A study of chronic self-injurious behaviors in nonretarded adults

Phyllis J. Nelson Priest

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A study of chronic self-injurious behaviors in nonretarded adults

Priest, Phyllis J. Nelson, Ph.D.
Iowa State University, 1992

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A study of chronic self-injurious behaviors in nonretarded adults

by

Phyllis J. Nelson Priest

A Dissertation Submitted to the
Graduate Faculty in Partial Fulfillment of the
Requirements for the Degree of
DOCTOR OF PHILOSOPHY

Department: Professional Studies in Education
Major: Education (Counselor Education)

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For the Graduate College
Iowa State University
Ames, Iowa
1992

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DEDICATION

To all the participants who generously shared their time and candid self-disclosures to help clinicians understand better the complexities of chronic self-injurious behaviors. The courage of these participants may facilitate prevention, add to current knowledge, and improve treatment. Their contributions to this research may assist other individuals similar to themselves, enhancing health and quality of lives.
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INTRODUCTION

Self-mutilation, the deliberate destruction and/or alteration of the body without conscious suicidal intentions, has many manifestations. Common examples of deliberate self-mutilation without suicidal intention are hair pulling, cutting, picking, burning, self-punching, biting, and interfering with wound healing. Less common, but still quite prevalent, are amputations, enucleation, self-eviscerations, ingestion of nonfoods, stabbing, eye-poking, and inserting foreign objects into body orifices. This list is not inclusive; the range of self-mutilation is as wide as the human mind can conceive.

Because trichotillomania (chronic hair pulling) is the only specific self-mutilating behavior coded as a disorder in the Diagnostic and Statistical Manual III-R (DSM III-R) (APA, 1980), other self-injurious behaviors are generally treated as symptoms present in a variety of psychiatric and organic disorders. Examples of the latter are Tourettes Syndrome, Lesch-Nyhan Disease, and Cornelia de Lange Syndrome.

Self-harm can occasionally be present in psychosis (e.g., mania, schizophrenia). Five psychiatric disorders coded in the DSM III-R that do include references to self-mutilating behaviors are: borderline personality disorder (BPD), histrionic personality disorder, multiple personality disorder (MPD), sexual masochism, factitious disorder, and trichotillomania. More recently, post-traumatic stress disorder (PTSD) has been linked to self-mutilating behaviors. Specifically, rape trauma
and incest have been surfacing as salient signals to consider for epidemiological research.

Personality disorders have always been associated with self-mutilation (viz., borderline, antisocial, histrionic, multiple personality disorders), but a well-accepted premise is that some of these diagnoses have been injudiciously assigned. Other psychiatric disorders suspected of being associated with self-harm are depression, obsessive-compulsive disorders, and eating disorders (Favazza, 1989b). Research in physiological explanations for self-mutilation is gaining momentum (Pies, 1991; Herman & Chatoor, 1991), yet nearly all clinicians would concur that no single etiological factor will likely be discovered to explain the wide range of these complex behaviors.

Although the literature on self-mutilation is extensive, rarely has the circumfluent cognitions/feelings of these acts themselves been investigated. Furthermore, new perspectives and new hypotheses are emerging (e.g., borderline and multiple personality disorders are no longer routinely being used as "dumping grounds" for diagnosing patients who manifest self-mutilation).

Incidences of self-mutilation are neither isolated phenomena nor unique to severely retarded and autistic individuals. Although frequency and severity of self-mutilation are greatest among these two aggregates, this behavior also occurs in nonretarded, nondelusional, socially functional individuals. Incidence and epidemiology of self-harm among diagnosed psychiatric patients is unclear. However, even more obscure is the information of incidence in children and the general adult population.
Theoretical explanations and hypotheses of SIB are proposed in the discussion of self-mutilation including psychodynamic explanations (Lubin, 1961; Menninger, 1938), biological/organic postulations (Pies, 1991; Richardson & Zaleski, 1986), cultural (Herdt, 1982; Trindus, 1980), behavioral (Carr, 1977; Ross & McKay, 1979), and victimization explanations (Courtois, 1988; Russell, 1986). Favazza (1989b) tried to explain why patients engage in deviant self-mutilation by recording patients' explanations for their behaviors. Yet, these complex behaviors continue to be poorly understood. No one theory or hypothesis fits the wide range of self-injurious behaviors.

Classification seems problematic in the study of self-injurious behaviors. For convenience and brevity, SIB are categorized sometimes into three categories: (a) major or severe, (b) moderate, and (c) mild. Although narrowing the categories may be helpful for discussion, it does not resolve the understanding and management of self-injurious actions. There are over thirty illustrative terms in the literature to describe these self-mutilating behaviors. Those most commonly used are (a) self-mutilating behaviors (SMB), (b) self-injurious behaviors (SIB), (c) self-harm, and (d) self-destructive behaviors. For the purpose of this paper, SIB will be the abbreviation used in the text to designate self-injurious behaviors.

Since shame was often felt by the individual doing self-injury, great effort to hide these behaviors usually occurred for many years (Pattison & Kahan, 1983). Because the onset of self-harm is often reported in childhood, school teachers, counselors, and principals, as well as
established health-care providers must serve on the "front line," suspecting and helping child and adolescent self-mutilators. Likewise, for the adult self-mutilators, the attending physician, counselor, and emergency room staff must be more suspicious and inquisitive into fabrications, victimization, and self-mutilations.

Because intentional self-mutilation is often viewed as repugnant and intractable, clinicians and counselors have sometimes avoided discussing or exploring these hidden behaviors. Favazza (1987) estimated that self-mutilation occurs in 24% to 40% of psychiatric patients and in approximately 750 per 100,000 of the general population. Many of his subjects reported they had avoided disclosures of self-harm with their family physicians and had commonly fabricated excuses for the emergency room staff.

Incidence, physiopathology, psychopathology, epidemiology, prevention, and consistent successful therapy of self-mutilators are yet unclear. Recognizing that both cultural and evolutionary factors explain some self-injurious behaviors (e.g., tatoos), the self-harm studied in this research was maladaptive and pathological. This research did not attempt to investigate the biological factors. Instead, this research focused on epidemiological, psychodynamic, and victimization factors. Research into epidemiology, symptomatology, psychosocial issues, and physiological psychopathology continues to be needed for better treatment, management, intervention, and prevention.

The major purposes of this study were to investigate (a) types and frequencies of self-harm, (b) age of onset, (c) reasons of self-harm from
the subjects' perceptions, (d) the subjects' reports of experiencing pain and/or pleasure at the time of self-injury, (e) the subjects' specific thoughts/feelings immediately before and after self-harm, (f) incidence of childhood abuse, (g) incidence of adulthood rape, (h) gender and relationship of the abuser, and (i) correlation between the age of abuse and the age of onset of self-mutilation.

Problem Statement

The study was designed to investigate chronic self-injury and more specifically, the age of onset, types and frequencies of self-injurious behaviors, the subjects' perceptions of reasons for repetitive self-injury, childhood abuse, and adulthood rape victimization. Repetitive self-injurious behaviors may not be lethal, but death can result. These behaviors may be disfiguring, extremely perplexing, and demoralizing. For therapists, SIB is difficult to treat and remains frustrating. For patients, SIB continues to be devastatingly unmanageable and uncontrollable.

Research into epidemiology, symptomatology, psychosocial issues, and physiological psychopathology is needed for better treatment, management, intervention, and prevention. Gaining insight into a patient's state of mind immediately before and immediately after self-injurious acts are committed may be helpful in treatment planning. This investigation is examining the accuracy of the following premise held by most mental health practitioners regarding SIB: Tension exists before and relief/gratification appears after self-injury (APA, 1980).
Subjects for most research have been the retarded, the autistic, incarcerated males, and hospitalized, adolescent females. Prior to these types of studies, self-injury was reported in single case studies. However, within the last 3 years, several researchers (Favazza, 1989b; Stone, 1987) have investigated SIB in large research projects within the clinically diagnosed psychiatric population. Despite the prevalence of self-injury, these behaviors remain enigmatic. Adult women of the pilot group hid their self-injurious behaviors for many years from family members, peers, employers, and therapists. Some functioned socially and held steady employment, yet they secretly continued these habitual, maladaptive, destructive behaviors.

Definition of Terms

The following terms were defined for use within this dissertation:

**Abuse** - Nonaccidental attack or injury; maltreatment sexually, emotionally, physically, by neglect, or a combination of these forms.

**Affect** - Emotional reactions, mood, or feelings likely to be associated with an experience.

**Childhood** - Birth to 18 years old.

**Chronicity** - Long, drawn-out occurrences; specifically in this study, recurrent self-injurious behaviors occurring four times or more within a 2-year period.

**Clinician** - Refers to physicians, registered nurse practitioners, social workers, psychologists, mental health counselors, and other related academically prepared health care professionals.
Cognition - Mental processes in awareness, more specifically thoughts, interpretations, perception, and memory.

Neglect - Absence of adequate social, emotional, and physical care.

Postdromal period - Pertaining to the period of time following an event or action; specifically in this study, immediate postdromal period is a few seconds to 4 hours after self-injury.

Prodromal period - Pertaining to the period of time preceding an event or action; specifically in this study, immediate prodromal period is a few seconds to 4 hours before self-injury.

Rape - Forced or nonconsensual vaginal intercourse, sodomy, or fellatio.

Self-injurious behaviors - Deliberate destruction and/or alteration of body tissue. Synonyms are self-harm, self-mutilation, self-abuse, and auto-mutilation.

Pilot Study

While co-leading a women's psychotherapy group during 1990-1991 at a mid-western hospital, this investigator conducted a pilot study. The subjects included 7 women, ages 40-55, all of whom were adult victims of childhood sexual/physical abuse and/or rape. Six of the 7 engaged in chronic self-injury. These 6 subjects had one or more of these psychiatric diagnoses: (a) multiple personality disorder, (b) major depression, (c) generalized anxiety disorder, (d) psychoactive substance use disorder, (e) dysthymia, (f) adjustment disorder, and (g) personality disorder. No subject had been classified as suffering from post-traumatic stress disorder or a major psychotic disorder.
Although the DSM III-R requires both tension before and relief/gratification after a hair-pulling episode, these clients were expressing a myriad of feelings before and after self-injury. As the subjects participated in group therapy, commonalities (e.g., rage, shame, guilt, fears, avoidance behaviors, low self-esteem) in their expressed feelings and thoughts emerged. Although the range of emotions and cognitions was wide, commonalities (e.g., privacy, premeditation, need to control) also emerged when they discussed their self-injurious behaviors.

Tension was expressed in rage or guilt in the prodromal period, but this was not necessarily reduced in the post-injury period. Some subjects perceived rage as unchanged while others voiced a feeling of increased guilt and depression immediately after self-injury. Two subjects expressed "temporary relief of tension" in the immediate postdromal period of self-injury. The variation of affects/cognitions was greater in the immediate postdromal period than in the prodromal period.

The original instrument was administered by the researcher in a group setting providing privacy and space for each subject. After giving verbal instructions, the researcher remained present for subjects' questions about item ambiguities. Four of the 7 women in the pilot study reported onset of self-injurious behaviors by the age of 7, and 2 of the subjects had begun self-injurious behaviors by the age of 5. In terms of chronicity, 5 of the 7 patients had engaged in self-injury for over 30 years. For 3 subjects there was never a remission; for 2 subjects there was a 2-year remission. Human research ethics for this pilot study were
maintained in voluntarism, informed consent, confidentiality, and anonymity.

Instrument

No instrument or assessment tool could be found that addressed prodromal vs. postdromal affects/cognitions associated with self-injury. The interview format, history, and checklists for the pilot study were designed based on literature review and content the investigator heard and observed in the group. For example, feelings and cognitions as expressed by group members became part of the instrument checklist. Three clinicians, associated with the hospital and familiar with this population, proposed several recommendations to improve the instrument.

The original pilot instrument requested more information about abuse, family experiences and relationships, sexual attitudes, physical history, and psychiatric history than the revised one. The affects/ cognitions descriptors were originally presented in two columns (viz., before self-injury vs. after self-injury). A continuum of 10 boxes was presented with a range designated "very low-very high" for the subject to choose the degree of intensity, thus making a check in the appropriate box. The original pilot survey required 14-2 hours for the subjects to complete.

Unforeseen problems in the methods and instrument used in the pilot study emerged (e.g., too lengthy history intake, too difficult verbiage, some ambiguity in the checklists). Based on feedback from the subjects, critiques from the three peer clinicians, and observations by this
investigator, the checklist, history intake, and interview format were revised into the instrument used for this study (Appendix D).

The revised instrument was designed primarily as a retrospective questionnaire featuring six checklists:

1. Types of self-injury manifested by subject.
2. Stimuli, situations, and other factors associated with doing self-injury.
3. Intensity of pain or pleasure experienced during self-injury.
4. Specific feelings/thoughts and intensity BEFORE self-injury.
5. Identifying specific feelings/thoughts and intensity AFTER self-injury.

The lists evolved from expressions by the patients in the pilot study, information from professional literature, and the investigator's clinical experiences. A few more words/concepts were added after the list and research plan were critiqued by three professional mental health peers.

A Likert scale design was incorporated for each affect/cognition item. The subject was requested to rate the prevalence and intensity of each descriptor on a scale of "0" to "5." This continuum provided the opportunity for the subject to decide how accurately the concept fit him/herself and then to select a score. A "0" translated as NEVER experiencing the specific feeling/thought before or after self-injury. A response of "5" meant that the specific feeling/thought was VERY MUCH on the subject's mind immediately before or after the self-injuring act.
Hopefully, the subject would be able not only to have identified a specific affect/cognition, but also to have discriminated intensity of the affect/cognition.

Because of the commonality of sexual abuse/rape in the histories of the women in the pilot study, an inquiry of these factors was made. Straightforward inquiries followed the checklists to ascertain the prevalence and onset of abuse/rape in the subjects' histories. Data on gender and relationship of sexual abuser(s) were gathered in the hope that this information might contribute to epidemiology of self-mutilation.

Following completion of the paper and pencil questionnaire, the subject was interviewed privately by this researcher utilizing a standard procedure (viz., following exactly the survey items). The purposes of these face-to-face interviews were (a) to clarify any items on the checklist that the subjects found confusing, (b) to establish confidence that the researcher and the subjects shared the same definitions to eliminate ambiguity, (c) to assess the patient's state of mind, and (d) to express sincere appreciation for their participation.

Research Questions and Hypotheses

Descriptive/exploratory questions

This investigation asks the following questions:

1. What do subjects report as types of, frequencies of, and reasons for their self-injury?

2. Which of the following epidemiological factors is associated with self-injurious behavior: (a) age of onset, (b) seasons and events, etc.,
(c) triggering stimuli, (d) gender, (e) level of education, (f) history of child abuse and/or adult rape, and (g) relationship of age of first sexual abuse and onset of SIB?

3. What are: (a) the sex of the sexual abusers and (b) the relationship of the abuser to the abused?

4. Do subjects report experiencing pain and/or pleasure at the time of self-injury?

Hypotheses

To investigate specific affects/cognitions in the pre SIB and post SIB periods, the following hypotheses were formulated:

1. There will be no change in intensity of reported feelings/thoughts by subjects on the 28 descriptor items when comparing prodromal and postdromal responses.

2. There will be no change in intensity of reported feelings/thoughts by subjects on the 28 descriptor items when comparing prodromal and postdromal responses when data are sorted by sex.

3. There will be no change in intensity of reported feelings/thoughts by subjects on the 28 descriptor items when comparing prodromal and postdromal responses when data are sorted by history of victimization (viz., child vs. adult).

4. There are no significant differences within same group or between groups when comparing prodromal and postdromal responses on each of the 28 descriptor items when data are sorted by sex.
5. There are no significant differences within same group or between groups when comparing prodromal and postdromal responses on each of the 28 descriptor items when data are sorted by history of victimization.

Subjects and Settings

Sixty-three adults, obtained primarily by clinician referral, comprised the sample. Data, collected from additional subjects, were excluded based on 4 subjects declaring suicidal intentions with single, lethal episodes and 3 subjects exhibiting psychotic thinking during the interviews. The researcher remained blind to all subjects' clinical diagnoses. Following completion of the questionnaire, each subject was privately interviewed by the researcher for 1 to 2 hours. Because many subjects took the opportunity to ventilate old issues, a few subjects required 3 hours for the interview.

The face-to-face interview clarified confusing concepts and established confidence that the subject and researcher defined terms uniformly. This private interview allowed the subject to explain or to expand orally on his/her written responses. Many subjects spontaneously disclosed details of SIB and abuse although these were not elicited.

Subjects had generally hidden SIB from family members, peers, employers, and friends. Approximately 20 subjects also indicated they had not disclosed their SIB and/or abuse with their family doctor or emergency physicians. Several subjects described repeated hospitalizations for "psychiatric care," yet claimed that neither abuse nor SIB were addressed. Two subjects reported they had received electro-convulsive treatments for
major depressive episodes, but again neither abuse issues nor SIB were explored during their hospitalizations. The clear message is that subjects did not share their self-injurious behaviors and/or abuse.

This researcher initially felt that obtaining subjects for the sample would be totally dependent on clinician referrals. Psychiatrists, psychologists, psychiatric social workers, mental health counselors, general physicians, and clinical nurse specialists did refer 57 subjects. However, after one subject approached the researcher as a self-referral requesting to participate in the research, a classified ad in a university student paper resulted in five more self-referrals. Two of these subjects reported they had never disclosed their SIB to anyone including their family physicians.

Subjects generally reported an altruistic reason for participating in the research. Their typical messages included: "I've been through hell for so long; if I can help someone else, then I want to do this"; and "If I can help doctors and nurses be more understanding of my kind of behavior, then I want to help." Some participated in the research stating clearly that they hoped the interview would somehow help them in their own personal situations. Only a few subjects were hesitant to participate, voicing concern that SIB might reoccur. This researcher did not receive any feedback citing any exacerbations of SIB provoked by the interviews.

At the time of the research, all subjects were living in a midwestern state of the United States of America. Approximately 60 letters were sent to clinicians in both the private and public sectors (see Appendix A). The letter stated research objectives, request for referrals, and a
description of subject criteria. Copies of the subject letter (see Appendix B) and the Self-harm Survey accompanied the clinicians' letters.

Research subjects were required to meet these criteria:

1. Free of mental retardation diagnosis.
2. Be 21 years or older and his/her own guardian.
3. Free of psychosis at the time of interview.
4. Indicate that the repetitive SIB were not consciously suicidal intentions.
5. Meet the definition of chronicity (i.e., recurrent SIB had occurred two times or more within a 2-year period).
6. Have no organicity or suspected organicity underlying SIB.
7. Have voluntarily consented to participate in this research.

The following resources provided the stated number of subjects: private clinicians, 12; state hospitals, 20; regional mental health centers, 9; county hospitals, 11; self-referrals, 6; county homes, 2; and residential homes, 3. Subjects ranged in age from 21 to 62 years and included 47 females and 16 males. A wide range of education existed among the subjects, that is, eighth grade (n=1) to Ph.D. (n=1) with high school graduation (n=29) as the mode and mean was 13.0. All subjects were interviewed in clinical settings except for 3 subjects. Two requested their church as the setting and one subject was interviewed in her home because of unusual circumstances.
Limitations

Efforts to add to the understanding of chronic self-injury and assess change in affect/cognitions before and after self-injury have many limitations. The following limitations were recognized at the onset of this research:

1. This study was limited by the lack of a practical and available standardized measurement.

2. The use of retrospective self-reports to assess changes in cognitive and affective domains of the subjects may have lacked reliability.

3. This study was limited to primarily clinician referred subjects in a midwestern state of the United States of America. Only 6 subjects were self-referrals.

4. Intelligence testing was not done. Assumptions that subjects had average or above intelligence were based on the clinicians' and researcher's subjective observations.

5. This study was limited to a one-time, face-to-face interview with the researcher. Access to clinical histories, psychometric data, and other clinicians' observations was minimal.

6. This study investigated behaviors/affects/cognitions highly sensitive to personal privacy; therefore, distortions and/or non-disclosures may have occurred.

7. The study was limited to volunteers, so motivation may have made this sample non-representative of the general population. However, within the clinical population, the sample is representative.
8. Focusing on specific affects/cognitions was subject to individuals' denotative and connotative definitions. However, the researcher attempted to ascertain subjects' denotations in the face-to-face interviews. Likewise, these private interviews allowed much exchange with the subjects.

9. This study included only Caucasians by default of the referral and voluntary process.

10. The heterogenous population of humans who do chronic self-injury may limit generalizations.

11. This study may have been unintentionally and unconsciously observer-biased during the interviews although uniformity of researcher's questions and responses was attempted.

Human Subjects in Research Statement

The Iowa State University Committee on the Use of Human Subjects in Research granted approval of student participation in this research on November 21, 1991. The committee concluded that the rights and welfare of the human subjects were adequately protected, that the risks were outweighed by the potential benefits and expected value of the knowledge sought, that the confidentiality of data was assured, and that informed consent was obtained by appropriate procedures. A copy of the voluntary consent form is included in Appendix C. Two consents were signed and witnessed. One form was given to the subject as directed by the committee and the second signed form was kept by the researcher. Because of the highly private and sensitive issues in this research, the subject was
given the choice to use a pseudonym or his/her actual name. Cooperating clinical facilities submitted letters of approval for this research.

Explanation of Dissertation Format

This dissertation has been organized and written under the guidelines specified for the alternate dissertation format (Iowa State University Graduate College Thesis Manual). The alternate format allows presentation of the research in manuscript form suitable for submission to referred scholarly journals.

The dissertation is comprised of an introduction, a review of literature, two manuscripts, a summary, references, acknowledgments, and appendices. The first manuscript, entitled "Self-injurious Behaviors in Childhood: Retrospective Adult Interviews," will be submitted to The School Counselor, the journal of American School Counseling Association. The second manuscript, entitled "Differential Diagnoses of Chronic Self-injurious Behaviors," will be submitted to the Journal of Traumatic Stress, an interdisciplinary, international journal for peer-reviewed original papers in the dynamic field of traumatic stress. This journal serves as a primary reference for professionals who study and treat people exposed to highly stressful and traumatic events. The doctoral candidate is the sole author of both manuscripts.
REVIEW OF LITERATURE

Introduction

The review of the literature describes explanations, comorbidity, incidence, associative factors, and recent research of SIB. Despite the prevalence of SIB, attempts to understand it, to therapeutically treat it, and to prevent it have been minimally successful. Until recently, SIB have primarily been reported via single-case studies. Recent research on larger samples in diverse populations has provided new insight, yet this phenomenon remains enigmatic. The literature is voluminous. In order to illustrate SIB, the author has been selective, hopefully representative, yet far from exhaustive.

Over 30 illustrative terms in the literature describe SIB. Most commonly used are (a) self-mutilating behaviors (SMB), (b) self-injurious behaviors (SIB), (c) self-harm, (d) auto-mutilation, and (e) self-destructive behaviors. For the purpose of this literature review, the term utilized by the specific author will be maintained in describing his/her studies.

Theoretical explanations and hypotheses of SIB include psychodynamic, religious, cultural, behavioral, humanistic, existential, biological/organic, and victimization postulations. However, no one theory or hypothesis fits the wide range of SIB. Worthy contributions representing each theory have been gleaned from the literature.

Favazza (1989a) explained that individuals who do SIB have often been met by negativity from both laypersons and health professionals.
Laypersons express repulsion and disgust while health providers voice discouragement, frustration, and emotional blackmail from individuals who do SIB. However, among patient peers, the mutilator has obtained higher status according to Ross and McKay (1979). They found that the mutilator on the ward may be viewed as somewhat of a hero/heroine, or a martyr having the ability to withstand pain. Hence, the mutilator received contrasting reactions and feedback, all of which may be perceived as reinforcement.

Self-mutilation has long been considered a symptom of various psychiatric disorders. Graff and Mallin (1967), Pao (1969), and Rosenthal, Rinzler, Walsh, and Klausner (1972) described "wrist-cutting" and "delicate self-cutting" syndromes. These scientists gave the impetus to consider SIB as a distinct disorder. Lacey and Evans (1986) described a "multi-impulsive disorder" that includes interchangeable symptoms (e.g., binge-eating, substance abuse, kleptomania, self-mutilation). Favazza (1992) reported further developing the concept of a distinct syndrome which he renamed repetitive self-mutilation.

Shakespeare (1623) wrote, "Give sorrow words; the grief that does not speak whispers the o'erfraught hear and bid it break" in the dramatic masterpiece Macbeth (Act 4, Scene 5). Sigmund Freud (1936) described the necessity of gaining insight into the interdependence of mental pain and physical pain. Similarly, Eric Fromm (1968) purported that a causative relationship exists between the inability to emote and violence in society. Self-injurious behaviors can be dramatic, unpleasant, and sometimes violent. Candor and objectivity have been used to accurately
describe these phenomena of SIB. However, candor was not used to
sensationalize, but to present reality. Some examples may be shocking and
gruesome to the reader.

Psychodynamic Explanations

Violence toward oneself has been documented in early, single-case
studies of clinical records by Hartman (1926), Goodhart and Savitsky
(1933), Menninger (1938), and Lubin (1961). These early discourses were
primarily psychoanalytic interpretations of SIB. It is impossible to
discuss all the complexities of the many psychodynamic explanations in
this literature review. Summations have been presented. Menninger (1938)
wrote, "Mutilation is an attempt at self-healing." He claimed that self-
mutilation was a "partial suicide" in an attempt to refrain from suicide.
His explanation of castration was a compromise between instinctive and
repressing forces.

Lubin (1961) provided an extensive psychoanalytic analysis of one of
the most famous incidents of self-mutilation: Vincent van Gogh's
severance of his right ear. This interpretation focused on the
significance of religious symbolism. Lubin likened the severance to Jesus
Christ's crucifixion and van Gogh's "gift" of his ear to a prostitute as
in the words of Jesus, "Take, eat, this is my body" (I Cor. 11: 4).

Another interpretation by Lubin (1961) of the van Gogh self-
mutilation was that this self-mutilation was van Gogh's attempt to
recreate a ceremony of bull-fighting. Lubin proposed that the severance
of the ear symbolizes bravery and skill of a matador. History revealed
that van Gogh was intrigued by bullfights followed by the ritual in which
the ear of the bull was excised and offered as a special gift to a female
spectator. Van Gogh became the matador through ego identification.

The premise that self-mutilating behaviors are tension-reducing acts
of gratification analogous to masturbation has been accepted by most
psychoanalysts (Fenichel, 1945; Michael & Beck, 1973; Podvoll, 1969;
Siomopoulos, 1974; Slawson & Davidson, 1964; Stekel, 1961). According to
Freudian psychoanalytic theorizing, excitation of the body, by any means,
is a potential source of sexual excitement. Hence, the euphoria described
by some self-mutilators is similar to orgasmic experiences.

After a patient had self-amputated his tongue, Michael and Beck
(1972) suggested that this behavior was a symbolic act of self-castration
and possibly saved his genitals. They argued, "The tongue is also used as
a source of gratification by internal sucking, often unconsciously as a
masturbatory equivalent. It is like having a built-in nipple, pacifier,
or penis" (Michael & Beck, 1973, p. 96). Podvoll (1969) purported that
when high-risk mutilation patients disclose masturbatory wishes, fellatio
fantasies, or homoerotic thoughts, preoccupation with self-mutilating
ideations diminish or cease.

Self-mutilation has also been viewed as a way of dealing with sexual
conflicts. Favazza (1989a) illustrated this hypothesis by describing a
young woman with oedipal conflicts who thought of her "gaping cuts as
vaginas that need to be closed" (p. 285) with sutures. Favazza also
claimed that self-mutilators who were sexually abused in childhood may
eventually harm themselves to relieve their own sexual guilt. Stone
(1987) interpreted that SIB may be attempts to punish the original perpetrators in effigy by using their own skin as symbols for the offending persons.

Favazza (1989a) explained that self-castration removes the threat of genital sexuality in men who desire an infantile relationship with a mother figure. Past research of single-case studies (Cleveland, 1956; Blacker & Wong, 1963) found that gender confusion may underlie autocastration. An illustration is a transsexual who had wanted to be a girl since the age of six. He purposefully obtained employment as a surgical aide in a urology department. After several months assisting in surgery, he performed autocastration with great skill.

Lewis (1928) proposed that self-castration is a primitive attempt to be woman-like and to eliminate the threatening possibility of homosexuality. His case study was a 28-year-old man who had attempted self-castration to rid himself of homosexual desires. The patient specifically referred to his guilt of sodomy and the need to prevent further sinning.

Another psychoanalytic interpretation of SIB is that men who intentionally mutilate their own genitals are attempting to return to their mothers' wombs (Waller, 1991). These mutilations sometimes occurred in extreme schizophrenic regression.

Pao (1969) wrote that self-mutilation is a result of a repressed ego state with alteration of ego functioning serving to repress conflicts about castration, aggression, and separation-individuation. Thus, the blood produced by self-mutilation can serve as a solacing, transitional
object. Similarly, a psychodynamic interpretation (Kafka, 1969) evolved from the report of a woman who experienced the flow of blood resulting from her self-cutting as "a pleasant, warm, voluptuous bath that enclosed her like a security blanket" (p. 210).

Stone (1987) purported that, in some cases, self-mutilation appears to arise as a response to traumatic death, "where the horror is relived in the self-mutilative episodes and the death itself is denied" (p. 348). These self-mutilating acts symbolically served to replace the dead by the fantasy: "Let me die in your stead." Stone (1987) summarized that the focus of the individual is on the land of the dead containing the loved one; therefore, self-mutilation is a symbolic attempt to replace or reunite with the deceased.

Prohibitions against the expression of anger and parental hostility may foster the development of a punitive superego. According to House and Thompson (1985), stress can overwhelm ego defenses leading to self-injury. The extreme employment of ego defense mechanisms, especially dissociation and fantasy, helps explain the common descriptor words, "numb," "dead," and "out of my body" commonly voiced by subjects during self-harm.

Regression and preoccupation with their bodies were observed in patients by several psychoanalysts (Kafka, 1969; Pao, 1969; Podvoll, 1969). The mutilator was typically emotionally arrested during extreme conflicts which required much adjustment. These psychoanalysts suggested that when patients were faced with needs for adaptation, mutilators regressed to a preoedipal infantile stage during which satisfaction was found through tactile-kinesthetic stimulation.
Ross and McKay (1979) found childlike qualities (e.g., self-centeredness, inability to delay gratification, demanding of attention, preoccupation with their bodies) in many of the institutionalized adolescent females in their research. These researchers admitted uncertainty of whether regression preceded or accompanied self-mutilating acts or whether the girls had never advanced beyond the early childhood years.

Another psychoanalytic approach to self-mutilation, but from a group dynamics perspective (Marziali & Monroe-Blum, 1987), depicted uncontrollable behaviors resulting from projective identifications of rage. Similarly, their interpretation posited that self-mutilation was also a "relieving enactment of revenge" associated with childhood feelings of impotency, rage, resentment and unimportance.

Many theorists, including Marziali and Monroe-Blum (1987) explained that "control" is a critical issue in SIB. Having no control over their bodies or lives as children, self-mutilators grew up needing control. Although generally unconscious, this "control" can take the form of SIB by using a hammer or knife to attempt to establish control when one feels "out of control." Favazza (1989a) reported the thoughts of two subjects: one explained, "Self-harm gives me a feeling of control when I cannot find control in the environment" (p. 139), and a 32-year-old salesman who did self-harm by hitting himself with a hammer exclaimed, "Now, I'm calm again" (p. 139).

In most instances the body location of self-injury seemed to have personal significance. Psychoanalysts commented on autoeroticism, that
is, finding sexual pleasure in one's own body rather than with another person. For example, Blacker and Wong (1963) found self-castrators as having "vaginal needs." Masturbation and mutilation seemed interchangeable for some patients (Podvoll, 1969; Siomopoulos, 1974).

Podvoll (1969) also noted that attacking one's body with "scorn and contempt" was an attempt to love one's body. Gardner and Gardner (1975) and Kafka (1969) proposed that self-mutilation was commonly related to body narcissism. After having studied a female "cutter" for 5 years, Kafka hypothesized that the patient responded to her body in similar ways as a child needing security. Cutting reportedly gave this woman a security of knowing that she was alive. Kafka states, "As long as one has blood, one carried within oneself this potential security blanket capable of giving warmth and comforting envelopment" (Kafka, 1969, p. 209). For example, Kafka's patient reportedly had fantasies that an invisible layer around her stopped snowballs at some distance from her body. Interpretation was that this body was as a "not-me" object.

A well-accepted psychoanalytic hypothesis of self-mutilation is the confusion of self and not-self frequently reported in the out-of-body phenomenon. By burning or cutting the body, an attempt is made to highlight the distinction (Ross & McKay, 1979). Goldfarb (1958) identified a primitive yet maybe important principle: Pain may help children to learn to distinguish between self and the outside world.

Psychoanalytic interpretations of SIB are almost endless. As in most research of self-mutilation, psychoanalysis has been post hoc. The confounding and complexities of human lives make one theoretical
perspective insufficient, yet psychodynamic explanations can yield insight.

Religious Influences

Favazza (1989b) interviewed more than 300 self-mutilators and reported the reasons offered by patients for their self-mutilation behaviors (SMB). He found patients who engage in major or severe SMB usually were diagnosed with major depression, mania, or schizophrenia. Also, in this category of SMB were patients with disorders such as chronic encephalitis, acute drug toxicity, and transsexualism. He concluded that these subjects voiced reasons based on two primary themes: religion and sexuality. The religious theme found in Favazza's research (1989b) included Biblical influences, identification with Jesus Christ, sinfulness, heavenly commands, influence of demons, offering or missions to God, and feelings of reincarnation. Fortunately, severe mutilations are reported to occur 2% or less in this population (Favazza, 1989b). Favazza explained that most severe mutilations occur when persons are in psychotic states.

The following excerpts illustrate Biblical influence. References to self-amputation, enucleation, and castration are numerous in the Bible. The literal advice offered in the books of Mark and Matthew direct Christians to tear out an eye or cut off a hand or do self-castration. For example, Matthew 19, verse 12 states:

For there are eunuchs who have been so from birth, and there are eunuchs who have been made eunuchs by men, and there are eunuchs who have made themselves eunuchs for the sake of the kingdom of heaven. He who is able to receive it.
Also, in Mark 9, verses 43-48 and similarly in Matthew 5, verses 29-30, advice is offered:

If your right eye causes you to sin, pluck it out and throw it away; it is better that you lose one of your members than that your whole body be thrown to hell. And if your right hand causes you to sin, cut it off and throw it away; it is better that you lose one of your members than that your whole body go into hell. (p. 1001)

Favazza (1989b) provided several examples of individuals following the Biblical instructions. Two have been selected to illustrate severe self-mutilation. According to Favazza, a middle-aged man with a history of recurrent major depressive episodes "brooded for weeks" on the Biblical passage of eunuchs before doing self-castration. Favazza explained that the typical mutilator who did enucleation was a severely depressed incarcerated male with a Bible in his cell. After having discussed the Biblical passage from the book of Matthew in a Bible study, a young schizophrenic man attempted to saw off his hand. Not succeeding, he finally shot his hand with a weapon and then begged for surgical amputation.

Other single case studies (Goodhart & Savitsky, 1933; Hartman, 1926) presented similar psychotic situations of self-enucleation in patients who quoted Biblical references of Mark and Matthew. Carson and Lewis (1971) described a 16-year-old boy who, upon hearing a voice shout, "If thy right eye offend thee, pluck it out," did so immediately.

Self-mutilations for religious symbolism, sacrifice, and identification with Jesus Christ have been reported numerous times. Betts (1964) described a female patient who, identifying with Jesus Christ, drank her own blood and ate her own flesh symbolizing communion. Kushner
(1967) reported two cases: a 37-year-old schizophrenic patient turned to the Bible after having had his first homosexual experience. After reading the scripture about the eunuchs, he excised his penis, burned it, and exclaimed: "needing to be cleansed." The second case was a 35-year-old schizophrenic patient who did self-castration "to purify" himself so that he could pilot a spaceship for righteous people.

As early as 1882, religious influence was documented in clinical records as a primary factor for a 26-year-old manic woman who cut her arms, lacerated her vagina, and blinded herself in one eye (Howden, 1882). She claimed that God had ordered her to tear out her tongue, to fast, and to burn herself. Other severe lacerations and excisions of the genitals have been reported in association with heavenly commands and influences by demons (Evins, Whittle, & Rous, 1977; Crowder, Gross, Heiser, & Crowder, 1979). Crowder described a 44-year-old depressed man who expressed much guilt after having attended a topless nightclub. He reportedly shoved a pencil into his eye and claimed that St. Mary commanded him to cleanse his sins by doing this punishment.

Many more case studies could have been presented to illustrate the religious theme of self-mutilations. They truly did not represent chronic SIB, but exemplified severe, single events without suicidal intentions. The purpose of including these case studies was to illustrate the multicomplexity of SIB.

Across the life span, issues do exist that involve religion or stimulate people to address religion in their lives. More subtle and covert religious influences often go unnoticed yet permeate an
individual's life. Conway (1989) reported that victims of sexual abuse may struggle with the expression of anger, which contradicts the Judaeo-Christian principle of "turn the other cheek." Similarly, forgiveness is idealized as a resolution by a victim, yet if unachieved, may possibly leave more guilt. The point is clear: religious issues are relevant to the counseling process for many clients.

Worthington (1989) suggested that religion may be involved in both normative and nonnormative events, especially for religious people who are highly committed to their religious faith. He purported that a religious identity can be as strongly influential as either racial or cultural identity. Fowler (1981) argued that every life event might have religious significance. Malony (1988) and Pruyser (1976) commented that a person's faith cannot be understood apart from its content. All three of these researchers believed the necessity of the clinician to assess both the "what and the how" of an individual's faith. For subjects who self-mutilate, their religious interpretations may give insight into maintenance or amelioration of the problem.

Cultural Practices

Many culturally sanctioned SIB may have their roots in self-healing or religion. However, these practices (e.g., ear and nose-piercing, tatoos, scarring) continue to facilitate identity and status for some individuals. Herdt (1982) described tribal membership and status as represented by scarring of specific body parts. For example, shamans had to endure more self-mutilation than other tribal members to be elevated to
their tribal rank. He reports the common practice of lacerating the penis in pubertal rites for Australian aborigines. This is the price that these youth must pay to participate in that culture as adults. Herdt postulated that troubled adolescents who self-mutilate may be performing acts in an attempt to overcome problems similarly seen in primitive cultures.

Blood-brother ceremonies are performed in several societies. Facial cuts and scars are aspects of beauty in some African tribes (Trindus, 1980). He also reported that males in New Guinea typically lacerate their chests followed by application of mud packs to achieve an alligator appearance. Self-flagellation as penance or grieving rites have been documented for centuries.

**Behavioral Explanations**

Behavioral explanations for SIB are somewhat limited, for the behavioral focus is on maintenance rather than etiology. Compared with the multitude of psychodynamic interpretations, behavioral explanations are fewer in number. Favazza (1989b) explained the negative reinforcement theory which purports that a self-mutilative act facilitates maintenance of behavior by terminating or avoiding an aversive stimulus. Carr (1977) gave an example of an institutionalized little girl who initiated head banging when placed in a crib. He simply stated she presumably wanted to escape from the crib.

Skinner (1953) proposed a behavioristic account of masochism in which he suggested that individuals might deliberately expose themselves to aversive stimulation if, by doing so, they avoid even more consequences.
Favazza (1989b) reported subjects who admitted doing self-mutilation to avoid electroconvulsive treatments.

The positive reinforcement postulate holds that the behavior has been rewarded or it would become extinct. Gaining attention by self-mutilating acts has been one of the most successful behaviors in an institution or hospital. In most instances it is 100% effective! Ross and McKay (1979) found that additional staff for supervision after a female carved herself seemed to increase the incidence of self-mutilations. They exclaimed, "The maxim for some of the girls seemed to be, the larger the audience, the deeper the cut" (Ross & McKay, 1979, p. 58).

Seeing others being rewarded (i.e., receiving attention) after self-mutilation, some girls at Grandview, an institution specifically for delinquent female adolescents (Ross & McKay, 1979), began to imitate these behaviors. Ross & McKay declared that some girls were not serious about engaging in self-mutilating behaviors, at least not at first. However, after a time, the girls saw the rewards and behaved similarly as the models.

Closely related to doing self-mutilation were the threats of self-mutilation. Ross and McKay (1979) reported that the girls often tested the limits with their therapists. Typical statements were: "What would you do if I carved?" "I think I'll cut myself tonight," and "Don't be surprised if I'm not here tomorrow" (p. 61). These researchers found themselves many times asking the question: Why not use this extra attention and help proactively rather than reactively?
The literature contained numerous examples of self-mutilations employed by individuals lacking alternative behaviors to gain the ends they sought. Ross and McKay (1979) described the concept of manipulation or the behavioral term operant learning within their institution of Grandview School. Manipulators used SIB deliberately and intentionally to their advantage in many ways: to obtain attention, to get access to therapy, to win transfer to a more preferred location, and to get the institution to cater to their needs. Literally, the self-mutilators could manipulate themselves in and out of the institution. In this way, SIB are learned and reinforced adaptive behaviors.

Similarly, many individuals were reported to have been in environments which prevented them from utilizing healthy coping behaviors (Cox & Klinge, 1976; Crabtree, 1967; Nelson & Grunebaum, 1971). A child who has frequently been physically abused by his/her parents may learn to avoid further violence by injuring him/herself. When the parent sees the child already injured, the parent is less likely to abuse (Green, 1967; Money, Wolff, & Annecillo, 1972).

Green (1967) suggested that self-mutilating behavior in adolescents and adults represented an extension of behavior first learned in infancy. Insufficient information about early childhood behaviors of self-mutilators interferes in postulations. However, the hypothesis that repetitive rocking and head banging in infants may represent responses learned in socially and sensory deprived babies. Behaviorists interpreted these behaviors in terms of intermittent reinforcement or punishment conditions which make them resistant to extinction. They posited that the
parents were likely to have rewarded and then punished these SIB inconsistently.

A common behavioral premise holds that behaviors learned in infancy (e.g., hair pulling, scratching, head banging) surface when the individual encounters stressful situations. However, behaviorists explain that these primitive early adaptations may likely progress into more serious and dramatic forms such as cutting and burning.

Research by Lovaas, Freitag, Gold, and Kassorla (1965) demonstrated that SIB could be greatly increased in rate when contingent social reinforcement was given. Others reported the great difficulty in decreasing the frequency of SIB. Ross and McKay (1979) disclosed results from a treatment-research program in a training school for 12- to 17-year-old girls admitted with a history of delinquent behaviors. When the team of clinical psychologists began its research, 86% or 117 of the 136 girls had carved themselves at least once. Many had recurrent self-mutilations with an average of eight cuttings. Numerous other forms of SIB were uncovered and in spite of the team's best efforts to control these behaviors, the authors reported that they continued and even escalated sometimes. Behavioral therapy (e.g., covert conditioning, contingency management, token economy) were tried and unsuccessful.

Humanistic and Existential Explanations

Many investigators have concluded that self-mutilation is an existential statement validating one's existence (Collins, 1965; Kafka,
1969; Ross & McKay, 1979). Many of the mutilators at Grandview School reported before their self-injuries that they felt "dead or empty" (Ross & McKay, 1979). Depersonalization has been reported numerous times in individuals immediately before self-injurious acts. Depersonalization, a psychoanalytical term, refers to a state of losing one's identity and contact with the environment. Existentialists may describe this phenomenon as extreme alienation from oneself.

Miller and Bashkin (1974) suggested that the self-injurious act is the culmination of a sequence of specific events. Typically some frustrating experiences provoked the patient to feel totally rejected or abandoned as well as overwhelmingly angry. Hence, it was rage that triggered the depersonalization and extreme discomfort of alienation of reality. Therefore, in an attempt to escape this depersonalization, self-mutilating behaviors facilitate the discharge of rage and fear (Asch, 1971).

Self-injurious behaviors truly are associated with low self-esteem. Few researchers or therapists would disagree with this statement. Multiple investigators have reported self-mutilators to have a poor self-image and feelings of worthlessness, rejection, and futility (Crabtree & Grossman, 1974; Favazza, 1992; Mintz, 1964; Ross & McKay, 1979; Valente, 1991). Low self-esteem may be related to a depressive disorder or a function of guilt or powerlessness.

Friesen (1985) reported that self-mutilators described early episodic parental rejection, absence, or abandonment. Sexual abuse, emotional abuse, physical abuse, and neglect were commonly experienced. Friesen
also documented poor communication skills, distrust of others, ineptness in coping skills, and fears of abandonment that continued in adulthood.

Loneliness, distrust, and alienation make establishing a therapeutic relationship very difficult. Valente (1991) suggested that clients who fear abandonment and criticism benefit from a calm, nonjudgmental attitude and a staff sincerely wanting to understand. She warned that clinicians may experience ambivalence in wanting to be helpful, yet unconsciously deny the client's emotional pain.

Favazza (1989b) reported a 28-year-old librarian who exclaimed that when feelings of alienation "strike," self-mutilation was the only thing that provided her some relief. The patient described alienation for herself as "frantic and desperate." She used another descriptor: "cut off from the world, especially loved ones" (p. 140).

Negative perceptions harbored by self-mutilators are multiple. They described themselves as terribly imperfect, extremely ugly, and disfigured. One of Favazza's (1989b) subjects reported feeling extreme self-hatred associated with her father's attempt to have coitus with her at age 22. Other subjects in his research described having "internal ugliness," therefore voiced the need to correct something "external," so they frequently cut off all their hair.

Parental and sensory deprivation compounded roots of alienation in childhood. Mutilators have sometimes been referred to as "stimulation seekers." Self-injurious behaviors are their attempts to establish contact. Green (1967) conjectured that a child may mutilate him/herself
in an attempt to obtain parental contact even in the form of kinesthetic stimulation, namely physical punishment.

The famous Harlow studies (1964) experimenting with nonhuman primates revealed self-mutilatory behavior in later life, particularly self-biting in the parentally, socially deprived animals. Harlow raised the social isolates in bare wire cages which allowed them to see, smell, and hear their peers. However, Harlow prevented all physical contact between them (i.e., no touching, sucking, stroking).

Evidence of similar extreme social and sensory deprivation conditions was not validated in the histories of Money's, Wolff's, and Annecillo's (1972) patients. However, these investigators reported that their patients described homes and families as being insensitive to pain, indifferent, neglectful, and isolated.

Ross and McKay (1979) discovered that a significant proportion of the self-mutilating incidents at the Grandview School occurred while their adolescent females were in solitary confinement or restricted to their rooms. Because of similar discoveries, some institutions have redesigned their psychiatric units into atmospheres of trust and good feelings with "wholesome communities," "open-door" policies (Crabtree & Grossman, 1974).

Biological Explanations

Least understood are the biological, physiological explanations for SIB. It was not possible to identify all organic comorbidities of SIB, but the most common ones have been included in this literature review.
Self-mutilation was reported to be commonly manifested in Cornelia de Lange syndrome (de Lange, 1933). This congenital disorder is characterized by both mental and physical retardation, hirsutism, low birth weight, and distinguishing physical features such as extremely small face and head, micromelia of the feet and hands, and numerous other anomalies.

Severe SIB also frequently occurred in Lesch-Nyhan syndrome (Lesch & Nyhan, 1964), another organic disease characterized by mental retardation, choreoathetosis, hyperuricemia, and gouty tophi of the fingers. Fortunately, this X-linked enzyme deficiency disorder is rare but presents a dramatic example of SIB. Another chromosomal aberration (49XXXXY) has been documented with severe SIB, but because of insufficient clinical data it is difficult to draw conclusions.

Vinken and Bruyn (1982) identified a neurological disorder of benign intracranial hypertension and its possibility of being associated with self-mutilation in the patient's history. Severe SIB and inexorable headaches and papilloedema were manifested in a case study of a 22-year-old woman being treated for benign intracranial hypertension. The psychiatric literature on this comorbidity is sparse, but the lesson for physicians is to perform funduscopic examination when assessing patients with SIB.

Recent literature provides promising hypotheses in the biological domain. Pies (1991) explained three current biological postulates of SIB. However, discovering a single pathophysiology underlying all forms of SIB
is highly unlikely. Instead, it is SIB that is the "common pathway" for exploring neuropathological abnormalities.

Pies (1991) described the first possible organic explanation as an opiate dysregulation. Endogenous opiates (in the CNS) are released, thus making SIB even pleasurable and not painful. Richardson and Zaleski (1986) explained the release of endorphins, like the injection of morphine, creates a gratifying sensation and provides positive reinforcement for the immediate preceding behavior. Conversely, negative reinforcement causes diminished behaviors when a withdrawal or deficit of endorphins occurs.

A few studies using the opiate antagonist naltrexone has had some success in reducing SIB. Herman and Chatoor (1991) found that in normal adults, naltrexone antagonizes the mu-type opiate receptor. Also, they reported that naltrexone reduced SIB in two mentally retarded patients and one patient with Tourette’s syndrome.

A second organic hypothesis was dopaminergic dysregulation. Pies (1991) explained that low levels of dopamine characterize some specific neurological disorders. A low level of dopamine is also present in schizophrenics who sometimes manifest SIB.

A serotonergic dysfunction was the third organic hypothesis of SIB. Pies (1991) reported that lower levels of 5-HIAA, the major metabolite of serotonin, exist in the cerebrospinal fluid of depressed patients who had attempted suicide just prior to admission.

Although specific pharmacotherapy for SIB is in its infancy, neuroleptic drugs based on the serotonin and dopamine hypotheses are being
employed in a variety of disorders (e.g., trichotillomania, obsessive-compulsive disorder). Pies (1991) summarized that research on SIB will need to "tease out" the relative contributions of the various neurotransmitters.

Victimization and Trauma Explanation

To be victimized means to suffer physically or psychologically as a result of deliberate, incidental, or accidental experiences. The premise of trauma theory is that each individual uniquely interprets trauma resulting in coping behaviors to accommodate loss, tragedy, pain, rage, sorrow, or whatever unfolds due to catastrophic experience. The last two decades have produced an unprecedented interest in the psychological and social implications of violence and victimization. McCann (1988) reminded us that research on victimization is still in its infancy and any conclusions must be viewed cautiously.

However, researchers (e.g., Courtois, 1988; Kilpatrick, Veronen, & Best, 1985; Russell, 1986; Wilson & Krauss, 1982) have provided much data and insight into post-traumatic coping responses. One difficult problem facing researchers is distinguishing sources of trauma. For example, within the area of child victimization of sexual abuse, many factors (e.g., duration, perpetrator relationship, disclosure, physical and emotional abuse, prejudices, illnesses, etc.) can produce differing effects.

Frankl (1963) gave impetus for importance of individual response to suffering from his own confinement in Auschwitz. Lifton and Olson (1976)
also contributed to trauma theory having studied survivors of Hiroshima, the Buffalo Creek disaster, and the Vietnam war. Lifton and Olson (1976) purported that individuals develop images and symbolic forms of their life experience resulting in a sense of continuity or discontinuity of the self-structure. Hence, traumatic events are believed to disrupt these basic life symbols.

McCann (1988) suggested that victimization explanations have roots in the cognitive work of Kelly (personal construct theory, 1955) and Piaget (structural theory, 1970, 1971). These theorists and Beck (1967) hold the premise that how a human being constructs schemata about self, others, and the world contribute powerfully to responses and coping behaviors. Hence, victimization theories reflect dynamic interplay between a human being and his/her environment.

Mancuso (1977) built on Kelly's and Piaget's works, thus contributing important implications for trauma theory. Mancuso explained that as arousal always accompanies cognitive processing (schemata construction), persons attempt to reduce arousal by (a) avoidance or rejection, (b) interpretation of input, and (c) alteration of existing schemata. Within the field of victimization, the outcome or results, negative or positive, are expressed in emotions, cognitions, and behaviors. Horowitz, Wilner, Kaltreider, and Alvarez (1980) stated, "Phenomenological description of stress response syndromes has been difficult because psychological reactions always combine responses keyed to a recent serious life event with precious inner models of self and the world" (p. 85).
The application in self-mutilation is the appropriateness of the clinician to investigate schemata (e.g., safety, trust, relationships, self, power, esteem). Typically, the self-mutilator expresses self-degradation, blame, guilt, rage, alienation, rejection, and the belief that he/she deserves to be punished. McCann (1988) recommended that clinicians, while assessing schemata, should also explore aspects of previous and current life experiences that appear to shape, alter, or solidify schemata. For instance, a rape victim disclosed, "When I was a little girl, my mother always did say I was a slut (incest victim), so I guess I deserved this (rape), so I deserve to punish myself for being so bad (self-mutilation)" (Priest, 1992).

Victimization theory supports long-term treatment for compounded trauma. Horowitz (1976) explained that the longer the time is from the stressor event to the present time, the greater the chance that complex problems of major maladaptation will evolve. Courtois (1988) reported that many of her patients kept incest secrets for decades, often out of shame, guilt, fear, helplessness, threats, and/or ambivalence.

According to Favazza (1989a), many mutilators are survivors of incest victimization; however, his research focused more on self-mutilation in diagnostic groupings (e.g., mania, schizophrenia, personality disorders). Percentages of self-mutilators with histories of sexual abuse were not yet available at the time of his writing.

The anger of victims typically involved the need to find someone to blame for the misfortune, fate, or traumatic experience. Ross and McKay
(1979) observed that some self-mutilation in the adolescent females represented retaliatory behavior. The individual, either because she lacked the skills to retaliate directly or because the environment prevented it, would use self-mutilation as an indirect means of revenge. The researchers explained: "The harm that is done to the mutilator's body mirrors the harm that has been done to him/her" (Ross & McKay, 1979, p. 61). Ross and McKay reported hearing these messages: "See how badly you've treated me," and "Now look what you've made me do" (p. 61). Thus, the victim has attempted to place the burden, guilt, or responsibility on the perpetrator.

In one study (Horevitz & Braun, 1984), 70% of victims of extreme childhood abuse who developed multiple personality disorder also met the criteria for borderline personality disorder. Scurfield (1985) purported that differentiation between PTSD and borderline or antisocial personality disorders can sometimes be quite difficult. Victims of these three groups manifested ingrained personality patterns, including unstable affect, impulsivity, chronic anger, and self-mutilation. Scurfield suggested that these behaviors more likely reflected prolonged and unresolved victimization rather than representing a distinct diagnosis. Although these postulations are controversial, McCann (1988) explained that available evidence supports the notion that severe types of personality disturbances in some victimized populations may actually be a subtype of severe and chronic PTSD.

Post-traumatic stress disorder has developmentally passed through stages of the DSM I to proposed revisions in the DSM IV. McCann (1988)
suggested that underdiagnosis has occurred resulting in ineffective
treatment. Scurfield (1985) summarized that chronic or delayed forms of
untreated PTSD may result in maladaptive ingrained patterns, such as
paranoia, rage, or antisocial behaviors that may not be attributed to the
original traumatic event. Little is known about the delayed or chronic
types of PTSD. Post-traumatic stress disorder has been viewed as a
diagnosis capable of encompassing a variety of victimizing events,
including rape (Kilpatrick et al., 1985) and incest (Courtois, 1988).

Greenspan and Samuel (1989) reported three cases of women who began
cutting themselves after having been raped. These researchers were the
first to publish accounts of self-cutting, post-rape trauma. They posited
that self-mutilation behaviors were facets of the victims' post-traumatic
stress disorder (PTSD) and that clearly self-harm began after the rapes.

Research on self-aggression with PTSD was reported by Stone (1987).
He suggested that individuals who have experienced sexual abuse, incest,
and physical abuse in childhood have more difficulties expressing anger in
healthy ways than do nontraumatized adults. He documented findings of
self-mutilators revealing typical histories of "an older male relative
abusing a child (usually but not always female) sexually in a grossly
sadistic manner" (p. 348). He explained this extreme trauma often
resulted in conditioning the victim into a cycle of (a) intense sexual
desire, (b) sexual acts (sometimes perverse by societal norms), and
(c) self-mutilation. Stone posited, "The sexual act relieves the sexual
tension; the self-mutilation relieves the tension arising out of guilt and
tends therefore to be felt in a paradoxical manner as a kind of pleasure
or at least not purely-painful act" (p. 348). Through the self-mutilation, the victim was symbolically punishing herself and the perpetrator.

Similarly, Jehu (1988) reported that for many incest victims, intense anger and hostility are felt towards their abusive fathers but even more anger is felt towards their unprotecting mothers. Many victims have this accumulation of anger yet cannot successfully confront their offender and family members, but engage in denial, repression, loyalty, and even idealization of the family. Thus, often the victims are burdened with guilt, shame, and rage.

More evidence is presented in the post-traumatic stress disorders research by Feldmann (1988b). He posited violence became a way of life for Vietnam veterans diagnosed with PTSD. Although much of the violence in his subjects was directed outwardly, Feldmann argued that violence was a method of solving problems, an attempt to cope with life's frustrations and catastrophes.

Kohut (1965) viewed the emergence of various maladaptations, such as addictions, perversions, and compulsions as "disintegration products." He explained that disintegration likely serves as a defense of the fragile self, especially during intense stress or trauma. Kohut described this fragmentation as "disintegration anxiety, the deepest anxiety a person can experience" (p. 789).

Although Kohut did not specifically address post-trauma, his research and postulations seem applicable to PTSD victims. Certainly, trauma can be understood as disrupting a previously intact self, leading to
fragmentation with intense disintegration anxiety. It is this concept supported by Feldmann (1988b) that explains the notions of combat trauma inducing a structural change in the self that leads to the expression of self-pathology. Hence, Feldmann approached his PTSD victims with self-psychology-oriented therapy to repair the damaged self.

Comorbidity

Self-mutilation has been considered a symptom of many disorders and not in itself an entity until the early eighties. Pattison and Kahan (1983) and Favazza (1992) differentiated episodes of repetitive self-mutilation from single events and acts of high lethality of suicidal intentions. Classification of SIB is now controversial. Although SIB is historically identified as a manifestation of specific disorder entities, new evidence may alter this concept.

Five psychiatric disorders coded in the DSM III-R that do include references to self-mutilating behaviors are: borderline personality disorder, multiple personality disorder, sexual masochism, factitious disorder, and trichotillomania. Self-injurious behaviors have often been classified into three categories: (a) major or severe, (b) moderate, and (c) mild. Comorbidity of SIB and specific disorders has been reviewed.

For patients who engaged in severe self-mutilation, Favazza (1989b) found psychopathology to be associated with disorders of schizophrenia, major depression, mania, transsexualism, and organic mental disorders (i.e., chronic encephalitis and acute drug intoxication). Severe mutilation was defined as major destruction or alterations of body tissue
such as eye enucleation, facial skinning, amputations, and breast and genital ravages.

Several examples of major self-mutilation have been cited previously in this literature review under specific theoretical explanations. Favazza (1987) observed that the majority of these major acts occurred in psychotic states. One more example is provided to illustrate that although self-mutilation of the sexual and reproductive organs is quite rare, when it does occur, severity and irreversibility usually result.

Coons, Ascher-Svanum, and Bellis (1986) reported a 31-year-old pregnant female who had amputated her right breast. Her parents had discovered her after that action naked in bed and nonchalantly smoking a cigarette. According to the attending physicians, the patient denied psychotic symptomatology. Subsequently, she admitted auditory command hallucinations, hence, neuroleptic pharmacotherapy was initiated. The clinical impression was paranoid schizophrenia. Further investigation found a possible precipitating event that may have triggered the amputation. Just prior to the self-mutilation, she had propositioned her landlord and he had refused her. Therefore, interpretation was that this rejection by her male landlord was the culmination of a number of unsuccessful relationships, two abortions, a rape, and an out-of-wedlock pregnancy. The psychoanalytic interpretation of why she chose to amputate her breast was denial of her femininity. Denying her femininity allowed her to cope with all the failures and losses that she had accumulated in her life. Schizophrenia allowed the irrational expression of hostility, rejection, and inadequacy.
Bach-Y-Rita (1974) found histories of seizures, concussions, and episodic unconsciousness in prisoners who did frequent self-mutilation. Although a high possibility of neurological disorders existed in these subjects, concrete evidence was unattainable.

Another coexisting disorder in which major mutilation has occurred is dysmorphobia. The literature suggested that many patients with dysmorphobia do not have a major psychiatric disorder (Birtchnell, 1988). The following example illustrated that severe mutilation has occurred in nonpsychotic states. Walter and Streimer (1990) reported a 33-year-old male who unsuccessfully attempted to reconstruct a foreskin for himself. The patient had become familiar with a reconstructive procedure through reading a surgical textbook. When he found himself unable to control local bleeding, he sought a nearby emergency room. The attending physicians described the subject as having a history of pre-morbid obsessional and narcissistic traits, hypochondriasis, and preoccupation with body perfection.

Favazza (1989b) identified a wide variety of conditions such as personality disorders, eating disorders, compulsive disorders, and factitious disorders that were associated with moderate or mild self-mutilation. Recent research has provided data to suspect associative links between sexual abuse and psychopathology in which self-mutilation is manifested. Rosenfield (1979) and Mullen, Romans-Clarkson, and Walton (1988) identified short- and long-term pathological effects (e.g., depression and anxiety) in women with histories of sexual abuse.
Similar links have been proposed between sexual abuse and anorexic or bulimic eating disorders (Goldfarb, 1958; Waller, 1991). One hypothesis is that sexual abuse resulted in disgust for femininity and sexuality. This preoccupation with body image and disgust evolved into anorexia nervosa or bulimia. Identified as engaging in SIB are 40.5% of bulimics and 35% of anorexics (Valente, 1991).

Hurt and Clarkin (1990) identified "clusters" of behaviors, suggesting that because of the heterogeneity in borderline personality, treatment strategies fit the cluster. They cited an example as a criterion of SIB and impulsive behaviors would form an "impulse cluster." Individuals in this cluster might be expected at times under stress to engage in high-risk behaviors yielding immediate gratification with little concern for consequences. The borderline personality has had its share of SIB, but may have been a catch-all for misdiagnosed patients who also engaged in SIB.

Historically, similar to misdiagnoses of borderline personality disorder (BPD), the average patient has between three and four previous diagnoses before multiple personality disorder (MPD) is discovered. Tucker (1991) reported in a study of 21 men and 92 women with the disorder of MPD, 80-90% had been sexually abused and more than 90% were physically abused. Patients with MPD presented a variety of symptoms: depressed affect, odd sexual or violent behaviors, memory difficulties, self-abuse, and trance-like states. He commented that these patients may have the ability to voluntarily inhibit sensory capacities originating as a defense
to block pain, abuse, and severe trauma. Putnam (1985) estimated that 34% of patients diagnosed with MFD engage in chronic self-mutilation.

Antisocial personality disorders have been researched by investigators (Virkkunen, 1976; Ross & McKay, 1979). Having researched prisoners diagnosed with antisocial personality disorder, Virkkunen found that 24% engaged in self-injury. Similarly, Ross and McKay (1979) discovered that 80% of their adolescent institutionalized females who were diagnosed antisocial "carved." In fact, Ross and McKay reported carving parties occurred where the girls contractually agreed. In their opinion some girls carved out of a fear of ostracism or rejection, but at other times did so to be fashionable with peers.

Incidence, Onset, and Gender

In recent years, research has yielded new data regarding the incidence and prevalence of SIB. While incidence usually refers to the number of documented cases within a year, prevalence more often refers to an estimate in the population. Incidence is available only in research studies, and isolated, restricted populations (e.g., prisons, institutions), but estimates have been given by several researchers. Favazza (1989b) estimated SIB in 750 per 100,000 in the general population, whereas Whitehead and Ferrence (1973) estimated 1,400 cases per year per 100,000 population.

Within special populations, these researchers identified SIB in the following: 34% in patients with multiple personality disorders (Putnam, 1985), 24% of prisoners with antisocial personality disorders (Virkkunen,
1976), 35% of patients with anorexia (Jacobs & Isaacs, 1986), and 40.5% of patients with bulimia (Mitchell, Boutacoff, Hatsukami, Pyle, & Ekert, 1986). Toch (1975) found SIB incidence of 6.5% in male prisoners, even though most acts of self-mutilation were not recorded. Ross and McKay (1979) found that 86% of the girls at a juvenile delinquent facility manifested cutting. Severe self-injury was found in 15-20% of schizophrenic children, mentally retarded children, and children with organic dementia, according to Pattison and Kahan (1983). However, a rate as high as 40% has been documented in institutional settings for antisocial youth (Pattison & Kahan, 1983).

The following phrases describing frequency were found in the literature: quite common, frequent, well-known, and continuing disorder. References to an estimated high frequency were made, but data supporting these phrases were deficient. Because self-mutilation is almost always a private act and hidden, accuracy in documenting or estimating has been highly speculative. Many authorities (Favazza & Conterio, 1988; Pattison & Kahan, 1983; Valente, 1991) suggested that current data for SIB may be quite conservative; hence, prevalence may be greater.

Favazza and Conterio (1988) reported that from 250 usable mail questionnaires, 96% were female with a mean age of 28 years, and the average age of first self-harm was 13.5 years. These subjects reported a mean of 50 self-mutilative acts. The most common type of self-mutilation was cutting (72%), burning (35%), self-punching (30%), interference with wound healing (22%), hair pulling (10%), and breaking bones (8%). According to Pattison and Kahan (1983), in analysis of 56 published case
reports, SIB typically began in late adolescence with low levels of lethality and continued over many years with repetitive episodes. The range of subjects was 6 to 75 years, with a mean of 23 and a mode of 17 years. Forty-four (78%) of the subjects were under the age of 30 years. Thirty-four (60%) of the subjects reported age of onset of SIB from 16 to 25. However, Pattison and Kahan assumed that the subjects over age 30 were atypical; then the mean age of onset was 17 for the younger cohorts. The age of 6 was the onset for three cases of SIB. Multiple episodes were clearly the norm with duration of self-mutilation from 5 to 34 years.

Pattison and Kahan (1983) reported 27 (49%) of the subjects were male and 29 (51%) were female. They found no significant differences regarding types, onset, duration, or clinical features between males and females who did self-harm. Cutting was the most prevalent form of self-mutilation in the institutionalized, adolescent females (Ross & McKay, 1979). The arms were their most preferable sites; however, no body surface was immune.

Research

Excluding single-case studies of the early and mid-20th century, research into SIB was minimal until the '70s with hypotheses not supported well by data. However, in the '70s a British and Canadian large scale epidemiological study (Whitehead & Ferrence, 1973) focused attention on the phenomenon of SIB by documenting incidence as high as 1,400 per 100,000. Bach-Y-Rita (1974) investigated 22 mutilators noting a range of 3 to 150 scars in these subjects.
Ross and McKay (1979) disclosed extensive results from a treatment research program in a Canadian training school for 12- to 17-year-old delinquent adolescent girls. Incidence, forms, associative and epidemiological factors, and plausible explanations of etiology were recorded. When the team of clinical psychologists began its research, 86% or 117 of the 136 girls had carved themselves at least once. Many had recurrent self-mutilation with an average of eight carvings. Numerous other forms of SIB were uncovered and in spite of the team's best efforts to control these behaviors, the authors reported the SIB continued for months.

Ross and McKay (1979) explained that individual psychotherapy was tried, as well as psychodrama, behavioral therapy (covert conditioning, contingency management, token economy), family therapy, art music therapy, milieu therapy, group therapy, and relaxation therapy; yet self-mutilations persisted and at times, even worsened. They admitted, "We counseled, punished, lectured, cajoled, reprimanded, educated, and isolated--all to no avail" (p. 3). Finally, the research team suspended clinical expertise and began listening to the girls about their self-mutilations.

Ross and McKay (1979) described three times that self-mutilation was eliminated during their research project. Ironically, the first time, the research team neither knew that the self-mutilation had been reduced, nor how the reduction had been accomplished. The second time, the team recognized that SIB had been eliminated, but they still did not know how. But on the third time of SIB elimination, the systematic, unorthodox
strategies of reconceptualization, coopting carving, depathologizing, normalizing, and deromanticizing had been deliberately employed.

Having analyzed 56 published case reports of self-harm, Pattison and Kahan (1983) reported a typical pattern of onset in late adolescence, multiple recurrent episodes, low lethality, deliberate harm, and persistence of SIB over many years. They argued that their data revealed a deliberate self-harm syndrome that differs substantially from other classes of self-destructive behaviors. These authors proposed that revisors of the DSM IV consider "deliberate self-harm" as a separate diagnostic syndrome.

Similarly, Favazza (1992) argued that repetitive self-mutilation is a repetitive response to disturbing psychological or environmental events; it meets the criteria for a disorder of impulse control (p. 60). However, DSM III-R does not classify impulse disorders except for psychoactive substances and paraphilias. As a result of his past 5 years' research of SIB, Favazza recommended that repetitive self-mutilation be added to the list of Impulse Control Disorders Not Elsewhere Classified in the proposed DSM IV. Other impulsive disorders specifically listed in this category are kleptomania, trichotillomania, pathological gambling, and pyromania.

Following a personal disclosure of SIB on a Donahue daytime television show, Conterio received over 1,000 calls indicating similar issues and requesting information. Favazza and Conterio (1988) sent questionnaires with 250 usable ones returned. Epidemiological data revealed average age of respondent was 28 years and 13.5 years was average age of onset. The highest level of education was 1 year of college, and
annual salary was less than $10,000. Percentages of types of cutting have been discussed previously in this literature review. Sixty-six percent admitted having self-harmed within the past month while 18% disclosed that SIB was no longer a problem. Fifty-seven percent reported at least one drug overdose and one half of these had overdosed at least four times. Thirty-three percent expressed the likelihood of death within 5 years. The average number of self-mutilative acts was 50. Data of hospitalizations were also obtained.

Favazza (1989b) interviewed more than 300 self-mutilators and reported the reasons offered by patients for their self-mutilation. Subjects who did major self-mutilation responded within two primary themes: religion and sexuality. Subjects who manifested mild to moderate self-mutilation responded within the following themes: tension release, return to reality, establishing control, security, uniqueness, negative perceptions, pressure from multiple personalities, sexuality, venting anger, and relief from alienation.

Other reasons offered by subjects were: to avoid electroconvulsive treatment (ECT), to satisfy irresistible urges, to remove terrifying hallucination, and to save the world (Favazza, 1989b). Some subjects expressed the need to eliminate organs or limbs that they perceived as bad or dangerous to others. For example, one patient amputated his hand to prevent the urge to gamble.

Simeon et al. (1992) matched 26 self-mutilators to 26 control subjects by gender, age, education, axis I diagnosis of affective disorder, and axis II diagnosis of personality disorder. They reported
that self-mutilators had significantly more severe character pathology, greater lifetime aggression, and were more antisocial than the control subjects. The degree of self-mutilation was significantly correlated with impulsivity, chronic anger, and somatic anxiety. They also provided preliminary support for the hypothesis of serotonergic dysfunction that may be underlying self-mutilation.

Conclusion

Ross and McKay (1979) emphasized that an act of self-mutilation does not usually represent an isolated phenomenon. Instead, upon investigation the individual has likely been engaging in repetitive self-harm, often for many years. The literature provided evidence that SIB are more prevalent than once believed. Favazza and Conterio (1988) described chronic mutilators as now coming "out of the closet." All researchers expressed the need for mental health providers to become more familiar with the needs and demands of this population.

Self-mutilation is not a new phenomenon; references to SIB have been cited in the Bible. Although most research in modern science and medicine began with reports of single-case studies, empirical research using groups and controls has begun. Most data have been post-hoc and the confounding is exorbitant. Insurmountable difficulties seem present in SIB research. One question is this: Why do other individuals who have suffered similar abuses or disorders not engage in self-mutilation? Sibling research and epidemiological studies in SIB have great potential. If pharmacotherapy
and psychotherapy could be more beneficial, maybe time would allow measures for prevention thus reduce incidence and suffering.

Probably the least understood and what apparently needs extensive research is the biological, physiological component of SIB. The roles of genetics, neurotransmitters, endorphins, and hormones are being investigated. Although psychodynamic explanations are the oldest and most colorfully explicit, the victimization or trauma theory seems the most likely one to provide new insight. No matter how extensive the hypotheses have been, efficacious intervention of SIB has been minimal. Few, if any explanations lead to prevention. The multi-factorial complexity of SIB is recognized. Many researchers wrote about environmental stressors and trauma such as abuse, while others focused on behavioral reinforcements.

Taken as a whole, these studies point to roles of environmental, cultural, sociological, religious, cognitive, psychodynamic, and biological factors in SIB, but data are still sparse. Longitudinal studies, victimization studies, and increased epidemiological and psychopharmacological research give promises to more solutions. Re-evaluation of symptomatology may yield insight for possibly new diagnostic classifications. The researcher believes the practice of assigning multi-axial diagnoses be utilized when appropriate. Research providing increased evidence for reclassification of SIB may change prognoses.

Although SIB seem perverse and crazy, most of the subjects gave somewhat plausible reasons except for the few in psychoses. Consensus is that most patients want to stop but "don’t know how or can’t." Similarly,
clinicians can't agree on what to do. Perplexity continues, control strategies remain problematic, and human loss and suffering are prolonged.
PAPER I.

SELF-INJURIOUS BEHAVIORS IN CHILDHOOD:
RETROSPECTIVE ADULT INTERVIEWS
INTRODUCTION

Incidences of self-injurious behaviors (SIB) are neither isolated phenomena nor unique only to severely retarded and autistic individuals. These behaviors do occur in nonretarded, nondelusional, socially functioning children and adults. Incidences of SIB are estimated by Favazza (1987) to be 24% to 40% in psychiatric patients and in approximately 750 per 100,000 of the general population.

Self-injurious behavior, the deliberate and/or alteration of the body without conscious suicidal intentions, has many manifestations. Common examples are cutting, burning, self-punching, biting, scratching, and hair pulling. Less common and primarily found in psychoses are amputations, eye enucleation, self-eviscerations, stabbing, and eye-poking. This list is not inclusive; the range of self-injuries is as wide as the human mind can conceive.

The problem is that a sparsity of information still exists in biological research, management, epidemiology, and early childhood histories of self-abusers. Single case studies characterize the majority of the literature. Within the past 15 years, research using larger samples has investigated epidemiology and symptomatology (Favazza, 1987, 1989, 1992; Favazza & Conterio, 1988; Feldmann, 1988; Greenspan & Samuel, 1989; Ross & McKay, 1979; Stone, 1987).

Over the years, clinical literature has cursorily mentioned factors of childhood abuse being present in histories of self-mutilators. Three unique studies (Green, 1978; Kiser, Heston, Millsap, & Pruitt, 1991;

Kiser et al. (1991) purported that the reactions of children and adolescents to physical and/or sexual abuse present two distinctly different symptomatic pictures. They stated that 55% of abused children develop symptoms of post-traumatic stress disorder (PTSD). Those who do not develop such symptoms exhibit more anxiety, depression, externalizing behaviors, and more problems overall. They also found significant differences between children who were victims of a single abuse event and children who are or have been victims of ongoing abuse. The latter demonstrated significantly more maladaptive behaviors, including depression and psychoses.

After following 74 subjects for 4 years and monitoring SIB, van der Kolk, Perry, and Herman (1991) concluded that childhood trauma contributes to the initiation of self-destructive behavior, but deficits of secure attachments in adulthood maintain it. They explained that individuals who engage in chronic SIB are prone to react to current stresses as reenactment of childhood situations of trauma, abandonment, neglect, disrupted care, and violence. Van der Kolk et al. (1991) purported that sexual abuse was most strongly related to all forms of SIB. Witnessing domestic violence, however, was associated with suicide attempts but not with self-cutting or other SIB. These researchers found that childhood
trauma scores were not related to suicidal ideation but predicted suicide attempts, cutting, other SIB, and anorexia.

Whether early trauma of sexual abuse is more adverse than sexual abuse suffered in the teens is highly controversial. Evidence from non-clinical samples, however, strongly suggests a positive correlation between duration of abuse (which is also highly correlated with frequency) and adverse adjustments in later life (Browne & Finkelhor, 1986).

Insufficient evidence does not allow conclusions on the commonly held assumption that disclosure is always helpful! Jehu (1988) found that when a child did attempt to disclose incest, extreme negative reactions toward the child were often exhibited. Browne & Finkelhor (1986) reported that negative parental reactions to disclosure are definitely associated with adverse outcome for the victim. When a young daughter has attempted to tell her mother about the incest but is met with condemnation, disbelief, and punishment, additional trauma results.

However, the research of Harvey, Orbuch, Chwalisz, Garwood (1991) stated that when early disclosure of sexual assault meets with empathic reactions, coping is enhanced and maladaptations are lessened. These researchers also found that incest survivors had more difficulty in coping with any stress and in establishing intimate attachments than did nonincest survivors.

The likelihood of sexual abuse accompanied by SIB occurring among children today is quite possible. Although school officials and health providers in most states are mandatory reporters of child abuse, subtle signs and hidden self-injuries allow sexual abuse and SIB to go unnoticed.
Compounding the secrecy of the sexual abuse, the child or teen who is self-injuring has another secret. Self-injurious behaviors are almost always done alone and quite often on unexposed body parts, such as breasts, abdomen, and genitalia. Exceptions are incidences in the adolescent and incarcerated populations where SIB were not hidden, but associated with peer pressure (Favazza, 1992; Ross & McKay, 1979).

Counselors and school officials, as well as health-care providers, are on the "front-line." In fact, I purport that school professionals play a MORE crucial role in the identification and intervention of this population than the family physician. Schools allow professionals daily insight into children's lives. Although sexual abuse occurs within privacy and much is hidden by secrecy, abused children present signs and symptoms which should help us identify them and take appropriate action.

The purpose of this study was to investigate SIB: (a) modalities, (b) age of onset, (c) reasons of SIB from subjects' perceptions, (d) subjects' reports of pain and/or pleasure in SIB, (e) subjects' specific thoughts/feelings immediately pre and post self-injury, (f) incidence of childhood abuse, (g) gender and relationship of the abuser, and (h) incidence of adulthood rape.

Studying the data collected from 63 nonretarded adults who chronically self-injured and disclosed many details about their childhood has added to the body of knowledge about this population. Candor and exact words of the subjects have been included, not to sensationalize, but to present reality.
METHOD

Instrumentation

A 12-month pilot study with seven women who manifested chronic SIB provided insight for construction of a retrospective questionnaire and interview format. Sixty-three nonretarded, nonpsychotic adults completed retrospective questionnaires followed by private, face-to-face interviews with the researcher. The 1- to 3-hour interviews required subjects to toil through highly sensitive issues and explain their responses. Notes were recorded by the researcher following each interview.

Subjects

All subjects were clinician referrals except for 6 who answered an ad in a university newspaper. Subjects ranged in age from 21 to 62 years and included 47 females and 16 males. All subjects were presently or recently in therapy except for four. Two subjects had dropped out of therapy several years ago; 2 reported they had never seen a therapist regarding SIB or incest. Criteria for participation included: (a) voluntarism, (b) exclusion of diagnosis of retardation, (c) 21 years or older, (d) free of psychosis, (e) repetitive SIB for 2 years or more, (f) no organic pathology underlying SIB, and (g) the subject must have indicated the repetitive SIB were not consciously and primarily suicidal intentions. All subjects were Caucasian by default of voluntarism and the referral process, and the average level of education was 13 years.

The following resources provided the stated number of subjects: private clinicians, 12; state hospitals, 20; regional mental health
centers, 9; out-patient units of county hospitals, 11; self-referrals, 6; county homes, 2; and residential homes, 3. Subjects generally reported an altruistic reason for participating in the research.
RESULTS

Fifty-two (83%) of the 63 subjects reported sexual and emotional abuse in childhood (see Table 1). Not uncommon were the subjects who could remember only fragments of the abuse. This researcher regrets not having obtained from the questionnaire specific data defining the number of years of sexual abuse. However, in reviewing interview notes, this researcher believes the sexual abuse was frequently endured for 4-10 years for most of the 52 subjects. Also, the many descriptions of the sexual abuse would most likely be considered sadistic and humiliating by this society.

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Insert Table 1 about here

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The age of onset of SIB was shocking to this researcher because many subjects did report early childhood self-injuries (See Table 2). Most subjects reported a history of remissions and exacerbations of SIB, but almost all described a picture of escalation of severity of SIB over the years.

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Insert Table 2 about here

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Ages of first sexual abuse victimization of subjects are reported in Table 3. ALL subjects who reported sexual abuse also indicated emotional abuse. The data show that 98.1% of sexually abused subjects had been
victimized by age 13. This sample clearly indicated the onset of victimization occurred in early and middle childhood.

We must be keenly aware that children hide, lie, and deny abuse for many reasons. Courtois (1988) reminded us that ambivalence, fear, guilt, shame, and even attempts at protecting the abuser are common in the adult victim of child abuse. Therefore, this researcher believes a child is even more vulnerable to threats, fears, and the likelihood of denial than adults. Many subjects in this study voiced fears of being (a) jailed for their participation in "sex play," (b) separated from a loved one, (c) responsible for a brother kicked out of school or dad sent to prison, (d) maimed badly or even killed, (e) shamed by the teacher, or (f) alienated even more by peers. The subjects described living a life of fear and shame in their childhood.

A positive correlation (r=.32) of the age of being abused and the age of onset of SIB was statistically significant at the .01 level. Data showed that within 1-3 years after the first sexual abuse, the majority of the subjects reported initiating self-injury. The subject who reported sexual abuse at age 4 had started SIB by age 5-7 years. However, 2 subjects stated that concurrent with their sexual abuse was severe physical abuse. Both indicated they didn't have the need to punish themselves as children because they were so severely beaten anyway. They
wondered if there were a connection between their initiating SIB and leaving home (viz., taking up SIB when parents' physical abuse stopped).

All 63 (100%) subjects disclosed using multi-modal self-injurious acts. Cutting (78%), hitting (67%), scratching (56%), followed by burning (48%), were the most common self-injuries reported by these adult subjects. Self-hitting was defined as punching or slapping self, but incidences of hitting oneself with an instrument (e.g., hammer, board, etc.) were also included. Subjects reported utilizing broken glass and sharp rocks for cutting as young children, but they recalled using razor blades, knives, can openers, and scissors in adolescence. Scratching with sticks and fingernails and poking themselves with pencils, sticks, and diaper pins were commonly reported to have been done in childhood. However, these modalities again escalated into more harmful instruments (e.g., needles, sandpaper, ice picks) during adolescence. Burning was accomplished most often by using cigarette lighters during the teen years, which continued into adulthood.

The forearms were the most common sites of self-injury; however, no body part was immune. Three female subjects reported "carving" words (e.g., hate, bad, slut, kill, die) on their thighs during adolescence. Several subjects spontaneously showed the researcher their scars although it was not requested. One subject showed an old scar, strategically located where a watch would have been. She reported cutting her skin under her Cinderella watch "almost daily during third grade." Breasts, genitalia, abdomen, feet, eyebrows, and scalp were sites also chosen to
injure, but these were less common. Sites of fresh wounds were generally hidden with clothing. Most subjects reported doing SIB as a solitary act. Some subjects disclosed they kept their SIB a secret for many years. According to subjects' responses, as children they were seldom taken to a physician by their parents. Two middle-aged females reported disclosing histories of incest and SIB within just the past 2 years. One had 52 years of secrecy and the other 48 years of secret "torment." Both initiated self-injurious acts during early childhood. Excuses were offered to parents, teachers, principals, and peers. Many reported that upon occasionally seeing a physician, plausible explanations (e.g., fell on a barbed wire fence for lacerated genitalia) were proposed and were almost always unquestioned.

Most subjects admitted they badly wanted help, but for a multitude of reasons (e.g., shame, guilt, possible exposure of the incest, fears) felt they could not disclose their self-injurious practices. One reason commonly offered was, "If I really did tell someone what I was doing [SIB], they would think even more badly of me." Inferences were that the shame and guilt of incest were bad enough without the additional disclosure of SIB. The following vignette, a 30-year-old female subject's statement, is illustrative of this dynamic:

When I was eight years old, my 15-year-old cousin began to rape me in my mouth and butt. I kept it a secret 'cause I knew I'd get in big trouble and people would think I was bad. He kept this up until I was about 13. He called me a slut and whore. I hated him and the world. School was hard 'cause I saw him about every day and he threatened me. He laughed at me in the halls and when I got on the school bus. I wanted someone to ask me if I were okay, but I probably would have lied to protect him [shakes head] and so I wouldn't get into trouble. I know it wasn't my fault, but I feel so dirty and shame yet today. I
began scraping my skin with sandpaper when about 10 years old and then cutting about 13. I hate myself and still cut some so that I get some relief.

Forty-four (70%) of the subjects reported being abused only by males with an additional 8 (13%) subjects reported being sexually abused in childhood by both males and females. The female abuser was consistently reported as the subject's mother. No subject reported only a female sexual abuser. Of these victims, 41 (65%) disclosed that the sexual abuser had been only a relative, while 2 (3%) reported extrafamilial abuse only. Eleven (21%) subjects reported that they had been sexually victimized by both relatives and nonrelatives. Although abusers' identities were not specifically collected in data, the researcher's notes indicate abusers were identified in this order of frequency: fathers, step-fathers, brothers, grandfathers, cousins, uncles, and brothers-in-law.

All sexually abused subjects also reported experiencing emotional abuse. The researcher thinks it is helpful for the reader to read exact words that were messages to these children; therefore, included are a few examples of subjects' statements:

- "My dad said I was good for nothing but for sex."
- "My mom called me a slut ever since I can remember and called me ugly and that no one would want me except to fuck."
- "My step-dad said I was put on earth for men to enjoy and to forget about anything else, that I would fail at it anyway."
- "At bedtime, Dad said it [mutual fondling and masturbation] would make the boogeyman go away and I'd be safe."
- "When I was little, I remember waking up with my step-dad's penis in my mouth. He said it would comfort me!"
Degrading words (e.g., bad, stupid, ugly, good-for-nothing, whore, slut) were apparently daily references to the majority of subjects while growing up. Another extreme example of emotional abuse was the frequent use of threats if the incest secret were told to anyone. Not all, but many of the subjects expressed hatred toward the abuser, but they also expressed extreme anger toward the unprotecting parent. Several female subjects reported sensing that "As long as I can remember, Mom seemed jealous of me and seemed to hate me for what Dad did to me." The following vignette, a 26-year-old female's statement, is illustrative of such a scenario:

My mom knew my step-dad was having sex with me. It began when I was 7 years old, and I had to keep this a big secret. I started cutting my arms with razor blades about 8 years old. I wanted to scream, "Can't you see somebody is hurting me? I want somebody to help me." I hid it [cutting] for about 2 years, then it [cutting] got worse and had to have stitches at the hospital. But NOBODY [capitalization used to indicate subject's emphasis] asked me about sexual abuse! And I didn't tell. I was so ashamed I continued to keep the secret. In junior high, I finally told one of my favorite teachers and she didn't believe me. She told me I was naughty for talking like this, so I kept still again. My step-dad told me I was born to be his sex playmate. I ran away when I was 13 and could only make a living by prostitution. I've been in and out of jails. (Last cutting 2 days before this interview.)

Thirty subjects reported rape in childhood while 8 indicated "not sure." Of the rape victims, 24 (80%) had also been raped in adulthood. The positive correlation (r = .40) is statistically significant at the .01 level between these two factors. The chances of a child victim being repeatedly victimized again in life are moderately high.

One open-ended statement on the questionnaire was: "At the time I begin to hurt myself I say to myself _________." Ninety-five percent of
the responses had common themes of self-degradation, condemnation, deserving of punishment, and purpose (e.g., proving a specific point, revenge to abuser). All of the following statements are from subjects who were sexually abused by a relative over a prolonged time in childhood.

- "The blood is my release." (Female began sticking self with diaper pins at age 7 and cutting by age 13; described several incidences of fractured bones after hitting hand with a hammer.)

- "I want to hurt myself; I need to be punished." (Female began cutting at age 10).

- "I am bad. I deserve to look this way." (Female began cutting and burning at age 9).

- "I know better. It looks ugly, but I deserve it." (Began pulling hair out at age 4).

- "I've never been happy. I'm no good. I hate myself." (Began picking and scratching at age 6).

- "I can't take any more. It won't stop until I am hurt--physical evidence of harm, see blood, see mark." (Female began cutting at age 13.)

- "I'm going to make myself feel better." (Female began cutting at age 7).

- "I can't stand this tension. I have to get rid of it. I can't stand this god damn feeling." (Female began cutting and burning at age 17).

- "Fuck 'em all. I'll show them [abusers] I'm in control." (Female began cutting and pulling hair out at age 6).

- "I deserve this, now do a good job." (Cutting at age 16).

- "You bitch, you deserve it." (Female began cutting and pulling hair out at age 8 or 9).

- "I think I'm getting the pain out so everybody can see how much I hurt inside." (Male began self-punching and hitting himself with a hammer at age 17).

- "I don't want to keep the secret [incest] anymore." (Female began cutting at age 17).
• "You are bad, evil, you don't belong here, no one wants you." (Female began biting self at age 6 and bruising, burning, and scalding by age 13).

• "You stupid idiot." (Female began burning at age 15).

• "I'll never be happy. I'm no good. I hate myself. I want to die." (Female began picking and scratching at age 6).

• "Damn, what's controlling me? Please stop me from hurting myself any more." (Male began self-punching at age 10).

• "I want to prove to the world the pain is real." (Female began self-punching at age 12).

Many examples have been included at the cost of redundancy, for each subject courageously presents his/her reality. Space in this manuscript does not allow for all the sincere, candid responses to be printed. However, the examples are representative and clearly emphasize the emotional pain, rage, low self-esteem, and desperation that these adults still experience.

Most subjects identified 6-10 different reasons for their SIB. The four most frequent reasons, number, and percentages of subjects were: (a) relief from emotional pain, 59 (94%); (b) punish myself, 56 (86%); (c) express rage, 54 (86%); and (d) to comfort myself, 37 (59%). All 16 (100%) males identified relief of emotional pain as the most salient explanation for SIB. Emotional pain was described by subjects as guilt, extreme sadness, terror, loneliness, shame, and rage. The following vignette, a 35-year-old female’s statement, exemplifies many of these feelings:

We were a good religious family, so I didn’t dare tell anyone about the abuse. My dad routinely fondled me when I was little and he had sex (coitus) with me until I was 12. He told me then that he’d kick me out of the house and disown me if I ever got pregnant. So he stopped sex (coitus) with me and started having
oral sex (fellatio) with me about 13 so I wouldn't get pregnant! On Sunday, we went to church and sat together as a nice family and on Monday I got screwed. At dinner time at home, the food was always passed first to my father, then to my brothers, right past me and my sisters. Of course, Mom always got the last. We (the females) got what was left. The message in our house was if you were male, you got always what you wanted! (Reported biting and bruising self at age 6 and by age 13 reported cutting, burning, scalding, and inserting instruments into her vagina to cause bleeding. She explained that she felt rage toward her body and "cut what he [father] thought I was only good for.")

Suicide intention was collectively identified as the tenth most common explanation for SIB. However, no subject checked suicide as the most salient reason for SIB.

Perhaps many clinicians have wrongly concluded that SIB is primarily attention seeking per se. The reason, "Gain attention," was checked by 19 (30%). These messages were clearly, "Help. Help. I'm hurting. The pain is real." Some subjects explained that when the verbal attempt to cry for help was ignored or denounced, then a "physical cry" of SIB began. Their nonverbal messages were: "I want somebody to help me." Despite receiving emergency room treatment, several subjects indicated clinicians failed to inquire about their emotional needs.
DISCUSSION

Fifty-two (82.5%) subjects recalled severe sexual abuse in childhood or adolescence in a research investigating chronic SIB. These data revealed that 96% of these subjects who began SIB under the age of 18 indicated early and prolonged victimization. All but one subject reported abuse by age 13. Because of the complexity of SIB, one cannot conclude that prolonged, sadistic sexual abuse causes SIB; however, this epidemiological link should be recognized. Furthermore, the age of onset of SIB was found to occur within 3 years of the first sexual victimization. Early identification of abused children and intervention are critical to prevent long-term maladaptive effects.

The results of this study raise issues (e.g., sexual abuse, neglect, etc.) already familiar to the school counselor, as well as some shocking, repulsive, and highly perplexing results. The primary theme of this manuscript is to facilitate understanding of SIB in children through the testimonies of adults recalling their painful childhood experiences. One subject succinctly described school days as, "Going to school was hell and going home was hell." It is the researcher's belief that SIB continue to occur in children of today just as they did in the childhood of these adults. Most likely, SIB continue to be cleverly hidden now just as these adults hid them in childhood. Most school counselors are well aware of the overt signs of physical abuse and neglect. Sexual and emotional abuses which occur in privacy and secrecy are far more subtle and difficult to assess.
Indicators of Possible Sexual Abuse

School counselors can use the following indicators to recognize possible sexual abuse. This list was primarily generated by the subjects in this research. Of the following indicators, the first four are suggestive that SIB also may be occurring.

1. **Wearing long sleeves on a hot day. Overdressing to hide wounds.** Swimsuits, shorts, and short-sleeved shirts were avoided.

2. **Frequent absenteeism from physical education classes.** Four subjects admitted dropping from school explaining that absenteeism resulted in an "F" in PE. Taking showers, wearing shorts, and undressing thus exposing scars or fresh wounds would have caused extreme embarrassment.

3. **Involuntary urination.** Perhaps a dissociative state compounded by the child's urinary genital inflammation and pain resulted in urinary incontinence. Six subjects reported this symptom occurring in the elementary grade school.

4. **Poor appetite. Sometimes pica, eating nonfood substances (e.g., dirt, clay, paper).** Pica always warrants a mental health referral. Twelve subjects admitted eating nonfoods as children; 5 subjects admitted eating dirt. Three subjects reported this behavior sometimes yet occurs in adulthood; these 3 indicated experiencing repetitive, forced fellatio in childhood.

5. **Frequent staring, daydreaming, preoccupation, fantasizing, and inability to concentrate.** Dissociation and daydreaming were reported as the most common defenses spontaneously used to cope with the mental torment.

6. **Extreme shyness in a child. Wanting to be unnoticed.** Any attention or request for the child to stand up in front of the class caused panic. As children, they thought that "everybody could see what my dad did to me last night" (referring to fellatio, fondling, or coitus).

7. **Grimaces of fear and hyperstartled reflex.** Many subjects reported that having anyone approaching from behind or touching gave them much discomfort.

8. **Hypervigilance and avoidance of adults.** The presence of an adult male frequently caused the child to withdraw and to "be on guard."
9. Absence of normal, healthy friendships. Many subjects expressed either being fighters or loners. Loneliness was a constancy.

10. Pulling and scratching at the genitals; inability to sit quietly and/or difficulty in walking. Some recall that their genitalia were hurting, itching, and/or burning.

11. Arriving early at school and delaying departure to escape home. Because school provided safety and solace, several reported volunteering to help teachers and "hang around."

12. Excessively aggressive, disruptive, withdrawn, passive, or compliant behaviors. Subjects expressed sudden changes in their behaviors and attitudes occurred after the abuses had begun.

13. Painful urination. Subjects commonly reported this symptom and seeing a physician for treatment rarely occurred.

14. Torn, stained, or bloody underclothing. Subjects recall hiding their underwear, thereby avoiding exposure.

15. Poor academic performance, especially an abrupt deterioration. "I couldn't concentrate; I don't see how I got through school," was a typical expression of the difficulties in school performances.

16. Sleep disturbances including nightmares, difficulty falling asleep, and enuresis. Many subjects described experiencing these symptoms in both childhood and adulthood.

17. Precocious and unusual sexual behaviors (e.g., excessive masturbation, seductive behaviors). One subject described teaching female classmates "how to masturbate while in the restroom during third grade."

Counselor Implications

The subjects disclosed horror stories of being humiliated, discounted, or being called "liars" by family members and school officials. The researcher does not believe these negative reactions would occur from school counselors today; however, disbelief may likely continue to occur in reactions from other family members. Victims of incest often feel an intense betrayal. Children commonly believe that they are
responsible for the abuse because they are inherently "bad." Furthermore, abused children have learned that adults cannot be trusted; therefore, achieving trust with a maltreated child can be a most arduous task. The following suggestions may be helpful when counseling an abused child:

- Evaluate personal feelings of incest/abuse by autognosis so that personal emotions don't interfere in the interaction.
- Provide an atmosphere where the child feels safe and comfortable.
- Respond with genuine concern and sincerity, saying "I believe you."
- Assure the child that the abuse is not his/her fault; emphasize that no one will blame him/her for what has been done. Minimize guilt.
- Listen with empathy, sensitivity, and compassion.
- Avoid condemning or harshly criticizing the perpetrator for the child may both love and hate the abuser; instead, focus on the inappropriate, wrongful actions of the abuser.
- Counsel with an open communication style and avoid questioning.
- Allow the child to proceed at his/her own pace. Be patient.
- Accept that the maltreated child will not continuously focus on the abuse but will want to discuss other childhood interests as well.
- Encourage and accept any emotion that the child is expressing.
- Empower. Assist the abused child to recognize his/her strengths.
- Recognize that the abused child has many fears, thus may lie to protect the abuser.
- Reinforce the child's attempt at disclosures. Use counseling encouragers.
- Kindly praise the child for confidence entrusting you with the "secret."
- Facilitate hope so that the child believes situations can improve.
- Teach assertiveness skills.
- Reassure the child of your availability; be consistent and dependable.

- Avoid overprotection of the child in the school environment as this may further isolate the abused child.

- Use body language that also conveys empathy, sincerity, and support.

- Teach healthy ways to express rage instead of SIB or aggression.

- Refer child for mental health evaluation as needed; seek consultation in difficult situations.

Counseling traumatized children can be discomforting and intense. James (1989) recommended that elements of fun be integrated within the counseling session. James explained, "Many children who have had terrible things happen to them or who have witnessed horror do not believe they should ever laugh or have fun again" (p. 14). When the counselor laughs with the child, the message is that it is okay to have fun in spite of pain in life. Also, laughter can facilitate a therapeutic alliance and reinforce the theme that life goes on.

Misbehavior can truly be a misnomer. If we accept that behavior is purposeful, the school counselor is in a crucial role to consider possibilities of alternative dynamics. Children labeled "lazy, daydreamers, disruptive, stupid, discipline problems, drop-outs, and/or runaways" could be victims of child abuse. Many of the 52 subjects described themselves as having received those labels in school.

This researcher recognizes that many school counselors have become important authorities in sexual abuse prevention. Tennant (1988) cited specific steps for parents and teachers to take when a child is discovered to have been sexually abused. Participating and supporting programs based
on the "good-touch, bad-touch" and "good secrets, bad secrets" themes have helped abused children and potentially abused children. The preventive keys to sexual abuse are improved self-esteem, assertiveness skills, awareness, and empowerment. Naiveté abounds. Potential abuse is reality. Awareness and preparedness ensure more safety.

The school counselor is a key resource in selecting media and programs with other school officials. School nurses, social workers, teachers, and school counselors generally implement the educational, sexual abuse prevention programs. Hollander (1989) emphasized that ideally school personnel and parents jointly develop these educational programs. These cooperative efforts facilitate parental support for discussing these sensitive issues both in school and at home. Hollander concisely summarized 16 books as possible resources in sexual abuse prevention programs. Videotapes, films, and guest speakers offer additional media for the counselor to consider when planning a program. Mandatory reporting, sexual abuse prevention programs, and heightened sensitivity compel school counselors to assume leaders' roles.
SUMMARY

Fifty-two subjects who engaged in chronic SIB reported prolonged, sadistic, sexual, and emotional abuses in early and middle childhood. These were not victims of single abuse events. Findings of early SIB associated with severe sexual abuse reconfirmed results of researchers Green (1978), Rosenthal and Rosenthal (1984), and Kiser et al. (1991). Also, similar data were recorded on these subjects as in the research of van der Kolk et al. (1991); combined childhood trauma and dysfunctional relationships were pathognomonic of subjects engaged in chronic SIB. This researcher endorses the need to provide counseling and a supportive network for victimized children. Volmer and Pellegrino (1988) recognized this need and challenged counselors to go beyond providing abused children with physical care for acute injuries and attend to the emotional wounds.

Children purposefully hide SIB and sexual abuse. School professionals must carefully respond to vague, ambiguous warning signals. The subjects in this study had important messages for counselors and educators so that we can identify abused children and facilitate early intervention. These subjects reported having no one to talk to about their abuse or SIB. Doing schoolwork and completing assignments were sometimes nearly impossible for them. Being preoccupied with escape fantasies, fears, shame, and bodily pain did not facilitate learning. Children today have the availability of highly skilled school counselors who will listen and report abuse. These professionals are more likely to entertain alternative dynamics in discussing "misbehavior."
Perhaps, a common approach would be to deny, dissociate, and intellectualize the testimonies and statistics of this research. It is difficult to be empathic with statistics, but the researcher knows 52 human beings who brought garbage and unfinished business of childhood into the present. Prevention is our best hope. A child cannot flourish in life when experiencing fear, shame, pain, and terror. Any child abuse is too much. One child who engages in SIB is one too many.
REFERENCES


Table 1. Frequencies and percentages by gender of childhood abuse in subjects who self-injure (N=63)\(^a\)

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\(^a\)Subjects answered with multiple responses.
Table 2. Frequencies and percentages by gender by age of onset of self-injurious behaviors (N=63)

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PAPER II.

DIFFERENTIAL DIAGNOSES OF CHRONIC SELF-INJURIOUS BEHAVIORS
INTRODUCTION

Clinicians are challenged in recognizing the co-morbidity of post-traumatic stress disorder (PTSD) because of the heterogeneity of subjects who engage in chronic self-injurious behaviors (SIB). Perhaps borderline personality disorder (BPD) has been over diagnosed and PTSD has been under diagnosed in patients who engage in chronic SIB. Perhaps our current system of diagnosing mental disorders focuses more on classifications than on treatment plans. Differential diagnoses can be challenging. Multiple diagnoses may be indicated for some subjects engaged in chronic SIB.

Self-injurious behaviors, defined in this article, refer to the deliberate destruction and/or alteration of the body without conscious suicidal intentions. Common examples are cutting, picking, self-punching, burning, biting, hair pulling, and interfering with wound healing. Less common, but still prevalent, are amputations, enucleation, auto-castrations, ingestion of nonfoods, stabbing, eye-poking, and self-eviscerations. This list is not inclusive; the range of SIB is as wide as the human mind can conceive. These acts can be single events; however, this study included only repetitive self-injuries.

The purpose of this study was to investigate chronic SIB: (a) modalities, (b) age of onset, (c) reasons for SIB from subjects' perceptions, (d) factors/situations reported to be associated with SIB, (e) subjects' reports of pain and/or pleasure in SIB, (f) subjects' specific affects/cognitions immediately pre and post self-injury,
Brief Literature Review of Self-injurious Behaviors

Self-injurious behaviors are frequently found in the retarded, autistic, and incarcerated populations; these aggregates have usually represented the groups in SIB research investigations. However, SIB do occur in nonretarded, nondelusional, socially functioning children and adults. Incidences of SIB are estimated by Favazza (1987) to be 24% to 40% in psychiatric patients and in approximately 750 per 100,000 of the general population. Self-injurious behaviors are thought to occur more frequently in the general population than is documented (Favazza, 1989; Green, 1978; Rosenfield, 1979).

Single case studies of SIB characterize the majority of the literature. Psychoanalytic interpretations of single case studies (e.g., van Gogh's severance of his ear) are well known. Within the past 15 years, researchers using larger samples have investigated epidemiology and symptomatology (Favazza, 1987, 1989, 1992; Favazza & Conterio, 1988; Greenspan & Samuel, 1989; Ross & McKay, 1979; Stone, 1987).

Favazza (1989) investigated 300 self-mutilators and reported prevailing diagnoses and the reasons offered by patients for their SIB. Severe SIB were found in major depression, mania, and schizophrenia. Chronic encephalitis, acute drug toxicity, and transsexualism were other disorders found in this category. Religion and sexuality were the two primary reasons given by subjects in this substratum. Moderate SIB were
found in personality disorders (e.g., borderline, histrionic, multiple),
eating disorders, compulsive disorders, adjustment disorders, and
factitious disorders. Habit and relief of tension were reasons offered by
patients in this substratum.

Self-injurious behaviors have long been considered symptoms of
various neurological and standard psychiatric disorders as classified in
the DSM III-R. However, Graff and Mallin (1967) and Rosenthal, Rinzler,
Walsh, and Klausner (1972) described wrist-cutting syndromes. After
investigating 32 patients, Pao (1969) characterized a "delicate self-
cutting syndrome" (p. 195). These researchers gave the impetus for
considering SIB to be a distinct disorder. Lacey and Evans (1986)
described a "multi-impulsive disorder that includes interchangeable
symptoms (e.g., binge-eating, substance abuse, kleptomania, self-
mutilation)" (p. 641). Favazza (1992) proposed further developing the
concept of a distinct syndrome which he portrayed as "repetitive self-
mutilation" (p. 60). Pattison and Kahan (1983) differentiated episodes of
repetitive SIB of single events versus multi-events of high lethality.
Classification of SIB still remains controversial.

The relationship between physical and sexual abuse and psychiatric
illnesses was investigated in victimized patients versus nonvictimized
patients (Carmen, Rieker, & Mills, 1984). While not specifically studying
SIB, they found that a higher percentage of chronically abused patients
exhibited behavioral patterns of inward aggression in contrast with the
nonabused patients. These researchers described the victimized patients
had directed rage in an overt and active fashion of "suicidal intent
and/or savage self-hatred, with loss of control reflected in a variety of self-destructive and self-mutilating behaviors" (p. 380).

Receptive, empathic reactions to disclosures of incest led to greater successes in coping than did negative, rejecting reactions (Harvey, Orbuch, Chwalisz, & Garwood, 1991). Also, data revealed that early confiding, shortly after a sexual assault, resulted in improved coping skills, than late confiding, where years had passed from the period of trauma.

Theoretical Explanations of Self-injurious Behaviors

Theoretical explanations and hypotheses of SIB include psychodynamic, religious, cultural, behavioral, humanistic, existential, biological/organic, and victimization postulations. Favazza (1987) presented extensive discussion and examples of theoretical postulates of SIB in his book, Bodies Under Siege: Self-mutilation in Culture and Psychiatry. Causes are highly diverse; no one theory fits the wide range of SIB. Three relevant theories are briefly summarized.

Psychodynamic interpretation of SIB involves early interpersonal trauma; a punitive superego acts with an uncontrollable id in the presence of a poorly functioning ego. To cope with stress causing extreme anxiety, individuals unconsciously employ defense mechanisms (e.g., regression, introjection, fantasy, identification). Both Freud (1936) and Menninger (1938) explained that self-mutilations were "partial suicides." Menninger (1938) concluded that self-mutilation was the individual's attempt at self-healing.
Victimization and trauma theory focus on survivors' psychological responses to being victimized. The hypothesis is that maturing cognitive schemata are affected by traumatic life experiences; reactions are interpretations of traumatic events. The premise of trauma theory is that each individual uniquely interprets trauma to accommodate loss, tragedy, pain, rage, sorrow, or whatever unfolds due to catastrophic experiences. As a result, the individual develops behaviors to cope with the trauma (Beck, 1967; McCann, 1988).

Researchers (e.g., Courtois, 1988; Kilpatrick, Veronen, & Best, 1985; McCann, 1988; Russell, 1986; Wilson & Krauss, 1982) have provided data and insight into post-traumatic coping responses. These researchers posited one difficult problem facing researchers is distinguishing sources of trauma. For example, within the area of child victimization of sexual abuse, many factors (e.g., age of first victimization, duration, perpetrator relationship, disclosure, reactions to disclosure, threats, types of abuse, prejudices, socioeconomic class, illness) can produce differing effects.
METHOD

Pilot Study

While co-leading an out-patient women's psychotherapy group during 1991 at a midwestern hospital, this investigator conducted a pilot study. The subjects included 7 women, ages 40-60, who were all adult victims of childhood sexual/physical abuse. Six of the 7 engaged in chronic self-injury. Four subjects reported the onset of SIB by the age of 7, and 2 subjects had begun SIB by the age of 5. In terms of chronicity, 5 had engaged in some type of repetitive self-injury for over 30 years.

As the subjects participated in group therapy, commonalities in their disclosure of feelings and thoughts surfaced; however, differences emerged also. Intrapsychic phenomena associated with SIB were diverse. In trichotillomania, the DSM III-R (APA, 1980, p. 326) requires both tension before and relief/gratification after a hair-pulling episode. Although no one shared this specific diagnosis, these patients expressed variations in affects pre and post SIB. For some, tension was expressed in rage, shame, nervousness, sadness, and/or guilt in the immediate prodromal period, but these affects did not always subside in the post self-injurious period. This investigation evolved based on these observations of variations and inconsistencies.

Instrument and Procedure

The retrospective questionnaire was designed primarily from content expressed in the pilot study. The reasons associated with SIB, affects,
and cognitions generated by the pilot study subjects were organized into checklists. The original questionnaire and interview format were revised based on valuable feedback gained from the women in the pilot study.

For the new questionnaire, a Likert scale was constructed for each affect/cognition item listed. Each subject was requested to rate the prevalence and intensity of each descriptor on a scale of "0" to "5." A "0" translated as NEVER experiencing the specific feeling/thought immediately pre or post self-injury. The gradient scale ranged to "5," meaning that the specific feeling/thought was INTENSE or VERY MUCH on the subject’s mind immediately pre or post self-injury. This continuum provided the opportunity for the subject to decide how accurately the concept fit him/herself and then to select a score. Hopefully, the subject was able not only to have identified a specific affect/cognition, but also to have discriminated intensity.

One open-ended question requested a subject to write the specific self-message commonly occurring immediately prior to a self-injurious act. Data on modalities, reasons for SIB, factors/situations associated with SIB, pleasure/pain in SIB, types of abuse, gender, and relationship of perpetrator were recorded on checklists. Offering additional information was optional for the subjects.

Sixty-three nonretarded, nonpsychotic adults completed retrospective questionnaires followed by 1- to 3-hour private, face-to-face interviews with the researcher. Remaining blind to all subjects' clinical diagnoses, the researcher elicited explanations of responses in these interviews. Following each interview, the researcher recorded notes.
The study was limited, however, by the unavailability of a standardized measurement for affects/cognitions immediately pre and post self-injury. Also, the use of retrospective self-reports relied heavily on subjects' recall and honesty.

Subjects and Settings

Sixty-three subjects, obtained primarily by clinician referral, comprised the sample. The following resources provided the stated number of subjects: private clinicians, 12; state hospitals, 20; regional mental health centers, 9; county hospitals, 11; self-referrals, 6; county homes, 2; and residential homes, 3. Five of the self-referrals answered an ad from a university newspaper requesting subjects with histories of or current SIB. Subjects ranged in age from 21 to 62 years and included 47 females and 16 males. The average level of education was 13 years.

The following criteria defined the selection of the subjects: 21 years or older and his/her own guardian, free of psychosis at time of interview, SIB 2 years or more, having no organic pathology underlying SIB, voluntary, and having no diagnosis of retardation.

All but 6 subjects were currently or recently involved in some mental health care system. Four subjects had dropped out of therapy and 2 subjects reported they had never disclosed SIB to any physician or counselor.

By default of the referral and voluntary processes, this study included only Caucasians. Subjects generally reported altruistic reasons for participating in the research. A few participated in the research
stating clearly that they hoped the interview would somehow help them in their own personal situations.
RESULTS

The foci in this study are: (a) reasons for SIB given by subjects, (b) factor/situations reported to be associated with SIB, and (c) affects/cognitions of pre versus post SIB. This article first summarizes the data (age of onset, abuse, rape, modalities, pain/pleasure, etc.) to describe the subjects involved in this study.

Age of Onset, Abuse, Rape, Modalities, and Pain/Pleasure of SIB

Eleven (17.5%) subjects reported initiating SIB between the ages of 4-6; 31 (49.2%) subjects had begun SIB by age 12. By the age of 18 years, 54 (85.7%) subjects had engaged in SIB. Nine (14.3%) subjects began SIB after age 18. This sample was positively skewed with onset of SIB in childhood and adolescence.

Fifty-two (82.5%) subjects reported childhood sexual and emotional abuse. Twenty (38.5%) subjects reported their first victimization occurred between ages 3-5 years. A total of 51 (98.1%) subjects reported sexual abuse by the age of 13. Only 1 subject reported sexual abuse having begun during the teen years. The researcher's notes indicated that the majority of subjects reported sexual abuse of 4-10 years duration.

Of the 52 victimized subjects, 50 (96.2%) reported intrafamilial abuse. Nine of the 50 indicated both intrafamilial and extrafamilial abuse. Two (3.2%) subjects reported only extrafamilial abuse. Many subjects described sexual abuse which this society would label sadistic,
threatening, and humiliating. All subjects who checked sexual abuse on the questionnaire also checked emotional abuse.

The data showed that within 3 years of the first victimizations, the majority of subjects had initiated SIB. Typically, the sexually abused child of 5 had begun SIB by the age of 8. More often, the child had initiated SIB within 1-2 years. Two subjects reported that because concurrent physical abuse was so intense, perhaps SIB were delayed until they had left the abusing home.

Thirty (47.6%) reported rape in childhood and 24 (38.1%) reported rape in adulthood. No subject reported rape in adulthood only. Consistent with the expectation of adult victimization was a positive correlation (r=.40) of childhood rape with rape in adulthood. Once victimized, the individual is prey for further victimization in adult life; this phenomenon was higher in females.

Eleven subjects did not report child abuse; brief statements are offered to differentiate this substratum. Five reported initiating SIB after the age of 30. Four subjects expressed symptoms suggestive of major depression without associative factors (e.g., flashbacks, trigger stimuli). Among the remaining seven of this substratum, few commonalities existed. One male expressed heightened sexual feelings after SIB; he explained that seeing his blood was exciting and reported frequenting blood banks as well as engaging in SIB episodes. Two subjects expressed that SIB were associated with hearing voices. Two females and one male expressed that an intense impulsivity to swallow nonfood items (e.g., tacks, needles, pins) was always associated with their SIB. One other
male subject reported pulling his hair out and eating it during impulsive episodes.

Consistent with the expectations of this study, all 63 (100%) subjects reported using multi-modalities in SIB. Twenty-nine (46%) subjects indicated daily SIB during exacerbations. Cutting (78%), self-punching or slapping (67%), scratching (56%), followed by burning (48%) were the most common self-injuries reported by these adult subjects, as shown in Table 1.

Fifty-two (82.5%) expressed no or minimal physical pain at the time of self-injury, as illustrated in Table 2. Thirty-one (49.2%) subjects reported experiencing moderate or much pleasure/relief at the time of self-injury, as illustrated in Table 3. No differences were found in these substrata and frequencies of SIB. Subjects who experience pain and those who do not, engage in SIB at a similar frequency. Likewise, subjects who experience pleasure and those who do not also engage in SIB at a similar frequency.

Reasons Given by Subjects for SIB

The reasons that subjects gave for doing self-injury are shown in Table 4. The subjects were instructed to check all the reasons that seemed to fit, as well as add to the list if they wished. Most subjects
identified 6-10 different reasons. The most prevalent reasons are discussed and subjects' statements believed to be representative are presented.

To Relieve Emotional Pain: This reason, having the highest frequency, was checked by 59 (93.7%) subjects. The emotional pain was described by subjects as rage, extreme sadness, terror, loneliness, shame, and guilt. Attempts to escape from intense emotional torment were illustrated by statements such as these:

- "I can't stand the mental hell."
- "A little relief is better than none at all."
- "I hurt so badly, but the euphoria I feel afterwards is worth it."

To Punish Myself: This second most frequently checked reason was identified by 56 (88.9%) subjects. However, when subjects were asked to identify the one most salient reason for SIB, "Punish myself" ranked first. This reason may be complex, but if taken literally, most subjects voiced an extreme need to punish themselves. Three female subjects reported "carving" words (e.g., bitch, hate, bad, slut, ill, die) on their thighs during adolescence. The victimized subjects expressed the need for punishment based on self-blame for past abuse, said:

- "I need to see my blood to know that my body is really suffering 'cause that's what I deserve."
- "I guess maybe sometimes I liked it or I could have stopped it [incest]."
• "I guess I did something to make my grandfather want me, so I am bad."

• "I must have been born evil so that I guess I made them [abusers] do it."

• "I am convinced that I need to punish myself before God does for what I have done [references were about specific sexual acts done in childhood]."

• "I deserve to look this way [points to scars] for I am a bad person."

To Express Rage: This reason was selected by 54 (85.7%) subjects and ranked as the third most salient reason for SIB. Five subjects specifically expressed SIB as preventing homicide. Six subjects admitted using SIB as suicide prevention. Many subjects seemed to be aware and fearful of the intensity of their rage. Expressions of rage were:

• "I'm afraid of what I might do if I let go of my anger, so I hurt myself instead."

• "I feel so angry that I hurt myself. It's better than killing someone else."

• "I don't know how to express my anger, but I know it's there."

• "Sometimes, I think I could lose my mind and kill him [abuser]."

• "If I didn't hurt myself, I think I would commit suicide."

To Comfort Myself and See My Blood: These two reasons were checked by 37 (58.7%) and 21 (33.3%) subjects, respectively. Explanations suggested that these two reasons were interrelated. The following statements illustrated these two reasons:

• "The blood is warm and comforting as it trickles down my arms."

• "Once I see my blood, it's like I don't feel the emotional pain anymore. It seems like as the blood oozes out, so does my pain."

• "If I cut deeper and the blood spurts, then my pain seems to leave faster."
"The sight of blood seems to immediately comfort me because my dad would stop [coitus, fellatio, or sodomy] if he found blood on his penis."

"If I really see lots of blood, then I feel that I got even with them [foster parents/abusers]."

**To Keep From Going Crazy:** This reason was checked by 33 (52.0%) subjects, some of whom explained:

- "I go crazy when I think about the abuse."
- "It's a release. I have to get release or I'll totally flip out."
- "I feel like I'm going nuts."
- "I get to a point where I think I am going to explode or hurt someone or go crazy. It's terribly frightening."

**To Make Sure I Am Still Alive:** This reason was identified by 20 (31.3%) subjects with explanations similar to the following:

- "When I was a child and being abused, I was treated as an object, something not real, to be played with or tortured, but not as a real human being. So now I think I cut so that I can feel and know that I am alive."

**To Declare Freedom:** Twenty-one (33.3%) subjects checked this reason. The subjects expressed having no control over their bodies as children, and now as adults, control is a major issue. Explanations included:

- "It's my body and I'll do want I want to with it."
- "Nobody is going to tell me how I can treat myself now. I'm in control."

**To Gain Attention:** This reason was checked by 19 (29.8%) subjects expressing phrases such as:

- "I want somebody to help me."
- "Help. Help. I'm hurting."
- "Maybe somebody can now see the real pain I'm feeling inside."
Factors and Situations Associated with SIB

Subjects were asked to identify factors/situations that they perceived as being associated with their SIB (Table 5). The data revealed that flashbacks, trigger stimuli, anniversary dates of loss/death, nightmares, holidays, and anniversary dates of trauma were commonly identified. Subjects (except 2) explained that flashbacks and nightmares were recurrent memories of abusive events. The two exceptions reported flashbacks of sudden, unexpected deaths of loved ones. The majority expressed feelings of terror and shame as if the abuse were reoccurring. While flashbacks were experienced by 44 (69.8%) subjects, trigger stimuli were identified by 37 (58.7%) subjects.

Since trigger stimuli are individually unique, 37 subjects identified specific stimuli for themselves. When asked to list stimuli, subjects quickly did so. Common trigger stimuli included: pointing finger, dead animals, many odors (viz., whiskey, beer, body sweat, men's colognes, musty body parts), specific colors of carpet (as in former rooms of abuse), moustaches, beards, specific songs, and scenes of violence or lovemaking. Avoidance of trigger stimuli (viz., hugs, kissing, touching, sexual scenes, nude pictures, actual sexual encounters) occurred in many subjects. Some female subjects who did describe sexual relations, expressed feelings of disgust and/or ideations of sadism with the male partner. The majority reported impaired sexual relationships.
A series of paired t-tests were conducted to test differences in means between the reported scores of affects/cognitions immediately pre SIB and immediately post SIB (Table 6). This table is a composite and does not represent a specific subject.

Insert Table 6 about here

In comparing immediate pre SIB versus immediate post SIB, the data revealed no significant statistical differences in these specific feelings and thoughts: evil, sad, depressed, guilty, dead, shameful, fallen from God’s grace, numb, needing to obey God, nervous, and scared. In contrast, the data revealed significant changes in the other factors.

As noted in the table, the statistical means for a few feelings (viz., bored, sexual, dead, needing to obey God, and fallen from God’s grace) were low (mean <2.0); hence, few subjects expressed experiencing these affects/cognitions. Therefore, differences, even if statistically significant, may be clinically less meaningful. In contrast, these affects/cognitions (mean >2.5): worthless, empty, lonely, rejected, angry, need to be punished, abandoned, frustrated, hateful, going crazy, and compulsivity may be clinically more significant due to their magnitude.

Anger, worthlessness, and compulsivity (mean >4.0) changed significantly in intensity at the .01 level. In contrast, there were no statistical differences in the feelings of sadness (mean 3.5) and
depression (mean 4.1) in the post SIB period. The intensities of these two affects were moderately high before SIB and remained moderately high after SIB.

The feelings of being scared and ashamed pre SIB (mean 3.0) were reported as slightly increasing post SIB (mean 3.3), but these changes were not statistically significant. This researcher noted subjects expressing, "I was so scared that I may have done more damage [cutting] than I intended to." Although many subjects may be dissociating during the SIB, many expressed being terribly frightened of their SIB. This researcher consistently heard the practice of secrecy and nondisclosure of SIB. Many subjects admitted they were too ashamed to disclose SIB to their family doctor. Some reported never having been asked by a clinician about SIB or any history of abuse.

It is likely that denial would have persisted because of the intense shame of doing SIB. Many subjects reported giving plausible excuses as children for injuries (e.g., climbing over a barbed-wire fence for torn labia). According to these subjects, most explanations were apparently never questioned. Five subjects reported they had not disclosed SIB to their therapists until 6-12 months into therapy. Most admitted wanting the doctor, counselor, or teacher to question their injuries.

Compulsivity reflected high intensity in pre SIB (mean 4.2) versus post SIB (mean 1.9) and showed the greatest difference (t-value 8.8) of high statistical significance (.01 level). The researcher’s notes indicated the majority of subjects reported experiencing 1-8 hours of
crescendo tension prior to SIB episodes. A few explained that tension could intensify for over a week before self-injuries occurred.

There were no significant differences in gender when examining t-values. However, when contrasting percentages by gender reporting affects/cognitions experienced in the pre-SIB period, females reported an incidence of 20% or greater than males in feeling (a) worthless, (b) scared, (c) guilty, (d) dead, (e) need to be punished, (f) numb, (g) abandoned, (h) sinful, and (i) hateful. Males reported only one affect, that of feeling bored, exceeding 20% greater than females in the pre-SIB period. Gender differences in percentages in the post-SIB period were few. Females reported 20% or greater than males experiencing: (a) need to be punished and (b) compulsivity in the post-SIB period.

Premeditation was more often present in cutting and burning. Several subjects described rather elaborate plans for performing SIB, such as collecting razor blades or knives, cold packs, and compression towels and arranging them in their bathrooms. One subject described always taking a plastic sheet to protect the front seat of her car. This female explained that after gathering the SIB paraphernalia she drove to a nearby hospital, parking her car within one block of the emergency room, "just in case I cut deeper than planned." Her description and several others demonstrated premeditation, not impulsivity. However, some of these same subjects claimed that sudden impulsivity could be experienced but was not the norm for them.

For those few subjects in this study who swallowed tacks, needles, buttons, etc., impulsivity was always present, but this researcher did not
hear premeditation of these ingestions. Instead, the typical explanation for these few subjects was, "I see a tack and I swallow it." The following behaviors also were repetitive and associated more with impulsivity: picking, scratching, self-punching, and hair pulling.
DISCUSSION

The majority of these subjects, who engaged in chronic SIB, felt extremely rageful, worthless, sad, lonely, depressed, frustrated, rejected, shameful, out of control, and compulsive in the immediate pre self-injurious period. Self-injurious behaviors seemed purposeful; these were attempts to satisfy needs to be punished, to regain control, to relieve intense emotional pain, and to cope with feelings of going crazy.

For reasons not clearly understood, many individuals doing chronic SIB experience pleasure or relief (Favazza, 1987; Ross & McKay, 1979). It was clear that most individuals were intensely driven to find relief and apparently relief varied in many degrees.

The fact that several subjects clearly stated SIB were suicide prevention while others expressed homicidal prevention is consistent with Freud's and Menninger's hypotheses of SIB. Furthermore, the results of this study indicate the onset of SIB to be closely associated with early childhood sexual victimization, reaffirming previous studies (Carmen et al., 1984; McCann, 1988; van der Kolk, Perry, & Herman, 1991).

Childhood trauma contributes to the initiation of self-destructive behavior, but lack of secure attachments helps maintain it. Patients who repetitively attempt suicide or engage in chronic self-cutting are prone to react to current stresses as a return of childhood trauma, neglect, and abandonment. (van der Kolk et al., 1991, p. 1665)

Symptoms suggestive of PTSD were found in many of the subjects who had prolonged sexual and emotional abuse. Flashbacks, trigger stimuli, anniversary dates of loss, nightmare, holidays, and anniversary dates of trauma were clearly reported. Many subjects also voiced feelings of
detachment or estrangement from others (inability to have a loving or healthy sexual relationship). Furthermore, increased arousal, insomnia, irritability, difficulty in concentrating, and avoidance of situations that could arouse recollections of incestuous trauma as described by subjects also suggest PTSD.

Another commonality of PTSD combat victims and these adult childhood sexual abuse victims is the inability to plan for the future. This researcher observed in several pilot study subjects that so much time was spent in trying to cope with past trauma that lives appeared at a standstill or fixated in childhood.

This intense anxiety, manifested by terror and panic, is suggestive of impending decompensation and regression leading to reexperiencing childhood trauma. One premise is that SIB enable the subject to avoid the pain and terror of experiencing an abreaction alone. This researcher often heard the remark that a little relief is better than none at all.

A cluster of affects/cognitions (e.g., evil, sadness, depression, guilt, having fallen from God's grace) which may be more indicative of mood disorders were not found to change significantly after SIB, but remained moderately high. An underlying affective disturbance may be present in some subjects. The expression, "The rage and tension are released a little, but I still feel very sad and down," illustrated this dysphoria.
Rage was the most prevalent affect expressed. Outbursts of anger were reported to cause much difficulty in interpersonal relationships. Because rage significantly dropped in intensity following SIB, this important phenomenon should be recognized by clinicians. Facilitating the expression of rage in healthy ways is almost unknown to SIB patients. This phenomenon challenges all clinicians to facilitate the expression of rage in nondestructive manners (abreactive therapy, reframing, psychodramas, and a variety of cognitive/behavioral techniques).

For PTSD diagnosed patients who present continuous depressive features, a psychiatric evaluation should be considered to ascertain the need for antidepressant pharmacotherapy concurrent with abreactive therapy. Similarly, patients who manifest greater anxiety features may benefit from multi-modal therapy to reduce anxiety. The challenge is to make thorough assessments. Clinicians are aware of the occasional practice of transcribing new intakes by eliciting some information from previous histories and charts. Perhaps previous labels and classifications may be inaccurate, obsolete, and/or incomplete.

Regression was often observed; the clinician's challenge is to channel patients' energy into healthy and expressive play instead of their habitual destructions. Nurturance and trust are absolutely vital in establishing a therapeutic alliance. Because betrayals, mistrust, and condemnations have been these subjects' primary experiences, offering hope and respect are also crucial. These abused victims carry the garbage of childhood and unfinished business into their adulthood.
According to traumatology premises, the confusion the victimized subjects manifested evolved from interpretation of traumatic events when they were children. Humiliating and painful abuses, degrading parental messages, terror, shame, and guilt were present when cognitive schemata were being constructed. Lifton and Olson (1976) purported that individuals develop images and symbolic forms of their life experiences, resulting in senses of continuity or discontinuity of selves. Likewise, for the majority of subjects engaged in SIB in this study, schemata evolved out of their tormenting and chaotic worlds. A therapeutic implication is the need for the clinician to thoroughly investigate schemata (e.g., safety, trust, relationships, self, power, esteem) so that treatment plans can integrate interventions based on these findings.

This researcher distinctly heard differences among subjects disclosing features of compulsivity and impulsivity. For those subjects who described that the urge to cut may escalate over several hours or days, crucial intervention is possible. Intervention techniques must be tailor-made to fit patients' needs. For example, in PTSD, the opportunity for abreactions may be critical. Drop-in centers, day treatment staff, outpatient staff availability for supporting abreactions facilitating catharsis and healing are essential. Similarly, for the few patients who manifested clear symptoms of impulsivity, psychotherapy may be less promising, but anticomulsive drugs concurrent with psychotherapy may be more helpful.

A few subjects explained ameliorating interventions as follows. These interventions include programming the individual to refocus and
Because most subjects report SIB as a solo activity, the following alternative behaviors place the individual in a social environment (e.g., walking in a shopping mall, window shopping, meeting a friend for coffee, visiting a church). These alternatives sound so simple but several subjects explained that these alternative actions have helped. The key is a preplanned activity list designed by the patient. The few subjects who apparently experienced intense impulsivity in SIB could not have benefitted from this approach.

Some subjects explained that if sleep were possible, urges for SIB sometimes dissipated. This researcher frequently heard subjects express self-medication with sedatives and/or alcohol to achieve sleep. This concern validates again the necessity for a detailed interview intake to assess co-morbidity of substance abuse. As the danger of drug interaction with a prescriptive medication may exist, measures to induce sleep (e.g., self-hypnosis, meditation, imagery, biofeedback) may be more helpful. For the patient already on an antidepressant, adding an antianxiety agent with moderate sedative effects might be appropriate during high stress periods such as holidays. Intentional overdose or nonintentional drug interaction/potentiation is always a danger, thus pharmacotherapeutic precautions are necessary.

This researcher hypothesizes why some male clinicians have avoided sexual abuse inquiry in initial evaluations. Wanting to establish a therapeutic rapport and to avoid being perceived as offensive or intrusive, the inquiry of sexual issues may be omitted. Other reasons may be the avoidance of perpetuating society's myth that "shrinks" focus on
sex, and the urge to avoid any resemblance of sexual harassment. However, the team leader should be responsible for considering that an impact of chronic stress may be contributing to current situations; thus, abuse history should be a vital part of evaluation.

The majority of female subjects in this study voiced discomfort in interviews with male clinicians. Trust in human beings has been badly betrayed. Subjects, feeling intensely shameful and guilty, expressed extreme difficulty in disclosing their history of abuse. A highly sensitive, compassionate same-sexed counselor may be more successful in obtaining an accurate history.
SUMMARY

This sample was representative of patients who experienced severe, prolonged, incestuous sexual abuse in early and middle childhood. This researcher recognizes multiple variables may be interacting: predispositions for mental illnesses, and conditions of poor parenting, neglect, abandonment, and many others. It is difficult to attribute the human damage to sexual acts per se or to a combination of other circumstances which may be present.

For 52 (82.5%) subjects, however, postulates of victimization and trauma theories fit well. With the documentation of high frequency of childhood victimization and new evidence that prolonged abuse is associated with chronic stress, it can be concluded that a history of childhood abuse is critical in ALL interview intakes. Unless the clinician notes or classifies PTSD where appropriate, intervention for salient underlying pathology may not be addressed.

Remissions and exacerbations, chronicity and multi-modality of SIB were characteristic of all subjects. Low self-esteem, extreme rage, intense need to relieve emotional pain, loneliness, and alienation were found in all. Victimized patients engaging in SIB are the least likely to seek assistance. Also, they generally have a great deficit of coping skills. Therefore, when daily frustrations and stress appear, SIB appear to serve as their best coping mechanisms.

Perhaps some clinicians may be unaware of the impact of psychosocial trauma of chronic stress because research and the literature are still
scanty. The period between victim and patient has not been researched well as yet. Neglect, variations in socioeconomic classes, cultures, religions, and ethnic factors have been absent from much of the research.

In summary, when the clinical focus shifts from causality (stressor, e.g., combat) to reactions and symptoms, then perhaps PTSD may be more frequently considered in differential diagnoses of abuse victims who engage in SIB.
ACKNOWLEDGEMENTS

The author extends her deepest appreciation to the participants in this research who courageously and candidly shared highly sensitive experiences to help clinicians better understand SIB. Thanks are also extended to Anna Parks, M.S.W., my clinical master mentor and the co-leader of the pilot study, and to Paul Hanna, M.S., a skillful clinician who assisted in coordinating the pilot study and this research.
REFERENCES


Table 1. Frequencies and percentages by gender of occurrence of self-injurious modalities (N=63)\textsuperscript{a}

<table>
<thead>
<tr>
<th>Mode</th>
<th>Males (n=16)</th>
<th>Females (n=47)</th>
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<tr>
<td></td>
<td>Yes</td>
<td>%</td>
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<tr>
<td>Cutting</td>
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<tr>
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</table>

\textsuperscript{a}Subjects answered with multiple responses.
Table 2. Frequencies and percentages by gender of the degree of physical pain experienced at time of self-injury (N=63)

<table>
<thead>
<tr>
<th>Degree</th>
<th>Males (n=16)</th>
<th>Females (n=47)</th>
<th>All subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>Cum. %</td>
</tr>
<tr>
<td>No pain</td>
<td>10</td>
<td>62.5</td>
<td>62.5</td>
</tr>
<tr>
<td>Minimal pain</td>
<td>4</td>
<td>25.0</td>
<td>87.5</td>
</tr>
<tr>
<td>Moderate pain</td>
<td>1</td>
<td>6.3</td>
<td>93.8</td>
</tr>
<tr>
<td>Severe pain</td>
<td>1</td>
<td>6.3</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table 3. Frequencies and percentages by gender of degree of pleasure experienced at time of self-injury (N=63)

<table>
<thead>
<tr>
<th>Degree</th>
<th>Males (n=16)</th>
<th>Females (n=47)</th>
<th>All subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>Cum. %</td>
</tr>
<tr>
<td>No pleasure</td>
<td>6</td>
<td>37.5</td>
<td>37.5</td>
</tr>
<tr>
<td>Minimal pleasure</td>
<td>2</td>
<td>12.5</td>
<td>50.0</td>
</tr>
<tr>
<td>Moderate pleasure</td>
<td>5</td>
<td>31.3</td>
<td>81.3</td>
</tr>
<tr>
<td>Much pleasure</td>
<td>3</td>
<td>18.8</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table 4. Frequencies and percentages by gender of reasons reported for self-injury (N=63)*

<table>
<thead>
<tr>
<th>Reasons for self-injury</th>
<th>Males (n=16)</th>
<th>Females (n=47)</th>
<th>All subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>%</td>
<td>Yes</td>
</tr>
<tr>
<td>Relief of emotional pain</td>
<td>16</td>
<td>100.0</td>
<td>43</td>
</tr>
<tr>
<td>Punish myself</td>
<td>13</td>
<td>81.3</td>
<td>43</td>
</tr>
<tr>
<td>Express anger/rage</td>
<td>14</td>
<td>87.5</td>
<td>40</td>
</tr>
<tr>
<td>Comfort myself</td>
<td>9</td>
<td>56.3</td>
<td>28</td>
</tr>
<tr>
<td>To keep from going crazy</td>
<td>6</td>
<td>37.5</td>
<td>27</td>
</tr>
<tr>
<td>Carry out revenge</td>
<td>5</td>
<td>31.3</td>
<td>17</td>
</tr>
<tr>
<td>See my blood</td>
<td>5</td>
<td>31.3</td>
<td>16</td>
</tr>
<tr>
<td>Act of freedom</td>
<td>4</td>
<td>25.0</td>
<td>17</td>
</tr>
<tr>
<td>To make sure I am still alive</td>
<td>4</td>
<td>25.0</td>
<td>16</td>
</tr>
<tr>
<td>Gain attention</td>
<td>4</td>
<td>25.0</td>
<td>15</td>
</tr>
<tr>
<td>Suicide</td>
<td>4</td>
<td>25.0</td>
<td>15</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>25.0</td>
<td>14</td>
</tr>
<tr>
<td>Carry out a wish/desire</td>
<td>4</td>
<td>25.0</td>
<td>13</td>
</tr>
<tr>
<td>Prove a point</td>
<td>3</td>
<td>18.8</td>
<td>14</td>
</tr>
<tr>
<td>Distraction</td>
<td>5</td>
<td>31.3</td>
<td>12</td>
</tr>
<tr>
<td>Obey a command</td>
<td>5</td>
<td>31.3</td>
<td>7</td>
</tr>
<tr>
<td>I have no idea why I harm myself</td>
<td>3</td>
<td>18.8</td>
<td>6</td>
</tr>
<tr>
<td>Manipulate others</td>
<td>2</td>
<td>12.5</td>
<td>6</td>
</tr>
<tr>
<td>None of these</td>
<td>--</td>
<td>--</td>
<td>1</td>
</tr>
</tbody>
</table>

*Subjects gave multiple responses.
Table 5. Factors/situations associated with self-injury (N=63)*

<table>
<thead>
<tr>
<th>Mode</th>
<th>Males (n=16)</th>
<th>Females (n=47)</th>
<th>All subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>%</td>
<td>Yes</td>
</tr>
<tr>
<td>Flashbacks</td>
<td>10</td>
<td>62.5</td>
<td>34</td>
</tr>
<tr>
<td>Trigger stimuli</td>
<td>9</td>
<td>56.3</td>
<td>28</td>
</tr>
<tr>
<td>Anniversary dates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of loss/death</td>
<td>5</td>
<td>31.3</td>
<td>24</td>
</tr>
<tr>
<td>Nightmares</td>
<td>4</td>
<td>25.0</td>
<td>25</td>
</tr>
<tr>
<td>Holidays</td>
<td>7</td>
<td>43.8</td>
<td>21</td>
</tr>
<tr>
<td>Anniversary dates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>of trauma</td>
<td>8</td>
<td>50.0</td>
<td>19</td>
</tr>
<tr>
<td>Specific months</td>
<td>2</td>
<td>12.5</td>
<td>12</td>
</tr>
<tr>
<td>Specific seasons</td>
<td>2</td>
<td>12.5</td>
<td>11</td>
</tr>
<tr>
<td>Eating nonfoods (Pica)</td>
<td>4</td>
<td>25.0</td>
<td>8</td>
</tr>
<tr>
<td>Menstruation or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pre-menstrual tension</td>
<td>--</td>
<td>--</td>
<td>16</td>
</tr>
<tr>
<td>Pregnancies</td>
<td>--</td>
<td>--</td>
<td>4</td>
</tr>
</tbody>
</table>

*Subjects answered with multiple responses.

December and winter rated most frequently with November and fall as second highest.
Table 6. Differences of affects/cognitions of immediately pre self-injury vs. immediately post self-injury (N=63)\(^a\)

<table>
<thead>
<tr>
<th>Factor</th>
<th>Pre self-injury</th>
<th>Post self-injury</th>
<th>t-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
</tr>
<tr>
<td>Angry</td>
<td>4.2</td>
<td>1.5</td>
<td>2.8</td>
</tr>
<tr>
<td>Compulsive</td>
<td>4.2</td>
<td>1.5</td>
<td>1.9</td>
</tr>
<tr>
<td>Depressed</td>
<td>4.1</td>
<td>1.5</td>
<td>3.9</td>
</tr>
<tr>
<td>Worthless</td>
<td>4.1</td>
<td>1.7</td>
<td>3.2</td>
</tr>
<tr>
<td>Empty</td>
<td>3.9</td>
<td>1.6</td>
<td>3.0</td>
</tr>
<tr>
<td>Need to be punished</td>
<td>3.8</td>
<td>1.8</td>
<td>1.6</td>
</tr>
<tr>
<td>Frustrated</td>
<td>3.7</td>
<td>1.7</td>
<td>2.4</td>
</tr>
<tr>
<td>Rejected</td>
<td>3.7</td>
<td>1.8</td>
<td>2.7</td>
</tr>
<tr>
<td>Lonely</td>
<td>3.6</td>
<td>1.8</td>
<td>3.1</td>
</tr>
<tr>
<td>Out of control</td>
<td>3.5</td>
<td>1.9</td>
<td>1.6</td>
</tr>
<tr>
<td>Sad</td>
<td>3.5</td>
<td>1.7</td>
<td>3.3</td>
</tr>
<tr>
<td>Guilty</td>
<td>3.3</td>
<td>2.0</td>
<td>3.1</td>
</tr>
<tr>
<td>Going crazy</td>
<td>3.2</td>
<td>1.9</td>
<td>1.9</td>
</tr>
<tr>
<td>Abandoned</td>
<td>3.0</td>
<td>2.0</td>
<td>2.3</td>
</tr>
<tr>
<td>Nervous</td>
<td>3.0</td>
<td>1.9</td>
<td>2.6</td>
</tr>
<tr>
<td>Shameful</td>
<td>3.0</td>
<td>2.1</td>
<td>3.3</td>
</tr>
<tr>
<td>Hateful</td>
<td>2.9</td>
<td>2.2</td>
<td>1.8</td>
</tr>
<tr>
<td>Numb</td>
<td>2.9</td>
<td>2.2</td>
<td>2.5</td>
</tr>
<tr>
<td>Scared</td>
<td>2.7</td>
<td>2.1</td>
<td>2.8</td>
</tr>
<tr>
<td>Sinful</td>
<td>2.5</td>
<td>2.2</td>
<td>2.1</td>
</tr>
<tr>
<td>Fallen from</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>God’s grace</td>
<td>2.2</td>
<td>2.2</td>
<td>1.8</td>
</tr>
<tr>
<td>Revengeful</td>
<td>2.2</td>
<td>2.2</td>
<td>1.1</td>
</tr>
<tr>
<td>Evil</td>
<td>2.1</td>
<td>2.1</td>
<td>1.7</td>
</tr>
<tr>
<td>Out of my body</td>
<td>2.0</td>
<td>2.1</td>
<td>1.1</td>
</tr>
<tr>
<td>Dead</td>
<td>1.7</td>
<td>2.1</td>
<td>1.2</td>
</tr>
<tr>
<td>Bored</td>
<td>1.5</td>
<td>1.8</td>
<td>.9</td>
</tr>
<tr>
<td>Sexual</td>
<td>.6</td>
<td>1.3</td>
<td>.2</td>
</tr>
<tr>
<td>Obeying God</td>
<td>.5</td>
<td>1.3</td>
<td>.4</td>
</tr>
</tbody>
</table>

\(^a\)The rating scale for the factors ranged from 0 to 5 with 0=Never felt or thought, 1-Minimally felt or thought, 2-Somewhat or seldom felt or thought, 3-Sometimes or moderately felt or thought, 4-Much felt or thought, 5-Intensely or very much felt or thought.

\(^b\)Broken line indicates factors with pre SIB mean <3.0 should be viewed with caution when interpreting t-values.

*Significant difference at .05 level.

**Significant difference at .01 level.
SUMMARY AND DISCUSSION

Self-injurious behaviors, defined in this dissertation, refer to the deliberate destruction and/or alteration of the body without conscious suicidal intentions. This study included only repetitive self-injuries. Generally, these behaviors were recurring, superficial, compulsive, and moderately damaging (with a few exceptions of severe damage). Over a period of time, extensive scars developed, but the emotional pain appeared nearly incessant, resulting in demoralization. Most subjects questioned whether recovery were possible.

This investigation of chronic SIB evolved from the researcher hearing variations in patients' disclosures of affects and cognitions during the pre self-injury versus post self-injury periods. A retrospective questionnaire was designed based on these observations of seven middle-aged women who engaged in repetitive SIB. The original questionnaire and interview format of the pilot study were revised from these women's valuable feedback.

For this study, sixty-three (47 females, 16 males) nonretarded adults completed retrospective questionnaires followed by 1- to 3-hour private, face-to-face interviews with the researcher. These interviews allowed time for subjects to explain their responses and voluntarily disclose additional information. All subjects, except six self-referrals, were clinical referrals from various mental health professionals. Most expressed altruistic reasons for their voluntary participation in the study.
To reduce researcher bias and to increase objectivity, this researcher chose to be blind in this study to subjects' diagnoses. Data (onset of SIB, modalities and reasons of SIB, affects/cognitions, factors associated with SIB, abuse histories) collected for the stated hypotheses did not need to include subjects' diagnoses. These data primarily served as descriptive statistics reinforcing information on epidemiology and symptomatology of SIB.

The purpose of this study was to investigate chronic SIB: (a) modalities, (b) age of onset, (c) reasons for SIB from subjects' perceptions, (d) factors and situations reported being associated with SIB, (e) subjects' reports of pain and/or pleasure in SIB, (f) subjects' affects and cognitions immediately pre and post self-injury, (g) incidence of childhood abuse, (h) gender and relationship of the abuser, and (i) incidence of adulthood rape.

This sample was clearly skewed with an early onset of SIB in childhood and adolescence, earlier than was expected by this researcher. Only 9 subjects reported initiating SIB after the age of 18.

Although these findings do not allow conclusions about causality, they provide evidence of an association between prolonged sexual/emotional abuse in childhood and the onset of SIB. The victims' ages at the time of the first sexual assault, reported as occurring in early and middle childhood, were as expected based on known statistics. One phenomenon accompanied this early victimization that was not expected by this researcher: The onset of SIB usually began within 3 years of the
first sexual assault. Therefore, most of these subjects reported SIB occurring throughout childhood and adolescence.

Fifty-two subjects reported childhood sexual abuse; 11 subjects did not. Moreover, the data revealed these subjects’ victimizations were prolonged, incestuous (except 2), and what this society would describe as sadistic and humiliating. The researcher’s notes indicated the sexual abuse was of 4-10 years duration. Results also indicated subjects of childhood rape are likely to be revictimized in adulthood; the incidence of revictimization was greater for females.

Of the 11 subjects who did not report child abuse, few commonalities were found. One exception was the age of onset of SIB reported as after the age of 30 by 5 subjects. Another commonality also surfaced: a cluster of depressive features suggesting underlying mood disturbances.

All subjects reported multi-modalities in SIB. The following modalities are listed in order of frequency (highest to lowest): cutting, self-punching, scratching, and burning were the most common self-injuries. All described chronicity, remissions, and exacerbations. Forty-six percent of the subjects reported daily self-injuries during exacerbations. Consistent with expectations, 83% expressed no or minimal physical pain at the time of self-injury. Also, 49% subjects reported moderate or much pleasure/relief is experienced immediately after self-injury. The duration of relief, however, varied in a wide range.

Self-injurious behaviors often are seen in subjects who manifest a wide variety of symptoms. However, it is well known that individuals who self-injure by cutting, scratching, or burning frequently are classified
with the diagnosis of borderline personality disorder. This study provided data suggestive of PTSD in many subjects. These subjects clearly identified factors (viz., flashbacks, trigger stimuli, active avoidant behaviors, holidays) as being associated with their SIB. Unsatisfactory interpersonal relationships were common for most subjects. Gratifying sexual intimacies were almost nonexistent according to these subjects. Healthy coping skills were extremely insufficient. This evidence, as well as other researchers' conclusions that SIB are distinct separate syndromes, reinforce the move for nosologists and nosographers to reexamine SIB and PTSD.

The need to consider multi-axial diagnoses and multi-diagnoses on axes I and II for patients who engage in chronic SIB is supported by this study. For many subjects, depressive features were reported as not being relieved after SIB; therefore, these symptoms suggested underlying mood disturbances. Are SIB masking depressions not being addressed in treatment plans? In contrast, anxiety symptoms reported to have intensified immediately pre self-injury were indicated as relieved in immediate post self-injury. Heavy alcohol consumption and self-medication were commonly expressed as individuals' attempts to find relief to avert self-injurious acts. Co-morbidities should be considered in this population so that treatment plans can be more comprehensive and thus improve prognoses.

Self-injurious behaviors appear to be distinctly differentiated from suicide attempts, although an accidental suicide can occur or an individual can choose to engage in a lethal incident. Generally,
individuals who self-harm are seeking relief from intense emotional pain and unbearable tension through non-lethal injuries. This researcher found that most subjects reported 6-10 reasons for their SIB. Only 3 subjects admitted suicidal intentions as the salient reason for their SIB. This issue could be argued by those supporting a premise of unconscious desire for latent preexistence suicide.

Many reasons were identified by subjects for explaining SIB. The most common ones were as follows: (a) relief of emotional pain, (b) punish myself, (c) express rage, (d) comfort myself, (e) see my blood, and (f) keep myself from going crazy. An unexpected finding was that several subjects candidly stated that suicide prevention or homicide prevention was an important factor in choosing to engage in SIB. Furthermore, data from subjects' descriptions of the prodromal period of SIB indicated differences in compulsivity and impulsivity. Compulsivity with crescendo feelings characterized this prodromal period for most subjects.

This study reinforces the practice of taking a history of abuse as a routine procedure in all psychiatric intakes. A sensitive and empathic inquiry is indicated as necessary where SIB has been suspected or is known. A history of sexual and/or physical abuse is a common finding among children and adolescents being treated for psychiatric problems. However, one common oversight of intakes is that sexual and/or physical abuse histories are not routinely elicited in adults. The long-term effects of early, prolonged abuse on adult adjustment have not been well
investigated. Clinicians may only be cursorily considering early abusive trauma as a contributing factor in the patient’s presenting problems.

This issue of SIB in children has only recently been investigated by researchers. Furthermore, general information of SIB in children is perhaps not well known to school counselors and general health care providers. Signs and symptoms suggestive of SIB in children were contributed by the subjects. Hiding self-inflicted wounds and offering plausible excuses for injuries were reported as common practices as children and as adults. Denial, shame, and guilt of incest compounded the denial of their SIB. These victimized subjects have experienced frequent betrayal; trust is a crucial factor in establishing therapeutic alliances in treatment.

Because SIB have often become treatment-resistant, these repetitive, deliberately destructive behaviors cause serious management problems for mental health professionals. The human suffering and losses experienced by these individuals who engage in SIB are enormous. More research is needed in epidemiology, etiology, symptomatology, and intervention. Neurobiological research, focusing on neurotransmitters and the morphine-like state following SIB, is providing additional explanations. The period between victimization and patient often has been an unstudied phenomenon. Traumatology, focusing on individuals’ interpretations of trauma during schemata construction, is offering new postulates for SIB.

Additions to this research for future use may include expanding the epidemiological questions in the questionnaire (e.g., employment, relationship/marital histories, environment, siblings’ pathology). Also,
collecting data specifically on psychoactive substance abuse, histories of suicidal attempts, and incidence of the subjects acting as abusers would be valuable.

This researcher advocates the interview research method with this population. These face-to-face interviews were excellent in providing the opportunity for clarification and expansion of responses. Establishing rapport, providing an emotionally comfortable environment, and utilizing empathic counseling skills were important in facilitating effective interviews.

As cross-referencing was not available, this study was dependent upon each subject's honesty and recall. Having access to subjects' histories and files would have assisted in confirming subjects' reliability of disclosures. A double-blind study in the future would be valuable to allow more extensive analyses; team research would have been advantageous. Another recommendation is to replicate this study, but acquire subjects' diagnoses after all subjects had been interviewed. If only one researcher is investigating, keeping the researcher blind during these interviews is important in facilitating objectivity.

Increasing the number of subjects would be beneficial for statistical power. Path analyses could be computed to isolate and link variables in SIB and specific psychiatric diagnoses. For example, the clusters of affects/cognitions that showed significant differences in pre versus post self-injury periods could be analyzed for relationships.

Clinicians can strengthen their conceptual understanding of this complex phenomenon of SIB by appreciating the broad theoretical
explanations while entertaining newer postulates from neurobiology and traumatology. A heterogeneous population and the multiplicities of theories continue to cloud our management of SIB. These complexities and variations make each SIB patient even more challenging to the clinician for differential diagnoses and management. Similarly, research in SIB presents many challenges. Clarifying, refining, and even identifying what needs to be investigated characterizes SIB research.
REFERENCES


I Corinthians 11: 4.


Matthew 5: 29-30.

Matthew 19: 12.


ACKNOWLEDGEMENTS

First, I want to thank Dr. Gordon Hopper, my major professor and master mentor, for his patience, time, and faithful assistance in challenging me in this research.

Other committee members who advised me and offered their assistance were: Dr. Anton Netusil, Dr. Frederick Borgen, Dr. John Littrell, and Dr. Frederick Duffelmeyer. Thank you for your energies and time.

Special thanks to Anna Parks, M.S.W., and Paul Hanna, M.S., my skillful clinical mentors who enthusiastically encouraged and assisted me in this research. I will be forever grateful for their excellent cooperation and professional friendship.

With the persistent encouragement and support from devoted life-long friends, Kirpal, Doris, and John, I have been able to pursue graduate work. Thank you.

I express generous gratitude to my children, John Brian and Susan Laurel, who taught me much about living, loving, and learning. Their patience and love have sustained and comforted me throughout the years of study.

With the inspiration from my parents, Charles O. Nelson and Lela Nelson, who are now deceased, I find myself in life-long learning.

A final thank you to all the clinicians who supported this research by referring subjects. My sincere thanks and appreciation goes to all the courageous subjects who generously shared their time and candidly described personal experiences in the interviews. Without their
cooperation and disclosures, this research would not have been possible. Dear subjects, thank you for teaching me.
APPENDIX A.

LETTER TO CLINICIAN
November 25, 1991

Dear

This letter is to request your assistance with the recruitment of subjects for my research which will be published as a dissertation. I need your help in finding adult males and females who purposefully engage in chronic self-injurious behaviors. Patients' responses may contribute to our understanding of epidemiology, symptomatology and management of this difficult and often chronic problem. Research methods include:

1. Hospital pilot study which was completed 11/1/91.
2. Retrospective survey (Appendix C) to be completed by each subject in my presence immediately followed by a private 20 minute exit interview.

Criteria for selection of subjects are:

1. Intelligence must be within normal or above normal range
2. Must be 21 years or older
3. Free of psychosis at the time of interview
4. Must indicate that the intent of the self-mutilating acts was not consciously suicidal
5. No organicity or suspected organicity underlying the self-mutilation
6. Has voluntarily consented to participate in this research
7. Must meet a criterion of chronicity (viz., recurrent self-injurious behaviors occurring at least 2 times or more within a 2 year period)

Confidentiality, privacy, and respect are assured. NO NAMES will be recorded. Code names will be used. Enclosed are copies of letters to subjects and consent forms for your review and for distribution to potential subjects. The survey is provided ONLY for your review; I will administer the survey. Arrangements for meeting subjects in your office complex can be done either by mail or by phone (Subjects may call me collect). However, if arrangements through a clerical staff is preferable, I will be happy to cooperate, wherever possible, at mutually convenient times.

I will be pleased to send you a summary of the survey results if you desire; please indicate when referring subjects. Your timely response will be appreciated. Thank you for your assistance.

Respectfully yours,

Phyllis J. Priest, MS, RNCS
2138 Sunset Drive
Ames, Iowa 50010
(515) 292-9425
APPENDIX B.

LETTER TO POTENTIAL SUBJECT
Dear Friend,

I need your assistance in my effort to gain knowledge about persons who purposefully engage in self-injurious behaviors. Your therapist/doctor has identified you as a possible subject for this research. The honest responses you can provide will add to the knowledge and insight of therapists and may help them better meet the needs of individuals similar to you. You may find it meaningful to contribute to research as many other participants have.

The research plan is in two steps:

1. Filling out a four page survey. After reading a single word or phrase, you are asked to rate yourself on a scale of 0 to 5 as to how the word or phrase most accurately describes YOU and your FEELINGS and THOUGHTS. This checklist requires about 15-20 minutes to complete.

2. Meet privately with me for another 15-20 minutes following your completion of the survey. At this time you can obtain answers to any questions that you may have about the research. Also, I can meet you and be assured that I understand your responses to the survey.

Please consider participation in this research. The results of this research will be used in my dissertation. PRIVACY and CONFIDENTIALITY are assured. NO NAMES will be recorded. I respect your right to refuse participation. If you do give consent to participate you can change your mind and withdraw from the project at any time.

Please inform your physician/therapist of your decision. Whether or not you choose to participate, I sincerely wish you continued recovery.

Sincerely,

Phyllis J. Priest
Researcher
(515) 292-9425
APPENDIX C.

CONSENT FOR PARTICIPATION IN RESEARCH
CONSENT FOR PARTICIPATION IN RESEARCH

Please read each item carefully before signing this consent.

1. I, ____________________________, hereby give my voluntary consent to:
   ___ Participate in the research project as described in the attached letter and participate in a private interview with the researcher.

2. I understand that I can refuse to give my consent and that my refusal would not in any way compromise my right to receive treatment.

3. I understand that this consent may be revoked at any time at my request.

4. I am aware that I can discuss matters pertaining to this study with the researcher.

5. I recognize the privacy and confidentiality as it relates to my personal name and identity will be maintained. However, I do acknowledge that the summarized research results of the study will be submitted to Iowa State University Graduate School and possibly to professional journals but in no way will my name or identity be divulged.

Date: ___________________________     ___________________________

Signature of subject

Signature of witness
Phyllis Priest, researcher
(515) 292-9425
APPENDIX D.

SELF-HARM SURVEY
Thank you for your willingness to participate in this study. Your honesty in answering these questions will help others who harm themselves. Do not write your name on the survey. Please take your time answering the questions.
SELF-HARM SURVEY

1. Please CHECK the list of self-injuries that you have done:
   ____ Cutting
   ____ Biting
   ____ Throwing yourself
   ____ Burning
   ____ Inserting foreign objects into body parts
   ____ Depriving yourself of food or water
   ____ Hitting
   ____ Cutting hair
   ____ Swallowing nonfoods
   ____ Picking
   ____ Pulling hair out
   Other: __________________________
   ____ Stabbing
   ____ Pouring chemicals
   __________

2. Now from the LIST ABOVE, CIRCLE the ones that you do most often.

3. How old were you when you began to hurt yourself? __________________________

4. As best as you can recall, CHECK the items that are associated with your self-harm:
   ____ Holidays
   ____ Nightmares
   ____ Menstruation or pre-menstrual tension
   ____ Anniversary dates of trauma
   ____ Specify months (identify)
   Specifying seasons (e.g., spring, fall, etc.)
   ____ Trigger stimuli (e.g., objects, smells, sounds, sights) identify:

5. CHECK: When injuring yourself, you experience:
   ____ No pain
   ____ Minimal pain and/or
   ____ Moderate pain
   ____ Severe pain
   ____ No pleasure
   ____ Minimal pleasure
   ____ Moderate pleasure
   ____ Much pleasure

6. What do you say to yourself at the time you begin to hurt yourself? ______________
7. **JUST BEFORE** Self-injury

Please focus on the LAST TIME when you hurt yourself. What type of self-injury was this?

Listed below are some feelings and thoughts. Please rate how much these exist within YOU on a scale of 0 to 5 **JUST BEFORE** (up to 4 hours) self-harm. A response of 0 means Never felt or thought. A response of 5 means this feeling or thought is VERY MUCH on your mind.

<table>
<thead>
<tr>
<th>Feeling/Thought</th>
<th>Your rating</th>
<th>Feeling/Thought</th>
<th>Your rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>evil</td>
<td></td>
<td>need to be punished</td>
<td></td>
</tr>
<tr>
<td>sad</td>
<td></td>
<td>numb</td>
<td></td>
</tr>
<tr>
<td>worthless</td>
<td></td>
<td>abandoned</td>
<td></td>
</tr>
<tr>
<td>empty</td>
<td></td>
<td>sexual</td>
<td></td>
</tr>
<tr>
<td>bored</td>
<td></td>
<td>frustrated</td>
<td></td>
</tr>
<tr>
<td>scared</td>
<td></td>
<td>sinful</td>
<td></td>
</tr>
<tr>
<td>shameful</td>
<td></td>
<td>revengeful</td>
<td></td>
</tr>
<tr>
<td>guilty</td>
<td></td>
<td>hateful</td>
<td></td>
</tr>
<tr>
<td>dead</td>
<td></td>
<td>going crazy</td>
<td></td>
</tr>
<tr>
<td>lonely</td>
<td></td>
<td>depressed</td>
<td></td>
</tr>
<tr>
<td>rejected</td>
<td></td>
<td>nervous</td>
<td></td>
</tr>
<tr>
<td>angry</td>
<td></td>
<td>compulsive</td>
<td></td>
</tr>
<tr>
<td>fallen from God's grace</td>
<td></td>
<td>obeying God</td>
<td></td>
</tr>
<tr>
<td>out of control</td>
<td></td>
<td>Other: (Identify please)</td>
<td></td>
</tr>
<tr>
<td>out of my body</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do these feelings/thoughts that you rated describe you in other situations of self-injury?

Yes  __________  No  __________
8. **Just After**

Please focus on how you felt immediately after (up to 4 hours after) this self-injury. **Rate yourself on the same scale of 0 to 5.** A response of 0 means "NEVER felt or thought." A response of 5 means thought is "VERY MUCH on your mind."

<table>
<thead>
<tr>
<th>NEVER felt or thought at all</th>
<th>VERY MUCH on my mind</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Your rating</th>
<th>Your rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. evil</td>
<td>16. need to be punished</td>
</tr>
<tr>
<td>2. sad</td>
<td>17. numb</td>
</tr>
<tr>
<td>3. worthless</td>
<td>18. abandoned</td>
</tr>
<tr>
<td>4. empty</td>
<td>19. sexual</td>
</tr>
<tr>
<td>5. bored</td>
<td>20. frustrated</td>
</tr>
<tr>
<td>6. scared</td>
<td>21. sinful</td>
</tr>
<tr>
<td>7. shameful</td>
<td>22. revengeful</td>
</tr>
<tr>
<td>8. guilty</td>
<td>23. hateful</td>
</tr>
<tr>
<td>9. dead</td>
<td>24. going crazy</td>
</tr>
<tr>
<td>10. lonely</td>
<td>25. depressed</td>
</tr>
<tr>
<td>11. rejected</td>
<td>26. nervous</td>
</tr>
<tr>
<td>12. angry</td>
<td>27. compulsive</td>
</tr>
<tr>
<td>13. fallen from God's grace</td>
<td>28. obeying God</td>
</tr>
<tr>
<td>14. out of control</td>
<td>29. Other: (Identify please)</td>
</tr>
<tr>
<td>15. out of my body</td>
<td></td>
</tr>
</tbody>
</table>

Do these feelings/thoughts that you rated describe you in other situations of self-injury?

Yes ____  No _____
9. CHECK the following phrase/words that best describe what you think your PURPOSE of self-harm has been for you.

___ To keep from going crazy
___ Distraction
___ Gain attention
___ Carry out revenge
___ Express anger/rage
___ Comfort myself
___ Carry out a wish/desire
___ To make sure I am still alive
___ I have no idea why I harm myself
___ Prove a point (identify)
___ Other (identify)
___ Relief of emotional pain
___ Act of freedom
___ See my blood
___ Suicide
___ Obey a command
___ Manipulate others
___ Punish myself
___ None of these

10. Now, from the ABOVE LIST, CIRCLE the most common purpose.

History:

11. ___ Age  ___ Highest grade of education  CHECK: ___ Male  ___ Female

12. As a child (Birth to 18), I was abused.  No  Not sure  Yes

   If yes, CHECK:  sexually___  emotionally___  physically___  neglected___

   Age of first sexual abuse was ___.

   Sex (gender) of the abuser(s) was ___ male, ___ female, or ___ both.

   The abuser(s) was ___ related to me, ___ not related to me, or ___ both.

13. CHECK:

   I was raped in childhood (Birth to 18).  No  Not sure  Yes

   I have been raped since becoming an adult.  No  Not sure  Yes

14. Your comments: (optional)