



# Healing Self-Injury

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## SIV: TREATING VERSUS HEALING

### From *The Cutting Edge*

“Recovering from SIV” -- usually the next phrase after this topic header is “how to stop self-injury” without further thought. However, it is crucial that the terminology and definitions commonly used be explored.

- What is recovery?
- What is healing?
- How can these words be quantified, and who is to determine their meanings?
- Is recovery defined by the absence of active SIV?
- How long should someone live without SIV before they are considered healed?
- Are these the measures that seem appropriate or important?
- To whom are these measures important?

People living with SIV have many concurrent struggles. SIV does not occur in a vacuum. There are several perspectives to consider when thinking descriptively about individuals living with SIV. The most popular is the medical – psychiatric – model in which the person is seen through the filter of mental illness and its many labels. It is not unusual for those who have a history of trauma, and who are living with SIV, to be given many if not most of the following diagnoses:

- mood disorders (depression and bipolar, also known as manic-depression),
- anxiety disorder,
- panic disorder,
- one of several personality disorders
- usually borderline personality disorder, but possibly also
- narcissistic
- schizotypal or
- histrionic personality disorders
- obsessive-compulsive disorder,
- psychotic disorder (usually brief psychotic episodes)
- body dysmorphic disorder



- some type of eating disorder
- chemical abuse or dependency (this can include alcohol, nicotine, and caffeine).

On occasion s/he may also be given the label of post traumatic stress disorder, which is not as commonly appreciated by biopsychiatrists as it is by clinicians educated in trauma dynamics. Even more rarely s/he may be diagnosed with one of the dissociative disorders (particularly dissociative disorder not otherwise specified (DDNOS), or dissociative identity disorder (DID), formerly known as multiple personality disorder (MPD)) which are also trauma-based. Although treatment varies according to diagnosis for most problems, it is interesting to observe how SIV is addressed regardless of the label one receives.

A quick look through mental health literature that mentions SIV indicates that the crucial focus is on the stopping of self-injurious actions. SIV is seen as a highly problematic behavior and a symptom of serious mental illness. The goal of the various treatments mentioned is the cessation of the behavior. The research defines a positive outcome as the decreasing or elimination of SIV from the life of the person being studied. This is true whether the SIV is believed to be purely biological versus trauma-based, versus the consequence of a personality disorder. There is some disagreement about what causes self-injury, but little argument about what should be done about it – it should be stopped. Therefore, treatments for SIV are focused on those that are most successful for quickly and fully eliminating it.

There are many treatments that effectively stop SIV. Most of these methods continue to be the primary choices that mental health practitioners turn to when faced with a patient or client who self-injures. Drugs are the most common treatment recommendation, and can be from almost any psychotropic category although the use of minor tranquilizers (Valium and Valium-related drugs) has been discouraged by most practitioners. This means that the drugs could be any, and possibly many, of the following:

- antidepressants (the newer and very popular selective serotonin reuptake inhibitors {SSRI's} such as Prozac; the older monoamine oxidase inhibitors {MAOI's}, as well as others),
- antipsychotics (both the older,
  - o “typical” antipsychotics such as Haldol and Stelazine, and
  - o the new “atypical” drugs such as Risperdol and Clozaril),
- naltrexone (such as Revia),
- anticonvulsants (such as Depakote), and
- lithium.

Some of these drugs have well-known and dangerous consequences; others are presented as not very harmful (though this is highly argued by researchers who are not supported by

the pharmaceutical industry). Drugs can be suggested as the only treatment method, or can be part of a varied approach to managing SIV. Dosage recommendations vary, as do the effects of the chemicals. They are sometimes reported as helpful, but, not surprisingly, are often reported to serve more as chemical restraints rather than healing agents. The duration of treatment with these drugs is generally expected to be long term. Some psychiatrists are now suggesting that they might need to be used prophylactically for life.

A mental health practitioner who is very threatened by the presence of SIV can turn to the use of force to deal with the self-injury as well as their own discomfort. It is not uncommon for those who self-injure (especially women) to be forcibly hospitalized “for their own good.” If SIV should occur during hospitalization, then the woman might also be physically restrained (by other persons as well as straps) and secluded (seclusion rooms are padded cells). She may also be medicated against her will. This may or may not be related to a belief that the SIV is actually a suicide attempt. Although the vast majority of self-injury is not seriously injurious, much less potentially lethal, a woman living with SIV may be mistaken for a very incompetent suicidal person. (It is not uncommon for people living with SIV to want to die sometimes as well -- as a matter of fact, the SIV is often a means of ameliorating suicidal urges). One psychiatrist described his treatment for SIV as consisting of 24 hour supervision while keeping the woman an inpatient on a psychiatric unit, as well as the use of leather gloves to eliminate SIV. This type of treatment is coercive and disempowering, often retraumatizing, and serves the needs of the provider much more than the recipient of the services.

Therapeutic methods for treating people living with SIV include behavioral therapies which focus on thought management – cognitive control of emotions, “therapeutic contracting,” and conditioning strategies. The emphasis remains on eliminating the behavior and replacing it with alternative behaviors that are considered more acceptable. Contracting consists of a written contract between provider and client in which the client agrees not to hurt herself, to attempt a variety of substitute actions if she feels the urge to self-injure, and describes consequences if she does self-injure. It is not unusual for the consequence to be the termination of the therapy relationship, or agreement to hospitalization. On occasion a woman might also be effectively shamed into stopping SIV. If SIV is depicted as a weakness, or immature and highly manipulative behavior, the woman will feel ashamed about herself and her needs. That shame might be powerful enough to make her stop self-injuring, at least temporarily. Another method of effectively shaming someone into stopping SIV has been described by Armando Favazza, MD, (his book, *Bodies Under Siege*, was reviewed in Volume 6, Issue 23), the self-proclaimed “father of self-mutilation,” who has written about analytically interpreting self-injury as something that would revolt the patient, in essence encouraging the patient to disgust herself into stopping. The example he used was interpreting the SIV as a form of masturbation (there are psychoanalysts who actually believe that the wounds from cutting

represent vaginas). The woman's strong and negative reaction to his interpretation was to be used against her, basically stating that the louder she protested against the interpretation, the more it applied. This example is a clear depiction of the extremes a clinician might go to to get the desired result of stopping SIV. Other extreme methods include the use of negative stimuli to condition the client to stop self-injuring. These methods are most often used with persons who are mentally retarded (who have very little choice about how they are treated in institutional settings). Some forms of punishment discussed in the literature include time-outs and electric shocks. Certainly these are highly coercive tactics geared to stopping the SIV regardless of the methods necessary to do so, and without much understanding about the purpose it serves. If stopping SIV is the only goal, then the ends will always seem to justify the means. What happens to women who receive these types of treatments? Oftentimes, they eventually rebel against coercive, restrictive, and/or punitive methods and leave the system. Many women, when threatened with losing supports and resources because of their SIV, lie about it. A therapist may be otherwise helpful, but become adamant that therapy is contingent on stopping SIV. The client may then be forced to lie to keep her mostly beneficial relationship with the therapist. Unfortunately, doing so adds to the isolation and shame so common for most of us who have lived with SIV. For the professional, believing the lie results in a false sense of security about the methods used to stop SIV. Had I been a research subject during the time I was living with SIV and attempting to get help from the mental health system, I would have been a perfect example of a "success story." I sought out help from mental health professionals, aware of some of my trauma history and openly wanting to deal with my problems. Being honest about the SIV in my life, I was "treated" with commitment, restraint, seclusion, drugging, contracts, and shaming. On paper, all those techniques would appear to have been effective in curing me of SIV. In reality I was further traumatized by those I had turned to for help. I lied about the SIV and behaved "appropriately" as I awaited my discharge. I then left the mental health system behind and slowly began the process of healing, without further involvement in the system.

Practitioners who are educated and experienced in trauma based therapies are likely to be the most helpful clinicians for women living with SIV. Certainly trauma is the causative factor of SIV. SIV is a coping mechanism used to manage the sequelae of the trauma (the profoundly discomforting emotional states, dissociation, inability to communicate, . . .). Most of the recent focus on self-injury has focused on the existence of childhood sexual abuse as a precursor to SIV. While certainly a great number of persons living with SIV have experienced sexual abuse, it is crucial that the perspective not become too narrow. There are many forms of trauma. Childhood sexual abuse is the most commonly identified trauma linked to a later need for SIV. However, abuse experiences such as physical violence (experienced by oneself or witnessed occurring to others), emotional abuse, and neglect have a tremendous impact on a person. Sexual and other violence in adulthood is also prevalent. Trauma can also take the form of war experiences, long-term

invasive medical procedures, and extreme poverty. What is most important is that the impact of the trauma be acknowledged as the source of many of the various difficulties experienced by the person in later life. These problems, to the clinician aware of the impact of trauma, are logical outcomes of the survived experiences, and not simply a conglomeration of unrelated pathology.

Therapists who understand the holistic impact of trauma on a person can more easily understand the use of SIV as a coping tool to deal with trauma's aftereffects. Trauma survival has many aftereffects and these require the use of coping mechanisms. SIV is simply one coping mechanism in the midst of many. If it is kept in perspective, it can be understood and ultimately healed. Difficulties arise when therapists are particularly reactive to the need for SIV, and therefore lose their focus on the greater picture. Effective trauma therapy (and I believe all healing) is based on the principle of empowerment. Trauma, reduced to its essence, is the experience of powerlessness, regardless of whether the source is childhood abuse or a natural disaster. Coercion, no matter how "in one's best interest" it might seem, is disempowering, and a reenactment of the initial powerlessness. People need to grow into a newer sense of self, a self with greater awareness and choices. It is not helpful to mandate people into health. Simply replacing problematic behaviors with more socially acceptable ones does not touch the core issues in need of healing. Substitute behaviors may serve as a bridge between needing to self-injure and the healing of the traumatic roots. Replacing some coping methods with ones that "look better" may appear attractive, but is that truly healing? Taken to an extreme, a person with lists of "what to do if I feel like drinking, using drugs, cutting, working compulsively, having unsafe sex, going back to an abusive relationship, binge eating, starving, smoking, . . ." can be a prisoner to the solutions she's been given.

What is most important is the recognition of the depth of the impact of trauma on one's heart and spirit, and less focus on behavior that is seen as pathological. Most of the time SIV is healed by healing the reasons it became necessary in the first place. Effective therapy for the repercussions of trauma can take a long time and be expensive. Yet the process of change and empowerment cannot be rushed. Healing from SIV requires the development of a relationship with one's own strengths and abilities. This relationship is fostered by relationships with others who also recognize one's strength, and who not only abhor coercion, but celebrate personal wisdom and experience. There are therapists who are absolute gifts to those of us struggling with SIV, who encourage us to trust our own wisdom and survival strategies. These therapeutic relationships are partnerships that develop over time, and in which the dynamics of the relationship itself are the critical healing factor. Yet it is becoming increasingly difficult for even the middle class to be able to afford long-term therapy. Most insurance plans provide for short-term therapy and limit the choice of therapists to those on their plan. These providers may or may not understand trauma. Economically disadvantaged people have

even fewer resources.

Bigotry is a profound obstacle to openness about SIV. While it is seen as helpful to have recovering addicts work with people struggling with addiction, and women who have left violent relationships work with women who are currently being battered, nowhere can you find clinicians working with people who self-injure who are free to disclose their own histories of SIV. Labels of mental illness have a powerfully negative impact. Disclosing a history of SIV could cost a clinician her job. Coming out as a person who has used SIV to survive can cost many of us important relationships and opportunities. However, there is so much to gain from the simple and profound act of coming together to share a similar problem. Discovering that you are not alone with the secret and shame of SIV can be a life-changing experience, more important than any therapy tool available. While many of us see ourselves in a very negative light, we do not view other survivors the same way. If we come together, whether in person or on pages of newsletters such as this one, we can combat our own fears and self-hates by discovering the compassion and understanding we have for each other. This is an incredibly soothing balm to the spirit. Therefore, we need to consider one other perspective on healing from SIV that is rarely, if ever, mentioned. Women and men living with SIV are healing every day without walking through clinic or hospital doors. Many of us have discovered our personal truths about SIV and have found others who share our experiences and hopes. This newsletter is one example of a collective group moving into healing from SIV. The newsletter itself provides that which I sought after the most for myself – a space, free from the threat of coercive reaction, where I could explore my own SIV: the reasons for it, my reactions and feelings about it, and how I was healing my life. Learning that I was not alone, in my SIV or my perspectives about its functions, was a great boost to my hope that I could guide my own healing. In connecting with others, I learned to have compassion for my own struggles and needs, as I was able to see myself as one of a community of persons who deserved respect and admiration rather than shame.

Let us remember that there are many of us actively and passionately healing from painful histories who do not access the traditional systems of care to assist the process. We are not limited to professional opinions to guide our healing. We are collectively empowering ourselves as we connect with each other. In this way not only can we individually continue our healing journeys, but we can push for progress in our communities and society. The time has come for the strengths of survivors, including those who live with SIV, to be acknowledged.