7. It is recommended that more research be performed related to the recovery from self-mutilating behaviors.
8. It is recommended that long-term studies be conducted on the maintenance of recovery from self-mutilating behaviors.
9. It is recommended that self-mutilation be considered a disorder in itself, being coded as a mental health disorder in the Diagnostic and Statistical Manual of Mental Disorders IV-TR.

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