



October 2003

## Understanding and Responding to Women Living with Self-Inflicted Violence

**T**he *Women, Co-Occurring Disorders and Violence Study* was created to generate knowledge on developing effective services for women trauma survivors and their children. This research project focused on the multiple issues faced by women survivors of violence and the struggles they shared, and on the development of services that were effective in facilitating recovery. One of the areas addressed in this project was a highly stigmatized behavior known as Self-Inflicted Violence (SIV).

### INTRODUCTION

SIV has also been referred to as self-mutilation, deliberate self-harm, self-injury, delicate wrist cutting, parasuicidal behavior, as well as other labels. SIV is a not uncommon behavior utilized by survivors of trauma, particularly those who have experienced childhood abuse of some sort (physical abuse, sexual abuse, emotional abuse, and/or neglect). Many of these people also struggle with substance abuse problems and other mental health concerns. Until recently the topic of SIV was restricted to discussion of the diagnosis of Borderline Personality Disorder (BPD). However, recent efforts to explore the sequelae of trauma have identified a strong connection between the survival of abuse and the occurrence of SIV. This correlation provides us with new insights as well as a direction for recovery.

SIV refers to specific forms of violence, such as hitting, cutting, burning, or punching, directed at one's own body. The intention behind this behavior is complex, primarily serving to restore homeostasis. Although physical injury may result, the majority of the injuries

~  
*...recent efforts to explore the sequelae of trauma have identified a strong connection between the survival of abuse and the occurrence of SIV.*  
~

caused by SIV are minimal. However, other people perceive the behavior as being very harmful, not necessarily because of the physical wounding, but as a reaction to the reality that the person herself is the source of the injury. When not comprehending the functions SIV serves, the observer is often left horrified and confused by the behavior.

It has long been presumed that the majority of people living with SIV are

women who are in their teenage years or young adulthood, most often white and middle class. This perception has come under scrutiny as the issue has been more openly discussed and pursued. It is now known that all sorts of persons live with SIV, including men and boys, people from all races and cultures, and from all economic classes. The most common denominator among all of these diverse people is the experience of psychic stress, a sort of "psycho-spiritual crisis," which most often has its roots in a history of childhood trauma. The aftereffects of such trauma are profound and lasting until they are addressed. Attempts to eliminate SIV without addressing its roots produce ineffective and often retraumatizing consequences.

Although there have been attempts to estimate the frequency of SIV, the actual figure remains unknown as the stigma of SIV is a powerful silencing factor. Many people who live with self-injury keep the behavior private. This need for secrecy stems from both personal shame and the desire to avoid unwanted interventions. Oftentimes, mental health service providers do not screen for the existence of SIV. Others overreact if a client discloses living with SIV, while some misinterpret SIV as suicidal. This latter misperception is a common one and produces an inappropriate over-reactive response that may discourage disclosure in the future.

Fortunately, both psychiatric providers and general medical professionals are starting to address this misconception.

## REASONS FOR SELF-INFLICTED VIOLENCE

SIV serves people for many reasons, and a person living with SIV may self-injure for one reason or many. Often different forms of SIV serve different purposes for the same person. While personal in nature, there are common reasons people living with SIV have for their particular self-injury.

### Affect Regulation

Trauma survivors struggle greatly to integrate their experiences conceptually as well as emotionally. Many survivors of childhood abuse live with profound grief, rage, shame, and terror. Even when trauma is historically removed, its impact remains. SIV is often utilized as a means of moderating intense affect, especially those emotions that are highly uncomfortable, which the person feels forbidden to experience or express. It is not unusual to hear a person say that the drops of blood from self-cutting serve to replace tears of grief and/or outrage that the person does not yet feel safe to express directly. In this regard, the emotional pain suffered is comparatively much greater than the physical pain caused by the wound. When such emotions consume a person, she is often numb to the physical pain caused by the self-injury at the time she injures herself.

*The stopped voice becomes a hand lifting knife, razor, broken glass to cut, burn, scrape, pop, gouge. The skin erupts in a mouth, tongueless, toothless. A voice drips out, liquid. A voice bubbles out, fluid and scabby. A voice sears itself for a moment, in flesh. This is a voice emerging on the skin, a mouth appearing on the skin. The body which could not be air on the larynx becomes the stroke of a razor on the breastbone or of a red-hot knife-tip upon the wrist.*

*Taken from Janice McLane's The Voice on the Skin: Self-Mutilation and Merleau-Ponty's Theory of Language, Hypatia, 11:4, Fall, 1996.*

SIV is often utilized to diminish an overwhelming sense of helplessness. Situations which bring out feelings of helplessness or hopelessness are often highly problematic for trauma survivors. The experience of helplessness is often the base trigger for flashbacks, intense emotions, and dissociative responses. SIV serves as a short-circuit of those states, and in that regard is experienced as an empowering choice for the survivor.

### Dissociation

Dissociation is a psychic disconnection from one's physical self, a very adaptive means of surviving extremely traumatic

~  
*It is not unusual  
to hear a person  
say that the drops  
of blood from  
self-cutting serve  
to replace tears  
of grief and/or  
outrage that the  
person does not  
yet feel safe to  
express directly.*  
~

experiences by finding a way to separate one's spirit from the physical experiencing of the trauma. As a result of dissociation, people who self-injure often feel no physical pain at the time that they actually hurt themselves; discomfort from the wounds comes later, after the body and mind are essentially more integrated.

Dissociation can be a very uncomfortable experience, and an unwanted one, in spite of its inherent function as a coping mechanism. People who are unable to manage dissociative experiences can engage in SIV as a way of grounding themselves in their bodies. For example,

scratching oneself to the point of drawing blood often reconnects the psychic self with the physical self, as the injury gives a woman a sense of her edges, of her physical boundary. The SIV helps the perception of the body to become a concrete rather than ethereal experience.

### Flashbacks/Re-Enactments

Flashbacks, unexpected reliving of past horrors, are not an uncommon experience for survivors of abuse and other forms of trauma. They can be triggered by circumstances, smells, sights, or anniversary dates that connect to the past experience, often overwhelming a person who feels she is reliving the difficult memory in the present moment. SIV serves as an outlet for stopping flashbacks, with the injury itself ending the sensations and grounding the woman in the present.

An abuse survivor struggling to heal from her history may depict her abuse trauma through re-enactments. This can serve as an attempt to process the experience as well as to make it known to another in a nonverbal way. Many survivors of childhood rape have been threatened to not speak out, and this sense of being threatened often remains long after the perpetrator has left. A child may also have been told that no one would believe her if she did speak out. Later, in an attempt to "speak" in some fashion, a woman may injure her breasts or genitals as a symbolic, or at times literal, representation of her historical experience.

### Expression

Some survivors turn to self-injury as a means of depicting and expressing the degree of emotional pain that they are in. While unable to express this pain directly, they turn to the wounds on their bodies to speak out their histories. SIV can also be used to physically signify one's survival, that is one's body has survived the trauma it experienced. Many survivors struggle greatly with feelings of self-blame and shame, and SIV can serve as a mechanism of self-punishment for them. A woman who is angry with herself might choose to punch herself as a means of self-punishment. In this regard, the SIV ends the experience of shame and fear of greater retribution.

## Averting Suicide and Other Directed Violence

People who grow up in violent situations may learn to handle their lives in violent ways. Some of these people become perpetrators, while others do not. People living with SIV are rarely violent with others. Turning to self-injury, directing the violence towards their own bodies rather than another person's, is an ethical choice some people living with SIV make in the attempt to avoid becoming a perpetrator.

Perhaps the most initially confusing aspect of SIV as a coping mechanism is its utilization as an outlet for suicidality. SIV is often chosen as an option that prevents suicide by diminishing the current state of despair the person is in. While mental health professionals oftentimes misinterpret self-injury as "parasuicidal," the cuts and bruises of SIV are not failed, pathetic, suicide attempts. They are, in actuality, after-effects of what is essentially a lifesaving action.

*Taking away the patient's protective mechanisms may not only increase the behavior and undermine the therapeutic relationship, but may actually be dangerous...*

*Barent Walsh, M.D., from Antisuicidal Effect of Self-Injury Calls for Tolerance, in Clinical Psychiatric News, July, 2001.*

## Multiple Personalities

Some people who have Dissociative Identity Disorder (formerly known as Multiple Personality Disorder) experience SIV. The creation of the personalities is an adaptation for survival of extreme trauma, and occurs in early childhood. To manage the whole array of trauma sequelae, SIV is practiced by one or more of the personalities for a whole range of coping needs. It may also serve as a way of communicating between personalities who may not be aware of each other's existence.

SIV serves many purposes, and manages a wide array of traumatic aftereffects. The type of SIV may vary with the purpose it serves. For example, a woman feeling outrage, who is unable to directly

express her anger, may strike her fists to her own face, while an experience of dissociation is managed by self-cutting of her arms. While those forms of self-injury are useful for managing their particular triggers, they are not replaceable with other forms of self-harm.

## TREATMENT

Traditional treatment responses to women living with SIV have been singularly focused on the elimination of the behavior, this goal being set with a sense of great urgency. Self-injuring persons in the mental health system are typically treated with interventions such as multiple psychotropic medications (at times against the patient's will) including the use of anti-psychotics, behavioral

*It is crucial that a woman direct her own healing process, and not be stigmatized, punished, or retraumatized for her choices.*

contracts, and restraint and seclusion. These forms of intervention are typically only effective in the short term, and often escalate the incidence of self-injury in the long term. Coercive interventions lead to further retraumatization and disempowerment and trauma survivors respond to such with an increased need to use the coping skills they already have, of which SIV is one.

A sound approach to the development of effective treatment for SIV is the contextualization of the client as a trauma survivor. With this perspective, SIV becomes an understood and acknowledged coping mechanism for the after-effects of trauma survival.

A person does not heal from needing SIV, nor from trauma itself, by attempts to eliminate the coping mechanisms which allow her to survive her history. Healing is a process of growth in which, by increasing understanding of the impact and repercussions of trauma, the survivor begins to expand her perspective and options for making choices. It is crucial that a woman direct her own healing process, and not be stigmatized, punished, or retraumatized for her choices. Rather than pathologize her coping choices, it is crucial to see them as creative, although limited, solutions for managing horrific experiences. As the aftereffects of trauma are addressed, the need for SIV diminishes. Interventions that facilitate recovery from trauma will provide the necessary ingredients for healing from SIV, as the need for SIV stems from unresolved experiences.

People may or may not wish to focus directly on SIV during the course of healing from their traumatic pasts. Those who are interested in direct interventions often find psychotherapy and the use of workbooks on the topic helpful in assisting them in identifying their particular form of SIV, as well as the needs that the behavior serves to manage. The person can then develop a wider range of choices to manage the triggers for her self-injury. She can substitute other behaviors while at the same time doing the deep emotional work that trauma therapy facilitates. It is imperative that the choice to create substitute behaviors be the client's, and not the clinician's choice.

*The first and most important goal is to encourage communication about self-injury as a relevant aspect of the client's life that has some relationship to her past and other issues of concern. Working consistently to achieve this goal allows the client to address the second and third goals when they are salient for the client. The second goal is to improve the quality of the client's life as it relates to self-injury. This might include reducing shame and isolation, receiving adequate medical attention to the self-injury when needed, and decreasing self-*

criticism for injuring. The third goal is to significantly diminish the use of self-injury as a coping skill...Only when the client desires to make changes regarding her behavior about self-injury should the second and third goals become central or even relevant to the therapy process.

*Robin E. Connors, from Self-Injury: Psychotherapy with People Who Engage in Self-Inflicted Violence. Copyright 2002 by Jason Aronson Inc. Northvale, NJ.*

SIV can be addressed directly or indirectly during the recovery process. It is imperative that the woman who is living with self-injury makes her own treatment decisions. Some women choose to actively address SIV as an important aspect of their lives, and seek

to change or moderate the behavior directly. Others do not consider actively working on SIV to be a priority. For them, SIV often diminishes and abates as the woman works on other aspects of trauma recovery, especially when she is able to process and begin to heal the deep and profound emotional and relational wounds caused by the experience of violence.

Integrated services for people with multiple vulnerabilities, services which acknowledge trauma as critical in both the assessment and treatment of clients, will further provide us with more extensive information on SIV as we begin to learn from the women themselves about the process of recovery. With each step forward towards understanding the complexity and impact of traumatic experiences, there is a greater hope for recovery and healing.

*Ruta Mazelis, BS, is the publisher/ editor of The Cutting Edge: A Newsletter for People Living with Self-Inflicted Violence, an international quarterly on the topic of self-injury, founded in 1990. The information for this fact sheet was compiled from Ms. Mazelis' extensive research on this topic and presentations she has developed on self-inflicted violence for a variety of audiences. Ms. Mazelis also has experience in both inpatient and outpatient mental health and substance abuse counseling, and serves as a consultant to various projects at local and federal levels. She can be reached at [Rutamaz@eohio.net](mailto:Rutamaz@eohio.net).*

---

## RESOURCES:

**Self-Injury: Psychotherapy with People Who Engage in Self-Inflicted Violence.** *Robin E. Connors, Ph.D. Copyright 2002. Jason Aronson Inc. Northvale, NJ.*

**The Scarred Soul: Understanding and Ending Self-Inflicted Violence.** *Tracy Alderman, Ph.D. Copyright 1997. New Harbinger Publications, Inc. Oakland, CA.*

**Women Living with Self-Injury.** *Jane Wegscheider Hyman. Copyright 1999. Temple University Press, Philadelphia, PA.*

**Understanding Self-Injury: A Workbook for Adults.** *Kristy Trautmann and Robin Connors. Copyright 1994. Pittsburgh Action Against Rape, Pittsburgh, PA.*

**The Cutting Edge: A Newsletter for People Living with Self-Inflicted Violence.** *Sidran Institute [cuttingedge@sidran.org](mailto:cuttingedge@sidran.org), 410-825-8888, [www.sidran.org](http://www.sidran.org).*

**between the lines: a documentary about cutting.** *Film, black and white, 16mm, 21 minutes. Sophie Constantinou, Producer Fanlight Productions 47 Halifax St., Boston, MA, 02130 800-937-4113. [fanlight.com](http://fanlight.com)*

**The Voice on the Skin: Self-Mutilation and Merleau-Ponty's Theory of Language.** *Janice McLane, Ph.D. Hypatia, 11:4, Fall, 1996, pages 107-118.*

---

*The Women, Co-Occurring Disorders and Violence Study is generating knowledge on the development of integrated services approaches for women with co-occurring substance abuse and mental health disorders who also have histories of physical and/or sexual abuse.*

*This fact sheet was written by Ruta Mazelis, and is a product of the Women, Co-Occurring Disorders and Violence Coordinating Center which is operated by Policy Research Associates, in partnership with the National Center on Family Homelessness and the Cecil G. Sheps Center for Health Services Research. The Coordinating Center provides technical assistance to program sites, conducts cross-site process and outcome evaluations, and develops a range of application products from the study sites.*

*The Women, Co-Occurring Disorders and Violence Study is funded by the Substance Abuse and Mental Health Services Administration's three centers – The Center for Substance Abuse Treatment, The Center for Mental Health Services, and The Center for Substance Abuse Prevention.*

*For more information on this Initiative, please contact Policy Research Associates, 345 Delaware Avenue Delmar, NY, 12054, 518-439-7415, e-mail: [wvcc@prainc.com](mailto:wvcc@prainc.com), web: [www.prainc.com](http://www.prainc.com).*